

**STATE OF TENNESSEE
BUREAU OF TENNCARE**



2015

Annual Update Report

OF THE

**2013 QUALITY ASSESSMENT AND
PERFORMANCE IMPROVEMENT STRATEGY**

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Acronyms

AAAD	Area Agency on Aging and Disability
AAP	American Academy of Pediatrics
ACS	Affiliated Computer Services Inc.
ADHD	Attention Deficit Hyperactivity Disorder
APCD	All Payers Claim Database
AQS	Annual Quality Survey
ASH	Abortion, Sterilization, Hysterectomy
ASO	Administrative Services Only
BA	Business Associate
BCBST	BlueCross BlueShield of Tennessee
BHO	Behavioral Health Organization
BMI	Body Mass Index
C & Y	Children and Youth
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCFTN	Cervical Cancer Free Tennessee
CCMS	CareCommunications Management System
CD	Consumer Direction
CDC	Centers for Disease Control and Prevention
CEHRT	Certified EHR Technology
CFR	Code of Federal Regulations
CHCS	Center for Health Care Strategies
CLS	Community Living Supports
CLS-FM	Community Living Supports-Family Model
CM	Case Management
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CRA	Contractor Risk Agreement
DBM	Dental Benefits Manager
DIDD	Department of Intellectual and Developmental Disabilities
D-SNPs	Dual Special Needs Populations
DHS	Department of Human Services
DM	Disease Management
ECF CHOICES	Employment and Community First CHOICES
ED	Emergency Department
EHR	Electronic Health Record
EP	Eligible Professional
EPLS	Excluded Parties List System
EPSDT	Early Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review

EQRO	External Quality Review Organization
ERC	Enhanced Respiratory Care
EVV	Electronic Visit Verification
FEA	Fiscal Employer Agent
FHSC	First Health Services Corporation
HCBS	Home and Community-Based Services
HCFA	Health Care Finance and Administration
HEDIS	Healthcare Effectiveness Data and Information Set
FFM	Federally Facilitated Market
HHA	Home Health Agency
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HHS	Health and Human Services
HMO	Health Maintenance Organization
I/DD	Intellectual and Developmental Disabilities
ICD	International Classification of Diseases
LEIE	List of Excluded Individuals and Entities
LEP	Limited English Proficiency
LOC	Level of Care
LTC	Long Term Care
LTSS	Long Term Services and Supports
MCC	Managed Care Contractor
MCO	Managed Care Organization
MDS	Minimum Data Set
MFP	Money Follows the Person
MIPPA	Medicare Improvements for Patients and Providers Act
MLTSS	Medicaid Managed Long Term Services and Supports
MMIS	Medicaid Management Information System
MOS	Model of Support
MRR	Medical Record Review
MU	Meaningful Use
NASUAD	National Association of States United for Aging and Disabilities
NCI-AD	National Core Indicators – Aging and Disabilities
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NF	Nursing Facility
OCR	Office for Civil Rights
OeHI	Office of eHealth Initiatives
OIG	Office of Inspector General
ONC	Office of the National Coordinator for Health Information Technology

ORR	On Request Report
PA	Performance Activity or Prior Authorization
PAC	Pharmacy Advisory Committee
PAE	Pre-Admission Evaluation
PAHP	Prepaid Ambulatory Health Plan
PBM	Pharmacy Benefits Manager
PCP	Primary Care Provider
PCP	Person-centered Planning
PDV	Provider Data Validation
PER	Personal Emergency Response System
PH	Population Health
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PIPP	Provider Incentive Payment Portal
PLHSO	Prepaid Limited Health Services Organization
PMV	Performance Measure Validation
POC	Plan of Care
QA	Quality Assurance
QI	Quality Improvement
QI/QM	Quality Improvement/Quality Management
QIA	Quality Improvement Activity
QI/UM	Quality Improvement/Utilization Management
QM/QI	Quality Management/Quality Improvement
QMP	Quality Management Program
QuILTSS	Quality Improvement in Long Term Services and Supports
RFP	Request for Proposal
SED	Serious Emotional Disturbance
SIM	State Innovation Model (grant)
SNF	Skilled Nursing Facility
SPMI	Serious and Persistent Mental Illness
SPOE	Single Point of Entry
SSI	Supplemental Security Income
STORC	Standard Obstetric Record Charting system
STS	Short-term Stay
TDCI	Tennessee Department of Commerce and Insurance
TDMHSAS	Tennessee Department of Mental Health and Substance Abuse Services
TDOH	Tennessee Department of Health
UM	Utilization Management
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) HEDIS
URLAC	Voluntary Reversible Long Acting Contraceptive

SECTION I: INTRODUCTION

Managed Care Goals, Objectives, and Overview

CMS Requirement: Include a brief history of the State's Medicaid managed care programs.

On January 1, 1994, Tennessee launched TennCare, a new health care reform program. This original TennCare waiver, TennCare I, essentially replaced the Medicaid program in Tennessee; Tennessee moved almost its entire Medicaid program into a managed care model.

TennCare I was implemented as a five-year demonstration program and received several extensions after the initial waiver expiration date of December 30, 1999. The original TennCare design was extraordinarily ambitious. TennCare I extended coverage to large numbers of uninsured and uninsurable people, and almost all benefits were delivered by Managed Care Organizations (MCOs) of varying size, operating at full risk. Enrollees under the TennCare program are eligible to receive only those medical items and services that are within the scope of defined benefits for which the enrollee is eligible and determined by the TennCare program to be medically necessary. To be medically necessary, a medical item or service must be recommended by a health care provider and must satisfy each of the following criteria:

- It must be required in order to diagnose or treat an enrollee's medical condition
- It must be safe and effective
- It must be the least costly alternative course of diagnosis or treatment that is adequate for the medical condition
- It must not be experimental or investigational

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

When 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 uninsurable persons with incomes below poverty and "Medicaid rollovers," persons losing Medicaid eligibility who met the criteria for the demonstration population.

In 2004, in the face of projections that TennCare's growth would soon make it impossible for the state to meet its obligations in other critical areas, Governor Phil Bredesen proposed a TennCare Reform package to accomplish goals such as "rightsizing" program enrollment and reducing the dramatic growth in pharmacy spending. With approval from the Centers for Medicare & Medicaid Services (CMS), the state began implementing these modifications in 2005.

On October 5, 2007, the waiver for the TennCare II extension was approved for three additional years. The TennCare II extension made additional revisions in the program, one of which was to require that

children in the demonstration population who have incomes below 200 percent of poverty be classified as Title XXI children. The extension also mandated a new cap on supplemental payments to hospitals.

The integration of behavioral health into the managed care model evolved from the TennCare I waiver. In 1996, behavioral health services were carved out and the Partner's program was established whereby Behavioral Health Organizations (BHOs) contracted directly with the Bureau of TennCare to manage behavioral health services. A primary focus of the carve-out was to provide services for the priority population, a group that included adults with serious and persistent mental illness (SPMI) and children with serious emotional disturbance (SED). The Bureau began integrating behavioral and medical health care delivery for Middle Tennessee members in 2007 with the implementation of two expanded MCOs. TennCare continued the process with the implementation of new MCO contracts in West Tennessee in November 2008 and East Tennessee in January 2009. The transferring of behavioral health services to Volunteer State Health Plan of Tennessee for TennCare Select members completed the Bureau's phased-in implementation of a fully integrated service delivery system that works with health care providers, including doctors and hospitals, to ensure that TennCare members receive all of their medical and behavioral services in a coordinated and cost-effective manner.

On December 15, 2009, TennCare received approval from CMS for another three-year extension of the waiver, to begin on July 1, 2010, and to continue through June 30, 2013. However, Amendment seven (7) to the TennCare demonstration contained was approved on July 22, 2009 and included for the implementation of the CHOICES program outlined by the General Assembly's Long-term Care and Community Choices Act of 2008. Under the amendment, the State provides community-based alternatives to people who would otherwise require Medicaid-reimbursed care in a Nursing Facility (NF), and to those at risk of Nursing Facility (NF) placement. The CHOICES program utilizes the existing Medicaid MCOs to provide eligible individuals with nursing facility services or home and community based services. Tennessee was one of the first states in the country to deliver managed Medicaid long-term care and the only state to do so in a manner that does not require enrollees to change their MCO.

The CHOICES program was implemented in stages over time in different geographic areas of the state. The first phase of the CHOICES program was successfully implemented in Middle Tennessee on March 1, 2010, with the East and West Grand Region MCOs' implementation occurring in August 2010. Also, in August 2010, the Statewide Home and Community Based Waiver for the Elderly and Disabled was terminated as it was no longer needed with full implementation of the CHOICES program.

With implementation of the CHOICES program, the MCOs became responsible for coordination of all medical, behavioral, and long-term care services provided to their members. Currently, the only remaining carve-out services are for dental and pharmacy services, as well as, long term services and supports for individuals with intellectual disabilities.

MCO Contracting and Turnover Experience

Traditionally, MCOs have been "at risk." However, because of instability among some of the MCOs participating in TennCare, the "at risk" concept was replaced in July 2002 with an "administrative services only" arrangement. The state added its own MCO, TennCare Select, to serve as a backup if other plans failed or there was inadequate MCO capacity in any area of the state. TennCare Select is administered by BlueCross BlueShield of Tennessee (BCBST). TennCare Select serves enrollees such as

foster children, children receiving Supplemental Security Income (SSI) benefits, and nursing facility or Intermediate Care Facility for Persons with Intellectual Disabilities residents under age 21.

Maintaining MCO participation in Middle Tennessee has been problematic over the years. During the 2006-2007 state fiscal year, one of the major TennCare priorities was recruiting well-run, well-capitalized MCOs to Middle Tennessee. In addition to bringing in new MCOs, the Bureau wanted to establish a new service-delivery model – an integrated medical and behavioral health model. Another crucial factor in the implementation was structuring the MCOs' contracts to return the organizations to full financial risk. To meet these goals, the state conducted its first Request for Proposal (RFP) process for TennCare MCOs. The Bureau secured contracts with two successful bidders. The two new MCOs "went live" on schedule on April 1, 2007. TennCare placed the managed care contracts for the East and West grand regions of the state up for competitive bid in January 2008. In April 2008, the state awarded the regional contracts to two companies in each region. The MCO contractors accepted full financial risk to participate in the program and the new contracts also established an integrated medical and behavioral health care system for members. The plans began serving West region members on November 1, 2008 and began serving members in the East region January 1, 2009. In September 2009, behavioral health services for TennCare Select enrollees were transferred to BCBST. Beginning in January 2015, TennCare has contracted with three statewide MCOs.

Between 1994 and 2002, dental services were part of physical health services delivered by TennCare's medical MCOs. Some MCOs chose to contract directly with dentists and operate their own dental networks, while others subcontracted their dental program to a Dental Benefits Manager (DBM). During this time, dentists did not participate in the TennCare program to the extent desired or anticipated by the State. Differences in the practice of dentistry versus medicine made participation in a managed care "medical" model a challenging business decision for dentists. Dentists complained of red tape and inefficiencies associated with participation in multiple MCOs relative to credentialing, authorization, billing, and reimbursement. Each MCO or its dental subcontractor negotiated dental reimbursement rates individually with dentists, and fees were a confidential, contractual matter. Most dentists only signed contracts with certain MCOs, which complicated enrollee access. Effective October 2002, in an effort to strengthen dental provider networks and improve enrollee access to care, the State moved from a managed care medical model to a managed care dental model for administration of dental services. The dental benefit was removed (carved-out) from the MCOs. Definitive funding was allocated for the revamped dental program, and administration of the dental benefit was awarded to a single DBM following a competitive bid process. The dental contract was an Administrative Services Only (ASO) contract where the DBM was not financially "at risk" for delivery of dental care. The State paid the DBM an administrative fee for managing the dental benefit and covered expenditures associated with dental claims.

The Dental carve-out model has proven to be beneficial for the State, enrollees, and providers. DBM administration has resulted in more streamlined administrative processes making the program more "dental" friendly for providers. Dentists sign one provider agreement, are subjected to one credentialing process, and are reimbursed on a fee-for-service basis using one approved maximum allowable dental fee schedule. A single DBM means there is one set of program policies, one provider agreement, one provider reference manual, one claims processor, and one organization responsible for all contract deliverables. State oversight of Medicaid dental services is simplified because the Bureau of TennCare is responsible for one DBM versus multiple MCOs delivering or subcontracting for dental care.

The DBM has also been responsible, among other things, for maintaining and managing an adequate statewide dental provider network, processing and paying claims, managing program data, conducting utilization management and utilization review, detecting fraud and abuse, as well as meeting utilization benchmarks or outreach efforts reasonable calculated to ensure participation of all children who have not received screenings.

In February 2013, the Bureau of TennCare issued an RFP for Dental Management and Administrative Services. Following a competitive bid process, the contract for the new DBM was awarded to DentaQuest on April 24th and signed on May 3rd. The new DBM took effect October 1, 2013. The contract with DentaQuest is a three-year, partial risk-bearing contract with two one-year extension options. TennCare decided to transition from an ASO contract to a partial risk-bearing contract to properly incentivize the DBM to improve quality of dental care while lowering costs.

As mentioned in an earlier paragraph, the pharmacy program was carved out of the managed care plans in 2003 and transformed to a singular Pharmacy Benefits Manager (PBM) payer system, which still remains in place today. The first PBM, Affiliated Computer Services (ACS), went into effect for the latter half of 2003 and established the preferred drug list. First Health Services Corporation (FHSC) became the PBM in 2004 and remained until 2008. SXC Health Solutions (which later became known as Catamaran) followed FHSC until 2013 at which time Magellan Medicaid Administration became the current PBM.

The largest drivers of change in pharmacy utilization since the carve-out came with a change in the Grier Consent Decree in 2005 and establishment of the Medicare Part D program in 2006. These changes allowed TennCare to more effectively manage the pharmacy program and shifted most dual eligible members to a Medicare drug plan. The program has recently implemented changes due to the Affordable Care Act, but so far the required changes mostly affect drug manufacturers and processes internal to the Medicaid program and are transparent to the plan members.

Until recently TennCare services were offered through three (3) managed care contractors (MCCs) covering various regions of the state. Each of these MCCs were limited to one of Tennessee's three grand regions, although a single entity could hold more than one contract. On October 2, 2013, the Bureau of TennCare issued a Request for Proposals (RFP) for three organizations to furnish managed care services statewide to the TennCare population. The RFP required the winning bidders to provide physical health services, behavioral health services and Long Term Services and Supports (LTSS) throughout the state, with actual service delivery to begin in Middle Tennessee on January 1, 2015, and in East and West Tennessee later that calendar year.

On December 16, 2013, the Bureau announced that the winning proposals had been submitted by Amerigroup, BlueCare, and UnitedHealthcare, the three companies that currently form TennCare's managed care network. New contracts with these entities will last from January 1, 2014 through December 31, 2016 and contain options for five (5) one (1) year extensions.

Each enrollee has an MCO for his/her primary care, medical/surgical, mental health and substance abuse, and long-term health services and a Pharmacy Benefits Manager (PBM) for his/her pharmacy services. Children under the age of 21 and enrolled in the TennCare program are eligible for dental services, which are provided by a Dental Benefits Manager (DBM).

Population Description/Changes

All Medicaid and demonstration eligibles are enrolled in TennCare, including those who are dually eligible for TennCare and Medicare. There are approximately 1.4 million persons currently enrolled in TennCare. There are several mechanisms for TennCare eligibility.

TennCare Medicaid serves Tennesseans who are eligible for a Medicaid program. Some of the groups TennCare Medicaid covers include:

- Children under age 21
- Women who are pregnant
- Single parents or caretakers of a minor child
- Two-parent families with a minor child living at home
- Individuals who need treatment for breast or cervical cancer
- People who receive a Supplemental Security Income (SSI) check
- People who have received both an SSI check and a Social Security check in the same month at least once since April 1977 AND who still receive a Social Security check
- People who live in a nursing home and have income below \$2,022 per month (300% of SSI benefit) OR receive other long-term care services that TennCare pays for

TennCare Standard is only available for children under age 19 who are already enrolled in TennCare Medicaid AND:

- Lack access to group health insurance through their parents' employer, OR
- Their time of eligibility is ending and they don't qualify anymore for TennCare Medicaid.

There are two ways these children can qualify and be able to keep their healthcare benefits:

- The Uninsured category is only available to children under age 19 whose TennCare Medicaid eligibility is ending, who do not have access to insurance through a job or a family member's job, and whose family incomes are below two-hundred percent (200%) of the poverty level.
- The Medically Eligible category is only available to children under age 19 whose TennCare Medicaid eligibility is ending and whose family income equals or is greater than 200% of the poverty level. To be medically eligible, the child must have health conditions that make the child "uninsurable." The family is unable to purchase healthcare insurance for the child in the private market because of the child's health conditions.

Coinsurance for some services is required for members with TennCare Standard if the family income is over ninety-nine percent (99%) of the poverty level.

CHOICES in Long-Term Services and Supports

In July 2009, CMS approved an amendment to the TennCare waiver that allows MCOs to coordinate all of the care a TennCare member needs, including medical, behavioral, and long-term services and supports for specified populations. Implementation of CHOICES for the Middle Grand Region MCOs occurred on March 1, 2010, and subsequently for the East and West Grand Region MCOs on August 1, 2010. Initial implementation included two CHOICES groups: CHOICES Group 1 and CHOICES Group 2, with CHOICES Group 3 beginning on July 1, 2012.

CHOICES Group 1 is for individuals receiving services in a Nursing Facility (NF). These individuals are enrolled in TennCare Medicaid, except for individuals continuously enrolled in CHOICES Group 1 since before July 1, 2012 that do not meet the new nursing facility level of care criteria in effect as of July 1, 2012, but continue to meet the level of care criteria in effect prior to July 1, 2012, and are eligible in the demonstration CHOICES 1 and 2 Carryover Group.

CHOICES Group 2 is for individuals who meet the NF Level of Care (LOC) and are receiving Home and Community-Based Services (HCBS) as an alternative to NF care. Those in CHOICES 2 may be enrolled in either TennCare Medicaid, if they are SSI-eligible, or in the demonstration CHOICES 217-Like HCBS Group or CHOICES 1 and 2 Carryover Group. The CHOICES 217-Like HCBS Group is composed of adults age 65 and older, or age 21 and older with physical disabilities, who:

- Meet the NF level of care requirement;
- Are receiving HCBS; and
- Would be eligible in the same manner as specified under 42 CFR § 435.217, 435.236, and 435.726, and Section 1924 of the Social Security Act, if the HCBS were provided under a Section 1915(c) waiver. With the statewide implementation of CHOICES, the Bureau will no longer provide HCBS under a Section 1915(c) waiver.

Individuals continuously enrolled in CHOICES Group 2 since before July 1, 2012 who do not meet the new nursing facility level of care criteria in effect as of July 1, 2012, but continue to meet the level of care criteria in effect prior to July 1, 2012, and who meet institutional income standards are eligible in the demonstration CHOICES 1 and 2 Carryover Group.

CHOICES Group 3 was implemented July 1, 2012. This option is for individuals age 65 and older, and adults age 21 and older with physical disabilities, who qualify for TennCare as SSI recipients or in the At Risk Demonstration Group, who do not meet the nursing facility level of care, but who, in the absence of HCBS, are “at-risk” for nursing facility care, as defined by the State.

Interim CHOICES Group 3 was closed to new enrollment on June 30, 2015. Individuals who applied for the program before July 1, 2015 and are enrolled in Interim CHOICES Group 3 are permitted to remain in the group so long as they continue to meet financial and medical criteria and remain continuously enrolled in TennCare in in Interim CHOICES Group 3.

In November 2010, Tennessee was recognized by the Center for Health Care Strategies (CHCS) for its statewide implementation of the new TennCare CHOICES Long Term Services and Supports program. In its report *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*, CHCS identified Tennessee as one of five innovative states with demonstrated expertise in managed care approaches to long-term care. Tennessee, along with Arizona, Hawaii, Texas and Wisconsin, was noted as a “true pioneer” in designing innovative approaches to delivering care to the elderly and adults with disabilities. Tennessee in particular was recognized for its open communication and collaboration with the public and stakeholders in designing and implementing the new program.

The key component of the CHOICES program is person-centered care coordination. The “whole person” care coordination approach includes:

- Implementation of active transition and diversion programs for people who can be safely and effectively supported at home or in another integrated community setting outside the nursing home; and
- Installation of an electronic visit verification system to monitor home care access, timeliness and quality through the use of GPS technology, and to immediately address potential gaps in care.

Other components of CHOICES include:

- Consumer choice of service setting and providers
 - Consumer-directed care options, including the ability to hire non-traditional providers like family members, friends, and neighbors with accountability for taxpayer funds.
 - Broadening of residential care choices in the community beyond nursing facilities with options such as companion care, community living supports and adult “foster” family living arrangements and improved access to assisted care living facilities.
- Simplified Process for Accessing Services
 - Streamlining the member’s eligibility process for faster service delivery and the enrollment process for new providers.
 - Maintaining a single point of entry for people who are not on TennCare today and need access to long-term care services through Medicaid or other available programs.
 - Use of existing Medicaid funds to serve more people in cost-effective home and community settings.

Evolution of Health Information Technology

TennCare continues to work to enhance accurate and timely data collection, analysis, and distribution. The Bureau’s comprehensive information management strategy affects every aspect of Tennessee’s “Medicaid Enterprise,” from medical policy to eligibility policy to budget and financial accountability. The process of transforming from a traditional transaction-driven medical program to a health care monitoring and management organization recognizes the advantages of Tennessee’s unique, fully managed care framework and builds on the Bureau’s commitment to be a wise and efficient contractor of services, steward of public funds, and advocate for quality healthcare for all constituents. With guidance from the Bureau’s Health care Informatics group, the State is revamping its data strategy to take into account changes in the Health Information Exchange (HIE) landscape. This includes taking steps to critically examine current data assets and design options to collect and analyze data, make better use of currently available encounter data via the State’s Medicaid Management Information System (MMIS), and target methods to distribute the resulting information in ways that are most streamlined and effective for providers through enhanced dashboards, web portals, and DIRECT Messaging.

As an early leader in the work to develop digital health information capacity, Tennessee has built a comprehensive set of health information technology (HIT) and health information exchange (HIE) assets. One of these is the collective level of experience and lessons learned among stakeholders about fostering HIT and HIE innovation amidst evolving health systems, technology environments, and data priorities. In his State of the State address of 2003, Governor Bredesen pledged resources to build Tennessee’s health information infrastructure. Subsequently, various eHealth initiatives spanning the entire state were pursued. Seeded with capital investments from federal, state, and local sources, these initiatives have evolved with the continued support of Governor Haslam’s administration. As is the case

in many other states, Tennessee has fine-tuned its HIT/HIE strategy in response to policy and marketplace drivers while continuing to expand the Medicaid Electronic Health Record (EHR) Incentive Program and offer HIE resources that promote adoption and meaningful use of HIT. A robust Medicaid EHR Incentive Program is now well established and providing incentive payments to Tennessee providers. Now having successfully moved beyond the start-up phase, this program is actively engaged in activities to foster meaningful use, conduct auditing, and support ongoing provider outreach and technical assistance.

Both the Bureau of TennCare and the Office of eHealth Initiatives (OeHI) within Tennessee's Health Care Finance and Administration Division play integral leadership roles in the promotion of statewide HIT/HIE. Given the interdependencies between Health Information Technology adoption and Health Information Exchange, efforts to administer Health Information Technology for Economic and Clinical Health (HITECH) Act programs in Tennessee are a highly integrated collaboration between TennCare and OeHI. These programs include the State HIE Cooperative agreement Program and the CMS Medicaid EHR Incentive Program. Strategies and activities are guided with input and active participation by an array of other state partners and stakeholders such as state government agencies, TennCare MCOs, health information organizations throughout the state, and provider associations. For example, to disseminate information about specific EHR Incentive Program features and policies, both TennCare and OeHI have conducted dedicated outreach to entities such as the Tennessee Medical Association, Tennessee Hospital Association, Tennessee Primary Care Association, the Children's Hospital Alliance of Tennessee, and TennCare's MCOs.

CMS Requirement: Include an overview of the quality management structure that is in place at the state level.

Although the Bureau of TennCare established a Division of Quality Oversight several years ago, a culture of quality has also been fostered throughout the Bureau. Both TennCare's Vision and Mission statements reflect that culture:

Vision Statement – "Setting the standard in health care management by delivering high quality, cost-effective care that results in improved health and quality of life for eligible Tennesseans."

Mission Statement – "To maintain an exemplary system of high quality health care for eligible Tennesseans within a sustainable and predictable budget."

Core Values:

- **Commitment:** Ensuring that Tennessee taxpayers receive value for their tax dollars
- **Agility:** Be nimble when situations require change
- **Respect:** Treat everyone as we would like to be treated
- **Integrity:** Be truthful and accurate
- **New Approaches:** Identify innovative solutions
- **Great customer service:** Exceed expectations

All quality improvement activities are consistent with the "three aims" outlined in the National Quality Strategy for better care, healthy people/healthy communities, and affordable care.

Darin Gordon is the Director of the Health Care Finance and Administration (HCFA) Division for the state of Tennessee, with Wendy Long, M.D. serving as the Deputy Director. The Chief Medical Officer for the Bureau of TennCare, Vaughn Frigon, M.D., reports directly to Darin Gordon and in turn provides supervision for the Quality Oversight, Pharmacy, Dental, and Provider Networks divisions of the Bureau. The Division of Quality Oversight is led by Judith Womack, R.N. and is comprised of a staff of 23 individuals.

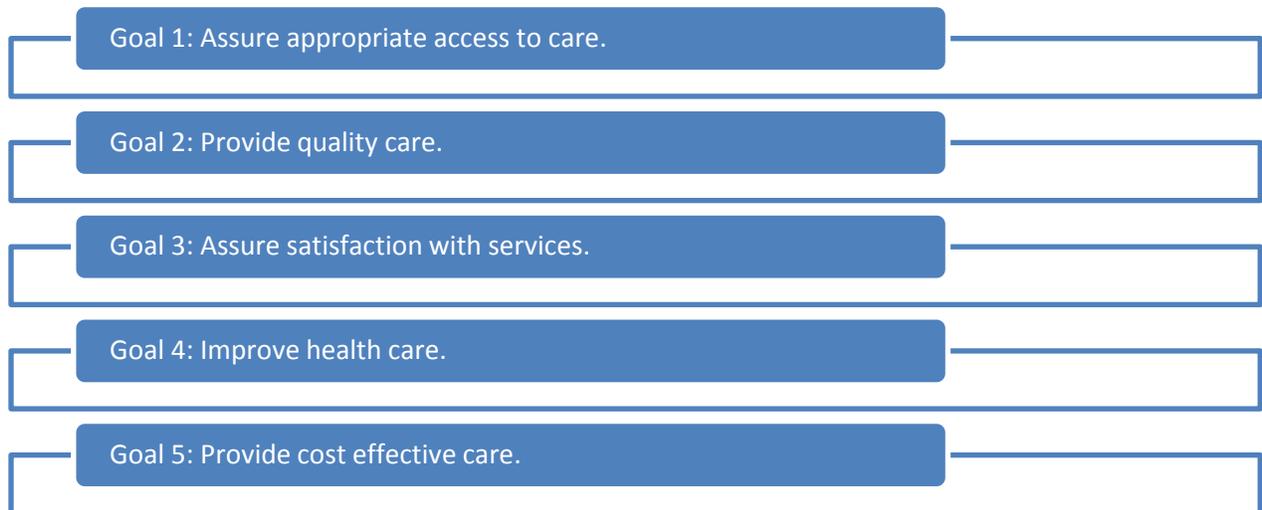
The Division of Quality Oversight is responsible for monitoring many of the activities of the MCOs and for enforcing quality requirements defined in the MCO and DBM Contractor Risk Agreements. This Division is also responsible for developing and monitoring the External Quality Review Organization (EQRO) contract as well as a contract with the Tennessee Department of Health.

CMS Requirement: Include general information about the state's decision to contract with MCOs/PIHPs (i.e., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid.

The State's decision to contract with MCOs and a Prepaid Ambulatory Health Plan (PIHP) for most services, as well as two PAHPs for pharmacy and dental, is rooted in nearly 20 years of experience with managed care in Tennessee. The use of these Managed Care Contractors (MCCs) has allowed the State to move from the role of being primarily a payer of claims to a role of orchestrating and coordinating an entire system of care. The use of MCCs without appropriate oversight and direction cannot guarantee a cost-effective system that delivers quality care. However, we have learned that when the state is willing and able to leverage meaningful oversight strategies, managed care offers the best chance of delivering the kind of system we want. Goals addressing cost, quality, and access can be built into the system, along with carrots and sticks to make sure these goals are reached. Such levers are largely unavailable in a fee-for-service system.

CMS Requirement: Include a description of the goals and objectives of the state's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state's priorities and areas of concern for the population covered by the MCO/PIHP contracts.

Five primary goals for TennCare enrollees shape the Quality Strategy. Ensuring appropriate access to care, providing quality care, and assuring satisfaction with services are processes that ultimately contribute to the fourth and fifth goals of improving health care and providing cost-effective care.



These five goals and their associated objectives align with the three aims of the National Quality Strategy:

- **Better Care** - Improve the overall quality of care by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities** - Improve the health of the United States population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care** - Reduce the cost of quality health care for individuals, families, employers, and government.

Progress toward these five goals is gauged by physical and behavioral health performance measures implemented in 2007 with others added as needed. These objectives are drawn from nationally recognized and respected measure sets. Many of the strategy objectives are statewide weighted Healthcare Effectiveness Data and Information Set (HEDIS) rates or statewide average Consumer Assessment of Healthcare Providers and Systems (CAHPS) rates. The MCOs annually complete and submit all applicable HEDIS measures designated by the National Committee for Quality Assurance (NCQA) as relevant to Medicaid. The MCOs are required to contract with an NCQA-certified HEDIS auditor to validate the processes of the health plan in accordance with NCQA requirements. In addition, MCOs annually conduct CAHPS surveys (adult survey, child survey, and children with chronic conditions survey) using an NCQA-certified CAHPS survey vendor.

Since the CHOICES benefits are integrated into TennCare’s managed care structure, progress towards the five primary goals set forth in the Quality Strategy is also assessed using the Long Term Services and Supports performance measures. 2011 served as the baseline year for these performance measures. In anticipation of standardized Medicaid Managed Long Term Services and Supports (MLTSS) measures in development by NCQA, new measures have been added for 2014 for needs assessment and care planning domains.

Strategy Goals and Objectives

The tables below present the Quality Strategy goals and objectives established by the State for physical and behavioral health as well as Long Term Services and Supports.

Physical and Behavioral Health Goals	
Goal 1: Assure appropriate access to care for enrollees	
Objective 1.1: By 2016, the statewide weighted HEDIS rate for adults' access to preventive/ambulatory health services will increase to 83.4% for enrollees 20-44 years old, and the rate for enrollees 45-64 years old will be maintained at 88.6% or above.	Data Source: <i>A Comparative Analysis of Audited Results from TennCare MCOs.</i>
Objective 1.2: By 2016, the statewide weighted HEDIS rate for children and adolescents' access to primary care practitioners will increase to 95.3% for enrollees 7-11 years old and 93.09% for enrollees 12-19 years old.	Data Source: <i>A Comparative Analysis of Audited Results from TennCare MCOs.</i>
Objective 1.3: By 2016, 97% of TennCare heads of household and 98% or greater of TennCare children will go to a doctor or clinic when they are first seeking care rather than a hospital (emergency room).	Data Source: <i>The Impact of TennCare: A Survey of Recipients.</i>
Goal 2: Provide quality care to enrollees	
Objective 2.1: By 2016, the statewide weighted HEDIS rate for adolescent well-care visits will increase to 47.20%.	Data Source: <i>A Comparative Analysis of Audited Results from TennCare MCOs.</i>
Objective 2.2: By 2016, the statewide weighted HEDIS rate for timeliness of prenatal care will be maintained at 82.7% or above.	Data Source: <i>A Comparative Analysis of Audited Results from TennCare MCOs.</i>
Objective 2.3: By 2016, the statewide weighted HEDIS rate for breast cancer screening will increase to 46.9%.	Data Source: <i>A Comparative Analysis of Audited Results from TennCare MCOs.</i>
Objective 2.4: By 2016, the statewide weighted HEDIS rate for cervical cancer screening will increase to 71.29%.	Data Source: <i>A Comparative Analysis of Audited Results from TennCare MCOs.</i>
Goal 3: Assure enrollees' satisfaction with services.	
Objective 3.1: By 2016, 95% of TennCare enrollees will be satisfied with TennCare.	Data source: <i>The Impact of TennCare: A Survey of Recipients.</i>
Objective 3.2: By 2016, the statewide average for adult CAHPS getting needed care-always or usually will increase to 87.05%.	Data Source: <i>A Comparative Analysis of Audited Results from TennCare MCOs.</i>
Objective 3.3: By 2016, the statewide average for child CAHPS getting care quickly-always or usually will increase to 92.42%.	Data Source: <i>A Comparative Analysis of Audited Results from TennCare MCOs.</i>
Goal 4: Improve health care for program enrollees.	
Objective 4.1: By 2016, the statewide weighted HEDIS rate for HbA1c testing will be increased to 83.51%.	Data Source: <i>A Comparative Analysis of Audited Results from TennCare MCOs.</i>

Physical and Behavioral Health Goals	
Objective 4.2: By 2016, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 59.14%.	Data Source: <i>A Comparative Analysis of Audited Results from TennCare MCOs.</i>
Objective 4.4: By 2016, the state will maintain a total statewide EPSDT screening rate of at least 80%.	Data source: <i>CMS-416.</i>
Objective 4.5: By 2016, the statewide weighted HEDIS rate for antidepressant medication management will be increased to 52.04% for acute phase and 32.64% for continuation phase.	Data Source: <i>A Comparative Analysis of Audited Results from TennCare MCOs.</i>

Long-Term Services and Supports

Performance measures in the Quality Strategy specific to CHOICES were initially established based on certain Section 1915(c) waiver assurances and sub-assurances, including level of care, service plan, qualified providers, health and welfare, administrative authority, and participant rights. The table below reflects these core domains and performance measures and how TennCare monitors each under the 1115 waiver authority to ensure prompt remediation of individual findings and promote system improvements in the managed long-term services and supports delivery system. Additional measures have been added for 2014 in anticipation of new standardized MLTSS program measures under development by NCQA.

Long-Term Services and Supports Goals		
Goal 1: CHOICES Group 2 members have a level of care determination indicating the need for institutional services prior to enrollment in CHOICES and receipt of Medicaid-reimbursed HCBS.		
Domain	Performance Measure	Measurement Method
Level of Care	Number and percent of CHOICES Group 1, Group 2 and Group 3 members who had an approved CHOICES Pre-Admission Evaluation (i.e., nursing facility level of care eligibility) prior to enrollment in CHOICES and receipt of Medicaid-reimbursed HCBS.	<u>Data Source:</u> MMIS report <u>Sampling Approach:</u> 100% of all CHOICES Group 1, Group 2 and Group 3 members enrolled <u>Frequency:</u> Quarterly <u>Remediation:</u> TennCare is responsible for quarterly reports and review/analysis of data, as well as remediation of individual findings.
Goal 2: CHOICES members are offered a choice between institutional (NF) services and HCBS.		
Domain	Performance Measure	Measurement Method
Service Plan	Number and percent of CHOICES Group 2 member records reviewed with an appropriately completed and signed freedom of choice form that specifies choice was offered between institutional services and HCBS.	<u>Data Source:</u> Member record review <u>Sampling Approach:</u> Stratified, with strata comprised of CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. For the first auditing year, sample size will be 60 records per stratum with a 10% oversample to determine subsequent error for future audits. For following years, sample size will be based on the first auditing year's sampling error in order to achieve a 95% confidence interval. <u>Frequency:</u> Semi-annually in April and October <u>Remediation:</u> TennCare is responsible for semi-annual member record review and review/analysis of data.

Long-Term Services and Supports Goals

		MCOs will be responsible for remediation of individual findings with review/validation by TennCare.
Goal 3: LTSS Assessment Composite		
Domain	Performance Measure	Measurement Method
Service Plan	Number and percent of CHOICES Group 2 and 3 members reviewed for whom an assessment, including key elements specified in the CRA or by TennCare protocol, was completed within the timeframes specified in the CRA.	<p><u>Data Source:</u> Member Record Review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of CHOICES Groups 2 and 3 members enrolled in each of the MCOs per region serving the CHOICES population. The year one chart review will be a convenience sample of 25 records per MCO per region. Subsequent sample size will be based on the first auditing year's sampling error to achieve a 95% confidence interval. Any records used previously in a semi-annual audit will be excluded.</p> <p><u>Frequency:</u> Annually in October</p> <p><u>Remediation:</u> TennCare is responsible for annual member record reviews and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.</p>
Goal 4: LTSS Plan of Care Composite		
Domain	Performance Measure	Measurement Method
Service Plan	Number and percent of CHOICES Group 2 and 3 members reviewed for whom a plan of care, including key elements specified in the CRA or by TennCare protocol, was completed within the timeframes specified in the CRA.	<p><u>Data Source:</u> Member Record Review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of CHOICES Groups 2 and 3 members enrolled in each of the MCOs per region serving the CHOICES HCBS population. A 95% confidence interval will be achieved. Any records used previously in a semi-annual audit will be excluded.</p> <p><u>Frequency:</u> Annually in October</p> <p><u>Remediation:</u> TennCare is responsible for annual member record reviews and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.</p>

Long-Term Services and Supports Goals

Goal 5: Plans of Care are reviewed/updated at least annually.

Domain	Performance Measure	Measurement Method
Service Plan	Number and percent of CHOICES Groups 2 and 3 member records reviewed whose plans of care were reviewed and updated prior to the member's annual review date.	<p><u>Data Source:</u> Member record review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of CHOICES Group 2 and 3 members enrolled in each of the MCOs per region serving the CHOICES HCBS population. A 95% confidence interval will be achieved. Any records used previously in a semi-annual audit will be excluded.</p> <p><u>Frequency:</u> Annually in October</p> <p><u>Remediation:</u> TennCare is responsible for annual member record review and review/ analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.</p>

Goal 6: CHOICES HCBS providers meet minimum provider qualifications established by the State prior to enrollment in CHOICES and delivery of HCBS.

Domain	Performance Measure	Measurement Method
Qualified Providers	Number and percent of CHOICES HCBS providers reviewed for whom the MCO provides documentation that the provider meets minimum qualifications established by the State and was credentialed by the MCO prior to enrollment in CHOICES and delivery of HCBS.	<p><u>Data Source:</u> Provider record review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of HCBS providers contracted with each of the MCOs serving the CHOICES Group 2 and 3 population; sample size-25 records per stratum. Sample size may be adjusted in subsequent years based on individual findings.</p> <p><u>Frequency:</u> Annually</p> <p><u>Remediation:</u> TennCare is responsible for annual provider record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.</p>

Goal 7: CHOICES Group 2 and 3 members (or their family member/authorized representative, as applicable) receive education/information at least annually about how to identify and report instances of abuse, neglect, and exploitation.

Domain	Performance Measure	Measurement Method
Health and Welfare	Number and percent of CHOICES Group 2 and 3 member records reviewed which document that the member (or their family member/authorized representative, as applicable) received education/information at least annually about how to identify and report instances of abuse, neglect and exploitation.	<p><u>Data Source:</u> Member record review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 and 3 population. Sample size will be based on the first auditing year's sampling error in order to achieve a 95% confidence interval. Any records used previously in a semi-annual audit will be excluded.</p> <p><u>Frequency:</u> Annually in October</p> <p><u>Remediation:</u> TennCare is responsible for annual member record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.</p>

Long-Term Services and Supports Goals		
Goal 8: Critical incidents are reported within timeframes specified in the Contractor Risk Agreement.		
Domain	Performance Measure	Measurement Method
Health and Welfare	Number and percent of critical incident records reviewed in which the incident was reported within timeframes specified in the Contractor Risk Agreement.	<p><u>Data Source:</u> Sample record review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of reported incidents for CHOICES Group 2 and 3 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. For the first auditing year, sample size will consist of 60 records per stratum with a 10% oversample to determine subsequent error for future audits. For following years, sample size will be based on the first auditing year's sampling error in order to achieve a 95% confidence interval.</p> <p><u>Frequency:</u> Semi-annually</p> <p><u>Remediation:</u> TennCare is responsible for semi-annual record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.</p>
Goal 9: CHOICES members are informed of and afforded the right to request a Fair Hearing when services are denied, reduced, suspended, or terminated.		
Domain	Performance Measure	Measurement Method
Participant Rights	Number and percent of CHOICES Group 2 and 3 member records reviewed in which HCBS were denied, reduced, suspended, or terminated as evidenced in PoC and, consequently, member was informed of and afforded the right to request a Fair Hearing as determined by the presence of a Griener consent decree notice.	<p><u>Data Source:</u> Member record review</p> <p><u>Sampling Approach:</u> Stratified, with strata comprised of reported incidents for CHOICES Group 2 and 3 members enrolled in each of the MCOs per region serving the HCBS population. Sample size will be a subset of the sample used in Sub-Assurance 2.</p> <p><u>Frequency:</u> Semi-annually in April and October</p> <p><u>Remediation:</u> TennCare is responsible for semi-annual record review and review/analysis of data. MCOs will be responsible for remediation of individual findings with review/validation by TennCare.</p>

Data Sources

HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare Managed Care Organizations (MCOs)

Using individual MCO results, the External Quality Review Organization (EQRO) calculates the statewide weighted HEDIS rates and the statewide CAHPS averages in this annual report.

The Impact of TennCare: A Survey of Recipients

Two of the strategy objectives rely on information obtained from an annual survey conducted by the Center for Business and Economic Research at the University of Tennessee Knoxville. TennCare contracts with the Center to conduct a survey of 5,000 Tennesseans to gather information on their perceptions of their health care. The design for the survey is a “household sample,” and the interview is conducted with the head of the household. This report allows comparison between responses from all households and households receiving TennCare.

CMS-416 Report

The Statewide EPSDT Screening Rate is calculated by utilizing MCO encounter data submissions in accordance with specifications for the annual CMS-416 report.

Medicaid Management Information Systems (MMIS) Report

The MMIS Report is run quarterly based on CHOICES enrollment during the reporting period.

CHOICES Record Review (both member and provider records)

The CHOICES Record Reviews are conducted by TennCare staff from the Quality Oversight Division and/or Long Term Services and Supports to evaluate member or provider records. The reviews are completed annually or semi-annually based on the performance measure associated with each review.

CHOICES Critical Incidents Report

This report is submitted quarterly by each MCO to the LTSS Audit and Compliance Unit. Contents of the report include the aggregated number and type of incident, setting in which the incident occurred, and type of provider (provider agency or consumer directed worker) present at the time of the incident. In addition to contractual requirements for MCOs to review the number and types of incidents and findings from investigations, identify trends and patterns and opportunities for improvement, and develop and implement strategies to reduce the occurrence of incidents and improve the quality of CHOICES HCBS. Report data is reviewed by LTSS for similar purposes, with the ultimate goal being assurance of health and safety, and quality of care for persons receiving CHOICES HCBS.

CHOICES Critical Incident Audit

The CHOICES Critical Incident Audit supplements the information monitored through the quarterly CHOICES Critical Incidents Report. It addresses MCO determination, documentation, responsiveness, and investigation of critical incidents within specific timeframes on a member-specific basis. It also addresses the systemic response to patterns of incidents. This audit is conducted twice each year and the results are used to improve individual MCO performance and general program performance.

Development and Review of Quality Strategy

CMS Requirement: Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy. (CFR 438202(b))

CMS Requirement: Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final. (CFR 438202(b))

Steps for revising the *TennCare Quality Strategy* include:

- Convening a strategic planning meeting for all Quality Oversight staff, the Division of HealthCare Informatics, and the EQRO. At this meeting, a review of all data submitted by the MCOs, data collected by the EQRO, and statewide data collected from enrollee encounters is conducted.
- Collaboration with appropriate divisions within TennCare, with the Division of Quality Oversight holding responsibility for creating the draft.
- Review of the draft by TennCare’s Chief Medical Officer.
- After a final draft is completed, the Quality Strategy will be posted on TennCare’s website for public review. MCOs, advocacy groups, and beneficiaries will be notified of the posting and given a specific timeframe and e-mail address for comments to be returned to TennCare.
- After the designated time frame has elapsed, a final report will be developed including appropriate recommendations made during the public review period.

CMS Requirement: Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually). (CFR 438.202 (d))

The effectiveness of the Quality Strategy is assessed annually.

CMS Requirement: Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of “significant changes,” include the state’s definition of “significant changes.” (CFR 438.202 (d))

The Bureau of TennCare will update its quality strategy annually and will include significant changes that have occurred as well as updated evaluation data. Significant changes are defined as changes that: 1) alter the structure of the TennCare Program; 2) change benefits; and 3) include changes in MCCs. Updated interventions/activities will also be provided. Every three years, TennCare will coordinate a comprehensive review and update.

SECTION II: ASSESSMENT

Quality and Appropriateness of Care

CMS Requirement: Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs. This must include the state's definition of special health care needs. (CFR 438.204(b)(1)).

Since TennCare's inception, a continuous quality improvement (QI) process has been in place and has been refined over time. Assessment occurs in a variety of ways. Examples of these are listed below.

- All of the contracted MCOs are required to submit a full set of HEDIS and CAHPS data to TennCare annually. This information is also provided to Qsource, Tennessee's EQRO, for review and trending. Qsource then prepares an annual report of findings for the Bureau.
- The MCOs are contractually required to submit a variety of reports to various divisions within the Bureau of TennCare. The reports include performance improvement projects (PIPs), population health, EPSDT, dental, CHOICES care coordination, annual quality improvement/utilization management (QI/UM) descriptions, evaluations and work plans, provider satisfaction surveys, dual eligible care coordination, etc. These reports are reviewed either quarterly or annually, depending on the report, and an annual analysis is completed.
- Qsource conducts an Annual Quality Survey (AQS) for each MCO and the Dental Benefits Manager that evaluates contractual requirements related to quality.
- Periodic audits have been conducted related to compliance with federal requirements for Abortions, Sterilizations, and Hysterectomies (ASH). Beginning in 2013, Qsource has conducted this audit annually.
- Quality Oversight and Long Term Services and Supports staff conduct MCO audits related to compliance with the federal Standard Terms and Conditions for TennCare's CHOICES program.
- Collaborative workgroups, with all MCOs, are held periodically. These workgroups address issues related to Quality Redesign, EPSDT outreach, and high risk maternity.
- Periodic meetings are also held collaboratively with both MCOs and Dual Special Needs Populations (D-SNPs) to discuss ways of coordinating care.

CMS Requirement: Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment. (CFR 438.204(b)(2))

TennCare identifies the race, ethnicity, and primary language spoken of its enrollees upon application. Eligibility for TennCare and other Medicaid programs is determined by the Bureau of TennCare and the Federally Facilitated Marketplace (FFM). The application includes questions about race and ethnicity and instructs the applicant that response to these questions is voluntary. The application also includes questions about the applicant's preferred written and spoken language.

The contracts with the MCOs contain eligibility and enrollment data exchange requirements in CRA § 2.23.5. The requirements state that the MCOs must receive, process, and update enrollment files sent daily by TennCare, and the MCOs must update eligibility/enrollment databases within 24 hours of receipt of enrollment files.

TennCare uses information about language and need for an interpreter to identify those Limited English Proficiency (LEP) groups constituting 5% of the TennCare population or 1,000 enrollees, whichever is less. In CRA § 2.17.2.5, the contract with the MCOs requires that all vital documents be translated and available to the LEP groups identified by TennCare within 90 calendar days of notification from TennCare. The contracts with the MCOs also require the MCO to develop written policies and procedures for the provision of language interpreter and translation services to members in CRA § 2.18.2.

The contracts require that member materials such as the member handbook and the quarterly member newsletter contain statements on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free in CRA § 2.17.4.5.23 and 2.17.5.3.2.

CMS Requirement: Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care.

TennCare addresses disparities through tracking the rates of illness and chronic conditions in relation to key demographic factors. TennCare contractually requires the MCOs to include QM/QI activities to improve healthcare disparities identified through data collection and requires them to submit a Data Collection Strategy Report describing their data collection process in accordance with the Health and Human Services (HHS) Action Plan to Reduce Racial and Ethnic Health Disparities. Additionally, TennCare is directly working to reduce healthcare disparities through contractually requiring its MCOs to provide essential networks and services required to address disparity issues. These requirements include:

- Ensuring an adequate medical provider network of appropriately credentialed providers increasingly committed to evidence-based practices to improve access to care and higher quality outcomes.
- Requiring opt-out Population Health services to be available to all TennCare members while providing intensive case management to those high-risk members who choose to opt-in to the program.
- Proactively promoting health screenings and preventive healthcare services to all TennCare members.
- Providing care coordination and direct support services for CHOICES HCBS enrollees. CHOICES care coordination provides access to several important determinants of health often lacking for our long-term care population, including:
 - Nutritious food delivered by local meals-on wheels programs or prepared by homecare providers;
 - Safer home environments by building ramps and installing safety equipment, providing Personal Emergency Response Systems (PERS) and pest control services, and providing light housekeeping support; and
 - Personal care and other medical, behavioral, and long-term care services identified as needed through regular home visits by care coordinators.

Coordination of Care for Dual Members

Although TennCare did not receive a Dual Integration Grant, in May 2013, a coordination of care program for an estimated 30,000 TennCare enrollees who have both Medicaid and Medicare (Duals) was implemented. These dual members include both frail elderly members and young people with physical and/or mental disabilities. Ninety-five percent of these members live below 200% of the Federal Poverty Level. Compared with the typical Medicare member, they have more disabilities. Nationally, 87% of Duals have one or more chronic illnesses. In Tennessee, 65% of Duals have heart

disease, 30% have diabetes, 24% have Chronic Obstructive Pulmonary Disease (COPD), and 14% have depression.

Findings to date: During 2014, over 14,350 hospital admission notices were exchanged between hospitals, Medicare Dual Special Needs Populations (D-SNPs), and Medicaid MCOs. Many of these notices led to requests for assistance with discharge planning and HCBS assessments, Skilled Nursing Facility (SNF) diversions, coordination of services through coordination of the authorization process, and other means of coordinating care between MCOs and D-SNPs. Coordination of services upon hospital discharge occurred for over 10,000 of these members. Over 1,100 care coordination touches were provided for these dual members, ranging from requests for assistance with assessment and care planning to referrals for service coordination.

Prescription for Success

In 2014, TennCare partnered with the Tennessee Department of Mental Health and Substance Abuse Services, in conjunction with the U.S. Drug Enforcement Administration, the Tennessee Bureau of Investigation, and the State Departments of Health, Safety and Homeland Security, Corrections, and Children's Services to develop a report entitled *Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee*. This report outlines a comprehensive, multi-faceted plan to combat prescription drug abuse in Tennessee and includes information on each partner's current strategies in addition to the partnership's future collaborative goals. TennCare's current strategies include:

- *Covered Treatment Services* – TennCare covers a comprehensive continuum of substance abuse services for its beneficiaries, including outpatient, inpatient, and residential treatment/detoxification and medication-assisted treatment.
- *Formulary Regulations* – The TennCare Formulary has regulations in place (i.e., five prescription limit per month, policy for tamper-resistant prescriptions, and strict limitations on coverage of products containing buprenorphine) to prevent doctor shopping and prescription abuse.
- *Pharmacy "Lock-In" Program* – TennCare possesses the authority to restrict or "lock-in" TennCare enrollees to a limited and specified number of pharmacy providers if it is determined that the enrollee has abused TennCare's Pharmacy Program. There were 511 beneficiaries locked-in in 2012.
- *Prescriber Identification* – TennCare has developed a unique and innovative algorithm to identify prescribers who are potentially prescribing opioids in a way that is very inconsistent with their peers. Identified providers are manually evaluated by TennCare's pharmacy staff, and appropriate interventions (e.g., targeted education, blocking of prescriptions by the TennCare Drug Utilization Review Board, etc.) are employed based on the results of the manual evaluation.

National Performance Measures

CMS Requirement: Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders. (CFR 438.204(c))

At this time, CMS has not identified any required national performance measures.

CMS Requirement: Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP. If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting.

Child Health Quality Measures:

Goals reflect significant improvement over 2013 rates using the NCQA Minimum Effect Size Change Methodology.

Measure Name	2013 Data	2014 Data Update	2015 Data Update	2016 Goal
Timeliness of Prenatal Care	79.51%	80.70%	82.84%	82.69%
Frequency of Ongoing Prenatal Care (≥ 81% of expected visits) *	61.60%	63.08%	58.30%	64.68%
Childhood Immunization Status				
• DTaP/DT	80.17%	79.00%	78.22%	83.34%
• IPV	93.86%	93.07%	92.36%	95.47%
• MMR	91.44%	91.10%	90.18%	94.18%
• HiB	93.73%	92.62%	91.04%	95.60%
• Hepatitis B	93.33%	93.15%	92.95%	95.19%
• VZV	90.72%	91.47%	90.56%	93.44%
• Pneumococcal Conjugate	82.42%	81.13%	81.16%	85.71%
• Hepatitis A	89.55%	89.93%	89.52%	92.23%
• Rotavirus	68.43%	69.66%	68.74%	71.88%
• Influenza	43.74%	43.73%	44.23%	46.36%
• Combination 2	76.28%	75.24%	74.24%	79.33%
• Combination 3	73.02%	72.12%	72.13%	76.67%
• Combination 4	71.63%	71.18%	71.28%	75.21%
• Combination 5	56.98%	57.66%	57.31%	62.04%
• Combination 6	37.88%	38.24%	38.15%	40.15%
• Combination 7	56.13%	56.88%	56.69%	59.49%
• Combination 8	37.24%	38.07%	37.92%	39.47%
• Combination 9	31.99%	33.02%	32.56%	33.90%
• Combination 10	31.53%	32.89%	32.37%	33.42%
Adolescent Immunization Status				
• Meningococcal	65.69%	66.27%	67.74%	68.97%
• Tdap/Td	83.31%	83.57%	84.27%	86.64%
• Combination 1	64.40%	65.48%	66.75%	67.62%
Weight Assessment and Counseling for Nutritional and Physical Activity for Children/Adolescents				
• BMI Percentile (3 - 11 years)	49.42%	56.08%	65.98%	52.39%
• BMI Percentile (12 - 17 years)	49.74%	58.27%	67.14%	52.72%
• Counseling for Nutrition (3 - 11 years)	59.90%	63.76%	64.42%	62.90%
• Counseling for Nutrition (12 - 17 years)	55.01%	54.24%	56.91%	58.31%
• Counseling for Physical Activity (3 - 11 years)	45.54%	52.77%	55.64%	48.27%
• Counseling for Physical Activity (12 - 17 years)	48.02%	52.67%	56.09%	50.90%
Chlamydia Screening	53.62%	51.54%	52.03%	56.30%
Well-Child Visits in the First 15 Months of Life: Six or More Visits	62.32%	65.41%	60.69%	65.43%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	71.68%	70.80%	69.70%	75.26%
Adolescent Well-Care Visits	44.53%	50.27%	47.18%	47.20%

Child and Adolescent Access to Primary Care Practitioners				
• 12-24 months	96.94%	97.27%	94.22%	98.8%
• 25 months – 6 years	90.51%	90.26%	88.06%	93.22%
• 7 – 11 years	93.47%	93.96%	93.55%	95.33%
• 12 – 19 years	90.38%	90.91%	89.96%	93.09%
Appropriate Testing for Children with Pharyngitis	76.03%	77.75%	79.06%	79.07%
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication				
• Initiation Phase	46.02%	45.82%	47.78%	48.78%
• Continuation and Follow-Up Phase	57.54%	54.98%	59.69%	60.99%
Follow-Up After Hospitalization for Mental Illness*				
• 7 day follow- up	48.03%	54.70%	61.94%	50.91%
• 30 day follow-up	68.80%	71.85%	75.91%	72.24%

Adult Quality Measures:

Goals reflect significant improvement over 2013 rates using the NCQA Minimum Effect Size Change methodology.

Measure Name	2013 Data	2014 Data Update	2015 Data Update	2016 Goal
Adult BMI Assessment*	70.95%	78.50%	82.84%	74.55%
Breast Cancer Screening*	44.27%	52.47%	54.08%	46.95%
Cervical Cancer Screening	67.73%	66.25%	64.83%	71.29%
Chlamydia Screening in Women Ages 21-24	62.58%	62.56%	55.93%	65.73%
Follow-up After Hospitalization for Mental Illness*				
• 7 Day Follow-Up	48.03%	54.70%	61.94%	50.88%
• 30 Day Follow-Up	68.80%	71.85%	75.91%	72.24%
Controlling High Blood Pressure*	55.82%	56.98%	54.99%	59.14%
Comprehensive Diabetes Care: LDL-C Screening*	76.44%	75.56%	Retired	79.45%
Comprehensive Diabetes Care: Hemoglobin A1c Testing*	80.32%	79.76%	81.88%	83.51%
Antidepressant Medication Management*				
• Effective Acute Phase Treatment	49.10%	46.48%	48.62%	52.04%
• Effective Continuation Phase Treatment	30.78%	30.31%	31.39%	32.64%
Adherence to Antipsychotics for Individuals with Schizophrenia	61.91%	62.93%	59.70%	64.99%
Annual Monitoring for Patients on Persistent Medications				
• Annual monitoring for members on ACE Inhibitors or ARBs	90.61%	89.98%	90.61%	93.31%
• Annual monitoring for members on Digoxin	92.31%	94.06%	57.14%	94.76%
• Annual monitoring for members on diuretics	91.00%	90.59%	90.88%	93.73%
• Annual monitoring for members on anticonvulsants	72.89%	72.75%	Retired	76.54%
• Total Rate	88.86%	88.48%	90.33%	91.56%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (age 18+)				
• Initiation of AOD Treatment	36.78%	35.69%	37.22%	39.88%
• Engagement of AOD Treatment	9.82%	9.62%	9.83%	11.77%
Prenatal and Postpartum Care: Postpartum Care Rate	59.90%	58.77%	58.74%	63.49%

*Data was not collected according to ages specified.

Monitoring and Compliance

CMS Requirement: Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). (CFR 438.204(b)(3))

NCQA Accreditation – Each MCO must obtain and maintain NCQA accreditation. Failure to obtain and/or maintain accreditation is considered to be a breach of the Contractor Risk Agreement (CRA) and will result in termination of the Agreement. Achievement of provisional accreditation status requires a corrective action plan within 30 days of receipt of notification from NCQA and may result in termination of the Agreement. Each MCO is required to submit every accreditation report immediately upon receipt of the written report from NCQA. It is then reviewed by staff to determine areas of deficiency. If the reviewer deems necessary, a corrective action plan may be required.

Quarterly and Annual Reports from Managed Care Contractors – All MCCs are required to submit a variety of reports to TennCare both quarterly and annually. When received through a secure tracking system, each report is reviewed by staff and a corrective action plan is required for any report deemed deficient. Liquidated damages may be applied for deficient reports. Examples of reports include Population Health, EPSDT Outreach, Enrollment and Disenrollment, Community Outreach, Behavioral Health, Case Management, Nursing Facility Diversion Activities, Nursing Facility to Community Transition, HCBS Late and Missed Visits, CHOICES Care Coordination, HCBS Consumer Direction, Money Follows the Person, Cost and Utilization, Quality Management/Quality Improvement, NCQA Accreditation, Performance Improvement Projects, CHOICES Critical Incidents, HEDIS/CAHPS, Nurse Triage Line, Utilization Management Phone Line, Emergency Department (ED) Assistance Tracking, ED Threshold, Provider Satisfaction, Financial Management, Provider Networks, Customer Service, and Fraud and Abuse.

HEDIS results – Annually each MCO is required to submit all HEDIS measures designated by NCQA as relevant to Medicaid, with an exception for dental measures. The results must be reported separately for each Grand Region in which the MCO operates. The MCO must contract with an NCQA certified HEDIS auditor to validate the processes in accordance with NCQA requirement. HEDIS data is then submitted to both TennCare and the EQRO, which provides analyses of the data as well as a written comparative report.

Performance Improvement Projects (PIPs) – All MCOs are required to submit at least two clinical and three non-clinical PIPs annually. The two clinical PIPs must include one in the area of behavioral health that is relevant to one of the Population Health programs for bipolar disorder, major depression, or schizophrenia, and one in the area of either child health or perinatal (prenatal/postpartum) health. Two of the three non-clinical PIPs must be in the area of long-term services and supports. All PIPs must be in accordance with CMS Protocols for Performance Improvement Projects. After three years, a decision is made jointly between the MCO and TennCare on the continuation of the PIP.

Annual Quality Survey – The EQRO is contractually required to conduct an Annual Quality Survey of each MCC to assure compliance with contractual requirements. As part of the preparation for the survey, the EQRO, in conjunction with TennCare, reviews all contractual standards for changes that have occurred during the previous year and develops the criteria for review. EQRO staff conduct the survey and provide a detailed written report of findings for each MCO. If an MCO scores less than 100% on any element, a corrective action plan must be submitted within two weeks of receipt of the findings. Both

the EQRO and TennCare staff review the corrective action plans to ensure the MCCs take appropriate action. Follow-up on the plans is conducted by the TennCare Division of Quality Oversight.

Site visits/collaborative work groups – Both the Division of Quality Oversight and the Behavioral Health Operations Unit conduct periodic site visits to learn about and monitor various aspects of MCC activities.

Audits/Medical Record Reviews – Either annually or semi-annually the following Medical Record Reviews (MRRs) are conducted by either the EQRO or the Division of Quality Oversight.

- The EPSDT MRR was replaced with the Child Health Focus Study in 2014 with a focus on Body Mass Index (BMI) performance. However, in 2016 the EPSDT MRR will be continued as in the past. Focus studies are conducted at least annually by desk audits or, as deemed necessary, onsite at the provider offices, depending on the volume or capability of providers to submit records electronically. Collection of BMI measures is monitored, and education of provider staff is conducted if necessary.
- A sample of provider records is reviewed to determine compliance with Abortion, Sterilization, and Hysterectomy (ASH) federal regulations.
- CHOICES chart reviews are conducted to determine compliance with federal and/or state standards for Level of Care, Plans of Care, Freedom of Choice, Qualified Providers, Critical Incidents, Participant Rights, and Abuse and Neglect Education. Some of these areas are audited annually while some are audited bi-annually.
- Chart reviews are conducted on a quarterly basis by desk audits to determine compliance with the coordination of benefits for members who receive services from an MCO and are also enrolled in a Home and Community Based Services (HCBS), Department of Intellectual and Developmental Disabilities (DIDD) Waiver.

Provider Validation Surveys – TennCare’s EQRO is required to conduct a quarterly provider data validation (PDV) survey. The purpose of this activity is to determine the accuracy of the provider data files submitted by the TennCare MCCs and to use the results as a proxy to determine the extent to which providers are available and accessible to TennCare members. Liquidated damages are recommended each quarter if data for more than 10% of providers is incorrect for each data element.

Provider Satisfaction Surveys –Each MCO is required to submit an annual Provider Satisfaction Survey Report that encompasses both physical and behavioral health. The report must summarize the provider survey methods and findings and must provide an analysis of opportunities for improvement. An additional CHOICES Provider Satisfaction Survey Report is also required. This report must address results for CHOICES long-term services and supports providers. It also must include a summary of survey methods and findings as well as an analysis of opportunities for improvement.

Customer Satisfaction Surveys –

- Annually each MCO must conduct a CAHPS survey utilizing a vendor that is certified by NCQA to perform CAHPS surveys. The surveys conducted are the CAHPS Adult Survey, the CAHPS Child Survey, and the CAHPS Children with Chronic Conditions Survey. The data is then submitted to both TennCare and the EQRO, which provides analyses of the data as well as a written report.
- TennCare contracts with The University of Tennessee Center for Business and Economic Research to conduct a survey of 5,000 Tennesseans to gather information on their perceptions of their

health care. The design for the survey is a “household sample,” and the interview is conducted with the head of the household. The report, *The Impact of TennCare: A Survey of Recipients*, allows comparison between responses from all households and households receiving TennCare.

- TennCare contracts with the nine Area Agencies on Aging and Disability, the State’s Single Point of Entry, to conduct a face-to-face CHOICES Customer Satisfaction Survey. Previously, TennCare contracted with the EQRO, Qsource, to conduct an analysis of the customer satisfaction survey data and compile a report of findings. The report evaluates CHOICES members’ satisfaction with the services and supports they receive, as well as their overall contentment. In 2015, TennCare contracted with NASUAD to participate in the National Core Indicators consumer satisfaction survey for the elderly and adults with disabilities. TennCare continues to contract with the nine Area Agencies on Aging and Disability to conduct the face-to-face interviews. Human Services Research Institute completes the data analysis as a component of the contract with NASUAD. This NCI-AD survey measures CHOICES members’ satisfaction with services, their ability to access services, their understanding of their rights and their ability to live the life they intend with the necessary supports in place to help them achieve their desired health and psycho-social outcomes.

Prior approval of all member materials – The Division of Quality Oversight, in conjunction with Managed Care Operations staff, reviews all member materials that have clinical information included. Staff review information for clinical accuracy, culturally appropriate information, and appropriateness of clinical references. LTSS staff, in conjunction with MCO staff, review all member materials related to the CHOICES program as well as all materials submitted by the D-SNPs. All member materials must be approved by TennCare before distribution can occur.

Tennessee Department of Commerce and Insurance – The TennCare Oversight Division of the Tennessee Department of Commerce and Insurance is responsible for the administration and enforcement of the Health Maintenance Organization Act (TCA Title 56, Chapter 32), the Prepaid Limited Health Service Organization Act (TCA Title 56, Chapter 51), and the Administrators Act (TCA 56, Chapter 6, Part 4) with respect to the companies that contract with the TennCare Bureau. The TennCare Oversight Program is required to:

- Act upon licensure applications;
- Examine HMOs and Prepaid Limited Health Services Organizations (PLHSOs) at least once every four years (examinations conducted more frequently than once every four years are optional);
- Review and analyze annual reports filed by the Department of Health or its designee, the TennCare Bureau;
- Contract for an independent evaluation of the statutory standards where failures have been identified;
- Process eligible requests for independent review of denied TennCare provider claims;
- Review and either approve or disapprove material modifications to organization documents, contracts, evidences of coverage, rates, marketing materials, management personnel, and any other item that would materially change the operations of the HMO or PLHSO;
- Administer and enforce the TennCare Prompt Pay Act found at TCA 56-32-126; and
- Provide support services to the Selection Panel for TennCare Reviewers, pursuant to the TennCare Prompt Pay Act.

Policies and Procedures, developed by the MCOs, are reviewed by TennCare staff upon readiness review for new contracts or programs and as needed throughout the life of their contracts.

LTSS Audits – The LTSS Audit and Compliance Unit conducts eleven types of contract compliance audits as listed below, in addition to other audits conducted as the need arises. The measurement criteria for the audits are determined by the CRA with the MCOs or the contract with other entities.

- New Member Audit for members who are new to Medicaid and/or CHOICES – addresses identification of services in the Plan of Care (POC), MCO authorization of HCBS, and the timely initiation of HCBS.
- Referral Audits for existing Medicaid enrollees who are referred for potential enrollment in CHOICES – addresses MCO performance of applicant telephonic screenings, face-to-face assessments, and Pre-Admission Evaluation submissions.
- Critical Incident Audit – addresses MCO determination, documentation, responsiveness, and investigation of critical incidents within specified timeframes. It also addresses the systemic response to patterns of incidents.
- Fiscal Employer Agent (FEA) Audit – addresses the timeliness of support broker assignment to new Consumer Direction (CD) members, notification and provision of the support broker contact information to CD member and care coordinator, initiation of CD services, and frequency of contact with the member.
- Area Agency on Aging and Disability (AAAD) Audit – addresses AAAD performance related to information and referral requests, contact with members and potential members, processing of referrals related to the Minimum Data Set (MDS), ensuring face-to-face evaluations, and completion/submission of eligibility, evaluation and enrollment information consistent with contractual guidelines.
- Money Follows the Person (MFP) Audit – addresses MCO performance related to member eligibility qualifications, member notification about enrollment and disenrollment, reporting of inpatient admissions and discharges, and post inpatient admission follow-up.
- Provider Qualifications Audit – addresses MCO compliance with contract requirements by examining whether MCOs ensure that providers possess appropriate qualifications before serving CHOICES members.
- Short-Term Stay (STS) Audit – addresses MCO performance related to verification of Nursing Facility level of care prior to admission, verification that the MCO properly managed the STS benefit (i.e., 90 days or less), verification that the MCO reviewed circumstances resulting in multiple STS benefit periods, and verification of the MCO’s evaluation of services and supports for members receiving multiple STS.
- Annual Level of Care Reassessment Audit – addresses MCO performance as it relates to conducting a Level of Care Reassessment for all CHOICES members on an annual basis. The reassessment is conducted to ensure our members are receiving services consistent with their needs and are enrolled in the appropriate CHOICES group, particularly focusing on the Carryover demonstration group.
- Select Community Audit – addresses the MCOs performance related to enrolling members of the specified population into the program and completing assignment and assessment within specified timeframes.
- CHOICES MCO capitation Reconciliation Audit – determines if MCOs are exempt from recoupment of overpayments when members have had an extended period without services.

This process examines whether or not the lapse in service was justified or represents underperformance by the MCO, such that readjustment of the capitation payment is appropriate.

CHOICES Care Coordination Monitoring

Because care coordination is the cornerstone of an effective MLTSS program, monitoring the quality of the Care Coordination function is essential to the program's success. This monitoring is conducted by the LTSS QA unit and includes the following:

- CHOICES chart reviews are conducted to determine compliance with federal and/or state Standards for Level of Care, Plans of Care, Freedom of Choice, Qualified Providers, Critical Incidents, Participant Rights, and Abuse and Neglect Education. Some of these areas are audited annually while some are audited bi-annually. Chart reviews are conducted on a quarterly basis by desk audits to determine compliance with the coordination of benefits for members who receive services from an MCO and are also enrolled in Home and Community Based Services (HCBS) waiver.
- Ride-along assessments are conducted by TennCare staff with the CHOICES care coordinators to determine depth of knowledge of the program and available services as well as ensure program information is shared in a manner that reflects compliance with state and federal regulations.
- Person-centered planning (PCP) reviews of the member's plan of care along with interviews with the member are conducted. These activities evaluate the effectiveness of the person-centered planning process and ensure the member is being assisted as needed in driving the PCP process and receiving the assessed needed supports. They also assure that supports required to assist the member in meaningful day activities and achieving personal health and psycho-social outcomes are provided.

LTSS Quality Assurance Processes – In addition to the audits described above, processes are being implemented to ensure compliance with the HCBS Settings final rule and PCP provisions. These quality assurance and monitoring activities include oversight of provider transition plans, provider compliance with the new rule, implementation of an Individual Experience Assessment, standardizing plan of care documents across MCOs, and annual consumer/family satisfaction surveys.

LTSS Quality Assurance Surveys of Community Living Supports (CLS) and CLS –Family Model Providers -

Effective July 1, 2015, CMS approved new community based residential alternative benefits. These are small shared living arrangements designed to serve people who would otherwise require or be at risk of nursing facility placement because they can no longer live alone. These individuals also do not have family members or others who can assist them with ongoing support needs. The benefits offer assistance with daily living activities, and support the member's full participation in community activities. The Department of Intellectual and Developmental Disabilities (DIDD) conducts an initial survey of all newly-licensed CLS and CLS-FM providers. The initial survey includes an on-site visit to the home to observe service delivery in action. It also includes an administrative review of the agency's compliance with program requirements. DIDD will also conduct annual quality surveys of these providers, including on-site visits with members regarding their experience of care in the CHOICES program.

Readiness Reviews – TennCare conducts readiness reviews with the MCOs and other contractors whenever there are substantial changes to the contract requirements. This allows us to determine if the contractor is adequately prepared to implement programmatic changes. These reviews consist of a document review as well as an onsite review of critical processes and operating functions. Feedback is provided to the contractor and they are required to implement corrections before proceeding.

Critical Incidents and Complaints – TennCare has a mechanism within both, the Division of Quality Oversight and LTSS, for addressing critical incidents and quality of care concerns. These processes include tracking, receiving information from the MCOs, and resolving issues if possible. As a result staff have the ability to observe trends in MCC or program performance and utilize this information in quality improvement activities.

Dental Benefits Manager (DBM) Reports and Other Deliverables – The DBM is responsible for submitting a variety of monthly, quarterly, and annual reports and other deliverables through Team Track, TennCare’s secure tracking system. These reports are reviewed by the appropriate business owner at TennCare and a corrective action plan is issued for reports or other deliverables deemed deficient. Liquidated damages may be applied for deficiencies. Examples of DBM reports include Fraud and Abuse activities, QI/UM Committee Meeting minutes, Quarterly Outreach Activities, Case Referral and Corrective Action Assistance, Enrollee Cost Sharing, Quarterly Non-discrimination Compliance, Annual Member Satisfaction Surveys, Annual Provider Satisfaction Surveys, Annual Quality Improvement Activity (QIA) Dental Studies, and Annual QMP Report.

- The DBM is required to submit two PIPs related to children’s clinical dental care or administrative process annually. After three years, a decision will be made jointly between the DBM and TennCare on the continuation of the PIP.
- Qsource conducts an Annual Quality Survey of the DBM to assure compliance with contractual requirements. A detailed written report of findings is provided by the EQRO. If the DBM scores less than 100% on any element, a corrective action plan must be submitted and is reviewed by both Qsource and TennCare to assure the DBM takes appropriate action.
- The DBM is required to conduct both a Customer Satisfaction Survey and a Provider Satisfaction Survey and report on the findings annually.
- The DBM is responsible for maintaining and managing an adequate statewide dental provider network, processing and paying claims, managing program data, conducting utilization management and utilization review, and detecting fraud and abuse, as well as meeting utilization benchmarks for annual dental screening percentages, annual dental participation ratios, or outreach efforts calculated to ensure participation of all children who have not received screenings.

External Quality Review

CMS Requirement: Include a description of the state’s arrangements for an annual, external, independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time. (CFR 438.204(d))

Tennessee contracts with Qsource to provide External Quality Review (EQR) activities. The services to be provided under this contract include multiple tasks and deliverables, including an annual quality survey

of all MCOs and the DBM, that are consistent with applicable federal EQR regulations and protocols for Medicaid Managed Care Organizations and state-specific requirements related to Federal court orders. This contract allows the State to be compliant with Federal EQR regulations and rules and to measure MCC-specific compliance with State-specific Federal court orders and the TennCare Section 1115 Waiver. An RFP for External Quality Review services was released on June 2, 2015. QSource won the contract and began a new term on October 1, 2015.

The Annual Quality Survey must include, but not be limited to, review of enrollee rights and protections, quality assessment and performance improvement, structure and operation standards, measurement and improvement standards, and compliance with the appeal process. The survey process includes document review, interviews with key MCC personnel, and an assessment of the adequacy of information management systems. In addition to this survey, QSource conducts Performance Improvement Project validations and Performance Measure validations in accordance with federal requirements.

In addition, Qsource conducts an Annual Network Adequacy Survey to determine the extent to which the MCCs' networks are compliant with contractual requirements.

CMS Requirement: Identify what, if any optional EQR activities the state has contracted with the External Quality Review Organization (EQRO) to perform. The five optional activities include: validation of encounter data reported by an MCO or PIHP; administration or validation of consumer or provider surveys of quality of care; calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO; conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PIHP and validated by an EQRO; and conduct of studies on quality and focus on a particular aspect of clinical or nonclinical services at a point in time.

While Tennessee has not required the EQRO to conduct any of the specified optional activities, Qsource has assisted TennCare with a number of other activities that are not required by CMS. These activities are as follows:

- Participation in MCO collaborative workgroups.
- Training of MCO staff on conducting Performance Improvement Projects.
- Quarterly validation of the accuracy of provider information reported by the MCOs.
- Preparation of an annual comparative analysis of HEDIS measures, Relative Resource Use Measures, and CAHPS measures provided to TennCare by D-SNPS who have signed a MIPPA Agreement. Because the health plans are required to submit the measures listed above and because of improved statistical capability within the Bureau of TennCare, the measures that QSource might otherwise calculate are limited.
- Preparation of an annual Impact Analysis Report outlining national initiatives/changes that have potential to impact managed care in Tennessee.
- Planning and execution of an educational meeting three times a year for TennCare's Quality Oversight staff as well as all MCOs and the DBM.
- Analysis of the CHOICES Customer Satisfaction Survey.
- Assisting the Division of Quality Oversight with its strategic planning sessions and Quality Strategy development.
- Providing technical assistance to MCCs on a variety of topics including HEDIS and CAHPS reporting.

Until a few years ago, the EQRO validated encounter data, but with the implementation of the State’s information system, the encounter validation process reached a point where there was no added value due to the inherent system edits and checks.

CMS requirement: If applicable, identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are duplicative to those in 42 CFR 438.204(g). (CFR 438.360(b)(4))

Below is a table reflecting those contractual standards that are deemed met by the NCQA Accreditation Survey. Annually all contractual requirements are compared with the most current NCQA standards. Those contractual requirements that are greater than the comparable NCQA standard remain a part of the TennCare Annual Quality Survey. If any contractual standards are equal to or lesser than the NCQA standards they will be deemed met by the NCQA survey.

State Requirements Deemed Met by NCQA Accreditation Survey	
2015 State Standards	2015 NCQA Accreditation Standards
<p>CRA § 2.11.1.5.-2.11.1.5.1-4 (E/W, Middle, & TCS)</p> <p>The contractor may not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:</p> <ul style="list-style-type: none"> • The member’s health status or medical, behavioral health, or long-term care treatment options, including alternative treatments that may be self-administered; • Any information the member needs in order to decide among all relevant treatment options; • The risks, benefits, and consequences of treatment or non-treatment; or • The member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 	<p>QI 3B Affirmative Statement</p> <p>Contracts with practitioners include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.</p>
<p>CRA § 2.18.3 & 2.18.2-2.18.3 (E/W, Middle, & TCS)</p> <p>The CONTRACTOR shall participate in the State’s efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds.</p>	<p>QI 4A Cultural Needs and Preferences and RR 4B Interpreter Services</p> <p>The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.</p>
<p>CRA 2.8.4.3.2</p> <p>The CONTRACTOR shall develop and operate the “opt out” health risk management program per NCQA standards QI 8 for disease management. Program</p>	<p>QI 8, Elements A-J</p> <p><i>QI 8A– Program Content</i> The content of the organization’s programs addresses the following for each condition.</p> <ol style="list-style-type: none"> 1. Condition monitoring

State Requirements Deemed Met by NCQA Accreditation Survey

2015 State Standards	2015 NCQA Accreditation Standards
<p>services shall be provided to eligible members unless they specifically ask to be excluded.</p>	<ol style="list-style-type: none"> 2. Adherence to treatment plan 3. Medical and behavioral health co-morbidities and other health conditions 4. Health behaviors 5. Psychosocial issues 6. Depression screening 7. Information about the patient’s condition provided to caregivers who have patient’s consent 8. Encouraging patients to communicate with their practitioners about health conditions and treatment. <p><u>QI 8B–Identifying Members for DM Programs</u> The organization uses the following sources to identify members who qualify for DM programs.</p> <ol style="list-style-type: none"> 1. Claim or encounter data 2. Pharmacy data, if applicable 3. Health risk appraisal results 4. Laboratory results, if applicable 5. Data collected through the UM, case management, or care management process 6. Member and practitioner referrals <p><u>QI 8C–Frequency of Member Identification</u> The organization systematically identifies members who qualify for each of its DM programs.</p> <p><u>QI 8D–Providing Members with Information</u> The organization provides eligible members with the following written information about the program:</p> <ol style="list-style-type: none"> 1. How to use services 2. How members become eligible to participate 3. How to opt in or opt out <p><u>QI 8E–Interventions Based on Assessment</u> The organization provides intervention to members based on assessment.</p> <p><u>QI 8F–Eligible Member Active Participation</u> The organization annually measures active member participation rates.</p> <p><u>QI 8G–Informing and Educating Providers</u> The organization provides practitioners with written information about the DM program that includes:</p> <ul style="list-style-type: none"> • Instructions on how to use DM services. • How the organization works with a practitioner’s patients in the program. <p><u>QI 8H Integrating Member Information</u> The organization integrates information from the following system to facilitate access to member health</p>

State Requirements Deemed Met by NCQA Accreditation Survey	
2015 State Standards	2015 NCQA Accreditation Standards
	<p>information for continuity of care:</p> <ol style="list-style-type: none"> 1. A health information line 2. A DM program 3. A case management program 4. A UM program, if applicable 5. A wellness program, if applicable <p><u>QI 8I–Satisfaction with Disease Management</u> The organization annually evaluates satisfaction with its disease management services by:</p> <ol style="list-style-type: none"> 1. Obtaining member feedback 2. Analyzing member complaints and inquiries <p><u>QI 8J–Measuring Effectiveness</u> The organization employs and tracks one performance measure for each DM program. Each measurement:</p> <ol style="list-style-type: none"> 1. Addresses a relevant process or outcome 2. Produces a quantitative result 3. Is population based 4. Uses data and methodology that are valid for process or outcome being measured 5. Has been analyzed in comparison with a benchmark or goal
CRA 2.8.4.7.3	QI 7 Complex Case Management
The CONTRACTOR shall develop and implement the Complex Case Management Program according to NCQA standard QI7.	<p><u>QI 7A–Population Assessment</u> The organization annually:</p> <ol style="list-style-type: none"> 1. Assesses the characteristics and needs of its member population and relevant subpopulations 2. Reviews and updates its complex case management processes to address member needs, if necessary. <p><u>QI 7B–Identifying Members for Case Management</u> The organization uses the following sources to identify members for complex case management:</p> <ol style="list-style-type: none"> 1. Claim or encounter data 2. Hospital discharge data 3. Pharmacy data, if applicable 4. Data collected through UM management process, if applicable 5. Data supplied by purchases, if applicable 6. Data supplied by member or care givers 7. Data supplied by practitioners <p><u>QI 7C–Access to Case Management (CM)</u> The organization has multiple avenues for members to be considered for complex CM services, including:</p> <ol style="list-style-type: none"> 1. Health information line referral, if applicable 2. DM program referral 3. Discharge planner referral 4. UM referral, if applicable

State Requirements Deemed Met by NCQA Accreditation Survey

2015 State Standards	2015 NCQA Accreditation Standards
	<p>5. Member or caregiver referral 6. Practitioner referral</p> <p><u>QI 7D–Case Management Systems</u> The organization uses CM systems that support:</p> <ul style="list-style-type: none"> • Evidence-based clinical guidelines or algorithms to conduct assessment and management • Automatic documentation of the staff’s; members ID and date and time on the case or when interaction with the member occurred • Automated prompts for follow-up, as required by the case management plan. <p><u>QI 7E–Case Management Process</u> The organization’s complex case management procedures address the following:</p> <ol style="list-style-type: none"> 1. Initial assessment of members’ health status, including medications 2. Documentation of clinical history, including medications 3. Initial assessment of the activities of daily living 4. Initial assessment of mental health status, including cognitive functions 5. Initial assessment of life-planning activities 6. Evaluation of cultural and linguistic needs, preferences, or limitations 7. Evaluation of visual and hearing needs, preferences, or limitations 8. Evaluation of caregiver resources and involvement 9. Evaluation of available benefits within the organization and from community resources 10. Evaluation of an individualized case management plan, including prioritized goals, that considers the member’s and caregivers’ goals, preferences and desired level of involvement in the CM plan 11. Identification of barriers to meeting goals or complying with plan 12. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals 13. Development of a schedule for follow-up and communication with members 14. Development and communication of member self-management plans 15. A process to assess progress against case management plans for members <p><u>QI 7F–Initial Assessment</u> An NCQA review of a sample of organization’s complex case management files demonstrate that the organization</p>

State Requirements Deemed Met by NCQA Accreditation Survey

2015 State Standards	2015 NCQA Accreditation Standards
	<p>follows its' documented processes for:</p> <ol style="list-style-type: none"> 1. Initial assessment of member health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living 4. Initial assessment of mental health status, including cognitive functions 5. Evaluation of cultural and linguistic needs, preferences or limitations 6. Evaluation of visual and hearing needs, preferences or limitations 7. Evaluation of caregiver resources and involvement 8. Evaluation of available benefits within the organization and form community resources 9. Initial assessment of life-planning activities <p><u>QI 7G–Case Management-Ongoing Management</u> The NCQA review of a sample of organization’s complex case management files demonstrate that the organization follows its documented processes for:</p> <ol style="list-style-type: none"> 1. Development of case management plans, including prioritized goals, that take into account member and caregivers’ goals, preferences and desired level of involvement in the program 2. Identification of barriers to meeting goals and complying with the plans 3. Development and communication of member self-management plans 4. Assessment of progress against case management plans and goals, and modifications as needed. <p><u>QI 7H–Satisfaction with Case Management</u> At least annually, the organization evaluates satisfaction with its case management program by:</p> <ol style="list-style-type: none"> 1. Obtaining feedback from members 2. Analyzing member complaints
CRA 2.14.1.6 - 2.14.1.6.5	UM 2A - UM Criteria
<p>The UM program shall have criteria that:</p> <ul style="list-style-type: none"> • Are applied based on individual need. • Are applied based on an assessment of the local delivery system. • Involve practitioners in developing, adopting, and reviewing them. • Are annually reviewed and updated as appropriate. 	<p>The organization has written policies for applying the criteria based on individual needs.</p> <p>The organization has written policies for applying the criteria based on an assessment of the local delivery system.</p> <p>Involves appropriate practitioners in developing, adopting, and reviewing criteria.</p> <p>Annually review the UM criteria and the procedures for applying them, and updates the criteria when appropriate.</p>

State Requirements Deemed Met by NCQA Accreditation Survey	
2015 State Standards	2015 NCQA Accreditation Standards
CRA § 2.14.1.8 (E/W, Middle and TCS)	UM 4 Licensed Health Professionals
The CONTRACTOR shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. The CONTRACTOR shall have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member’s condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.	<p><i>Element A:</i> The organization has written procedures</p> <ul style="list-style-type: none"> • Requiring appropriately licensed professionals to supervise all medical necessity decisions • Specifying the type of personnel responsible for each level of UM decision-making. <p><i>Element C:</i> The organization ensures that a physician or other health care professional, as appropriate, reviews any non-behavioral healthcare denial based on medical necessity.</p> <p><i>Element D:</i> The organization ensures that a physician, appropriate behavioral health care practitioner or pharmacist, as appropriate, reviews any behavioral healthcare denial of care based on medical necessity.</p> <p><i>Element E:</i> The organization</p> <ul style="list-style-type: none"> • Has written procedures for using board-certified consultants to assist in making medical necessity determinations • Provides evidence that organization uses board-certified consultants for medical necessity determinations.
CRA 2.14.1.10	UM 4F – Affirmative Statement about Incentives
The CONTRACTOR shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced.	<p>The organization distributes a statement to all members and to all practitioners, providers, and employees who make UM decisions, affirming the following:</p> <ul style="list-style-type: none"> • UM decision making is based only on appropriateness of care and service and existence of coverage. • The organization does not specifically reward practitioners or other individual for issuing denials of coverage. • Financial incentives for UM decision makers do not encourage decisions that result in under utilization.
CRA 2.14.1.12	UM 4F – Affirmative Statement about Incentives
The CONTRACTOR shall assure UM activities are not structured so as to provide incentives to deny, limit, or discontinue medically necessary covered services.	<p>The organization distributes a statement to all members and to all practitioners, providers, and employees who make UM decisions, affirming the following:</p> <ul style="list-style-type: none"> • UM decision making is based only on appropriateness of care and service and existence of coverage. • The organization does not specifically reward practitioners or other individual for issuing denials of coverage. • Financial incentives for UM decision makers do not encourage decisions that result in under utilization.

State Requirements Deemed Met by NCQA Accreditation Survey	
2015 State Standards	2015 NCQA Accreditation Standards
CRA.2.14.1.13	UM 11A – Assessing Satisfaction with UM Process
The provider survey as required by Section 2.14.1.12 shall assess provider/office staff satisfaction with UM processes to identify areas for improving.	The organization’s annual assessment of satisfaction with the UM process includes: <ol style="list-style-type: none"> 1. Collecting and analyzing data on practitioner satisfaction to identify improvement opportunities. 2. Taking action designed to improve practitioner satisfaction based on its assessment of practitioner data.
CRA 2.14.4.1	UM 12, Element A
The CONTRACTOR shall provide emergency services without requiring prior authorization or PCP referral, as described in Section 2.7.1, regardless of whether these services are provided by a contract or non-contract provider. The CONTRACTOR shall provide post-stabilization care services in accordance with 42 CFR 422.113	The organization’s emergency services policies and procedures require coverage of emergency services in the following situations: <ol style="list-style-type: none"> 1. To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonable, would have believed that an emergency medical condition existed. 2. If any authorized representative, acting for the organization, authorized provision of emergency services.
CRA 2.15.1.5.4	QI 2, Element B
All information about the QM/QI program will be made available to providers and members.	The organization annually makes information about its QI program available to the following groups: <ol style="list-style-type: none"> 1. Members 2. Providers
CRA 15.1.5.3	QI 4, Element A
The CONTRACTOR shall collect data on race and ethnicity.	The organization: <ol style="list-style-type: none"> 1. Assesses the cultural, ethnic, racial, and linguistic needs of its members. 2. Adjusts the availability of practitioners within its network, if necessary.
CRA § 2.27.2 & 2.27.2.8 (E/W, Middle, & TCS)	RR 6C Authorization
In accordance with HIPAA regulations, the CONTRACTOR shall, at a minimum: Make available to TENNCARE enrollees the right to amend their PHI data in accordance with the federal HIPAA regulations. The CONTRACTOR shall also send information to enrollees educating them of their rights and necessary steps in this regard.	The organization has policies and procedures that address members' right to authorize or deny the release of PHI beyond uses for treatment, payment or health care operations.
CRA § 2.26.1; 2.26.1.1; 2.26.1.2; 26.1.3; 2.26.1.5	CR 9 – Elements A, C, and F
If the CONTRACTOR delegates responsibilities to a subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6 as described below:	<i>CR 9A Written Delegation Agreement-</i> The written delegation document: <ol style="list-style-type: none"> 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity 3. Requires at least semiannual reporting of the delegated entity to the organization

State Requirements Deemed Met by NCQA Accreditation Survey

2015 State Standards	2015 NCQA Accreditation Standards
<ul style="list-style-type: none"> • The CONTRACTOR shall evaluate the prospective subcontractor’s ability to perform the activities to be delegated. • The CONTRACTOR shall require that the agreement be in writing and specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or imposing other sanctions if the subcontractor’s performance is inadequate. • Effective with any new subcontracts or upon the next amendment to existing subcontracts, the CONTRACTOR shall include a requirement that the subcontract may be terminated by the CONTRACTOR for convenience and without cause upon a specified number of day’s written notice. • The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary. 	<p>4. Describes the process by which the organization evaluates the delegated entity’s performance</p> <p>5. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.</p> <p><i>CR 9C Right to Approve and Terminate-</i> The organization retains the right to approve, suspend and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation document.</p> <p><i>CR 9F Opportunities for Improvement-</i> For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.</p>

CMS Requirement: If applicable, for MCOs or PIHPs serving only dual eligibles, identify the mandatory activities for which the state has exercised the non-duplication under 438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under 438.358(b)(1) and (b)(2). (CRA 438.360(c)(4))

Not applicable.

SECTION III: STATE STANDARDS

Access Standards

CMS Requirement: This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for access to care, as required by 42 CFR, Part 438, subpart D. These standards should relate to the overall goals and objectives listed in the quality strategy's introduction. States may either reference the access to care provisions from the state's managed care contracts or provide a summary description of the contract provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

STATE ACCESS STANDARDS AS REQUIRED BY 42 CFR, PART 438, SUBPART D	
42 CFR 438.206 AVAILABILITY OF SERVICES	
42 CFR 438.206(b)(1) Maintains and monitors a network of appropriate providers	<p>The Contractor Risk Agreement (CRA) between TennCare and the MCOs addresses provider networks in section 2.11 including primary care providers, specialty service providers, prenatal care providers, behavioral health services, long-term services & supports providers, and safety net providers; credentialing and other certification; and network notice requirements.</p> <p>CRA Section 2.12 addresses provider agreements.</p> <p>CRA Section 2.18 addresses customer service for members, including member services toll-free phone line, interpreter/translation services, cultural competency, and member involvement with behavioral health services.</p> <p>CRA Attachment III addresses general access standards and Attachment IV addresses specialty network standards. Attachment V addresses access and availability for behavioral health services.</p>
438.206(b)(2) Female enrollees have direct access to a women's health specialist	<p>CRA Section 2.11.4 states that a sufficient number of providers must be enrolled in the TennCare program so that prenatal or other medically necessary covered services are not delayed or denied to pregnant women at any time, including during their presumptive eligibility period.</p>
438.206(b)(3) Provides for a second opinion from a qualified health care professional	<p>CRA Section 2.6.4 provides for a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition when requested by a member, parent, and/or legally appointed representative. The second opinion must be provided by a contracted qualified health care professional or the MCO must arrange for a member to obtain one from a non-contract provider. The second opinion shall be provided at no cost to the member.</p>
438.206(b)(4) Adequate and timely coverage of services not available in network	<p>CRA Section 2.11.1.9 States if the MCO is unable to provide medically necessary covered services to a particular member using contract providers, it must adequately and timely cover these services for that member using non-contract providers, for as long as the provider network is unable to provide them.</p>
438.206 (b)(5) Out of network providers coordinate with the MCO or PIHP with respect to payment	<p>CRA Sections 2.13.12-15 address circumstances under which out-of-network providers may seek payment from the MCO. It states the following:</p> <ul style="list-style-type: none"> • The MCO shall pay for any medically necessary covered services provided to a member by a non-contract provider at the request of a contract provider; • The payment shall not be less than 80% of the rate that would have been paid by the MCO if the member had received the services from a contract provider; and

- The MCO shall only pay for covered long-term care services for which the member was eligible and that were authorized by the MCO in accordance with the requirements of this agreement.

438.206(b)(6) Credential all providers as required by 438.214

CRA Section **2.11.9** addresses credentialing of both contract and non-contract providers.

CRA **2.11.9.1.1** states the MCCs must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.

CRA **2.11.9.1.1** states the MCCs must utilize the current NCQA standards for credentialing and recredentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship.

CRA **2.11.9.1.2** states that all credentialing applications must be completely processed within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable.

438.206(c)(1)(i) Providers meet state standards for timely access to care and services

CRA Attachment III states that, in general, MCOs shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, and professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24 hour a day, seven day a week basis. At a minimum, this shall include:

Primary Care Physician or Extender

- Rural – 30 miles or 30 minutes.
- Urban – 20 miles.
- Patient Load – 2,500 or less for physician; one-half this for a physician extender.
- Appointment/Waiting times – Not to exceed 3 weeks from date of a patient’s request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Specialty Care and Emergency Care

- Not to exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.

Hospital Care

- Transport distance will be the usual and customary, not to exceed 30 miles, except in rural areas where access distance may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

Long-Term Care Services

- Transport distance to licensed Adult Day Care providers will be the usual and customary, not to exceed 20 miles in urban areas, not to exceed 30 miles for suburban areas, and not to exceed 60 miles in rural areas except where community standards and documentation shall apply.

General Optometry Services

- Transport Distance: Usual and customary, not to exceed 30 miles, except in rural areas where community standards and documentation shall apply.
- Appointment/Waiting Times: Usual and customary, not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Lab and X-ray services

- Usual and customary, not to exceed 30 minutes, except in rural areas where community access standards and documentation will apply.
- Appointment/Waiting Times: usually and customary, not to exceed 3 weeks, for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Access to specialty care (CRA Attachment IV)

- The MCO must have provider agreements with providers practicing the following specialties: Allergy,

Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Neonatology, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult, child, and adolescent), and Urology.

- Travel distance must not exceed 60 miles for at least 75% of non-dual members.
- Travel distance must not exceed 90 miles for all non-dual members.

Access for Behavioral Health Services (CRA Attachment V)

- *Psychiatric Inpatient Hospital Services* – Travel does not exceed 90 miles for at least 90% of members. Maximum time for admission/appointment is 4 hours (emergency involuntary), 24 hours (involuntary), and 24 hours (voluntary).
- *24 Hour Psychiatric Residential Treatment* – Must contract with at least one provider of service in the Grand Region for adult members. Travel distance does not exceed 60 miles for at least 75% of child members and does not exceed 90 miles for at least 90% of child members. Maximum time for admission/appointment is within 30 days.
- *Outpatient Non-MD Services* – Travel distance does not exceed 30 miles for all members. Maximum time for admission/appointment is within 10 business days; if urgent, within 48 hours.
- *Intensive Outpatient [may include day treatment (adult), intensive day treatment (children/adolescents), or Partial Hospitalization]* – Travel distance does not exceed 90 miles for at least 90% of members. Maximum time for admission/appointment is within 10 business days; if urgent, within 48 hours.
- *Inpatient Facility Services (Substance Abuse)* – Maximum time is within 10 business days; if urgent, within 48 hours. Maximum time for admission/appointment is within two calendar days, or, for detoxification, within four hours in an emergency and 24 hours for non-emergency.
- *24 Hour Residential Treatment Services (Substance Abuse)* – Must contract with at least one provider of service in the Grand Region for adult members and one provider of service in the Grand Region for child members. Timeframe: within 10 business days.
- *Outpatient Treatment Services (Substance Abuse)* – Travel distance does not exceed 30 miles for all members. Timeframe: within 10 business days; within 24 hours for detoxification.
- *Mental Health Case Management* – Not subject to geographic access standards. Timeframe: within seven calendar days.
- *Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, Peer Recovery services, or Family Support services)* – Not subject to geographic access standards. Timeframe: within ten business days.
- *Supported Housing* – Not subject to geographic access standards. Timeframe: within 30 calendar days.
- *Crisis Services (Mobile)* – Not subject to geographic access standards. Timeframe: face-to-face contact within one hour for emergency situations and four hours for urgent situations.
- *Crisis Stabilization* – Not subject to geographic access standards. Timeframe: within 4 hours of referral.

438.206(c)(1)(ii) Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid Fee For Service

CRA section 2.12.9.65 requires that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees.

438.206(c)(1)(iii) Services included in the contract are available 24 hours a day, 7 days a week

CRA Section 2.7.1.1 requires that emergency services be available 24 hours a day, seven days a week.

438.206(c)(1)(iv-v) Mechanisms/monitoring to ensure compliance by providers

Each MCO has a provider services unit that monitors the network for compliance with certain standards. The Bureau of TennCare has contracted with Qsource, TennCare’s EQRO, to conduct a quarterly provider data validation (PDV) survey. The purpose of this activity is to determine the accuracy of the provider data files submitted by the TennCare MCCs and to use the results as a proxy to determine the extent to which providers are available and accessible to TennCare members. The survey is conducted using a hybrid methodology developed to maximize response rates. The survey consists of telephone calls and facsimile follow-up protocol as necessary. The validation tool was programmed into a Microsoft Access database

and pre-populated with data elements from the MCC provider files. Qsource attempts to contact providers up to three times by telephone. Providers were also notified of a toll-free number to allow the provider to call back if the time was not convenient. The following standards are monitored through this survey.

- MCC Data Accuracy - Provider Credentialed Specialty/Behavioral Health Service Code.
- Provider Panel Status (Open/Closed)
- Routine and Urgent Care Services - Provider offices were questioned regarding whether they offered routine and/or urgent care during the time reported for validation. Accuracy was determined by comparing the responses to the thresholds specific to each provider.
- Services for Patients - Two questions were asked of the providers: 1) Do you provide services to patients less than 21 years of age? And 2) Do you provide services to patients 21 years of age and older?
- Primary Care Services
- Prenatal Care Services

438.206(c)(2) Culturally competent services to all enrollees

MCCs are contractually required in CRA 2.18.3 to participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds. Additionally, CRA 2.8.4.3.1 states that health coaching or other interventions for health risk management shall emphasize self-management strategies addressing healthy behaviors, self-monitoring, co-morbidities, cultural beliefs, depression screening, and appropriate communication with providers.

42 CFR 438.207 ASSURANCES OF ADEQUATE CAPACITY AND SERVICES

438.207(b)(1) Offer an appropriate range of preventive, primary care, and specialty services

CRA 2.7.5.1 states, "The Contractor shall provide preventive services which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services, and immunizations in accordance with TennCare Rules and Regulations."

CRA 2.7.5.2.1 states, "The Contractor shall provide or arrange for the provision of medically necessary prenatal care to members beginning on the date of their enrollment in the ... MCO. This requirement includes pregnant women who are presumptively eligible for TennCare, enrollees who become pregnant, as well as enrollees who are pregnant on the effective date of enrollment in the MCO. The requirement to provide or arrange for the provision of medically necessary prenatal care shall include assistance in making a timely appointment for a woman who is presumptively eligible and shall be provided as soon as the Contractor becomes aware of the enrollment."

CRA 2.7.6.1.1 requires that the MCOs provide EPSDT services (TennCare Kids) to members under age 21. CRA 2.7.6.3.1-2 further requires that the MCO provide periodic comprehensive child health assessments, meaning, "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth." At a minimum, these screens must include periodic and interperiodic screens and be provided at intervals which meet standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. See the response for 438.207(b)(2) (below) for further standards of care.

438.207(b)(2) Maintain network sufficient in number, mix, and geographic distribution

CRA Attachments III, IV and V outline standards that the MCOs have to meet.
(See Attachment I of this document to see the full set of standards.)

42 CFR 438.208 COORDINATION AND CONTINUITY OF CARE

438.208(b)(1) Each enrollee has an ongoing source of primary care appropriate to his or her needs

CRA Attachment III outlines standards for primary care providers that each MCO has to meet. The requirements for Primary Care Physicians or Extenders are as follows:

- Distance/Time Rural: 30 miles
- Distance/Time Urban: 20 miles

- Patient Load: 2,500 or less for physician; one-half this for a physician extender
- Appointment/Waiting Times: Usual and customary practice, not to exceed three weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- Documentation/Tracking requirements:
 - Health plans must have a system in place to document appointment scheduling times.
 - Tracking – Plans must have a system in place to document the exchange of member information if a provider other than the primary care provider (i.e., school-based clinic or health department clinic) provides health care.

438.208(b)(2) All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP

The MCOs are responsible for the management, coordination, and continuity of care for all their TennCare members. They coordinate care among PCPs, specialists, behavioral health providers, and long-term care providers and develop/maintain policies and procedures to address this responsibility. For CHOICES members, these policies and procedures specify the role of the care coordinator/care coordination team in conducting these functions (CRA 2.9.1). Additionally, MCOs coordinate with other state and local departments and agencies to ensure that coordinated care is provided to members (CRA 2.9.16).

438.208(b)(3) Share with other MCOs, PIPHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services

MCOs use their Population Health and CHOICES care coordination programs to support the continuity and coordination of covered physical health, behavioral health, and long-term care services, and to support collaboration between providers (CRA 2.9.9.8).

438.208(b)(4) Protect enrollee privacy when providing care

The MCOs are required to comply with all applicable HIPAA and HITECH requirements including, but not limited to, the following (CRA 2.27.2):

- Compliance with the Privacy Rule, Security Rule, and Notification Rule
- The creation of and adherence to sufficient Privacy and Security Safeguards and Policies
- Timely reporting of violations in the access, use, and disclosure of PHI
- Timely reporting of privacy and/or security incidents

438.208(c)(1) State mechanisms to identify persons with special health care needs

CRA 2.9.16 requires MCOs to coordinate with a variety of agencies to assure that those individuals with special health care needs receive the services they need. These agencies include:

- *Tennessee Department of Mental Health & Substance Abuse Services* and *Tennessee Department of Intellectual & Developmental Disabilities (DIDD)* interface and assure continuity and coordination of specialized services in accordance with federal PASRR requirements.
- *Tennessee Department of Children's Services* addresses the needs of children who are in State custody. The TennCare Select MCO serves the majority of these children in order to have continuity when children move from place to place in the state.
- *Tennessee Department of Health, Children's Special Services Program*
- *Area Agencies on Aging and Disability (AAADs)* collaborate on intake of members new to both TennCare and CHOICES. AAADs also assist CHOICES members in Groups 2 and 3 with the TennCare eligibility redetermination process.

MCOs are responsible for the delivery of medically necessary covered services to school-aged children. They are encouraged to work with school-based providers to manage the care of students with special needs. The State implemented a process, referred to as TennCare Kids Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services

<p>on the IEP that the MCOs are to consider for payment (CRA 2.9.16.7.1).</p> <p>Each MCO has a predictive modeling system that allows it to identify high risk individuals and their needs (CRA 2.8.2.1).</p>
<p>438.208(c)(2) Mechanisms to assess enrollees with special health care needs by appropriate health care professionals</p>
<p>For members determined to need a course of treatment or regular care monitoring, the MCO shall have a mechanism in place to allow members to directly access a specialist as appropriate for the members' condition and identified needs (CRA 2.14.3.3).</p>
<p>438.208(c)(3) If applicable, treatment plans developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state standards</p>
<p>Not Applicable</p>
<p>438.208(c)(4) Direct Access to specialists for enrollees with special health care needs</p>
<p>The MCOs establish and maintain a network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of its members (adults and children) without excessive travel requirements. TennCare monitors compliance with specialty network standards on an ongoing basis (CRA 2.11.3.2-3).</p>
<p style="text-align: center;">42 CFR 438.210 COVERAGE AND AUTHORIZATION OF SERVICES</p>
<p>438.210(a)(1) Identify, define, and specify the amount, duration, and scope of each service.</p>
<p>See Attachment II for covered benefits.</p>
<p>438.210(a)(2) Services are furnished in an amount, duration, and scope that is no less than those furnished to beneficiaries under fee-for-service Medicaid.</p>
<p>All covered benefits are provided if medically necessary through a capitated arrangement with the MCCs.</p>
<p>438.210(a)(3)(i) Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.</p>
<p>CRA 2.6.3 relates to Medical Necessity Determinations. It states that the MCCs may establish procedures for the determination of medical necessity with the determination being made on a case by case basis and in accordance with the definition of medical necessity defined in TCA 71-5-144 and TennCare rules and regulations. However, this requirement does not limit the MCCs' ability to use medically appropriate cost-effective alternative services in accordance with Section 2.6.5.</p>
<p>438.210(a)(3)(ii) No arbitrary denial or reduction in service solely because of diagnosis, type of illness or condition</p>
<p>CRA Sections 2.6.3.2 and 2.6.3.3 state the MCCs may not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The MCCs must not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.</p>
<p>438.210(a)(3)(iii) Each MCO/PIHP may place appropriate limits on a service, such as medical necessity.</p>
<p>CRA Sections 2.6.3.2 and 2.6.3.3 state the MCCs may not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The MCCs must not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.</p>
<p>42 CFR 438.210(a)(4) Specify what constitutes "medically necessary services".</p>
<p>CRA 2.6.3 relates to Medical Necessity Determinations. It states that the MCCs may establish procedures for the determination of medical necessity with the determination being made on a case-by-case basis and in accordance with the definition of medical necessity defined in TCA 71-5-1944 and TennCare rules and regulations governing medical necessity, which are delineated at 1200-13-16. Specifically, to be medically necessary, the benefit must meet each of the following criteria:</p>

- It must be recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within the scope of his or her license who is treating the enrollee;
- It must be required in order to diagnose or treat an enrollee's medical condition;
- It must be safe and effective;
- It must not be experimental or investigational; and
- It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

438.210(b)(1) Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services.

438.210(b)(2)(i) Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions.

CRA Section 2.14.1.9 states that MCOs must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. They must also have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any Amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional that has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional that has appropriate expertise in providing long-term care services.

CRA Section 2.14.2.1 states that MCOs must have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The policies and procedures shall provide for consultation with the requesting provider when appropriate. If prior authorization of a service is granted by the MCO and the service is provided, payment for the prior authorized service shall not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time the prior authorization was granted.

CRA 2.14.5.1 states that MCOs must have in place an authorization process for covered long-term services and cost effective alternative services that is separate from but integrated with the prior authorization process for covered physical and behavioral health services.

438.210(b)(3) Any decision to deny or reduce services is made by an appropriate health care professional.

CRA Section 2.14.1.9 states that MCOs must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorizations and decision making. They must also have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

438.210(c) Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

438.210(d) Provide for the authorization decisions and notices as set forth in 438.210(d).

438.210(e) Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services.

CRA 2.14.7, Notice of Adverse Action Requirement, requires MCOs to:

- Clearly document and communicate the reasons for each denial of a prior authorization request in a

manner sufficient for the provider and member to understand the denial and decide about requesting reconsideration of or appealing the decision;

- Comply with all member notice provisions in TennCare rules and regulations; and
- Issue appropriate notice prior to any contractor-initiated decision to reduce or terminate CHOICES or non-CHOICES nursing facility services and shall comply with all federal court orders, and federal and state laws and regulations, regarding members’ transfer or discharge from nursing facilities.

Structure and Operations Standards

CMS Requirement: This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for structure and operations, as required by 42 CFR, Part 438, subpart D. These standards should relate to the overall goals and objectives listed in the quality strategy’s introduction. States may either reference the structure and operations provisions from the state’s managed care contracts, or provide a summary description of such provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

STATE STRUCTURE & OPERATIONS STANDARDS AS REQUIRED BY 42 CFR, PART 438, SUBPART D	
42 CFR 438.214 Provider Selection	
438.214(a)	Written Policies for Selection and Retention of Providers.
	CRA Section 2.11.1.3.3 states the MCO must have in place written policies and procedures for the selection and retention of providers. These policies and procedures must not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment.
438.214(b)(1)	Uniform credentialing and recredentialing that each MCO/PIHP must follow.
	<p><i>CRA 2.11.8.1 - Credentialing of Contract Providers:</i></p> <ul style="list-style-type: none"> • The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action. • The MCO must completely process credentialing applications from all types of providers (physical health, behavioral health, and long-term care providers) within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. “Completely process” means that the MCO shall approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the MCO. • The MCO must ensure all providers submitted to it by the delegated credentialing agent are loaded to its provider files and into its claims processing system within 30 days of receipt. <p><i>CRA 2.11.8.2 - Credentialing of Non-Contract Providers</i></p> <ul style="list-style-type: none"> • The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing of licensed independent providers with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. • The MCO must completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable. “Completely process” means that the MCO shall review, approve, and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the MCO.

- The MCO must notify TennCare when it denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

CRA 2.11.8.3 - Credentialing of Behavioral Health Entities

- The MCO must ensure each behavioral health provider’s service delivery site meets all applicable requirements of law and has the necessary and current license/certification/accreditation/designation approval per state requirements.
- When individuals providing behavioral health treatment services are not required to be licensed or certified, it is the responsibility of the MCO to ensure, based on applicable state licensure rules and/or program standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.

CRA 2.11.8.4 - Credentialing of Long-Term Care Providers

- The MCO must develop and implement a process for credentialing and recredentialing long-term care providers. The process must, as applicable, meet the minimum NCQA requirements. In addition, the MCO must ensure that all long-term care providers, including those credentialed/recruited in accordance with NCQA standards, meet applicable State requirements, as specified by TennCare in State Rule, in this agreement, or in policies or protocols.
- The MCO must develop policies that specify by HCBS provider type the credentialing process, the recredentialing process including frequency, and ongoing provider monitoring activities.
- Ongoing CHOICES HCBS providers must be recredentialed at least annually.
- All other CHOICES HCBS providers (e.g. pest control and assistive technology) must be recredentialed, at a minimum, every three years.
- At a minimum, credentialing of LTC providers must include the collection of required documents, including disclosure statements, and verification that the provider:
 - Has a valid license or certification for contracted services;
 - Is not excluded from participation in the Medicare or Medicaid programs;
 - Has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TennCare;
 - Has policies and processes in place to conduct, in accordance with Federal and State law and rule and TennCare policy, criminal background checks, which must include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, and List of Excluded Individuals/Entities, on all prospective employees who will deliver CHOICES HCBS and to document these in the worker’s employment record; and
 - Has a process in place to provide and document initial and ongoing education to its employees who will provide services to CHOICES members, and
 - Is compliant with the federal HCBS Settings rule.
- Recredentialing of HCBS providers must include verification of continued licensure and/or certification (as applicable) and compliance with policies and procedures identified during credentialing, including background checks and training requirements, compliance with the HCBS settings rule, critical incident reporting and management, and use of the Electronic Visit Verification (EVV) system.
- For both credentialing and recredentialing process, the MCO must conduct a site visit, unless the provider is located out of state, in which case the site visit may be waived and the reason documented in the provider file.

438.214(c) Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment.

CRA Section 2.11.1.3.3 requires MCOs to have in place written policies and procedures for the selection and retention of providers. These policies and procedures shall not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment.

438.214(d) MCOs/PIHPs may not employ or contract with providers excluded from Federal Health Care Programs.

CRA 2.20.1.5 states, “The contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive TennCare funds.....shall screen their owners and employees against the federal exclusion databases.”

CRA 2.20.3.6 states, “The contractor shall have provisions in its Compliance Plan regarding conducting monthly comparison of their provider files, including atypical providers, against both the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE) and provide a report of the result of comparison to TENNCARE each month. The contractor shall establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers’ Disclosure forms.”

CRA 2.20.3.7 states, “The contractor shall have provisions in its Compliance Plan regarding performing a monthly check for exclusions of their owners, agents and managing employees. The contractor shall establish an electronic database to capture identifiable information on its owners, agents and managing employees and perform monthly exclusion checking. The contractor shall provide the State Agency with such database and a monthly report of the exclusion check.”

42 CFR 438.218 Enrollee Information

438.218 Incorporate the requirements of 438.10

CRA 2.17 incorporates the responses to CFR 438.10. Primary language is identified by the enrollment contractor at the time of each person’s application for TennCare services. If the primary language is omitted from the enrollment files received by the MCO, the MCO staff then collects the information during new member calls. Requirements for the MCOs are as follows:

- Must submit all materials that will be distributed to members to TennCare for prior approval. This includes, but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, and system generated letters. Modifications to existing materials must also receive prior approval.
- All member materials must be worded at a sixth grade reading level and must be clearly legible. They must also be available in alternative formats for persons with special needs at no expense to the member. Formats may include Braille, large print, and audio, depending on the needs of the member.
- All vital documents must be translated and available in Spanish. Within 90 calendar days of notification from TennCare, all vital documents must be translated and available to each Limited English Proficiency (LEP) group identified by TennCare that constitutes 5% of the TennCare population or 1,000 enrollees, whichever is less.
- All written member materials must notify enrollees that oral interpretation is available for any language at no expense to them and how to access those services.
- The MCO must provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. They must provide written notice at least 30 days before the effective date of a request.
- The contractor must use the approved Glossary of Required Spanish Terms in the Spanish translation of all member materials.
- All educational materials must be reviewed and updated concurrently with the update of the Clinical Practice Guidelines to assure the materials reflect current evidence-based information.
- The MCO must develop a member handbook based on a template provided by TennCare and update it periodically (at least annually). It must be distributed within 30 calendar days of receipt of notice

of enrollment in the MCO or prior to enrollees' enrollment effective date and at least annually thereafter. Members must receive a revised member handbook whenever material changes are made.

CRA 2.17.4.7 requires that each member handbook include the following:

- Table of Contents.
- Explanation of how members will be notified of member-specific information such as effective date of enrollment, PCP assignment, and care coordinator assignment for CHOICES members.
- Explanation of how members can request to change PCPs.
- Description of services provided including benefit limits, the consequences of reaching a benefit limit, non-covered services, and use of non-contract providers, including that members are not entitled to a fair hearing about non-covered services and that members shall use contract providers except in specified circumstances.
- Explanation that prior authorization is required for some services, including non-emergency services provided by a non-contract provider, and that service authorization is required for all long-term care services; that such services will be covered and reimbursed only if such prior authorization/service authorization is received before the service is provided; that all prior authorizations/service authorizations are null and void upon expiration of a member's TennCare eligibility; and that the member shall be responsible for payment for any services provided after the member's eligibility has expired.
- Descriptions of the Medicaid Benefits, Standard Benefits, and the covered long-term care services for CHOICES members, by CHOICES group.
- Description of TennCare cost sharing or patient liability responsibilities including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts. Further, the information shall specify the instances in which a member may be billed for services, and shall indicate that the member may not be billed for covered services except for the amounts of the specified TennCare cost sharing or patient liability responsibilities and explain the member's right to appeal in the event that they are billed for amounts other than their TennCare cost sharing or patient liability responsibilities. The information shall also identify the potential consequences if the member does not pay his/her patient liability, including loss of the member's current nursing facility provider, disenrollment from CHOICES, and, to the extent the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare.
- Information about preventive services for adults and children, including TennCare Kids; a listing of covered preventive services; and notice that preventive services are at no cost and without cost sharing responsibilities.
- Procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract providers. The handbook shall advise members that if they need a service that is not available from a contract provider, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider.
- Information on the CHOICES program, including a description of the CHOICES groups; eligibility for CHOICES; enrollment in CHOICES, including whom to contact at the MCO regarding enrollment in CHOICES; enrollment targets for Group 2 and Group 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3.
- Information on care coordination for CHOICES members, including but not limited to the role of the care coordinator, level of care assessment and reassessment, needs assessment and reassessment, and care planning, including the development of a plan of care for members in CHOICES Groups 2 and 3.
- Information on the right of CHOICES members to request an objective review by the State of their needs assessment and/or care planning processes and how to request such a review.
- Information regarding consumer direction of eligible CHOICES HCBS, including but not limited to the

roles and responsibilities of the member or the member's representative, the services that can be directed, the member's right to participate in or voluntarily withdraw from consumer direction at any time, the role of and services provided by the FEA, and a statement that voluntary or involuntary withdrawal from consumer direction will not affect a member's eligibility for CHOICES.

- Explanation of emergency services and procedures on how to obtain emergency services both in and out of the contractor's service area, including but not limited to an explanation of post-stabilization services, the use of 911, locations of emergency settings, and locations for post-stabilization services.
- Information on how to access the primary care provider on a 24 hour basis as well as the 24 hour nurse line. The handbook may encourage members to contact the PCP or 24 hour nurse line when they have questions as to whether they should go to the emergency room.
- Information on how to access a care coordinator, including the ability to access a care coordinator after regular business hours through the 24 hour nurse triage/advice line.
- Notice of the right to file a discrimination complaint as provided for by applicable federal and state civil rights laws, including but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act of 1990, as well as a complaint form on which to do so. The notice must be considered a Vital Document and shall be available at a minimum in the English and Spanish languages.
- Information about the Long-Term Care Ombudsman Program.
- Information about the CHOICES consumer advocate, including but not limited to the role of the consumer advocate in the CHOICES program and how to contact the consumer advocate for assistance.
- Information about how to report suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 *et seq.*) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 *et seq.* and TCA 37-1-601 *et seq.*), including the phone numbers to call to report suspected abuse/neglect.
- Complaint and appeal procedures.
- Notice that in addition to the member's right to file an appeal directly to TennCare for adverse actions taken by the MCO, the member shall have the right to request reassessment of eligibility related decisions directly to TennCare.
- Written policies on member rights and responsibilities, pursuant to 42 CFR 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs.
- Written information concerning advance directives as described in 42 CFR 489 Subpart I and in accordance with 42 CFR 422.128.
- Notice that enrollment in the contractor's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the contractor's MCO and notice of continuation of care when entering the contractor's MCO as described in Section 2.9.2 of this Agreement.
- Notice to the member that it is his or her responsibility to notify the MCO, TennCare, and Department of Human Services (DHS) (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify DHS (or for SSI eligibles, SSA) could result in the member not receiving important eligibility and/or benefit information.
- Notice that a new member may request to change MCOs at any time during the 45 calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TennCare. This notice must include instructions on how to contact TennCare to request a change.
- Notice that the member may change MCOs at the next choice period and shall have a 45 calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TennCare. This notice shall

include instructions on how to contact TennCare to request a change.

- Notice that the member has the right to ask TennCare to change MCOs based on hardship, the circumstances which constitute hardship, explanation of the member's right to file an appeal if such request is not granted, and how to do so.
- Notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TennCare for termination forms and additional information on termination.
- TennCare and MCO member services toll-free telephone numbers, including the TennCare hotline, the MCO's member services information line, and the MCO's 24/7 nurse triage/advice line with a statement that the member may contact the MCO or TennCare regarding questions about the TennCare program, including CHOICES, as well as the service/information that may be obtained from each line.
- Information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free.
- Information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law.
- Directions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans."
- Information that the member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Information on appropriate prescription drug usage.
- Any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

Provider Directory requirements, listed in CRA 2.17.8, are as follows:

- The MCO must distribute information regarding general provider directories to new members within 30 calendar days of receipt of notification of enrollment in the MCO or prior to the member's enrollment effective date. Such information must include how to access the provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider's participation in the network. Members receiving a hard copy of the provider directory must be advised that the network may have changed since the directory was printed and told how to access current information regarding participating providers.
- The MCO must provide information regarding the CHOICES provider directory to each CHOICES member as part of the face-to-face visit (for members enrolled through the SPOE) or face-to-face intake visit (for current members) as applicable, but not more than 30 days from notice of CHOICES enrollment. Such information shall include how to access the CHOICES provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider's participation in the network. Members receiving a hard copy of the CHOICES provider directory shall be advised that the network may have changed since the directory was printed, and how to access current information regarding the MCO's participating providers.
- The MCO is also responsible for maintaining updated provider information in an online searchable electronic general provider directory and an online searchable electronic CHOICES provider directory. A PDF copy of the hard copy version will not meet this requirement. The online searchable version of the general provider directory and the CHOICES provider directory shall be updated on a daily basis during the business week. In addition, the MCO must make available upon request, in hard copy format, a complete and updated general provider directory to all members and an updated CHOICES provider directory to CHOICES members. The hard copy of the general provider directory and the CHOICES provider directory shall be updated at least on an annual basis. Members receiving a hard copy and/or accessing a PDF version of the hard copy on the MCO's website of the general provider directory or the CHOICES provider directory must be advised that the network may

have changed since the directory was printed and told how to access current information regarding participating providers, including the searchable electronic version of the general provider directory and the CHOICES provider directory as well as the member services line.

- Provider directories (including both the general provider directory and the CHOICES provider directory), and any revisions thereto, must be submitted to TennCare for written approval prior to distribution to enrollees. The text of the directory must be in the format prescribed by TennCare. In addition, the provider information used to populate the provider directory must be submitted as a TXT file or such format as otherwise approved in writing by TennCare and be produced using the same extract process as the actual provider directory.
- The MCO must develop and maintain a general provider directory, which shall be made available to all members. The provider directory must be posted on the MCC website and provided in hard copy upon request of the member. Members must be advised in writing regarding how to access the provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider’s participation in the network. Members receiving a hard copy of the provider directory must be advised that the network may have changed since the directory was printed and told how to access current information regarding participating providers. The online version of the provider directory shall be updated on a daily basis. The general provider directory must include the following: names, locations, telephone numbers, office hours, and non-English languages spoken by contract PCPs and specialists; identification of providers accepting new patients; identification of whether or not a provider performs TennCare Kids screens; hospital listings, including locations of emergency settings and post-stabilization services, with the name, location, and telephone number of each facility/setting; and a prominent notice that CHOICES members should refer to the CHOICES provider directory for information on long-term care providers.

42 CFR 438.224 Confidentiality

438.224 Individually identifiable health information is disclosed in accordance with Federal privacy requirements.

Individually identifiable health information is used and disclosed in accordance with HIPAA privacy requirements (CRA 2.23.2.1).

42 CFR 438. 226 Enrollment and Disenrollment

438.226 Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in 438.56

CRA Section 2.5.3 states that the MCO must not request disenrollment of an enrollee for any reason, and TennCare shall not disenroll members for any of the following reasons:

- Adverse changes in the enrollee’s health;
- Pre-existing medical or behavioral health conditions;
- High cost medical or behavioral health bills;
- Failure or refusal to pay applicable TennCare cost sharing responsibilities, except when this results in loss of eligibility for TennCare;
- Enrollee’s utilization of medical or behavioral health services;
- Enrollee’s diminished mental capacity; or
- Enrollee’s uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity’s ability to furnish services to either this particular enrollee or other enrollees).

42 CFR 438.228 Grievance Systems

438.228(a) Grievance system meets the requirements of Part 438, subpart F

438.228(b) If applicable, random State reviews of notice of action designation to ensure notification of enrollees in a timely manner

CRA Section 2.19.3 outlines all requirements related to appeals as stated below:

- The MCO must have a contact person who is knowledgeable of appeal procedures and shall direct

all appeals, whether the appeal is verbal or the member chooses to file in writing, to TennCare. Should a member choose to appeal in writing, the member shall be instructed to file via mail or fax to the designated TennCare P.O. Box or fax number for medical appeals.

- The MCO must have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The MCO must notify TennCare of the names of appointed staff members and their phone numbers. Staff must be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.
- The MCO must educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action must be taken by the MCO regarding the handling and disposition of an appeal.
- The MCO must identify the appropriate internal individual or body having decision-making authority as part of the appeal procedure.
- The MCO must have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the MCO. However, members shall not be required to use a TennCare-approved appeal form in order to file an appeal.
- Upon request, the MCO must provide members a TennCare approved appeal form(s).
- The MCO must provide reasonable assistance to all appellants during the appeal process.
- At any point in the appeal process, TennCare has the authority to remove a member from the MCO when it is determined that such removal is in the best interest of the member and TennCare.
- The MCO must require providers to display notices of members' right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The MCO must ensure that providers have correct and adequate supply of public notices.
- Neither the MCO nor TennCare shall prohibit or discourage any individual from testifying on behalf of a member.
- The MCO must ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.
- TennCare may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which must be followed by the MCO. However, the MCO must not be precluded from challenging any judicial requirements, and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed, or otherwise rendered inapplicable, the MCO must not be required to comply with such guidelines or rules during any period of such inapplicability.
- The MCO must provide general and targeted education to providers regarding expedited appeals (described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.
- The MCO must require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the MCO when requested by TennCare.
- The MCO must provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation.
- The MCO must urge providers who feel they cannot order a drug on the TennCare Preferred Drug List to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).
- Member eligibility and eligibility-related grievances and appeals (including but not limited to long-

term care eligibility and enrollment), including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities shall be directed to TennCare.
42 CFR 438.230 Subcontractual Relationships and Delegation
438.230(a) Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities
In accordance with contractual requirements, MCOs must monitor all delegated functions to ensure that they are in compliance with all regulations (CRA 2.26.1).
438.230(b)(1) Before any delegation, each MCO/PIHP must evaluate prospective subcontractor’s ability to perform.
All MCOs must evaluate prospective subcontractors’ ability to perform the activities to be delegated in accordance with contractual requirements (CRA 2.26.1.1).
438.230(b)(2) Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor’s performance is inadequate.
MCOs must require that all delegated agreements be in writing and specify the activities and report responsibilities delegated to the subcontractor. Contracts require that delegation may be revoked or sanctions applied if the subcontractor’s performance is inadequate (CRA 2.26.1.2).
438.230(b)(3) Monitoring of subcontractor performance on an ongoing basis
MCOs must monitor all subcontractors on an ongoing basis and subject them to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations (CRA 2.26.1.4).
438.230(b)(4) Corrective action for identified deficiencies or areas for improvement
MCOs must identify deficiencies or areas for improvement and require subcontractors to take corrective action as necessary (CRA 2.26.1.5).

Measurement and Improvement Standards

CMS requirement: This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for measurement and improvement, as required by 42 CFR, Part 438, Subpart D. These standards should relate to the overall objectives listed in the quality strategy’s introduction. States may either reference the measurement and improvement provisions from the state’s managed care contracts, or provide a summary description of such provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

STATE MEASUREMENT & IMPROVEMENT STANDARDS AS REQUIRED BY 42 CFR, PART 438, SUBPART D
42 CFR 438.236 Practice Guidelines
438.236(b) Practice guidelines: 1) are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.
CRA Section 2.15.4 states that the MCO must utilize evidence-based clinical practice guidelines in its Population Health Programs. Wherever possible, MCOs utilize nationally recognized clinical practice guidelines. On occasion, tools for standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances are developed through a formal

process and are based on authoritative sources that include clinical literature and expert consensus. The guidelines must be reviewed and revised whenever the guidelines change and at least every two years. The MCO is required to maintain an archive of its clinical practice guidelines for a period of five years. Such archive must contain each clinical guideline as originally issued so that the actual guidelines for prior years are retained for program integrity purposes. NCQA standard QI 9, Element A requires that guidelines be distributed to appropriate practitioners. All MCOs are required to be NCQA accredited. As part of the accreditation survey, files are reviewed to assure that the NCQA requirements for clinical practice guidelines are met.

It should be noted that TennCare defines evidenced-based practice as a clinical intervention that has demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness. Implied in that definition is that the evidence-based guidelines will incorporate the enrollee's needs and interests as part of the development of evidence-based guidelines.

438.236(c) Dissemination of practice guidelines to all providers, and upon request, to enrollees

All MCOs are required to be NCQA accredited. As part of the accreditation survey, files are reviewed to assure that the NCQA requirements for clinical practice guidelines are met.

42 CFR 438.240 Quality Assessment and Performance Improvement Program

438.240(a) Each MCO and PIHP must have an ongoing quality assessment and improvement program.

CRA Section 2.15 addresses the Quality Assessment and Performance Improvement standards for the MCOs. They must:

- Receive and maintain accreditation from NCQA.
- Have a written program that clearly defines its quality structures and processes and assigns responsibility to appropriate individuals.
- Use NCQA standards as a guide and include a plan for improving patient safety.
- Address physical health, behavioral health, and long-term care services.
- Be accountable to the MCC Board of Directors and executive management team.
- Have substantial involvement of a designated physician and designated behavioral health practitioner.
- Have a Quality Improvement (QI) Committee that oversees the QI functions.
- Have an annual work plan.
- Evaluate the program annually and update as appropriate.
- Make all information available to providers and members.
- Make performance data available to providers and members.
- Use results of activities to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from providers and members.
- Take appropriate action to address service delivery, provider, and other QI issues as they are identified.
- Participate in workgroups hosted by TennCare and agree to establish and implement policies and procedures, including billing and reimbursement, in order to address specific quality concerns.
- Collect data on race and ethnicity.
- Include QM/QI activities to improve healthcare disparities identified through data collection.
- Have a QM/QI committee which must include medical, behavioral health, and long-term care staff as well as contract providers, including medical, behavioral, and long-term care. This committee analyzes and evaluates results, recommends policy decisions, and ensures participation of providers. It must also review and approve the QM/QI program description, annual evaluation, and associated work plan prior to submission to TennCare.

438.240(b)(1) and 438.240(d) Each MCO and PIHP must conduct PIPs and measure and report to the state its performance. List out PIPs in the quality strategy.

CRA 2.15.3 – Performance Improvement Projects (PIPs) – requires that each MCO must perform at least two clinical and three non-clinical PIPs. The two clinical PIPs must include one in the area of behavioral health that is relevant to bipolar disorder, major depression, or schizophrenia and one in the area of

either child health or perinatal (prenatal/postpartum) health.

One of the three non-clinical PIPs must be in the area of long-term care. The MCOs must use existing processes, methodologies, and protocols, including the CMS protocols.

List of PIPs conducted in 2014 (Some topics were conducted by more than one MCO):

- Follow-up Care for Children Prescribed ADHD Medication
- Member Response to Smoking Cessation
- Increasing LDL Screening in CHOICES Members with Cardiovascular Conditions
- Prenatal and Postpartum Care – will target member and provider interventions improve eligible member access to prenatal care and postpartum care
- Appropriate Testing for Children with Pharyngitis
- Cultural Assessment Data Collection
- CHOICES Culture of Integration Survey
- SF-12 Survey
- Cultural Assessment Data Collection
- Depression Among Group 2 CHOICES members
- CHOICES Re-Credentialing: Does targeted provider outreach and enhanced internal processes for HCBS providers lead to improved compliance with the re-credentialing process?
- Improving Diabetes Monitoring for People with Diabetes and Schizophrenia
- Decreasing Member Reported Balance Billing Incidents
- Improving Screening Rates for Adolescents Ages 12 to 21
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) HEDIS
- Improving Screening Rates for Children Ages Birth to 15 months

438.240(b)(2) and 438.240(c) Each MCO and PIHP must measure and report performance measurement data as specified by the State. List out performance measures in the quality strategy.

CRA 2.15.6 states that MCOs must complete all HEDIS measures designated by NCQA as relevant to Medicaid. Due to a Dental carve-out, the dental measures are excluded. Measure results are reported separately for each Grand Region of the state. MCOs must use the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid specifications as identified by NCQA. The MCOs must contract with an NCQA certified HEDIS auditor to validate the processes of the MCO in accordance with NCQA requirements. Audited HEDIS results are submitted both to TennCare and to the EQRO, who then provides a written report to TennCare. See Attachment V for a list of all HEDIS measures.

438.240(b)(3) Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services.

CRA Section 2.14, Utilization Management (UM), requires MCOs to provide for methods of assuring the appropriateness of inpatient care. Such methodologies must be based on individualized determinations of medical necessity in accordance with UM policies and procedures and, at a minimum, must include:

- Pre-admission certification process for non-emergency admissions;
- A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity.
- Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews must not result in delays in the provision of medically necessary urgent or emergency care.
- Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and
- Prospective review of same day surgery procedures.

MCOs must review ED utilization data, at a minimum, every six months to identify members with utilization exceeding the threshold defined by TennCare as ten or more visits in the defined six month period (CRA 2.14.1.16.1).

MCOs must have in place, and follow, written policies and procedures for processing requests for initial and continuing prior authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions (CRA 2.14.2.1).

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services (CRA 2.14.1.9).

MCOs must not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. MCOs may not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history (CRA 2.14.1.10).

MCOs must have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition (CRA 2.14.1.11).

438.240(b)(4) Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

MCOs are contractually required to have in place a written Quality Management/Quality Improvement program that describes all of the mechanisms that they have in place for assessing the quality and appropriateness of care for all enrollees, including those with special health care needs (CRA 2.15).

438.240(e) Annual review by the State of each quality assessment and improvement program. If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.

The MCO quality assessment and improvement programs are reviewed in two different ways. The first is an annual review, by Quality Oversight staff, of the QI/UM program descriptions and annual evaluations, as well as the work plans submitted for the following year. After review of these documents, they will be approved by TennCare or denied with a Corrective Action Plan requested. The second review is done annually by the EQRO and includes the following:

- Policies and procedures ensuring coordination between physical, behavioral health, and long-term care (LTC) services by including the following key elements:
 - Screening for behavioral health needs
 - Referral to physical health, behavioral health, and LTC providers
 - Screening for LTC needs
 - Confidentiality
 - Exchange of information
 - Assessment
 - Treatment plan development
 - Collaboration
 - Case management (CM) and population health (PH)
 - Provider training
 - Monitoring implementation and outcomes
 - Encourages PCPs and other providers to use state-approved behavioral health screening tool
- Processes in place to assure that members discharged from psychiatric inpatient hospitals and psychiatric residential treatment facilities are evaluated for mental health CM services and provided with appropriate behavioral health follow-up services.
- Process in place to identify and enroll eligible members in each PH program including CHOICES

members, through the same process used for identification of non-CHOICES members and the CHOICES care coordination process.

- Processes to assure that each Population Health program includes the development of program descriptions that serve as the outline for all activities and interventions in the program. Condition monitoring, patient adherence to the program, consideration of other co-morbidities and condition related lifestyle issues are addressed.
- Processes to assure that PH program descriptions address how the CHOICES care-coordinator will receive notification of the member’s participation, information collected about the member, and educational materials given to the member.
- Processes to identify CHOICES member needs when they are in transition between MCOs. Must assure that a comprehensive needs assessment is immediately conducted, the plan of care is updated, and the changes in services are implemented within 10 days of the MCO becoming aware of the change in needs.
- Processes for assuring that members transitioning from a nursing facility to a community based residential alternative or to live with a relative or other caretaker, the care coordinator makes contact with the member within the first 24 hours of transition and visits the member in his/her new residence within seven days of transition.
- Processes to assure the MCO conducts a CHOICES level of care assessment at least annually and within five business days of awareness of a change in a member’s functional or medical status that could potentially affect eligibility.

In addition to the reviews mentioned above, NCQA reviews QI/UM standards every three years as part of the MCO Accreditation process.

42 CFR 438.242 Health Information Systems

438.242(a) Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

By contract, each MCO must maintain all information related to interactions with enrollees and providers, including complaints and appeals. Each MCO is also required by contract to maintain all information and/or encounter information for providers with whom the MCO has a capitated arrangement both current and historical. Each MCO is also required to maintain all records and information related to member health status and outcomes.

438.242(b)(1) Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees.

By contract, each MCO is required to maintain all member enrollment and other information, both current and historical. By contract, each MCO is required to maintain all claims information and/or encounter information and all authorization and care coordination both current and historical.

438.242(b)(2) Each MCO and PIHP must ensure data received is accurate and complete.

By contract, each MCO is responsible for ensuring that the level of care is accurate and complete and reflects the member’s current medical and functional status based on information gathered and/or claims and encounters submitted.

SECTION IV: IMPROVEMENT AND INTERVENTIONS

CMS Requirement: Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to:

- *Cross state agency collaborative*
- *Pay-for-performance or value-based purchasing initiatives*
- *Accreditation requirements*
- *Grants*
- *Disease management programs*
- *Changes in benefits for enrollees*
- *Provider network expansion*

Describe how the state’s planned interventions tie to each specific goal and objective of the quality strategy.

PLANNED INTERVENTIONS’ ALIGNMENT WITH QUALITY STRATEGY GOALS AND OBJECTIVES		
GOAL	OBJECTIVE	INTERVENTION
ACCESS TO CARE	Adult’s access to preventive/ ambulatory health services	<p><u>Distribution of Member Materials:</u> MCOs distribute a large number of educational and informational materials to their membership, including but not limited to member handbooks, newsletters, fact sheets, and brochures. Each MCO is required to receive prior written approval from TennCare of all materials that are distributed to members, whether developed by the MCOs or their contractors. TennCare staff reviews the submitted materials for both clinical and programmatic content and either approves or denies them within 15 calendar days from the date of submission. QO staff works closely with the MCOs regarding continual quality improvement of materials developed.</p>
	Children & adolescents’ access to primary care	<p><u>MCC EPSDT (TennCare Kids) Collaborative:</u> The Division of Quality Oversight will continue to host ad hoc MCC EPSDT (TennCare Kids) collaborative meetings that include representatives from all MCOs, the Dental Benefits Manager, and the Department of Health. This group addresses ways of reaching out to TennCare enrollees who are under the age of 21 as well as to their families.</p>
	Children and adults visit doctor/clinic when first seeking care as opposed to hospital/ED	<p><u>Strategic Planning:</u> Annually, the Division of Quality Oversight staff, in collaboration with Qsource and the Division of Healthcare Informatics, reviews and analyzes all data coming in to the Division of Quality Oversight through MCC reporting and other areas. At that time, and in subsequent meetings, decisions are made about areas of performance that need additional emphasis. In 2014, staff expanded strategies to address excessive ED utilization including:</p> <ul style="list-style-type: none"> • Establishment of an internal ED Utilization Workgroup; • Research of initiatives from other states; • Reviewed TennCare MCOs excessive ED initiatives; • Developed baseline and trending data needs; • Developed sampling methodology;

		<ul style="list-style-type: none"> • Established a target population of the top five ED utilizers for each MCO by region and began auditing MCO records for these individuals; • The goal for 2015 is to continue conducting medical record reviews and determining if appropriate interventions were conducted by the MCOs. <p>Opportunities for improvement include:</p> <ul style="list-style-type: none"> • Appropriate use of other resources, e.g., medical home, nurse triage line, and urgent care facilities; • Overall reduction of non-acute/non-accident ED usage; • Engaging members and their family members; • Education
QUALITY OF CARE	Adolescent well-care visits	<p><u>Teen Newsletter:</u> As described above, the MCC EPSDT (TennCare Kids) Collaborative focuses its efforts on improving health care access, education, and services for enrollees. An extremely hard population to reach is the adolescent population. For this reason, the Collaborative specifically targets this age group through a quarterly MCO teen newsletter that includes adolescent-specific articles that address physical, behavioral, and dental health. In 2015, we began allowing the MCOs to deliver this newsletter through social media rather than always through a mailing.</p>
	Timeliness of Prenatal Care	<p><u>Cross State Agency Collaborative:</u> The Division of Quality Oversight will continue to host collaborative meetings addressing maternity issues with prenatal and postpartum care. This group includes representatives from all MCOs and the Tennessee Department of Health as well as TennCare. The group has previously developed a number of interventions related to tobacco use and pregnancy, provider referral to MCO maternity programs, information for referrals for substance abuse, Neonatal Abstinence Syndrome flyers, and provider information about performing and billing postpartum depression screening. A large initiative for the past year was conducting the first ever collaborative Women’s Health Provider conference. All three MCOs provided funds for this event and all three MCO Medical Directors participated in the event’s panel discussion. A provider tool kit addressing preconception health, training outreach workers to talk about preconception health, and provider information about availability of breast pumps has now been developed and is being piloted in nine (9) practice sites.</p>
		<p><u>DOH Perinatal Advisory Committee:</u> The Quality Oversight Clinical Quality Review Manager participates on the Department of Health’s Perinatal Advisory Committee. The committee continues to meet quarterly to address Neonatal Abstinence Syndrome, Postneonatal Follow-up, Baby and Me Tobacco Free, Safe Sleep, Breastfeeding, and the Tennessee Infant Mortality Reduction Strategic Plan. Educational Objectives in Medicine for Perinatal Social Workers and Educational Objectives for Nurses are under revision for 2014 approval.</p>

	Breast and Cervical Cancer Screening	<p><u>Breast and Cervical Cancer Screening Program:</u> The Department of Health’s Breast and Cervical Screening Program provides breast and cervical cancer screening to eligible women and diagnostic follow up tests for those with suspicious results. Women diagnosed with breast or cervical cancer or pre-cancerous conditions for these cancers are enrolled for treatment coverage through TennCare. The mission of the program is to reach and serve lower income uninsured or underinsured women for these basic preventive health screening exams. “Cancer screening saves lives.”</p> <p><u>DOH Collaborative Work Group:</u> TennCare staff participate in the Cervical Cancer Free Tennessee (CCFTN) Initiative, led by the Tennessee Department of Health, by serving on the Cervical Cancer Elimination Committee and the Cervical Cancer Executive Committee. This initiative has as its focus the elimination of cervical cancer by 2040. Objectives include provider awareness, access to care, and targeted consumer education through social marketing. The workgroup meets every two months. CCFTN initiatives include:</p> <ul style="list-style-type: none"> • Local, regional, and statewide “Ask Me” campaign with 3-inch buttons and “CAN WE TALK” posters; • PowerPoint and pamphlets developed for statewide distribution; • Targeted outreach in counties with high cervical cancer rates,; • Outreach to Amish communities; • Adding Tennessee to the website www.cervicalcancerfreeamerica.org; • National and local TV coverage; • Tops and Bottoms Program for breast and cervical cancer awareness statewide training; • TennCare MCO HEDIS results serving as the baseline for the measures; • Inclusion in TennCare Quality Oversight Strategic Planning Meetings; • “Teal for Two” cervical cancer awareness training in five Tennessee regions; • Letter from Commissioner to providers urging them to recommend vaccines including HPV; • Discussion with the Tennessee American Academy of Pediatrics to develop a professional HPV training package for physicians; • “Tips and Time-savers for Talking with Parents about HPV Vaccine” fact sheet developed and available at http://www2.aap.org/immunization/illnesses/hpv/hpv.html; and • The Office of Minority Health’s development of culturally relevant educational messages that will improve programs and increase breast cancer screening and mammograms.
	Child Health	<p><u>Body Mass Index (BMI) Focus Study:</u> From a statistically valid random sample, this focus study was conducted in 2014 to determine compliance with the following measures: height, weight, BMI percentile or value (depending upon age), Counseling for Nutrition, and Counseling for Physical Activity. The analysis includes calculations and rates of the overall and critical component-specific documentation rates for the whole population and stratified by MCO, age group, grand region, and provider type. A BMI Medical Record Review Summary Form is used to summarize deficiencies in provider documentation</p>

		<p>and provide opportunities for provider education and quality improvement. Based upon a review of the findings, corrective action, together with follow-up, may be indicated.</p> <p><u>Activities Related to Child Health Conducted by Individual MCOs:</u></p> <ul style="list-style-type: none"> • The HEDIS Compliance Impact Report uses claims data to show non-compliant measures at a member level. As a result a monthly report was created to identify members who were missing required immunizations two months prior to their 13th birthday. A brochure entitled “<i>Protecting Teens and Young Adults</i>” is then sent to both male and female members who were on this report. • The Pregnancy Identification List compiles all pregnant members based on claims data, pharmacy data and obstetric authorizations. Each weekly list of pregnant members is combined quarterly to mail the Tdap Immunization/Maternity Postcard to pregnant members. • The Be Wise Immunize Program provides an outreach reminder to eligible TennCare Kids members who will reach certain age milestones. These mailings remind parents about the importance of childhood and adolescent immunizations, and include a schedule of immunizations recommended by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC). These interventions encourage parents to call their health care provider for an appointment. • The “Taking Care of Baby and Me” program provides pregnant members prenatal packets offering healthcare information, MCO contact information for assistance in scheduling appointments or transportation, and an incentive (gift card) to members when their doctor sends written verification to the MCOs indicating the member has been seen.
<p style="text-align: center;">SATISFACTION</p>	<p style="text-align: center;">Consumer Satisfaction</p>	<p><u>CAHPS Survey:</u> Annually, each MCO must conduct a CAHPS survey by entering into a contract with a vendor that is certified by NCQA to perform CAHPS surveys. The vendor must conduct the adult survey, the child survey, and the survey for children with chronic conditions. Survey results must be reported to TennCare separately for each required CAHPS survey and must be reported by grand region.</p>

	Complaint Process	<p><u>Quality of Care Complaint Process:</u> The Division of Quality Oversight receives enrollee complaints that are sent directly to TennCare. These complaints are addressed in a variety of ways – through calls to the person submitting the complaint, correspondence with the MCOs, or referrals to other agencies. The Division of Quality Oversight receives Home Health Agency (HHA) critical incident reports that are sent directly to TennCare from the MCOs. Quality of Care Concerns may also be received from other Divisions within the Bureau of TennCare. The incidents are investigated and addressed in a variety of ways – action taken by agency or other agency, action taken by MCO, corrective action as indicated, and follow-up actions. Critical incidents related to the LTSS population are forwarded to the TennCare LTSS Division.</p>
IMPROVE HEALTH CARE	Hb1A1c Testing and Controlling High Blood Pressure	<p><u>MCO Diabetes Collaborative:</u> TennCare’s Population Health staff facilitates the MCO Population Health Collaborative, which consists of representatives from the three MCOs, Department of Health, University of Tennessee Extension program, American Diabetes Association, and TennCare staff. The group has broadened its concentration from diabetes only to include obesity, heart attack, and stroke. This past year, the collaborative supported several initiatives focused on reaching TennCare members and providers, including:</p> <ul style="list-style-type: none"> • Million Hearts, a national initiative launched by Health and Human Services to reduce heart attacks and strokes across the United States; • Creation of educational resources for providers to promote completion of annual diabetic retinal eye exams; • Partnership with the UT Extension Walk Across Tennessee program to encourage physical activity and healthy lifestyles; and • Continued work with both the Tennessee Department of Health’s Diabetes Program and the University of Tennessee Extension’s Stanford Diabetes education initiative. The group is currently working on identifying ways to address the prevalence of diabetes, obesity and hypertension in the Latino community. This formal group has elected not to meet at this time. However all three Managed Care Organizations are continuing to conduct multiple diabetes related activities and are involved in the Million Hearts Campaign. Activities related to this campaign include: <ul style="list-style-type: none"> • Smoking cessation activities; • Monthly reports of members with cholesterol screening gaps; • Offering education on monitoring/controlling BP and medication adherence; • Facebook posts on heart health • Automated educational calls to members, recurring every two (2) months, on Coronary Artery Disease, Cholesterol Management, and Controlling Blood Pressure; • Educational packets distributed at Tennessee Medical Association conferences in six (6) cities; • Educational packets/toolkits distributed in face-to-face visits with top volume providers;

	<p>F/U after hospitalization for mental illness</p>	<p><u>MCO Monitoring:</u> The contracted MCOs are required to submit a <i>Post-Discharge Services</i> quarterly report that shows the length of time between psychiatric hospital discharge and first subsequent mental health service that qualifies as a post-discharge service. These services may include MD services, non-MD services, substance abuse outpatient services, psychosocial rehabilitation services, and mental health case management services. TennCare reviews the reports and determines if the MCO meets the performance measure benchmark listed in the Contractor Risk Agreement. A service that qualifies as a post-discharge service must be received by a member within seven calendar days of discharge. For the reporting period of calendar year 2014, 59% of a MCO’s post-discharge services must meet the standard in order to be considered compliant with the performance measure. When an MCO falls under the performance measure, TennCare first issues a Corrective Action Plan (CAP) to alert the MCO to address the issue with contracted providers. The response to the CAP also helps TennCare learn more about MCO initiatives to improve compliance. At this time, no MCOs are under a CAP for the <i>Post-Discharge Services</i> report.</p> <p><u>Children and Youth Continuum Work Group:</u> The TennCare Division of Behavioral Health Operations participates in the Department of Mental Health and Substance Abuse Services’ (TDMHSAS) Children and Youth (C & Y) Crisis Continuum Workgroup. The group includes representatives from all MCOs, the Department of Children’s Services, Youth Villages (statewide C & Y crisis provider), and the Council on Children’s Mental Health. The workgroup is addressing the need for the development of a Crisis Stabilization Unit for children and youth under the age of 18. Over the past year, TennCare has developed draft planning documents and visited potential physical plant sites. TennCare is working with TDMHSAS leadership to move this initiative forward.</p>
	<p>EPSDT (TennCare Kids) screening</p>	<p><u>Community Outreach:</u></p> <p>In 2015, the Contractor Risk Agreement was revised to reflect new criteria for EPSDT outreach. This was done after an in-depth discussion was held with both the EPSDT Outreach staff and the Medical Director’s from each MCO. All federal requirements will continue to be met. Each MCO must submit to TennCare a comprehensive EPSDT outreach plan by December 1, 2015. The following must be included in each plan:</p> <ul style="list-style-type: none"> • Methodology for developing the plan to include data assessments conducted, policy and procedure reviews, and any other research that may have been conducted; • Outreach efforts that include both written and oral communications as well as both rural and urban areas of the state; • Outreach efforts to teens; • Interim evaluation criteria; • Annual evaluation criteria. <p>Each plan must be resubmitted quarterly with updates on their progress.</p> <p>While the MCOs are expected to develop a comprehensive outreach plan, other outreach criteria also remain as contractual requirements. They are</p>

		<p>as follows:</p> <ul style="list-style-type: none"> • Outreach member materials – must include materials addressing LEP (limited English proficiency), • New member calls if screening rate is below 90%; • Minimum of six (6) outreach contacts per member per calendar year; • Method for notifying families when screenings are due • Follow-up for members who do not receive their screenings timely; • Two attempts to re-notify families if no services were used within a year; • Must have outreach activities informing pregnant women of the need for infant screens. <p>Currently, all of the MCOs have Spanish-speaking bilingual outreach staff at community outreach events targeting the Hispanic TennCare population to promote the importance of preventive health care and to educate members about how to access their benefits and improve their health outcomes by properly utilizing available health care resources.</p>
	<p>Antidepressant medication management</p>	<p><u>Children’s Special Workgroups:</u> The TennCare Division of Behavioral Health Operations participates in regular workgroup meetings with the Department of Children’s Services addressing the issues affecting children in foster care. This workgroup includes representatives from all MCOs and the Department of Mental Health and Substance Abuse Services. These meetings focus on the use of psychotropic medications, coordination of treatment, and identification of data that can be shared between agencies that will increase the quality of care. The workgroup continues to review the data on an annual basis and discuss relevant issues.</p>
	<p>F/U care for children prescribed ADHD medication</p>	

LTSS-CHOICES		
LEVEL OF CARE	Pre-admission evaluation	<p>CHOICES Monitoring: CHOICES Audits are conducted twice a year, with not all measures being evaluated both times, to evaluate CHOICES Assurances. Specific measures monitored include the number and percentage of:</p> <ul style="list-style-type: none"> • CHOICES Group 2 members who had an approved CHOICES Pre-Admission Evaluation prior to enrollment in CHOICES and receipt of Medicaid-reimbursed HCBS. • CHOICES Group 2 member records reviewed with an appropriately completed and signed freedom of choice form that specifies choice was offered between institutional services and HCBS. • CHOICES Group 2 member records reviewed whose plans of care were reviewed/updated prior to the member’s annual review date. • CHOICES HCBS providers reviewed for whom the MCO provides documentation that the provider meets minimum qualifications established by the State and was credentialed by the MCO in accordance with NCQA guidelines prior to enrollment in CHOICES and delivery of HCBS. • CHOICES Group 2 member records reviewed which document that the member/authorized representative (as applicable) received education/information at least annually about how to identify and report instances of abuse, neglect and exploitation. • Critical incident records reviewed in which the incident was reported within timeframes specified in the Contractor Risk Agreement. • CHOICES Group 2 member records reviewed in which HCBS were denied, reduced, suspended, or terminated as evidenced in the Plan of Care and consequently, the member was informed of and afforded the right to request a Fair Hearing when services were denied, reduced, suspended, or terminated as determined by the presence of a Grier consent decree notice.
SERVICE PLAN	Freedom of choice	
	Completion of Assessment	
	Plan of care updated	
PROVIDERS	Documentation of minimum qualifications	
HEALTH & WELFARE	Education/information	
	Critical incidents	
	Right to fair hearing when services denied, reduced, suspended or terminated	

Other Interventions Affecting All Goals and Objectives

Pay-for-performance or value-based purchasing initiatives:

TennCare has been providing Quality incentives, based on improvement to specific HEDIS measures, to the MCOs for several years. As a result of the Quality Redesign meetings, the Quality Incentive performance measures were re-evaluated. The following measures were included in the July 2015 Contractor Risk Agreement (CRA) for payment year 2016. These measures were selected because all three (3) MCOs scored below the 25th National Medicaid Average. The MCOs intend to also use the same incentive measures, as appropriate, in provider contracts. The EPSDT measure was selected because of performance as reflected in the CMS 416 report. The measures are:

- Timeliness of Prenatal Care;
- Postpartum Care;
- Medication Management for People with Asthma – 75% measure;

- Diabetes – Nephropathy, Retinal Exam, and BP <140/90;
- Follow-up Care for Children Prescribed ADHD medication-initiation phase;
- Follow-up Care for Children Prescribed ADHD medication – continuation phase. Both initiation and continuation measures have to be calculated in order to receive the quality incentive payment;
- Adolescent Well-Care Visits;
- Immunizations for Adolescents – Combo 1;
- Antidepressant Medication Management – acute and continuation;
- EPSDT screening ratio 90% or above.

Quality Improvement Collaborative Meetings:

Qsource facilitates three meetings a year that are attended by TennCare and MCCs. Each meeting is organized around a specific quality improvement topic and features keynote presentations, panel discussion, and breakout session. Qsource also arranges for continuing education opportunities to be offered at all of the health plan meetings.

LTSS Initiatives:

- **Quality Improvement in Long Term Services and Supports (QuILTSS)** – In the fall of 2013 TennCare began the QuILTSS initiative with the assistance of Lipscomb University’s School of TransformAging, supported by a Robert Wood Johnson Foundation State Quality and Value Strategies Program grant. Community forums, stakeholder meetings and an on-line survey for members, families, and providers were implemented. The quality framework that resulted from this input focused on Satisfaction, Person Centered Practices/Culture Change, Staffing/Staff Competency, and Clinical Performance. This framework has been applied to NFs since August 2014 through a quarterly submission process that allows TennCare to evaluate NF quality practices and provide quarterly supplemental rate adjustments, based on quality practices and performance. In the first year of implementation, NFs have expanded their quality improvement activities to include resident, family, staff satisfaction surveys and Culture Change/Person Centered Practices assessments. NFs have produced quality improvement activities based on the results of these surveys and assessments. As a result changes were made that are consistent with the proposed regulations for Long-Term Care Facilities (CMS-3260-P) and which support the delivery of more person-centered care in more homelike environments.

The QuILTSS process for NFs will continue to develop, ultimately resulting in per diem rate adjustments based on performance on the domains of the quality framework. TennCare is additionally developing plans to apply the QuILTSS framework to CHOICES HCBS services and eventually to the performance of the MCOs. The HCBS component will focus on the direct care services of Personal Assistance and Residential Services adjusting the reimbursement rates for these services consistent with the provider’s performance in the QuILTSS quality domains. The application of the QuILTSS quality framework to MCOs will result in differential payment to MCOs based on performance in the QuILTSS quality domains.

While many of the quality strategies ensure compliance with minimum standards, the QuILTSS initiative incentivizes providers and MCOs to improve quality to approach the expectations of members who receive services.

- **Enhanced Respiratory Care (ERC)** - In 2010, TennCare began providing enhanced reimbursement to NFs that provide Enhanced Respiratory Care (ERC) services (chronic ventilator

care, ventilator weaning and frequent tracheal suctioning). It is the intent to apply payment reform strategies to ERC such that reimbursement is aligned with preferred outcomes. NFs are currently collecting clinical performance data and technology use data for submission to TennCare. After an adequate baseline period, TennCare will establish benchmarks for quality and technology and will adjust reimbursement to provide higher reimbursement to those facilities that are producing better outcomes with more state-of-the-art technology. In addition, we have implemented CRA changes to increase MCO focus on this vulnerable and high-cost population. MCOs are implementing changes to provider contracting and the utilization review and authorization practices as well as improved quality monitoring of these services. MCOs have been required to obtain clinical expertise in the area of respiratory care to improve their functioning with the service area and population.

- **Workforce Development** - Through its extensive stakeholder input processes, Tennessee has identified that one of the most critical aspects of LTSS value pertains to the level of training and competency of professionals delivering direct supports—whether in a NF or in the community. As a result of these processes TennCare is planning to invest in the development of a comprehensive training program for individuals paid to deliver LTSS. We will establish a framework through research of best practices and stakeholder meetings, including members and providers, and will develop a comprehensive competency based workforce development program and credentialing registry. This program will be offered through secondary, vocational/technical schools, trade schools, community colleges, and 4-year institutions, offering portable, stackable credentials and college credit toward certificate and/or degree program. Professionals delivering services will have the opportunity to both learn and earn by acquiring shorter term credentials with clear labor market value. They will continue to build competencies to access more advanced jobs and higher wages—career path for direct support professionals. The earned credentials will be recognized and accepted (portable) by employers across service settings and a registry for search/matching by individuals, families, providers based on needs/interests of person needing support will be developed. Agencies employing better trained and qualified staff will be appropriately compensated for the higher quality of care experienced by individuals they serve, with higher compensation for staff based on competencies earned.
- **Person-Centered Planning (PCP)** – PCP will become an increasing focus for MCO and TennCare staff. Program activities have already begun. MCO LTSS staff and leadership is being trained on person-center thinking, PCP, and how to operate as a person-centered organization. LTSS are also being trained in person-centered thinking, planning and practices in order to ensure person-centered care coordination and service delivery. PCP training will be required for providers who wish to be considered a “Preferred Provider” in the HCBS network. For providers needing assistance to come into compliance with HCBS Settings requirements, TennCare will facilitate focus groups of non-compliant and compliant providers who can talk through provider specific issues and problem-solve how to achieve compliance together. Participation will be voluntary and can include consumers and family members who may aid in the problem solving process. The primary focus will be on residential settings in the living arrangement category and on non-residential settings in regards to facility based day and sheltered workshop services. We will also provide one-on-one technical assistance to these providers.

Grants:

- **Money Follows the Person** - TennCare implemented its Money Follows the Person (MFP) Rebalancing Demonstration Grant program in October 2011. A unique incentive payment structure rewards MCOs who are successful in achieving the state's transition, rebalancing, and related benchmarks established under the program. In addition to help significant numbers of individuals transition from institutions to qualified residences in the community, the State has utilized rebalancing funds to increase housing capacity across the state, creating more affordable and accessible housing for individuals served in Medicaid programs. The framework, developed in conjunction with stakeholders, focuses on quality from the member's perspective – the member's experience of care. The data will be used in the calculation of payments in order to properly align incentives, enhance the customer experience of care, support better health and improved outcomes for persons receiving LTSS.
- **State Quality and Values Strategy Program** - In 2013, TennCare was awarded a grant from the Robert Wood Johnson Foundation's State Quality and Value Strategies Program to fund technical assistance in the state's Quality Improvement in Long-Term Services and Supports (QuILTSS) value-based purchasing initiative. As part of the QuILTSS initiative, TennCare will develop a new payment approach based in part on a quality framework, including a core set of quality domains and quality performance measures that will be collected to measure the quality of services provided by LTSS providers, both those in nursing facilities and in home and community based services (HCBS). The framework, developed The data will be used in the calculation of payments in order to properly align incentives, enhance the customer experience of care, support better health and improve health outcomes for persons receiving LTSS.
- In 2013, TennCare was awarded a grant from the Robert Wood Johnson Foundation to fund technical assistance in the state's Quality Improvement in Long-Term Services and Supports (QuILTSS) value-based purchasing initiative. As part of the QuILTSS initiative, TennCare will develop a new payment approach based in part on a quality framework, including a core set of quality domains and quality performance measures that will be collected to measure the quality of services provided by LTSS providers. These providers include both those in nursing facilities and in home and community based services (HCBS). The framework, developed in conjunction with stakeholders, focuses on quality from the member's perspective—the member's experience of care. The data will be used to calculate payments in order to properly align incentives, enhance the customer experience of care, support better health and improve health outcomes for persons receiving LTSS.
- **State Innovations Model** - In 2015, TennCare was awarded a State Innovations Model (SIM) grant by CMS. This grant will support TennCare's LTSS program in its implementation of value-based purchasing models for NF and HCBS services as well as Enhanced Respiratory Care services within NFs. It also supports the development and implementation of a comprehensive competency based workforce development program and credentialing registry for direct service workers in NF and HCBS settings. These initiatives will further advance the vision of improved quality of services from the perspective of the member.

Asthma Advisory Committee:

TennCare's Managed Care Organizations are working in collaboration with the Tennessee Department of Health, the American Lung Association, Vanderbilt University, numerous physicians and educators around the state and TennCare Population Health staff. The first meeting for the initiative was in May of

2015 with a goal of putting together a coalition for asthma prevention in each county of the state. Goals for the initiative include:

- Enhanced data availability, sharing;
- Improved quality of care for children with asthma;
- Improved coordination of care for children with asthma, and;
- Enhanced knowledge/understanding of asthma among key populations (general public, parents, children, providers).

Clinical Practice Guidelines:

MCOs are contractually required to utilize evidence-based clinical practice guidelines in their Population Health Programs that have been formally adopted by the MCO's QM/QI committee or other clinical committees. The guidelines must include a requirement to conduct a mental health and substance abuse screening and must be reviewed and revised whenever the guidelines change and at least every two years. The MCOs are required to maintain an archive of its clinical practice guidelines for a period of five years.

HEDIS Measures:

Annually, each MCO must submit all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusion from the complete Medicaid HEDIS data set shall be dental measures and must use the hybrid methodology for any measure containing Hybrid Specifications as identified by NCQA. The results must be reported annually for each grand region in which the Contractor operates. They must contract with an NCQA-certified HEDIS auditor to validate their processes in accordance with NCQA requirements.

Each DNSP that has signed a MIPPA agreement with TennCare also submits HEDIS and CAHPS measures designated for D-SNPs to both TennCare and Qsource, who then aggregates the data and provides a written report.

Performance Improvement Projects:

Requirements for the MCOs to conduct Performance Improvement Projects relevant to the enrollee population will be continued. The two clinical PIPs must include one in the area of behavioral health that is relevant to one of the Population Health programs for bipolar disorder, major depression, or schizophrenia and one in the area of either child health or perinatal (prenatal/postpartum) health. Two of the three non-clinical PIPs must be in the area of long-term services and supports. CMS protocols must be utilized.

Quality Redesign Meetings:

In December 2014, the Division of Quality Oversight began a series of meetings to assess current quality activities across MCOs. MCO participants in the various meetings included Chief Medical Officers, Quality Directors, EPSDT coordinators, and Population Health Directors. TennCare's Quality Oversight Director and Assistant Director, along with the Chief Medical Officer, met with these groups and collaboratively worked on needed changes. The meetings and their results are as follows:

- December 5, 2014 – Included a review of all quality metrics with a discussion of both challenges and priorities for quality improvement.
- January 20, 2015 – Meeting included TennCare's Pharmacy Director and the Pharmacy Benefits Manager (PBM). Discussed procedures for assuring that case managers had access to PBM when necessary to assist enrollees. Subsequently MCOs submitted names of case managers to the PBM and obtained appropriate access.

- February 19, 2015 – The core group met with Population Health Directors and Quality Directors for each MCO. Discussed the appropriateness of continuing various collaborative workgroups to address specific quality improvement topics. The ultimate decision was that two workgroups should remain. The Maternity Workgroup would continue until the joint Provider Toolkit was completed and distributed to providers. This toolkit has subsequently been printed and a pilot project has begun. It was decided that the EPSDT workgroup, which had been dormant for a few months, would continue addressing innovative ways to reach TennCare’s under 21 population and would address topics to include in teen newsletters.
- March 3, 2015 - Addressed the selection of quality measures that should be included in pay for performance incentives for both the MCOs as well as their network providers. Ultimately the joint decision included nine (9) HEDIS measures on which all three (3) health plans scored at 25% of the National Medicaid Average. They included both adult and child measures. The tenth measure was an EPSDT screening ratio of 90% or above. Subsequently these measures were included in the MCO Contractor Risk Agreement and in the MCO network provider contracts as appropriate.
- April 14, 2015 – This meeting included the core group in addition to the EPSDT Managers from each MCO. All MCO contract requirements related to EPSDT were reviewed for effectiveness and change recommendations were made. After review by a number of TennCare staff, some of the current contract citations were removed while other requirements were added.
- July 9, 2015 – A meeting was held with the core group and included the EPSDT Managers from each MCO as well as the EPSDT Director for the Tennessee Department of Health. Possible ways to collaborate on outreach were discussed.

Strategic Planning:

Annually, the Division of Quality Oversight staff, in collaboration with Qsource and the Division of HealthCare Informatics, review and analyze all data coming in to the Division of Quality Oversight through MCC reporting and other areas. At that time, and in subsequent meetings, decisions are made about areas of performance that need additional emphasis. In early 2014, Quality Oversight chose to develop additional improvement strategies addressing two major issues: 1) excessive ED utilization and 2) heart attacks/strokes.

Heart Attacks and Strokes –

The Million Hearts Campaign, a national initiative to prevent one million heart attacks and strokes by 2017, was identified as a program that is closely aligned with improving outcomes in this area. TennCare and the MCOs are focusing on reaching members/citizens as well as contracted providers to build awareness of the campaign and its focus areas. There are also future plans for the MCOs to address operational/system changes targeted on the campaign.

There has been great reception and participation in the campaign by the MCOs and within TennCare. In this first year, the MCOs came up with a number of innovative ideas, such as providing Million Hearts literature and giveaways (e.g., red heart-shaped stress relievers, pens, and bracelets) to attendees at community events, involving health plan staff in the Measure Up/Pressure Down® National Day of Action; Educating Member Education Specialists on the importance of decreasing sodium intake; and placing the Million Hearts website hot link on the provider page of the MCO

website. Continued support of this initiative is expected to improve the health of members/citizens, increase provider awareness of the ABCS and align provider payment with Million Hearts measures.

Population Health:

In December 2011, Quality Oversight staff began leading discussions with the MCOs about moving from disease management to a more comprehensive Population Health model. Discussion continued throughout 2012. Up until this point a traditional disease management model was utilized, addressing only those members who already have a distinct disease process. Beginning in January 2013, a phased in implementation of the new model began with full implementation occurring in July of 2013. The newly designed model was a collaborative effort across all MCOs and reflects a consensus of all participants.

Advantages of the Population Health model include:

- Targeting all members' needs across the continuum, with all eligible populations being included;
- Providing both proactive and reactive interventions;
- Targeting interventions based on risk and lifestyle, not just disease;
- Addressing multiple risks and co morbidities in a whole person approach;
- Addressing upstream causes of poor health (e.g., nutrition, physical inactivity, substance abuse); and
- Mirroring the national trend.

This program will be continued in order to address the health of all enrollees and will be evaluated carefully. The group has developed both process and outcome measures related to the new model, but are currently in the process of refining them to assure the best possible data collection.

Under the new Population Health model, the entire TennCare population for each MCO is stratified into the following seven programs, with specific minimum interventions required for each:

1. *Wellness* - To include behavioral and physical Health Promotion, and Preventive services.
2. *Low to Moderate risk Maternity* - Formerly Opt out low to moderate DM maternity program.
3. *"Opt Out" Health Risk Management* - Includes members in the low or moderate risk categories with one of the current DM conditions; members in high risk category with multiple conditions who did not "Opt in" to the high risk Chronic Care management program; and members who may not have a chronic disease but need help with any health risk they might have, such as tobacco use or weight management. This must include, at a minimum, obesity and tobacco cessation programs.
4. *Care Coordination* - Helps members navigate and coordinate health care services available to them. A care plan may or may not be developed.
5. *"Opt In" Chronic Care Management* - Includes members with complex chronic conditions that fall within the top 3% of the population and who agree to participate. Formerly opt out high risk DM plus other chronic conditions
6. *"Opt In" High Risk Maternity* - Includes members having high risk pregnancy needs and who agree to participate.
7. *"Opt In" Complex Case Management* - Includes members that fall within the top 1% of population but have complex needs outside of chronic conditions . Members may also be identified as potentials for CM by trigger list or referrals.

Healthy Women, Healthy Babies - A Provider Call to Action:

TennCare's MCOs, in collaboration with the Tennessee Department of Health and TennCare, have launched the *Healthy Women, Health Babies* campaign and created a Maternity Toolkit for a three month pilot study. The pilot period is October – December 2015 for Knox and Sullivan counties in East

Tennessee. This goal of the initiative is to prevent unintended pregnancies, improve preconception health, and prevent harmful drug use during pregnancy.

Providers are asked to join the provider call to action by engaging their female patients if child-bearing age in preconception health counseling. Providers begin the conversation with their female questions with one vital question: **“Do you want or plan to become pregnancy within the next year?”** The answer they give will allow providers to individualize their female patient’s primary care to best meet her overall and reproductive needs. The toolkit includes patient educational materials, such as Voluntary Reversible Long Acting Contraceptive (VRLAC) counseling and “10 Things You Should Know Before Pregnancy”.

This pilot will hopefully help provider’s female patients increase the likelihood that future pregnancies are by choice and decrease the likelihood of complications and/or adverse outcomes with future pregnancies. The tool kit contains:

- VRLAC information such as TennCare coverage benefits and counseling codes;
- Tennessee Tobacco Quitline Referral Form Link;
- Maternity Care Management Notification Form;
- Posters;
- Patient Education Resource and;
- Quick Reference MCO Contact Card.

MCO Provider Agreements:

The Tennessee Department of Commerce and Insurance (TDCI) operates under an inter-agency agreement with the Bureau of TennCare to review all MCOs’ provider agreements to ensure the provider agreements meet the uniform requirements set forth in the CRA. When TDCI receives a provider agreement that contains clinical information or other information outside their area of expertise, a copy is sent to the Bureau of TennCare for review and comments. As a means of quality assurance, the Tennessee Comptroller’s office is responsible for auditing the activities of TDCI.

Compliance with Federal Requirements:

Annually, QSource conducts an Abortion, Sterilization, and Hysterectomy (ASH) audit in the MCO’s office to assess documentation compliance with state and federal regulations. When coverage requires the completion of a specific form, the form must be properly completed as described in the form instructions. An Exit Conference is conducted for the purpose of reviewing results of the audit and providing opportunities for education and quality improvement. Based upon a review of the findings, corrective action may be indicated.

Intermediate Sanctions

42CFR 438.204(e) For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 CFR, Part 438, Subpart I.

CRA E.29.1 Addresses Intermediate Sanctions:

- TennCare may impose any or all sanctions upon reasonable determination that the contractor failed to comply with any corrective action plan (CAP) or is otherwise deficient in the performance of its obligations under the Agreement, which shall include, but may not be limited to the following:
 - Fails substantially to provide medically necessary covered services;
 - Imposes on members cost sharing responsibilities that are in excess of the cost sharing permitted by TennCare;
 - Acts to discriminate among enrollees on the basis of health status or need for health care services;

- Misrepresents or falsifies information that it furnishes to CMS or to the State;
- Misrepresents or falsifies information furnished to a member, potential member, or provider;
- Fails to comply with the requirements for physician incentive plans as listed in 42 CFR 438.6(h);
- Has distributed directly, or indirectly through any agent or independent contractor, marketing or member materials that have not been approved by the State or that contain false or materially misleading information; and
- Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.
- TennCare shall only impose those sanctions it determines to be appropriate for the deficiencies identified. However, TennCare may impose intermediate sanctions on the contractor simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe and/or numerous. Intermediate sanctions may include:
 - Liquidated damages;
 - Suspension of enrollment in the contractor's MCO;
 - Disenrollment of members;
 - Limitation of contractor's service area;
 - Civil money penalties as described in 42 CFR 438.704;
 - Appointment of temporary management for an MCO as provided 42 CFR 438.706
 - Suspension of all new enrollment, including default enrollment, after the sanction's effective date;
 - Suspension of payment for members enrolled after the sanction's effective date and until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or
 - Additional sanctions allowed under federal law or state statute or regulation that address areas of non-compliance;
 - Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or
 - Additional sanctions allowed under federal law or state statute or regulation that address areas of non-compliance.

Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.

Each Division of TennCare is responsible for recommending sanctions on MCO if any of the following are identified. The Division of Managed Care Operations reviews all recommendations for sanctions and has the final responsibility for either approving or disapproving them. Once sanctions are approved, the MCO involved is notified that the sanctions will be imposed. Liquidated damages may be assessed for a variety of quality of care issues, including:

- Failure to perform specific responsibilities or requirements that result in a significant threat to patient care or to the continued viability of the TennCare program;
- Failure to perform specific responsibilities or requirements that pose threats to TennCare integrity, but which do not necessarily imperil patient care;
- Failure to perform specific responsibilities or requirements that result in threats to the smooth and efficient operation of the TennCare Program
- Failure to meet performance standards

Deficiencies may be identified through review of MCO reports, audits, or failure to meet other contractual obligations.

Health Information Technology

42 CFR 438.204(f) Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy. Describe any innovative health information technology (HIT) initiatives that will support the objectives of the state's quality strategy and ensure the state is progressing toward its stated goals.

Tennessee's Quality Strategy represents a different route for meeting the goals and priorities outlined by ONC for expanding statewide e-Prescribing, sharing electronic structured lab results from labs, and supporting patient care transitions with electronic care summaries. These basic HIE building blocks will support numerous care improvements for patients, including better treatment and diagnosis, improved chronic care coordination, and reductions in medication errors and unnecessary repeat testing, as well as protecting enrollee privacy by utilizing electronic health records.

In addition to promoting Electronic Health Records, and in accordance with the HITECH Act of 2009, a Business Associate's (BA) disclosure, handling, and use of PHI must comply with HIPAA Security Rule and HIPAA Privacy Rule mandates. Under the HITECH Act, any HIPAA business associate that serves a health care provider or institution is now subject to audits by the Office for Civil Rights (OCR) within the Department of Health and Human Services and can be held accountable for a data breach and penalized for noncompliance.

With these new regulations in mind, TennCare's HIPAA business associate agreement explicitly spells out how a BA will report and respond to a data breach, including data breaches that are caused by a business associate's subcontractors. In addition, TennCare's HIPAA business associate agreement requires a BA to demonstrate how it will respond to an OCR investigation. CRA Section 2.12.9.55 requires that the provider safeguard enrollee information according to applicable state and federal laws and regulations including, but not limited, to HIPAA and Medicaid laws, rules and regulations.

SECTION V: Delivery System Reforms

CMS requirement: This section should be completed by states that have recently implemented or are planning to implement delivery system reforms. Examples of such delivery system reforms include, but are not limited to, the incorporation of the following services and/or populations into a managed care delivery system: aged, blind, and disabled population; long-term services and supports; dental services, behavioral health; substance abuse services; children with special healthcare needs; foster care children; or dual eligibles.

Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying enrollees in this population.
N/A
List any performance measures applicable to this population/service, as well as the reasons for collecting these performance measures.
N/A
List any performance improvement projects that are tailored to this population/service. This should include a description of the interventions associated with the performance improvement projects.
N/A
Address any assurances required in the state’s Special Terms and Conditions (STCs), if applicable.
N/A

In late 2013, TennCare began gathering input from stakeholders to redesign the long-term services and supports delivery system for individuals with intellectual and developmental disabilities (I/DD). Amendment 27 to the TennCare Demonstration is the culmination of more than 18 months of intense planning and discussion with stakeholders, including individuals with I/DD and their families, groups who advocate on their behalf, and providers of HCBS for individuals with I/DD and their associations. Amendment 27—in particular the proposed employment services array and service definitions—were developed with technical assistance and guidance from subject matter experts with the Office of Disability Employment Policy, Allan I. Bergman and Lisa Mills, Ph.D.

The new program (pending CMS approval), called *Employment and Community First CHOICES*, is specifically designed to align financial incentives to support integrated competitive employment and independent, integrated community living as the first and preferred option for individuals with intellectual and developmental disabilities. The comprehensive array of employment supports creates a pathway to employment, even for individuals with significant disabilities, with many services to be reimbursed on an outcome-basis as that step along the employment pathway is complete. Other employment services will be reimbursed in part on the provider’s performance (risk adjusted) on specified employment outcomes (once sufficient data is available to establish benchmarks), e.g., the # or % of persons supported employed in individual employment in integrated settings, # hours worked/week, and the # or % of people employed earning a competitive (or prevailing) wage.

The new Employment and Community First CHOICES program will demonstrate the following:

- A tiered benefit structure based on the needs of individuals enrolled in the program will allow the state to provide HCBS and other Medicaid services more cost-effectively so that more people who need HCBS can receive them. This includes people with intellectual disabilities who would otherwise be on the waiting list for a Section 1915(c)

waiver and people with other developmental disabilities who are not eligible for Tennessee's current Section 1915(c) waivers.

- The development of a benefit structure and the alignment of financial incentives specifically geared toward promoting integrated competitive employment and integrated community living will result in improved employment and quality of life outcomes.

The quality assurance and quality improvement structure for ECF CHOICES will be unique in that, in addition to quality activities performed by the MCOs, and quality assurance monitoring and improvement activities that will be conducted by TennCare, TennCare will contract with the Department of Intellectual and Developmental Disabilities (DIDD) to conduct Quality Assurance surveys of providers enrolled to deliver services in the *Employment and Community First CHOICES* program. DIDD Quality Assurance surveys are completed on site and include visits with people receiving services, thereby obtaining invaluable information about the quality of services from the member's perspective and their satisfaction with services. The survey process is already in place for the State's Section 1915(c) waivers for individuals with I/DD. The State will thus build on a well-developed quality strategy that has been hailed by CMS in the most recent evidentiary review of the 1915(c) waivers as a "model of best practices" to establish performance measures and processes for discovery, remediation, and ongoing data analysis as well as quality improvement. In addition to providing data specific to the quality of services offered in the ECF CHOICES program, this will ensure that TennCare has a comprehensive perspective of quality performance and strategies for quality improvement across the I/DD system as a whole. TennCare has contracted with DIDD to perform quality assurance surveys of providers who deliver Community Living Supports and Community Living Supports – Family Model services to individuals in the current CHOICES program.

Tennessee already participates in National Core Indicators for individuals with I/DD in existing LTSS programs. Once the population enrolled in *Employment and Community First CHOICES* is sufficient, data specific to the ECF CHOICES program will be gathered and reviewed. This data will be used to monitor compliance with HCBS setting requirements and to inform program improvements.

In the first quarter 2015, TennCare began working with behavioral health experts to design and implement a new Behavioral Health Crisis Prevention, Intervention and Stabilization Services benefit for individuals with I/DD who experience challenging behaviors that place themselves or others at risk of harm. The service will be delivered under a new person-centered model of support (MOS) designed to improve quality of life by promoting crisis planning and prevention. Crisis prevention includes person-centered assessment and planning, and training on the MOS as well as the needs of the individual in order to avoid potential triggers and to provide positive behavior supports so that individuals have the opportunity to experience greater independence and an improved quality of life, free of challenging behavior. The model will further support sustained integrated community living by equipping families and providers supporting individuals with I/DD to quickly identify and address potential crisis situations, intervening immediately to de-escalate a potential crisis situation whenever possible. When necessary, the MOS includes the availability of an in-home crisis intervention and stabilization response to assist and support the person or agency who is primarily responsible for supporting an individual with I/DD who is experiencing a behavioral crisis that presents a threat to the individual's health and safety or community living arrangement, or the health and safety of others. The goal is to stabilize in place, divert from inpatient, and support sustained integrated community living whenever possible and appropriate. If it is determined that short-term placement (i.e., respite) out of the current living arrangement is needed in order to stabilize the crisis or that inpatient psychiatric hospitalization is appropriate, the model will include preparation and planning for transition back to the appropriate community living arrangement as soon as appropriate, and with review and revision as needed of the Crisis Prevention and Intervention Plan prior to such transition. TennCare will be collecting quality data that will be used

to develop an incentive or shared savings model based on such key performance indicators, including a decrease in the PRN use of anti-psychotic medications, a decrease in crisis events, and increase in in-place stabilization when crises occur, and a decrease in inpatient psychiatric admissions and inpatient days.

SECTION VI: CONCLUSIONS AND OPPORTUNITIES

Identify any successes that the state considers to be best or promising practices.

The TennCare MCOs have successfully transitioned from Disease Management to Population Health (PH). All 1.2 million TennCare enrollees are now stratified into three PH levels across the care continuum based on their health risk rather than disease. This approach allows for both proactive and reactive interventions and supports staying healthy as well as managing a chronic illness.

An effective process is now in place for seamless coordination of a dual member surrounding an inpatient admission through TennCare's MIPPA Dual Care Coordination Project. Beginning in January of 2013, staff from TennCare's Long Term Services and Supports Division and the Quality Oversight Division began discussions with five D-SNPs related to coordinating care for dual eligible enrollees. These D-SNPs included two who are associated with currently contracted MCOs and three who had no contractual relationships with TennCare other than through the MIPPA agreements. Also included was one contracted MCO in the process of becoming a D-SNP who has since successfully completed the process and is now a fully-functioning collaborator. A series of planning meetings was held with all MCOs and these D-SNPs, with the ultimate goal of developing procedures that would allow all of the plans to refer to each other in order to meet the needs of the enrollees. The group gained consensus and jointly developed two referral tools that could be electronically sent on a daily basis. The tools include information about inpatient admissions and discharges and indicate needs for referrals for specific services, such as Nursing Facility Diversion and Exhaustion of Benefits. The Health Plans work together to address any issues in real time, and the TennCare staff have continued to have regular phone and face-to-face meetings to improve data collection and reporting processes. During such discussions, it was revealed that members admitted to the hospital for 'Observation' were not always captured, so the processes were revised to ensure inclusion of this important dual population for coordination of care. Quarterly reports are submitted to TennCare for monitoring and support of the process. In addition, these plans submit HEDIS data to TennCare for measures identified for D-SNPs by NCQA.

During the 2014 AQS, surveyors noticed several MCO improvements from the previous year, demonstrating a strong commitment to addressing the opportunities identified during the 2013 AQS. One key area was each MCO's continued commitment to participating in the statewide collaborative work groups with TennCare and other MCOs. These collaborations remain important strengths for 2014 and have improved how the MCOs educate and conduct outreach to members and providers by presenting a unified message on topics such as smoking cessation for pregnant members.

The following three programs from TennCare MCOs were listed in the 2013-2014 Medicaid Health Plans of America Best Practices Compendium:

BlueCare of Tennessee: CareCommunications Management System Technology

CareCommunications Management System (CCMS) is an internally developed, comprehensive tracking system that fully exceeds the State's TennCare Kids (EPSDT) requirements. CCMS is used to track each member's screening, diagnosis, and treatment as well as other HEDIS related prevention outreach. In addition to supporting TennCare Kids requirements, CCMS supports a wide spectrum of educational outreach capabilities to both members and to providers. This system is also utilized to make outreach calls to members who are not current with preventive screenings such as, but not limited to, Breast Cancer Screening, Cervical Cancer Screening, ADHD medication compliance, and any element of Comprehensive Diabetes Care. Key objectives: 1) improve the health of the population; 2) improve delivery of benefits, and 3) technology development. BlueCare Tennessee has the capability of capturing data from any parts of the company in multiple formats. Once the data has been captured, CCMS automatically integrates these data sources into a protected production environment. This program took place throughout the State of Tennessee and remained active in 2014.

UnitedHealthcare: Baby Blocks™

Baby Blocks reminds and rewards members for attending appointments during their pregnancy and into the first 15 months of their baby's life. The web-based application uses texting, email, and a consumer-friendly interface to impact HEDIS measures of prenatal care, postpartum care, lead screening, and well-child visits. Key objectives: 1) improve the health of the population, 2) enhance the patient experience of care (including quality, access and reliability), and 3) improve quality of care in a specific clinical area (e.g. prenatal care, diabetes, asthma, etc.). Baby Blocks users are more likely to achieve recommended rates of prenatal care than non-users.

Amerigroup Clinic Day Project

Amerigroup TN has conducted clinic days for Amerigroup's children population. To improve HEDIS quality scores and to gain administrative and operation efficiency, Amerigroup Clinic Days project has been created to develop a standardized general process and a tool kit to conduct Amerigroup Clinic days. This project integrated improved tools used to develop a robust clinic day's process for Amerigroup. Standardizing the process and developing a standard tool kit will result in a consistent quality program geared to improving member access to care, patient compliance and provider engagement. Among the tools that were developed to be used Statewide were:

- A tool that will allow staff to pull the top providers and their member panel for all HEDIS screening rates that fall below the 75th percentile;
- Health promotion material templates for Clinic Day events;
- Templates for provider and member communication for Clinic Day events;
- Member incentive program for member attending screenings Clinic Day events.

Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.

Lack of member engagement in chronic condition programs, wellness programs, and even complex case management programs continues to be a barrier to positive outcomes, both nationally and with the TennCare population. Proven programs can be implemented, but fail if members cannot be engaged. TennCare MCOs, as well as national research, have identified several reasons for lack of engagement by the Medicaid population. Lack of correct or current phone numbers is always the first barrier listed. Medicaid members are very mobile; they change phone numbers and discontinue use of cell phones frequently. Health plans have found this to be true even when the attempt is made one day after receiving the number. When using traditional identification methodologies, there is often a significant lag time between diagnosis and engagement attempts. Members are much more receptive to help at the time of diagnosis. Psychosocial issues also affect engagement rates. If a member has a behavioral health problem, lack of housing and food, or low self-worth, engaging them in health issues is difficult. Another concern for those attempting to engage Medicaid members in continuing programs is the fact that many want their immediate needs met and are not receptive to addressing long-term issues. Often initial engagement occurs but retention in a program does not. The last barrier identified is discovering the right message for the targeted audience. This is extremely difficult and varies tremendously among subpopulations. All TennCare health plans use motivational interviewing techniques in an attempt to engage their members. They are also testing engagement techniques such as social media, face-to-face engagement, focus group approaches, and telephonic strategies.

The transition to ICD-10 has proven to be a challenging endeavor for providers and TennCare MCOs. During the initial transition, providers are anticipated to spend additional time documenting more accurate patient data, clinical processes, and health outcomes. MCOs are establishing the technical capacity to ensure that services will be coded and billed according to the new ICD-10 structure. MCOs

will be training staff and providers to ensure that TennCare enrollees continue to receive timely and quality health care.

Reducing Emergency Department utilization continues to be a challenge as individuals seek ED services for treatment of chronic and ongoing complaints. Quality Oversight continues to explore initiatives to reduce unnecessary ED utilization.

The most pressing program challenge for the MIPPA Dual Care Coordination Project is the lack of engagement with hospitals in more effective communication surrounding discharge planning, particularly setting the member's first follow-up medical/behavioral appointment within seven days. Care coordination is happening between the Medicare and Medicaid Plans on the outpatient side of care, but improvement is needed in securing hospital participation.

Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.

Although some information systems present challenges to data collection for quality oversight and analysis, the State of Tennessee has multiple opportunities for the collection of data to track a variety of quality metrics. Tennessee is constantly seeking ways to upgrade data analytic capabilities across state systems as well as its Medicaid Management Information System (MMIS).

State Registries - The state's immunization cancer registries, as well as, a specialized traumatic head injury registry are all relational database systems which lend themselves well to data analytics.

Claims (APCD, MMIS, BC/BS, others) -Tennessee has the ability to perform data analytics on several aspects of claims systems within its ecosystem. An All Payers Claims Database system was implemented in the state and is now in the process of a re-launch with multiple enhancements being added to its functionality. The State also maintains an extensive data informatics staff dedicated to data analysis of MMIS data. In addition to this staff, Tennessee's 100% Medicaid managed care system provides additional system capabilities at each of TennCare's four MCOs.

Enrollment Reporting Systems - Tennessee is currently implementing a new eligibility system to provide for additional functionality for enrollment as well as data analytics and reporting.

EHR Information Exchange and Regional Health Information Collaborative - In Tennessee, HIE development/use has experienced many challenges. Taking advantage of a national initiative, the State has launched Direct Project to create the set of standards and services that, with a policy framework, can enable simple, directed, routed and scalable transport over the Internet to be used for secure and meaningful exchange between known participants in support of meaningful use. Direct technology offers providers a simple and secure way to communicate protected health information (e.g., clinical summaries, continuity of care documents, and laboratory results) between care settings, as well as directly with the patient who also owns a Direct address. Patients are able to communicate via Direct in a secure fashion by using personal health records that are Direct-enabled. The most basic implementation of the Direct Project is secure email via an email client or web portal, which works just like regular email but with an added level of security required for point-to point exchange of sensitive health information. Direct is advantageous for those with an EHR because it helps in meeting the meaningful use requirements for electronic exchange/transport/transfer of electronic health information. As many as four core and seven menu set measures could be met with various implementations of Direct. The state currently has nearly 5,000 DIRECT secure messaging users.

EHR system adoption in the state is currently at 41%, with over 50% of eligible providers having registered for the CMS incentive program to date. A total of 9,161 providers have registered for either the Medicare or Medicaid EHR incentive program as of the end of August, 2013. While the vast majority of these systems are currently early in the implementation phase, the state HIE infrastructure is also

evolving to meet the needs of health information exchange.

There are also two public regional HIEs and approximately ten private provider-based exchanges active in the state. The public exchanges have 89 clinics and 25 hospitals connected to date and exchanging data both with aggressive growth plans.

EHR and Meaningful Use – TennCare’s Quality Oversight division is responsible for the meaningful use aspect of the EHR incentive program. As such, the Division has four responsibilities:

- Evaluating meaningful use attestations (pre-payment verification)
- Facilitating successful meaningful use
- Collecting MU data
- Analysis and reporting

The prepayment verification procedures have been structured to encourage and enable providers’ continued participation in the program even if an attestation is at first incorrect or incomplete. The robust verification procedures also contribute to the success of that participation by correcting mistakes when they are first available for note and identifying areas of common challenge. A key administrative tool in the prepayment verification process is the TennCare attestation portal: the Provider Incentive Payment Program (PIPP) portal. This portal receives attestations, stores the most recent attestation in a given payment year, and allows TennCare staff to approve or return the attestations as they progress through various stages of the portal. Additional functionality in the portal to support administration of the program is constantly being planned and implemented, and such improvements will continue to affect the process, though not the content, of verification procedures. The goal of these improvements is to support electronic submission of Clinical Quality Measures and other measures as technology advances. These improvements will result in greater reliability of submissions, reducing clerical errors.

The Quality Oversight Meaningful Use Unit is in their fourth year of prepayment verification of meaningful use. The first year of meaningful use in Tennessee was 2012. Data is complete for payment years 2012 and 2013 and preliminary data is ready for payment year 2014. The biggest challenges in 2015 have been related to meaningful use rule changes issued by CMS via the Federal Register for both 2014 and 2015 payment years. In payment year 2014, CMS issued a rule change allowing providers to flex to previous editions of Certified EHR Technology (CEHRT) or to state 1 meaningful for stage 2 providers. This flexibility was added for providers if they were unable to update to 2014 Edition CEHRT due to delays in the availability of the 2014 Edition CEHRT by vendors. In addition for the same reason, providers in 2014 payment year who were due to report Stage 2 meaningful use measures were allowed to flex and report State 1 meaningful use measures. Much of the current logic in the Provider Incentive Payment Portal (PIPP) had to be changed to allow the providers to flex in payment year 2014. Although the rule change was not finalized until September 2014, PIPP changes were completed by November 12, 2014 to allow providers to begin flex attestations. As a result of the “Flex Rule”, only 168 (55%) of providers who could attest to meaningful use Stage 2 were successful and only 37 (22%) of those providers who did attest successfully attested to Stage 2 meaningful use measures. The prepayment tool was semi-automated in PIPP which enhanced the evaluation process. The number of first time meaningful users fell significantly in payment year 2014 and the conversion rate for providers moving from AIU to MU is about 45%. The remaining 55% will be targeted over the next year for outreach by TennCare’s new MU Clinical Educator. Overall, 59% of providers are returning for a second year of meaningful use. This reflects the effort of MU staff in providing technical assistance to those providers who struggle. There were 37 providers who successfully attested to Stage 2 measures in payment year 2014 with only 2 denials for a 95% approval rate and a 5% denial rate. In order to adapt to changes in the 2016 MU Rule, staff is involved in retooling PIPP MU pages, evaluation tools as well as updating web pages and providing educational webinars.

Telemedicine Initiatives - Tennessee has telemedicine facilities in over 100 cities across the state. A recent initiative is the STORC program, a telemedicine project developed through the efforts of Regional Obstetrical Consultants. The project is funded by a grant from the Blue Cross Tennessee Health Foundation and is designed to deliver perinatology services to rural areas. Since its initial implementation in 2009, STORC has now grown to include two physician hub sites, six Tennessee sites and four out-of-state sites. Via STORC services, patients are able to go to a local health center or hospital and meet with a mid-level caregiver and sonographer on site, and with a Maternal-Fetal Medicine specialist physician live via telemedicine equipment. A genetic counselor, diabetic counselor, behavioral health counselor, and interpreter can participate online as well. As of 2012, the technology is used to deliver care in other sub-specialties to which patients in rural areas would otherwise have no access. This technology can also be used to provide Continuing Medical Education.

Grants that support State HIT/EHR development or enhancement - The state of Tennessee has received grants from the Office of the National Coordinator (ONC), CMS, and SAMHSA/MITRE to further HIT and HIE across the state. ONC granted \$11.7 million for HIE advancement over a four year period (February 2010 to February 2014). These funds have assisted in upgrading the state's immunization system, electronic lab reporting, a state DIRECT HISP implementation, the statewide roll-out to providers of DIRECT technology, and ePrescribing adoption, as well as operations and oversight of the program. CMS has granted the state a HIT/HIE IAPD grant of \$25,551,041.00. \$12,184,496 of these funds is intended to fund administration of the CMS Provider Incentive Program and HIE program in Tennessee as well as updates to the State's incentive program registration system. \$13,366,543.00 of these funds is intended to fund HIE projects, including providing State HIE Core services, allowing access to clinical data contained in Medicaid claims to both providers and Medicaid recipients, development of regional HIE organizations, and assisting provider practices in attainment of meaningful use.

Tennessee also received an indirect grant from SAMHSA/MITRE to perform a pilot which provided the infrastructure for the Prescription Drug Monitoring Program to accept real-time updates from pharmacies located within the state at the time of dispensing of controlled substances.

Include recommendations that the State has for ongoing Medicaid and CHIP quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care enrollees, if applicable.

Evaluation of Meaningful Use Data - TennCare will continue to evaluate Meaningful Use Data as more becomes available and will subsequently streamline processes.

State Innovation Model (SIM) Grants - Tennessee received a SIM Design grant from the Centers for Medicare and Medicaid Innovation in 2013 that was used to develop payment and delivery system reform models (such as episodes of care and Patient Centered Medical Homes) to enhance the quality of care, improve the patient experience of care for members, and reduce costs.

The State, led by the Tennessee Health Care Innovation Initiative, applied in October 2014 for a SIM Testing grant to help accelerate the implementation of payment and delivery system reforms. If the State receives this grant, the following quality improvements will begin or be accelerated for managed care enrollees:

- Episodes of care will improve the quality of acute care received by members.
- Patient Centered Medical Homes will promote better care through care coordination as well as proactive closing of gaps in care.
- Health Homes will promote better quality, integrated physical and behavioral health care for TennCare members with severe and persistent mental illness.
- The grant will support Tennessee's chapter of the American Academy of Pediatrics in implementing a portfolio of quality improvement projects working with Tennessee pediatricians.
- Tennessee will implement quality- and acuity- based payment and delivery system reforms for long

term services and supports, including Nursing Facility services and Home and Community Based Services for seniors and adults with physical, intellectual, and developmental disabilities.

- Value-based purchasing for enhanced respiratory care will adjust facilities' rates based on performance on key performance indicators (e.g. infection rates).
- Tennessee is working on developing a comprehensive training program for professionals delivering long term services and supports. Staff training is an important quality measure, and agencies employing better trained staff will be appropriately compensated for the higher quality of care experienced by the individuals they serve.

GENERAL ACCESS STANDARDS

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum, this shall include:

- Primary Care Physician or Extender:
 - (a) Distance/Time Rural: 30 miles or 30 minutes
 - (b) Distance/Time Urban: 20 miles or 30 minutes
 - (c) Patient Load: 2,500 or less for physician; one-half this for a physician extender.
 - (d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
 - (e) Documentation/Tracking requirements:
 - + Documentation - Plans must have a system in place to document appointment scheduling times.
 - + Tracking - Plans must have a system in place to document the exchange of member information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.
- Specialty Care and Emergency Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.
- Hospitals
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.
- Long-Term Care Services:

Transport distance to licensed Adult Day Care providers will be the usual and customary not to exceed 20 miles for TennCare enrollees in urban areas, not to exceed 30 miles for TennCare enrollees in suburban areas and not to exceed 60 miles for TennCare enrollees in rural areas except where community standards and documentation shall apply.

- General Optometry Services:
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation shall apply.
 - (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- Lab and X-Ray Services:
 - (a) Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community access standards and documentation will apply.
 - (b) Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- All other services not specified here shall meet the usual and customary standards for the community as determined by TENNCARE.

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR's network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR's response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

SPECIALTY NETWORK STANDARDS

The CONTRACTOR shall adhere to the following specialty network requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. A provider is considered a "specialist" if he/she has a provider agreement with the CONTRACTOR to provide specialty services to members.

Access to Specialty Care

The CONTRACTOR shall ensure access to specialty providers (specialists) for the provision of covered services. At a minimum, this means that:

- (1) The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Neonatology, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent), and Urology; and
- (2) The following access standards are met:
 - o Travel distance does not exceed 60 miles for at least 75% of non-dual members and
 - o Travel distance does not exceed 90 miles for ALL non-dual members

Availability of Specialty Care

The CONTRACTOR shall provide adequate numbers of specialists for the provision of covered services to ensure adequate provider availability for its non-dual members. To account for variances in MCO enrollment size, the guidelines described in this Attachment have been established for determining the number of specialists with whom the CONTRACTOR must have a provider agreement. These are aggregate guidelines and are not age specific. To determine these guidelines the number of providers within each Grand Region was compared to the size of the population in each Grand Region. The CONTRACTOR shall have a sufficient number of provider agreements with each type of specialist in each Grand Region served to ensure that the number of non-dual members per provider does not exceed the following:

Maximum Number of Non-Dual Members per Provider by Specialty

Specialty	Number of Non-Dual Members
Allergy & Immunology	100,000
Cardiology	20,000
Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurology	35,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Psychiatry (adult)	25,000
Psychiatry (child & adolescent)	150,000
Urology	30,000

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR’s network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR’s response demonstrates existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions.

Attachment III: Access & Availability for Behavioral Health Services

ACCESS & AVAILABILITY FOR BEHAVIORAL HEALTH SERVICES

The CONTRACTOR shall adhere to the following behavioral health network requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TENNCARE will evaluate the CONTRACTOR's provider network relative to the requirements described below. Providers serving adults will be evaluated separately from those serving children.

Access to Behavioral Health Services

The CONTRACTOR shall ensure access to behavioral health providers for the provision of covered services. At a minimum, this means that:

The CONTRACTOR shall have provider agreements with providers of the services listed in the table below and meet the geographic and time for admission/appointment requirements.

Service Type	Geographic Access Requirement	Maximum Time for Admission/Appointment
Psychiatric Inpatient Hospital Services	Travel distance does not exceed 90 miles for at least 90% of members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24 Hour Psychiatric Residential Treatment	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for ADULT members ----- Travel distance does not exceed 60 miles for at least 75% of CHILD members and does not exceed 90 miles for at least 90% of CHILD members	Within 30 calendar days
Outpatient Non-MD Services	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; if urgent, within 48 hours

Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization)	Travel distance does not exceed 90 miles for at least 90% of members	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Abuse)	Travel distance does not exceed 90 miles for at least 90% of members	Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Abuse)	The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for ADULT members ----- The CONTRACTOR shall contract with at least one (1) provider of service in the Grand Region for CHILD members	Within 10 business days
Outpatient Treatment Services (Substance Abuse)	Travel distance does not exceed 30 miles for ALL members	Within 10 business days; for detoxification – within 24 hours
Mental Health Case Management	Not subject to geographic access standards	Within 7 calendar days
Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, or Peer Support)	Not subject to geographic access standards	Within 10 business days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

TENNCARE will evaluate the need for further action when the above standards are not met. At its sole discretion TENNCARE may elect one of three options: (1) TENNCARE may request a Corrective Action Plan (CAP), (2) a Request for Information (RFI), (3) or an On Request Report (ORR) depending on the severity of the deficiency.

The requested CAP, RFI or ORR response shall detail the CONTRACTOR’s network adequacy considering any alternate measures, documentation of unique market conditions and/or its plan for correction. If TENNCARE determines the CONTRACTOR’s response demonstrates the existence of alternate measures or unique market conditions, TENNCARE may elect to request periodic updates from the CONTRACTOR regarding efforts to address such conditions

At a minimum, providers for the following service types shall be reported on the Provider Enrollment File:

Service Type	Service Code(s) for use in position 330-331 of the Provider Enrollment File
Psychiatric Inpatient Hospital Services	Adult - 11, 79, 85 Child – A1 or H9
24 Hour Psychiatric Residential Treatment	Adult - 13, 81, 82 Child – A9, H1, or H2
Outpatient MD Services (Psychiatry)	Adult – 19 Child – B5
Outpatient Non-MD Services	Adult – 20 Child – B6
Intensive Outpatient/ Partial Hospitalization	Adult – 21, 23, 62 Child - B7, C2, C3
Inpatient Facility Services (Substance Abuse)	Adult – 15, 17 Child – A3, A5
24 Hour Residential Treatment Services (Substance Abuse)	Adult - 56 Child - F6
Outpatient Treatment Services (Substance Abuse)	Adult – 27 or 28 Child – D3 or D4
Mental Health Case Management	Adult - 31, 66, or 83 Child – C7, D7, G2, G6, or K1
Psychiatric Rehabilitation Services:	
Psychosocial Rehabilitation	42
Supported Employment	44
Peer Support	88
Illness Management & Recovery	91
Supported Housing	32 and 33
Crisis Services (Mobile)	Adult - 37, 38, 39 Child - D8, D9, E1
Crisis Respite	Adult – 40 Child – E2
Crisis Stabilization	Adult 41

2.6.1 CONTRACTOR Covered Benefits

- 2.6.1.1 The CONTRACTOR shall cover the physical health, behavioral health and long-term care services/benefits outlined below. Additional requirements for behavioral health services are included in Section 2.7.2 and Attachment I.
- 2.6.1.2 The CONTRACTOR shall integrate the delivery of physical health, behavioral health and long-term care services. This shall include but not be limited to the following:
- 2.6.1.2.1 The CONTRACTOR shall operate a member services toll-free phone line (see Section 2.18.1) that is used by all members, regardless of whether they are calling about physical health, behavioral health and/or long-term care services. The CONTRACTOR shall not have a separate number for members to call regarding behavioral health and/or long-term care services. The CONTRACTOR may either route the call to another entity or conduct a “warm transfer” to another entity, but the CONTRACTOR shall not require an enrollee to call a separate number regarding behavioral health and/or long-term care services.
- 2.6.1.2.2 If the CONTRACTOR’s nurse triage/nurse advice line is separate from its member services line, the CONTRACTOR shall comply with the requirements in Section 2.6.1.2.2 as applied to the nurse triage/nurse advice line. The number for the nurse triage/nurse advice line shall be the same for all members, regardless of whether they are calling about physical health, behavioral health and/or long-term services, and the CONTRACTOR may either route calls to another entity or conduct “warm transfers,” but the CONTRACTOR shall not require an enrollee to call a separate number.
- 2.6.1.2.3 As required in Sections 2.9.5 and 2.9.6, the CONTRACTOR shall ensure continuity and coordination among physical health, behavioral health, and long-term care services and ensure collaboration among physical health, behavioral health, and long-term care providers. For CHOICES members, the member’s care coordinator shall ensure continuity and coordination of physical health, behavioral health, and long-term care services, and facilitate communication and ensure collaboration among physical health, behavioral health, and long-term care providers.
- 2.6.1.2.4 Each of the CONTRACTOR’s Population Health programs (see Section 2.8) shall address the needs of members who have co-morbid physical health and behavioral health conditions.
- 2.6.1.2.5 As required in Section 2.9.5.2.2, the CONTRACTOR shall provide the appropriate level of Population Health services (see Section 2.8.4 of this Agreement) to non-CHOICES members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide Population Health services to enrollees with co-morbid physical and behavioral

health conditions. If a member with co-morbid physical and behavioral conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum, that the member's Population Health Care Manager collaborates on an ongoing basis with both the member and other individuals involved in the member's care. As required in Section 2.9.6.1.9 of this Agreement, the CONTRACTOR shall ensure that upon enrollment into CHOICES, the appropriate level of Population Health activities are integrated with CHOICES care coordination processes and functions, and that the member's assigned care coordinator has primary responsibility for coordination of all the member's physical health, behavioral health and long-term care needs. The member's care coordinator may use resources and staff from the CONTRACTOR's Population Health program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's care coordinator/care coordination team. The CONTRACTOR shall report on its Population Health activities per requirements in Section 2.30.6.1.

2.6.1.2.6 If the CONTRACTOR uses different Systems for physical health services, behavioral health and/or long-term care services, these systems shall be interoperable. In addition, the CONTRACTOR shall have the capability to integrate data from the different systems.

2.6.1.2.7 The CONTRACTOR's administrator/project director (see Section 2.29.1.3.1) shall be the primary contact for TENNCARE regarding all issues, regardless of the type of service, and shall not direct TENNCARE to other entities. The CONTRACTOR's administrator/project director shall coordinate with the CONTRACTOR's senior executive psychiatrist who oversees behavioral health activities (see Section 2.29.1.3.4 of this Agreement) for all behavioral health issues and the senior executive responsible for CHOICES activities (see Section 2.29.1.3.5 of this Agreement) for all issues pertaining to the CHOICES program.

2.6.1.3 CONTRACTOR Physical Health Benefits Chart

SERVICE	BENEFIT LIMIT
Inpatient Hospital Services	<p>Medicaid/Standard Eligible, Age 21 and older: As medically necessary. Inpatient rehabilitation hospital facility services are not covered for adults unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5).</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary, including rehabilitation hospital facility.</p>
Outpatient Hospital Services	<p>As medically necessary.</p>
Physician Inpatient Services	<p>As medically necessary.</p>

SERVICE	BENEFIT LIMIT
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	As medically necessary.
TennCare Kids Services	<p>Medicaid/Standard Eligible, Age 21 and older: Not covered.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. See Section 2.7.6.</p>
Preventive Care Services	As described in Section 2.7.5.
Lab and X-ray Services	As medically necessary.
Hospice Care	As medically necessary. Shall be provided by a Medicare-certified hospice.
Dental Services	<p>Dental Services shall be provided by the Dental Benefits Manager.</p> <p>However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM. This requirement only applies to Medicaid/Standard Eligibles Under age 21.</p>
Vision Services	<p>Medicaid/Standard Eligible, Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.</p> <p>Medicaid/Standard Eligible, Under age 21: Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TennCare requirements.</p>

SERVICE	BENEFIT LIMIT
Home Health Care	<p>Medicaid /Standard Eligible, Age 21 and older: Covered as medically necessary and in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).</p>
Pharmacy Services	<p>Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.</p> <p>The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid.</p> <p>Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section 2.6.2.2).</p>
Durable Medical Equipment (DME)	<p>As medically necessary.</p> <p>Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations.</p>
Medical Supplies	<p>As medically necessary.</p> <p>Specified medical supplies shall be covered/non-covered in accordance with TennCare rules and regulations.</p>
Emergency Air And Ground Ambulance Transportation	<p>As medically necessary.</p>
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)	<p>Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XI). Non-emergency transportation services shall be provided in accordance with federal law and the Bureau of TennCare’s rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XI) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee’s Medicaid State Plan or Section 1115</p>

SERVICE	BENEFIT LIMIT
	<p>demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section 1 of the Agreement).</p> <p>If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an escort.</p> <p>Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18).</p> <p>The CONTRACTOR is not responsible for providing NEMT to HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) and HCBS provided through the CHOICES program. However, as specified in Section 2.11.1.8 in the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III), the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity.</p> <p>Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XI) is not a covered NEMT service.</p> <p>If the member is a child, transportation shall be provided in accordance with TennCare requirements (see Section 2.7.6.4.6).</p> <p>Failure to comply with the provisions of this Section may result in liquidated damages.</p>
Renal Dialysis Services	As medically necessary.

SERVICE	BENEFIT LIMIT
Private Duty Nursing	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard), when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Private duty nursing services are limited to services that support the use of ventilator equipment or other life sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Prior authorization required, as described Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and 1200-13-14-.01 (for TennCare Standard) when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative. Prior authorization required as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).</p>
Speech Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TennCare requirements.</p>
Occupational Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TennCare requirements.</p>
Physical Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TennCare requirements.</p>

SERVICE	BENEFIT LIMIT
Organ and Tissue Transplant And Donor Organ Procurement	<p>Medicaid/Standard Eligible, Age 21 and older: All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to:</p> <ul style="list-style-type: none"> Bone marrow/Stem cell; Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral. <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TennCare requirements. Experimental or investigational transplants are not covered.</p>
Reconstructive Breast Surgery	<p>Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast shall only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.</p>
Chiropractic Services	<p>Medicaid/Standard Eligible, Age 21 and older: Not covered unless determined by the CONTRACTOR to be a cost effective alternative (see Section 2.6.5).</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with TennCare requirements.</p>

2.6.1.4 CONTRACTOR Behavioral Health Benefits Chart

SERVICE	BENEFIT LIMIT
Psychiatric Inpatient Hospital Services (including physician services)	As medically necessary.
24-hour Psychiatric Residential Treatment	<p>Medicaid/Standard Eligible, Age 21 and older: As medically necessary.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>
Outpatient Mental Health Services (including physician services)	As medically necessary.
Inpatient, Residential & Outpatient Substance Abuse Benefits¹	<p>Medicaid/Standard Eligible, Age 21 and older: Limited to ten (10) days detox, \$30,000 in medically necessary lifetime benefits unless otherwise described in the 2008 Mental Health Parity Act as determined by TENNCARE.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>
Mental Health Case Management	As medically necessary.
Psychiatric-Rehabilitation Services	As medically necessary.
Behavioral Health Crisis Services	As necessary.
Lab and X-ray Services	As medically necessary.
Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)	Same as for physical health (see Section 2.6.1.3 above).

¹When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.

2.6.1.5 Long-Term Care Benefits for CHOICES Members

2.6.1.5.1 In addition to physical health benefits (see Section 2.6.1.3) and behavioral health benefits (see Section 2.6.1.4), the CONTRACTOR shall provide long-term care services (including CHOICES HCBS and nursing facility care) as described in this Section 2.6.1.5 to members who have been enrolled into CHOICES by TENNCARE, as shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR, effective upon the CHOICES Implementation Date (see Section 1).

2.6.1.5.2 TennCare enrollees will be enrolled by TENNCARE into CHOICES if the following conditions, at a minimum, are met:

2.6.1.5.2.1 TENNCARE or its designee determines the enrollee meets the categorical and financial eligibility criteria for Group 1, 2 or 3;

2.6.1.5.2.2 For Groups 1 and 2, TENNCARE determines that the enrollee meets nursing facility level of care including for Group 2, that the enrollee needs ongoing CHOICES HCBS in order to live safely in the home or community setting and to delay or prevent nursing facility placement;

2.6.1.5.2.3 For Group 2, the CONTRACTOR or, for new TennCare applicants, TENNCARE or its designee, determines that the enrollee’s combined CHOICES HCBS, private duty nursing and home health care can be safely provided at a cost less than the cost of nursing facility care for the member;

2.6.1.5.2.4 For Group 3, TENNCARE determines that the enrollee meets the at-risk level of care; and

2.6.1.5.2.5 For Groups 2 and 3, but excluding Interim Group 3, if there is an enrollment target, TENNCARE determines that the enrollment target has not been met or, for Group 2, approves the CONTRACTOR’s request to provide CHOICES HCBS as a cost effective alternative (see Section 2.6.5). Enrollees transitioning from a nursing facility to the community will not be subject to the enrollment target for Group 2 but must meet categorical and financial eligibility for Group 2.

2.6.1.5.3 The following long-term care services are available to CHOICES members, per Group, when the services have been determined medically necessary by the CONTRACTOR.

Service and Benefit Limit	Group 1	Group 2	Group 3
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives		X	X
Personal care visits (up to 2 visits per day at intervals of		X	X

Service and Benefit Limit	Group 1	Group 2	Group 3
no less than 4 hours between visits)			
Attendant care (up to 1080 hours per calendar year; up to 1400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to \$900 per calendar year)		X	X
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

2.6.1.5.3.1 The CONTRACTOR shall review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF stays for Group 2 and Group 3 members only when (1) the member is enrolled in CHOICES Group 2 or 3, as applicable, and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 2 and Group 3 members and shall ensure that the member is transitioned from Group 2 or Group 3, as applicable, to Group 1 at any time a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for CHOICES Group 2 and Group 3 members.

- 2.6.1.5.3.1.1 The ninety (90) day limit shall be applied on a per admission (and not a per year) basis. A member may receive more than one short-term stay during the year. However, the CONTRACTOR shall be responsible for carefully reviewing any instance in which a member receives multiple short-term stays during the year or across multiple years, including a review of the circumstances which resulted in each nursing facility admission, and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 or Group 3 (as applicable) is appropriate.
- 2.6.1.5.3.1.2 The CONTRACTOR shall monitor, on an ongoing basis, members utilizing the short-term NF benefit, and shall submit to TENNCARE on a monthly basis a member-by-member status for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why the benefit limit has been exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community or transition to Group 1, as applicable, including the anticipated timeline.
- 2.6.1.5.4 In addition to the benefit limits described above, in no case shall the CONTRACTOR exceed the member's individual cost neutrality cap (as defined in Section 1 of this Agreement) for CHOICES Group 2 or the expenditure cap for Group 3.
- 2.6.1.5.4.1 For CHOICES members in Group 2, the services that shall be compared against the member's individual cost neutrality cap include the total cost of CHOICES HCBS and Medicaid reimbursed home health care and private duty nursing. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care pursuant to Section 2.6.5.2 of this Agreement including, as applicable: CHOICES HCBS in excess of specified CHOICES benefit limits, the one-time transition allowance for Group 2 and NEMT for Groups 2 and 3.
- 2.6.1.5.4.2 For CHOICES members in Group 3, the total cost of CHOICES HCBS, excluding minor home modifications, shall not exceed the expenditure cap (as defined in Section 1 of this Agreement).
- 2.6.1.5.5 CHOICES members may, pursuant to Section 2.9.7, choose to participate in consumer direction of eligible CHOICES HCBS and, at a minimum, hire, fire and supervise workers of eligible CHOICES HCBS.
- 2.6.1.5.6 The CONTRACTOR shall, on an ongoing basis, monitor CHOICES members' receipt and utilization of long-term care services and identify CHOICES members who are not receiving long-term care services. Pursuant to Section 2.30.11.5, the

CONTRACTOR shall, on a monthly basis, notify TENNCARE regarding members that have not received long-term care services for a thirty (30) day period of time. The CONTRACTOR shall be responsible for immediately initiating disenrollment of any member who is not receiving TennCare-reimbursed long-term care services and is not expected to resume receiving long-term care services within the next thirty (30) days, except under extenuating circumstances which must be reported to TennCare on the *CHOICES Utilization Report*. Acceptable circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. Such notification and/or disenrollment shall be based not only on receipt and/or payment of claims for long-term care services, but also upon review and investigation by the CONTRACTOR as needed to determine whether the member has received long-term care services, regardless of whether claims for such services have been submitted or paid.

- 2.6.1.5.7 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term care services to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:
 - 2.6.1.5.7.1 A member in Group 2 for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member's cost neutrality cap, and the member declines to transition to a nursing facility;
 - 2.6.1.5.7.2 A member in Group 2 or 3 who repeatedly refuses to allow a care coordinator entrance into his/her place of residence (Section 2.9.6);
 - 2.6.1.5.7.3 A member in Group 2 or 3 who refuses to receive critical HCBS as identified through a needs assessment and documented in the member's plan of care; and
 - 2.6.1.5.7.4 A member in Group 1 who fails to pay his/her patient liability and the CONTRACTOR is unable to find a nursing facility willing to provide services to the member (Section 2.6.7.2).
 - 2.6.1.5.7.5 A member in Group 2 or 3 who refuses to pay his/her patient liability and for whom the CONTRACTOR is either: 1) in the case of persons receiving CBRA services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the CONTRACTOR is unwilling to continue to serve the member, and the Bureau of TennCare has determined that no other MCO is willing to serve the member.
 - 2.6.1.5.7.6 The CONTRACTOR's request to no longer provide long-term care services to a member shall include documentation as specified by TENNCARE. The State shall make any and all determinations regarding whether the CONTRACTOR may discontinue providing long-term care services to a member, disenrollment from CHOICES, and, as applicable, termination from TennCare.

- 2.6.1.5.8 The CONTRACTOR may submit to TENNCARE a request to disenroll from CHOICES a member who is not receiving any Medicaid-reimbursed LTC services based on the CONTRACTOR's inability to reach the member only when the CONTRACTOR has exhausted all reasonable efforts to contact the member, and has documented such efforts in writing, which must be submitted with the disenrollment request. Efforts to contact the member shall include, at a minimum:
- 2.6.1.5.8.1 Multiple attempts to contact the member, his/her representative or designee (as applicable) by phone. Such attempts must occur over a period of at least two (2) weeks and at different times of the day and evening, including after business hours. The CONTRACTOR shall attempt to contact the member at the phone number provided in the outbound 834 enrollment file, any additional phone numbers the CONTRACTOR has on file, including referral records and case management notes; and phone numbers that may be provided in TENNCARE's TPAES system. The CONTRACTOR shall also contact the member's Primary Care Provider and any contracted LTC providers that have delivered services to the member during the previous six (6) months in order to obtain contact information that can be used to reach the member;
- 2.6.1.5.8.2 At least one (1) visit to the member's most recently reported place of residence except in circumstances where significant safety concerns prevent the CONTRACTOR from completing the visit, which shall be documented in writing; and
- 2.6.1.5.8.3 An attempt to contact the member by mail at the member's most recently reported place of residence at least two (2) weeks prior to the request to disenroll.

2.6.2 **TennCare Benefits Provided by TENNCARE**

TennCare shall be responsible for the payment of the following benefits:

2.6.2.1 Dental Services

Except as provided in Section 2.6.1.3 of this Agreement, dental services shall not be provided by the CONTRACTOR but shall be provided by a dental benefits manager (DBM) under contract with TENNCARE. Coverage of dental services is described in TennCare rules and regulations.

2.6.2.2 Pharmacy Services

Except as provided in Section 2.6.1.3 of this Agreement, pharmacy services shall not be provided by the CONTRACTOR but shall be provided by a pharmacy benefits manager (PBM) under contract with TENNCARE. Coverage of pharmacy services is described in TennCare rules and regulations. TENNCARE does not cover pharmacy services for enrollees who are dually eligible for TennCare and Medicare.

2.6.2.3 ICF/IID Services and Alternatives to ICF/IID Services

For qualified enrollees in accordance with TennCare policies and/or TennCare rules and regulations, TENNCARE covers the costs of long-term care institutional services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or alternative to an ICF/IID provided through a Home and Community Based Services (HCBS) waiver for persons with intellectual disabilities.

HEDIS 2015 MEASURES

Effectiveness of Care Measures	
<i>Prevention and Screening Measures:</i>	
Adult BMI Assessment (ABA)	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Broken Out by Age:	BMI Percentile: 3-11 years
	12-17 years
	Counseling for Nutrition: 3-11 years
	12-17 years
	Counseling for Physical Activity: 3-11 years
12 -17 years	
Childhood Immunization Status (CIS):	DTaP
	IPV
	MMR
	HiB
	HepB
	VZV
	PCV
	HepA
	RV
	Flu
	Combination 2
	Combination 3
	Combination 4
	Combination 5
	Combination 6
Combination 7	
Combination 8	
Combination 9	
Combination 10	
Immunizations for Adolescents (IMA):	Meningococcal
	Tdap/Td
	Combination 1
Human Papillomavirus Vaccine for Female Adolescents (HPV)	
Lead Screening in Children (LSC)	
Breast Cancer Screening (BCS)	
Cervical Cancer Screening (CCS)	
Chlamydia Screening in Women (CHL) – Broken Out by Age :	16-20 years
	21-24 years
<i>Respiratory Conditions:</i>	
Appropriate Testing for Children With Pharyngitis (CWP)	
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	

Effectiveness of Care Measures	
Pharmacotherapy Management of COPD Exacerbation (PCE):	Systemic corticosteroid Bronchodilator
Use of Appropriate Medications for People With Asthma (ASM) – Broken Out by Age:	5-11 years
	12-18 years
	19-50 years
	51-64 years
Medication Management for People with Asthma (MMA) – Broken Out by Age:	Medication Complication 50%: 5-11 years
	12-18 years
	19-50 years
	51-64 years
	Medication Complication 75%: 5-11 years
	12-18 years
	19-50 years
	51-64 years
Asthma Medical Ratio (AMR) – Broken Out by Age:	5-11 years
	12-18 years
	19-50 years
	51-64 years
Cardiovascular Conditions:	
Controlling High Blood Pressure (CBP)	
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	
Diabetes:	
Comprehensive Diabetes Care (CDC):	HbA1c Testing
	HbA1c Control (<7.0%)
	HbA1c Control (<8.0%)
	HbA1c Poor Control (>9.0%)
	Retinal Eye Exam Performed
	Medical Attention for Nephropathy
Blood Pressure Control (<140/90 mm Hg)	
Musculoskeletal Conditions:	
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	
Use of Imaging Studies for Low Back Pain (LBP)	
Behavioral Health:	
Antidepressant Medication Management (AMM):	Effective Acute Phase Treatment
	Effective Continuation Phase Treatment
Follow-Up Care for Children Prescribed ADHD Medication (ADD):	Initiation Phase
	Continuation and Maintenance Phase
Follow-Up After Hospitalization for Mental Illness (FUH):	7-day follow-up
	30-day follow-up
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	

Effectiveness of Care Measures	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	
<i>Medication Management:</i>	
Annual Monitoring for Patients on Persistent Medications (MPM):	ACE Inhibitors or ARBs
	Digoxin
	Diuretics
	Anticonvulsants
<i>Measures Collected Through CAHPS Health Plan Survey:</i>	
Medical Assistance With Smoking and Tobacco Use Cessation (MSC):	Advising Smokers and Tobacco Users to Quit
	Discussing Cessation Medications
	Discussing Cessation Strategies

Effectiveness of Care Measures Where Lower Rates Indicate Better Performance	
<i>Prevention and Screening:</i>	
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	
<i>Diabetes</i>	
Comprehensive Diabetes Care (CDC):	HbA1c Poor Control (>9.0%)

Access/Availability of Care Measures	
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Broken Out by Age:	20-44 years
	45-64 years
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Broken Out by Age:	12-24 months
	25 months-6 years
	7-11 years
	12-19 years
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET) – Broken Out by Age:	Initiation of AOD Treatment: 13-17 years
	≥ 18 years
	Engagement of AOD Treatment: 13-17 years
Prenatal and Postpartum Care (PPC):	≥ 18 years
	Timeliness of Prenatal Care
	Postpartum Care
Call Answer Timeliness (CAT)	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	

Utilization Measures	
Frequency of Ongoing Prenatal Care (FPC):	≥ 81 percent
Well-Child Visits in the First 15 Months of Life (W15):	6 or more visits
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	
Adolescent Well-Care Visits (AWC)	

2015 Consumer Assessment of Health Plans (CAHPS) Survey Topics

2015 CAHPS 5.0H Adult – Customer Satisfaction	
1.	Getting Needed Care (Always + Usually)
2.	Getting Care Quickly (Always + Usually)
3.	How Well Doctors Communicate (Always + Usually)
4.	Customer Service (Always + Usually)
5.	Shared Decision Making (A lot/Yes)
6.	Rating of all Health Care (9+10)
7.	Rating of Personal Doctor (9+10)
8.	Rating of Specialist Seen Most Often (9+10)
9.	Rating of Health Plan (9+10)

2015 CAHPS 5.0H Child	
1.	Getting Needed Care (Always + Usually)
2.	Getting Care Quickly (Always + Usually)
3.	How Well Doctors Communicate (Always + Usually)
4.	Customer Service (Always + Usually)
5.	Shared Decision Making (A lot/Yes)
6.	Rating of all Health Care (9+10)
7.	Rating of Personal Doctor (9+10)
8.	Rating of Specialist Seen Most Often (9+10)
9.	Rating of Health Plan (9+10)

2015 CAHPS 5.0H Child (Children with Chronic Conditions)	
1.	Getting Needed Care (Always + Usually)
2.	Getting Care Quickly (Always + Usually)
3.	How Well Doctors Communicate (Always + Usually)
4.	Customer Service (Always + Usually)
5.	Shared Decision Making (A lot/Yes)
6.	Rating of all Health Care (9+10)
7.	Rating of Personal Doctor (9+10)
8.	Rating of Specialist Seen Most Often (9+10)
9.	Rating of Health Plan (9+10)
10.	Access to Specialized Services (Always + Usually)
11.	Family-Centered Care: Personal Doctor or Nurse Who Knows Child (Yes)
12.	Family-Centered Care: Coordination of Care for Children with Chronic Conditions (Yes)
13.	Family-Centered Care: Getting Needed Information (Always + Usually)
14.	Access to Prescription Medicines (Always + Usually)