
# 2018 UPDATE TO THE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

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# Acronyms

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|---|---|
| AAAD | Area Agency on Aging and Disability |
| AAP | American Academy of Pediatrics |
| ACE | Adverse Childhood Experiences |
| ACS | Affiliated Computer Services Inc. |
| ADHD | Attention Deficit Hyperactivity Disorder |
| ADT | Admission, Discharge, Transfer |
| AI | Audacious Inquiry |
| AIU | Adopt, Implement, Upgrade |
| 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 |
| CAHPS | Consumer Assessment of Healthcare Providers and Systems |
| CAP | Corrective Action Plan |
| CCM | Chronic Care Management Group |
| CCT | Care Coordination Tool |
| CD | Consumer Direction |
| CDC | Centers for Disease Control and Prevention |
| CFR | Code of Federal Regulations |
| CHAT | Children's Hospital Alliance of Tennessee |
| CHCS | Center for Health Care Strategies |
| CKM | Clinical Knowledge Management |
| 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 |

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|---|---|
| CRA | Contractor Risk Agreement |
| DBM | Dental Benefits Manager |
| DD | Developmental Disabilities |
| DIDD | Department of Intellectual and Developmental Disabilities |
| D-SNPs | Dual Eligible Special Needs Plans |
| DHS | Department of Human Services |
| DM | Disease Management |
| DME | Durable Medical Equipment |
| ECF CHOICES | Employment and Community First CHOICES |
| ED | Emergency Department |
| EDI | Electronic Data Interchange |
| EHR | Electronic Health Record |
| EP | Eligible Professional |
| EPLS | Excluded Parties List System |
| EPSDT | Early and Periodic Screening, Diagnostic and Treatment |
| EQR | External Quality Review |
| EQRO | External Quality Review Organization |
| ERC | Enhanced Respiratory Care |
| EVV | Electronic Visit Verification |
| FEA | Fiscal Employer Agent |
| FHSC | First Health Services Corporation |
| FFM | Federally Facilitated Market |
| FFS | Fee-For-Service |
| HCBS | Home and Community-Based Services |
| HCFA | Health Care Finance and Administration |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HHA | Home Health Agency |
| HIE | Health Information Exchange |
| HIPAA | Health Insurance Portability and Accountability Act |
| HIT | Health Information Technology |
| HITECH | Health Information Technology for Economic and Clinical Health |
| HHS | Health and Human Services |

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|---|---|
| HMO | Health Maintenance Organization |
| HPE | Hewlett Packard Enterprise |
| HRM | Health Risk Management |
| IAM | Identify Access Management |
| I/DD | Intellectual and/or Developmental Disabilities |
| ICF/IID | Immediate Care Facility for Individuals with Intellectual Disabilities |
| IDEA | Individuals with Disabilities Education Act |
| IEP | Individualized Education Plan |
| ISP | Initial Support Plan |
| IUD | Intrauterine Contraceptive Device |
| LARC | Long Acting Removable Contraceptives |
| LEIE | List of Excluded Individuals and Entities |
| LEP | Limited English Proficiency |
| LOC | Level of Care |
| LTC | Long Term Care |
| LTSS | Long Term Services and Supports |
| MCC | Managed Care Contractor |
| MCO | Managed Care Organization |
| MDM | Master Data Management |
| MDS | Minimum Data Set |
| MFP | Money Follows the Person |
| MH | Mental Health |
| MIPPA | Medicare Improvements for Patients and Providers Act |
| MLTSS | Medicaid Managed Long Term Services and Supports |
| MMIS | Medicaid Management Information System |
| MRR | Medical Record Review |
| MU | Meaningful Use |
| NAS | Neonatal Abstinence Syndrome |
| NASUAD | National Association of States United for Aging and Disabilities |
| NCI | National Core Indicators |
| NCI-AD | National Core Indicators – Aging and Disabilities |
| NCQA | National Committee for Quality Assurance |

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|---|---|
| NDC | National Drug Code |
| NEMT | Non-Emergency Medical Transportation |
| NF | Nursing Facility |
| NPI | National Provider Identifier |
| OCR | Office for Civil Rights |
| OeHI | Office of eHealth Initiatives |
| OIG | Office of Inspector General |
| ONC | Office of the National Coordinator for Health Information Technology |
| ORR | On Request Report |
| PA | Performance Activity or Prior Authorization |
| PAE | Pre-Admission Evaluation |
| PAHP | Prepaid Ambulatory Health Plan |
| PASRR | Preadmission Screening and Resident Review |
| PBM | Pharmacy Benefits Manager |
| PCMH | Patient Centered Medical Home |
| PCP | Primary Care Provider |
| PCP | Person-Centered Planning |
| PCSP | Person-Centered Support Plan |
| PDV | Provider Data Validation |
| PERS | Personal Emergency Response Systems |
| PH | Population Health |
| PHI | Protected Health Information |
| PHIT | Pediatric Healthcare Improvement Initiative for Tennessee |
| PIHP | Prepaid Inpatient Health Plan |
| PIP | Performance Improvement Project |
| PIPP | Provider Incentive Payment Portal |
| PLHSO | Prepaid Limited Health Services Organization |
| POC | Plan of Care |
| QA | Quality Assurance |
| QI | Quality Improvement |
| QIA | Quality Improvement Activity |
| QI/UM | Quality Improvement/Utilization Management |

| | |
|---|---|
| QM/QI | Quality Management/Quality Improvement |
| QMP | Quality Management Program |
| QuILTSS | Quality Improvement in Long Term Services and Supports |
| RCI | Rapid Cycle Improvement |
| RFI | Request for Information |
| RFP | Request for Proposal |
| SED | Serious Emotional Disturbance |
| SIM | State Innovation Model (grant) |
| SOS | System of Support |
| SPMI | Serious and Persistent Mental Illness |
| SPOE | Single Point of Entry |
| SSA | Social Security Administration |
| SSI | Supplemental Security Income |
| STORC | Standard Obstetric Record Charting System |
| STC | Special Terms and Conditions |
| STS | Short-Term Stay |
| TAMHO | Tennessee Association of Mental Health Organizations |
| TCS | TennCare Select |
| TDCI | Tennessee Department of Commerce and Insurance |
| TDMHSAS | Tennessee Department of Mental Health and Substance Abuse Services |
| TEDS | Tennessee Eligibility Determination System |
| TNAAP | Tennessee Chapter of the American Academy of Pediatrics |
| TSPN | Tennessee Suicide Prevention Network |
| UM | Utilization Management |
| VLARC | Long Acting Removable Contraceptives |
| WCAG | Web Content Accessibility Guidelines |
| WCC | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents |

# 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.

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 served 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. Subsequent extensions of the TennCare II managed care demonstration were approved in 2009 and 2013.
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 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). TennCare 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 TennCare'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 July 22, 2009 TennCare received approval from CMS for a demonstration amendment to implement the CHOICES program outlined by the State's Long-term Care and Community Choices Act of 2008. Under the CHOICES program 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 implement managed Medicaid long-term services and supports and 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 covered medical, behavioral, and long-term services and supports provided to their members, age 65 and older and adults age 21 and older with physical disabilities. Currently, the only remaining carve-out services are for dental and pharmacy services, as well as Section 1915(c) waivers for individuals with intellectual disabilities.

Effective July 1, 2016, the Employment and Community First CHOICES program was added to the managed care demonstration. Employment and Community First CHOICES is an integrated managed long-term service and supports program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with intellectual and development disabilities (I/DD).

Employment and Community First CHOICES was initially implemented by Amerigroup and BlueCare on July 1, 2016, with UnitedHealthcare Community Plan joining on July 1, 2017. In Employment and Community First CHOICES, MCOs are responsible for coordination of all medical, behavioral, and LTSS provided to individuals with I/DD enrolled in the program. Additionally, unlike CHOICES, ECF CHOICES contains an adult dental benefit. The State's Dental Benefits Manager is responsible for developing a network of providers with I/DD experience to provide dental services to this population. Section 1915(c) waivers continue to be carved out of managed care, although individuals enrolled in those waivers are enrolled in managed care for their physical and behavioral health services.

The most recent extension of the TennCare demonstration waiver was approved by CMS in 2016, extending the life of the demonstration for five additional years under essentially the same terms and conditions (with minor modifications). Today, TennCare is a mature, data-driven managed care program with well-functioning component parts and a stable, established infrastructure that delivers high-quality care to many of the state's most vulnerable citizens. In its current approval period, TennCare retains its commitment to the program's core values, including broad access to care, improved health status of program participants, and cost effective use of resources.

**MCO Contracting and Turnover Experience**

Traditionally, MCOs, operating in the TennCare demonstration, 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 also serves enrollees in specific populations such as foster children, children receiving Supplemental Security Income (SSI) benefits, and children receiving services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities.

Maintaining MCO participation in Middle Tennessee has been a focus of the program 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, TennCare 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 competitive procurement process for TennCare MCOs. TennCare 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 Tennessee members on November 1, 2008 and began serving East Tennessee members on January 1, 2009. In September 2009, behavioral health services for TennCare Select enrollees were transferred to BCBST.

For most of TennCare's history, managed care organizations (MCOs) delivered services on a regional basis (e.g., East Tennessee, Middle Tennessee, and West Tennessee). On October 2, 2013, 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, TennCare announced that the winning proposals had been submitted by Amerigroup, BlueCare, and UnitedHealthcare Community Plan, 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.

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 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 efforts to ensure 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. In 2013, TennCare transitioned from an ASO contract to a partial risk bearing contract to reflect the maturation of the DBM model and to provide additional incentives for the DBM to improve quality of dental care while lowering costs.

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 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 reasonably calculated to ensure participation of all children who have not received screenings. As noted above, with the implementation of Employment and Community First CHOICES, the DBM also administers an adult dental benefit to individuals with I/DD enrolled in the MLTSS program, maintaining a network of participating dental providers with experience providing dental services for this population.

As mentioned, the pharmacy program was carved out of the managed care plans in 2003 and transferred to a single 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 a federal

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.

**Population Description/Changes**

All Medicaid and demonstration eligibles are enrolled in TennCare, including those are dually eligible for TennCare and Medicare. There are approximately 1.46 million persons currently enrolled in TennCare as of December 2017. 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:

- Low income children under age 21
- Women who are pregnant
- Caretakers of a minor child
- Individuals who need treatment for breast or cervical cancer
- People who receive Supplemental Security Income (SSI).
- People who have received both an SSI check and a Social Security check for the same month at least once since April 1977 AND who still receive a Social Security check
- People who live in a nursing home and have income below $2,250 per month (300% of SSI benefit) OR receive other long-term care services that TennCare pays for

***TennCare Standard*** is available for children under age 19 who are losing their TennCare Medicaid AND lack access to group health insurance through their parents' employer.

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 211% 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 211% of the poverty level. To be medically eligible, the child must have health conditions that make the child "uninsurable" from a pre-Affordable Care Act perspective.

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.

TennCare Standard also includes a number of demonstration eligibility categories for individuals enrolled in CHOICES and in Employment Community First CHOICES.

**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 Medicaid-reimbursed 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 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 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 of the Federal regulations and Section 1902(a)(10)(A)(ii)(VI) of the Social Security Act, if the home and community based services were provided under a 1915 (c) waiver, if the HCBS were provided under a section 1915(c) waiver. With the statewide implementation of CHOICES, TennCare no longer provides HCBS for older adults and adults with physical disabilities under a section 1915(c) waiver.

Individuals continuously enrolled in CHOICES Group 2 since before July 1, 2012 who do not meet the NF LOC 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 group is for individuals age 65 and older, and adults age 21 and older with physical disabilities, who do not meet NF LOC, but who, in the absence of HCBS, are "at-risk" of nursing facility placement, as defined by the State.

***Interim CHOICES Group 3*** was open for new enrollment July 1, 2012 and was closed to new enrollment on June 30, 2015. Interim CHOICES Group 3 was open to persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of CHOICES At-Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012, but not the NF LOC criteria effective as of July 1, 2012. There is no enrollment target on Interim Group 3. 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 Interim CHOICES Group 3.

Effective July 1, 2015, only SSI eligible individuals are eligible to newly enroll into 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 services and supports. 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
- Use 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 called community living supports family model and improved access to assisted care living facilities.
- Simplified Process for Accessing Services
    - Streamlining the 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 services and supports through Medicaid or other available programs.
    - Efficient use of Medicaid funds to serve more people in cost-effective home and community settings.

**Employment and Community First CHOICES**

In February 2016, CMS approved Amendment 27 to the TennCare demonstration that allows MCOs to coordinate HCBS (as well as medical and behavioral health services) for individuals with intellectual and other developmental disabilities. Dental benefits provided under the ECF CHOICES program are administered through the DBM. Statewide implementation of Employment and Community First CHOICES began on July 1, 2016. The program was implemented with a choice of only two MCOs: Amerigroup and BlueCare. A third MCO, UnitedHealthcare Community Plan, implemented ECF CHOICES on July 1, 2017.

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 other developmental disabilities. The comprehensive array of

employment supports, designed with technical assistance from subject matter experts with the federal Office of Disability Employment Policy creates a pathway to employment, even for individuals with significant disabilities.

Outcome- and other value-based payment approaches align incentives to help ensure that individuals progress toward their employment goals. Pre-employment services (such as Discovery, Exploration, and Job Development Plan) are reimbursed on an outcome-based once the deliverable for that service is completed, supporting the person to move forward to the next step along the employment journey. Job Development and Self-Employment Start-Up are also reimbursed on outcome-basis once the person is actually working in competitive, integrated employment. The payment is tiered based on the person's "acuity" level and paid in phases to support retention. Job Coaching is also tiered based on the person's acuity level, and also on the length of time the person has been employed and the amount of paid support needed as a percentage of hours worked in order to build and incentivize expectations of fading over time.

Community Integration Support Services, Transportation, Independent Living Skills Training and other wraparound services that support employment are combined with Self-Advocacy and Family Support Services to help support and empower individuals to achieve their employment and other community living goals.

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

- A tiered benefit structure based on the needs of individuals enrolled in the program allows the State to provide HCBS and other Medicaid services more cost-effectively so that more people who need HCBS can receive them. This includes people with 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 monitoring and continuous quality improvement structure for Employment and Community First CHOICES is unique in a number of ways. Certain services in the ECF CHOICES program are monitored by the Department of Intellectual and Developmental Disabilities (DIDD) through an Interagency Agreement between TennCare and DIDD. All other services are monitored by the MCOs, with the exception of Adult Dental, which is monitored by the DBM, and Benefits Counseling, which is monitored by the National Technical Assistance Center for Benefits Counseling, Virginia Commonwealth University. In addition, "invoice/reimbursement" type services (such as Individual or Family Education and Training) are monitored by TennCare's LTSS Audit & Compliance team.

While a Quality Monitoring survey process has long been in place for the State's Section 1915(c) waivers for individuals with ID, the Quality Monitoring survey process for Employment and Community First CHOICES has been uniquely designed to shift the focus from compliance monitoring to true quality monitoring and continuous quality improvement. This has been done in part because MCOs have roles related to compliance monitoring, accomplished through both on-going re-credentialing and provider contract monitoring. This allows the opportunity for Quality Monitoring to focus on authentic measures of quality, distinct from compliance. As part of this critical shift, a new quality monitoring evaluation tool for Employment and Community First CHOICES has

been developed to define quality indicators that represent provider performance above minimum compliance expectations. The approach to scoring quality monitoring surveys further emphasizes and reinforces the program's intentional focus on promoting employment and integrated community living by weighting domains focused on these outcomes. Finally, the results of the quality monitoring process are used to establish each provider's preferred provider status, allowing members in the process of selecting specific providers to distinguish providers achieving higher levels of quality. Where providers score below a certain threshold, a quality improvement plan is required, with approval and monitoring of implementation being done by the MCOs that contract with the provider. Adjustments in scoring are also planned as provider longevity with the program increases, setting increasingly higher bars for providers to achieve each of the preferred provider categories.

Employment and Community First CHOICES Quality Monitoring surveys are completed on site at provider agencies and include time spent with people receiving services, thereby obtaining invaluable information about the quality of services from the member's perspective as well as their satisfaction with services. This quality monitoring model includes establishing quality measures and processes for evaluating current provider performance, best practices that can be replicated, a focus on continued improvement, and opportunities for ongoing data analysis and identification of priority areas of focus for TennCare and MCO efforts aimed at developing the provider network as a whole. In addition to providing data specific to the quality of services offered in the Employment and Community First CHOICES program, the approach to quality monitoring ensures that TennCare has a comprehensive perspective of quality performance and strategies for quality improvement across the I/DD system as a whole, particularly as programs are aligned in support of employment and integrated community living. TennCare has also contracted with DIDD to perform quality monitoring surveys of providers who deliver Community Living Supports and Community Living Supports – Family Model services (residential benefits) to individuals in the current CHOICES program.

Employment and Community First CHOICES has 3 groups:

- *Essential Family Supports (Group 4)* – Children under age twenty one (21) with I/DD living at home with family who meet the NF LOC and need and are receiving HCBS as an alternative to NF Care, or who, in the absence of HCBS, are "At Risk of Nursing Facility placement" and adults age 21 and older with I/DD living at home with family caregivers who meet the NF LOC and are receiving HCBS as an alternative to NF care, or who, in the absence of HCBS, are "At risk of NF placement" and elect to be in this group. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like, Interim ECF CHOICES At-Risk Demonstration Group or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.
- *Essential Supports for Employment and Independent Living (Group 5)* – Adults age twenty-one (21) and older, unless otherwise specified by TennCare, with I/DD who do not meet nursing facility level of care, but who, in the absence of HCBS are "At Risk" of nursing facility placement. To qualify in this group, the adult must be SSI eligible or qualify in the Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups. When the enrollment target for ECF CHOICES Group 6 has been reached, an adult age 21 and older who meets NF LOC may choose to enroll in ECF CHOICES Group 5, so long as the person's needs can be safely and appropriately met in the community and at a cost that does not exceed the Expenditure Cap. On a case-by-case basis, TENNCARE may grant an exception to permit adults ages

eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 5, if they meet eligibility criteria.

- *Comprehensive Support for Employment and Community Living (Group 6*) – Adults age twenty-one (21) and older, unless otherwise specified by TennCare, with I/DD who meet nursing facility level of care and need and are receiving specialized services for I/DD. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. On a case-by-case basis, TENNCARE may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 6, if they meet eligibility criteria.

**Evolution of Health Information Technology**

TennCare continues to work to enhance accurate and timely data collection, analysis, and distribution. TennCare's comprehensive information management strategy affects every aspect of Tennessee's "Medicaid Enterprise," from medical and eligibility policy to budget and financial accountability. The process of transforming from a traditional transaction-driven medical program to a health care monitoring and management organization recognizes the advantages of Tennessee's unique, fully managed care framework and builds on the TennCare's commitment to be a wise and efficient contractor of services, steward of public funds, and advocate for quality healthcare for all constituents. With guidance from TennCare'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. Examples of these efforts are outlined through the following ongoing projects:

- ***Admission, Discharge, Transfer (ADT) feeds and Care Coordination Tools (CCT):*** Edifecs has developed a Clinical Knowledge Management (CKM) tool within the Edifecs Module to collect and standardize the hospital ADT feeds which will contain emergency room visits, inpatient admissions, and discharge information that will allow for follow-up care. The CCT will allow providers to coordinate their attributed patients' care across primary and behavioral health providers. Subsequently, claims data will be populated with the HIE data to allow for a common risk score, identify gaps in care and present to providers a patient register (history, medications, etc.).
- ***Quality Applications:*** These applications will allow TennCare to collect clinical quality data that cannot be acquired from processed medical billing claims. Ultimately, these Quality Apps will provide all payers, beginning with the State's Medicaid participating MCOs, with the necessary information to reimburse providers for high quality health outcomes. Initially, Quality Applications will be based on a contractor-provided service that will support two innovation strategies: Episodes of Care and Long Term Services and Supports. As part of payment reform efforts within the Tennessee Health Care Innovation Initiative, these two strategies aim to increase the quality of care, reduce health care costs, and improve the health of Tennessee's population. Episodes of Care Quality Applications will track certain quality measures for clinical encounters that are not included in medical billing claims data. LTSS Quality Applications will support the payment calculations, data aggregation, and quality measures for Nursing

Facilities and Home and Community Based Services value-based purchasing initiatives.

- ***Identify Access Management:*** This project will implement enterprise-wide Identify Access Management (IAM) for TennCare. This functionally is needed to ensure the privacy and security of patient clinical data and will be the standard for future TennCare applications. This is a security tool that automates user's provisioning based upon roles based access.
- ***Master Patient Index and Master Provider Directory:*** TennCare has contracted with Audacious Inquiry (AI) to implement a Master Data Management (MDM) module. This project will provide a data management tool that will enable TennCare to uniquely identify patients and providers through the use of MPI and Master Provider Directory.
- ***Care Coordination Tool:*** Tennessee has developed a shared Care Coordination Tool that will allow providers participating in the Patient Centered Medical Home (PCMH) and Tennessee Health Link programs to be more successful in the state's new payment models. The tool will identify and track the closure of gaps in care linked to quality measures. It will also allow providers to view their member panel and members' risk scores, which will facilitate provider outreach to members with a higher likelihood of adverse health events. The tool will also enable users to see when one of their attributed members has had an admission, discharge, or transfer from a hospital, such as a visit to the emergency room, and track follow-up actions. The Care Coordination Tool was piloted with nine practices from across Tennessee in the summer of 2016. Based on feedback from providers, additional enhancements and customization were made to the tool prior to launch and additional enhancements have been scheduled for future releases. The Care Coordination Tool was rolled out to PCMH and Tennessee Health Link providers in February 2017 and will continue to be available to participating PCMH and Tennessee Health Link.
- ***Integration of Behavioral Health Services with Primary Care Services:*** This project is designed to provide an electronic holistic view of an enrollee's care to providers and is currently in the developmental phase.

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.

Both TennCare and the Office of eHealth Initiatives (OeHI) within TennCare Division play integral leadership roles in the promotion of statewide HIT/HIE. Given the interdependencies between Health Information Technology adoption and Health Information Exchange, efforts to administer 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.

Additional examples of the evolution of Information Technology include the continued modularization of the Medicaid Management Information System (MMIS) and the Tennessee Eligibility Determination System (TEDS).

- ***Medicaid Management Information System:*** Tennessee currently has a contract with Hewlett Packard Enterprise (HPE) to provide Facility Management services. Direction from the Centers for Medicare and Medicaid Services has encouraged states to pivot from large single vendor systems and contracts to a modular environment with multiple contracts. After careful consideration of the current environment in Tennessee and multiple ongoing projects, Tennessee has elected to continue the business relationship with HPE. Going forward, TennCare will determine functionality that can be uncoupled and modularized. Examples of future modules are Program Integrity, Fee-For-Service (FFS) Claims, and Electronic Data Interchange (EDI). This approach allows an already highly modular Medicaid Enterprise to meet the objectives of CMS with the lowest amount of risk and greatest potential for success.
- ***Tennessee Eligibility Determination System:*** The goal of the TEDS project is to modernize and enhance the State's Medicaid and CHIP program eligibility determination system and processes through updated technology, as well as the eligibility appeals functions that protect and support the interests of the State's citizens while complying with the requirements of federal law and regulations. TennCare envisions a client service model that is customer-centric, efficient, and effective and provides a customer friendly experience. Within this vision TennCare enrollees, excluding applicants for Supplement Security Income (SSI) benefits, who must continue to file applications through the Social Security Administration (SSA), will be able to file applications for services or benefits, as well as report changes through an online process. Most required materials and verification documents will be scanned and stored electronically within the electronic case record. Whenever possible, verification of required information will be captured electronically through a web-based service and updated automatically in the electronic case record. Workers or automated processes will review applications and send additional questions or request additional documentation electronically or through print media to communicate with customers.

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

TennCare's commitment to quality and continuous improvement in the lives of Tennesseans are reflected in its Vision and Mission Statements:

***Vision Statement:*** "A healthier Tennessee"

***Mission Statement:*** "Improving lives through high-quality cost-effective care."

***Core Values***:

- **C**ommitment: Ensuring that Tennessee taxpayers receive value for their tax dollars
- **A**gility: Be nimble when situations require change
- **R**espect: Treat everyone as we would like to be treated
- **I**ntegrity: Be truthful and accurate
- **N**ew Approaches: Identify innovative solutions
- **G**reat customer service: Exceed expectations

All quality improvement activities are consistent with the "three aims" outlined in the National Quality Strategy for better care, healthy people/healthy communities, and affordable care. Wendy Long, M.D. is the Deputy Commissioner and Director of TennCare for the State of Tennessee. The Chief Medical Officer for TennCare, Victor Wu, M.D., M.P.H, reports to Director Long and in turn provides supervision for the Quality Improvement, Pharmacy, Dental, Provider Services, TSU, and Medical Appeals Divisions of TennCare. The Division of Quality Improvement is led by Karly Campbell and is comprised of a staff of 22 individuals.

The Division of Quality Improvement (QI) is responsible for leading the quality strategy for TennCare working across the Division to coordinate and support quality measurement and reporting. Additionally, the QI Division monitors many of the activities of the MCOs and enforces quality requirements defined in the MCO and DBM Contractor Risk Agreements. This Division is also responsible for developing and monitoring the External Quality Review Organization (EQRO) contract as well as contracts with the Tennessee Department of Health.

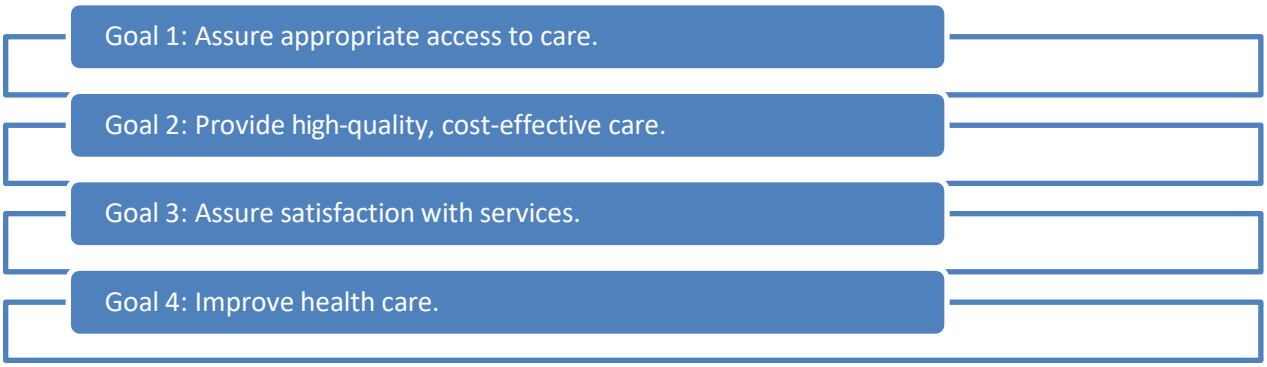
***CMS Requirement: Include general information about the state's decision to contract with MCOs/PIHPs (i.e., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid.***

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

***CMS Requirement: Include a description of the goals and objectives of the state's managed care program. This***

***description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state's priorities and areas of concern for the population covered by the MCO/PIHP contracts.***

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




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

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

Progress toward these four goals is gauged by physical health, behavioral health, long term services and support performance measures. The objectives are drawn from nationally recognized and respected measure sets. Many of the strategy objectives are statewide weighted Healthcare Effectiveness Data and Information Set (HEDIS) rates 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 that validates the processes of the health plan in accordance with NCQA requirements. In addition, they annually conduct CAHPS surveys (adult survey, child survey, and children with chronic conditions survey) using an NCQA-certified CAHPS survey vendor.

### *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:** The CMS-416 EPSDT screening rate will show incremental improvement through 2019 and beyond, bringing the statewide rate to the CMS standard of 80% in the coming years.<br>2018 Update: CMS-416 EPSDT screening rate increased from 69% to 74% between 2017 and 2018. Adolescent screening rate increased from 42.3% in 2016 to 53.14% in 2018.<br>2019 Goal: A particular focus will be on adolescent screenings, with a goal of improving the statewide HEDIS rate for adolescent well-care visits from 42.3% to the national median of 49.15%. | Data Sources: HEDIS/CAHPS Report: A Comparative Analysis of Audited Results from TennCare MCOs and CMC-416 |
| **Objective 1.2:** TennCare will establish and begin monitoring travel time standards to augment existing travel distance standards for primary care (adult and pediatric), OB/GYN, behavioral health, specialist (adult and pediatric), hospital, pharmacy, and pediatric dental networks.<br>2018 Update: All managed care plans achieved 100% compliance or have an approved corrective action plan in place.<br>2019 Goal: By 2019, each managed care plan will continue to have achieved 100% compliance or have an approved corrective action plan on file. | Data Source: TennCare Provider Services |
| **Objective 1.3:** By 2019, at least 37% of TennCare members will be cared for through a Patient Centered Medical Home (PCMH) model.<br>2018 Update: PCMH family practices are measured on 20 quality metrics, composed of 10 adult practice -only metrics and a 10-pediatric practice-only metrics.<br>2019 Goal: By 2019, PCMH family practices, pediatric practices, and adult-only practices will be measured on 17, 10, and 8, quality metrics, respectively, and providers will be given quarterly updates on how their performance compares to their peers statewide. | Data Source: TennCare Strategic Planning and Innovation Group |

| **Goal 2: Provide quality care to enrollees** | |
|---|---|
| **Objective 2.1:** By 2019, statewide HEDIS rates for timeliness of prenatal care, frequency of ongoing prenatal care (≥81% of expected visits), and postpartum care will improve to the national medians:<br>2016 Baseline and 2018 Update:<br>• Timeliness of prenatal care: from 76.34% to 79.21%<br>• Postpartum care: from 55.57% to 60.31%<br>2019 Goal:<br>• Timeliness of prenatal care: 78.97%<br>• Postpartum care: 58.66% | Data Source: HEDIS/ CAHPS Report: A Comparative Analysis of Audited Results from TennCare MCOs. |
| **Objective 2.2:** By 2019, TennCare will have designed 66 Episodes of Care, which are acute or specialist-driven health care events with a specified duration to treat physical or behavioral health conditions.<br><br>By 2019, every Episode of Care will have a minimum of two quality metrics, and providers will be given quarterly updates on how their performance compares to their peers statewide.<br>2018 Update:<br>• Providers are given quarterly updates on how their performance compares to peers statewide. There are currently 46 Episodes of Care, all with a minimum of two quality metrics. | Data Source: TennCare Strategic Planning and Innovation Group |
| **Objective 2.3:** Through 2019, the number of TennCare members enrolled in the Tennessee Health Link program for members with the highest behavioral health needs will remain at least 60,000 members each month.<br><br>By 2019, Health Link practices will be measured on 11 quality metrics, and providers will be given quarterly updates on how their performance compares to their peers statewide. | Data Source: TennCare Behavioral Health enrollment data |

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| **Objective 2.4:** By 2019, statewide HEDIS rates for the following child and adolescent immunization measures will improve to the national medians.<br>2016 Baseline and 2018 Update:<br>• Childhood MMR: 88.46% to 87.78%<br>• Adolescent Combo 1: 67.13% to 70.63%<br>• Childhood Influenza: 42.86% to 42.54%<br>2019 Goal:<br>• MMR: 90.42%<br>• Adolescent Combo 1: 70.04%<br>• Influenza: 45.95% | Data Source: HEDIS/ CAHPS Report: A Comparative Analysis of Audited Results from TennCare MCOs. |
| **Goal 3: Assure enrollees' satisfaction with services.** | |
| **Objective 3.1**: Through 2019, the number of TennCare enrollees who expressed satisfaction with TennCare will remain at least 95%.<br>2018 Update:<br>TennCare enrollee satisfaction with TennCare was 95% in the most recent survey of TennCare recipients. | Data source: The Impact of TennCare: A Survey of Recipients. |
| **Objective 3.2**: Through 2019, the statewide average for CAHPS measures Getting Needed Care (responding "Always" or "Usually") will remain above the national benchmarks of 80.82% for the adult Medicaid population and 84.39% for the child Medicaid population.<br>2018 Update:<br>CAHPS measure for Getting Needed Care ("Always" and "Usually") in 2018 was 83.90% for the adult Medicaid population and 87.85% for the child Medicaid population. | Data Source: HEDIS/ CAHPS Report: A Comparative Analysis of Audited Results from TennCare MCOs. |
| **Goal 4: Improve health care for program enrollees.** | |
| **Objective 4.1:** By 2019, the statewide HEDIS rates related to child and adolescent weight management will improve as follows:<br>2016 Baseline and 2018 Update:<br>• BMI percentile documentation: 69.55% to 77.98%<br>• Counseling for nutrition: will improve from 60.29% to the national median of 61.44%<br>• Counseling for physical activity will improve from 53.59% to the national median of 53.89%.<br>2019 Goal:<br>• BMI percentile documentation: 77.98%<br>• Counseling for nutrition: 61.44%<br>• Counseling for physical activity: 53.89% | Data Source: HEDIS/ CAHPS Report: A Comparative Analysis of Audited Results from TennCare MCOs. |

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| **Objective 4.2:** TennCare members will show improvement across the following Population Health outcome measures:<br>2016 Baseline and 2018 Update:<br>• Emergency department visits per 1000 members: 770 to 628<br>• Readmissions (within 30 days) per 100 members: 13.1 to 12.51<br>• NICU babies: 8,877 to 8,240; average length of stay remains less than 14 days.<br>• End stage renal disease per 100 members with diabetes: 7.7 to 7.6<br>2019 Goal:<br>• Emergency department visits per 1000 members: improve from 770 in CY 2015 to 600<br>• Readmissions (within 30 days) per 100 members: improve from 13.1 to 11.6<br>• NICU babies: improve from 8,877 to 8,250; average length of stay will remain less than 14 days<br>• End stage renal disease per 100 members with diabetes: improve from 7.7 to 7.3 | Data Source: TennCare Informatics Population Health Outcome Measures |
| | |

**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—largely measures of compliance with federal and/or state requirements. Upon implementation of Employment and Community First CHOICES, these performance measures were expanded to encompass the new program.

With this revision of the Quality Strategy, we seek to refocus our quality improvement efforts on the core objectives for which each MLTSS program was established and for which annual performance is measured and reported to CMS. (Compliance monitoring will continue to occur through a variety of mechanisms, including required reporting, audits, and MCO credentialing and re-credentialing processes.) In addition, we will incorporate the new quality components of the Medicaid Managed Care Rule specified in 42 C.F.R. § 438.330.

The following sections state the core objectives for the State's two MLTSS programs – CHOICES and ECF CHOICES.

| Long-Term Services and Support | | |
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| **Goal 1: CHOICES and Employment and Community First CHOICES members have a level of care determination indicating the need for institutional services or being "At-Risk" for institutional placement, as applicable, prior to enrollment in CHOICES or Employment and Community First CHOICES, as applicable, and receipt of Medicaid-reimbursed HCBS.** | | |
| **Domain** | **Performance Measure** | **Measurement Method** |
| Level of Care | Number and percent of CHOICES Employment and Community First CHOICES members who had an approved CHOICES Pre-Admission Evaluation (i.e., nursing facility or At-Risk level of care eligibility, as applicable) prior to enrollment in CHOICES or Employment and Community First CHOICES and receipt of Medicaid-reimbursed HCBS. | Data Source: MMIS report<br><br>Sampling Approach: 100% of all CHOICES and Employment and Community First CHOICES members enrolled<br><br>Frequency: Quarterly<br><br>Remediation: 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. | Data Source: Member record review<br><br>Sampling Approach: Stratified, with strata comprised of CHOICES Group 2 members enrolled in each of the MCOs per region serving the CHOICES Group 2 population. The sample population for both the New Member and Referral audits are drawn based on the total number of newly enrolled CHOICES members for the review period. Specifically, the New Member audit examines members who are new to both TennCare and CHOICES, and the Referral audit examines existing TennCare members who are new to CHOICES. Sample size for each audit is based on a 10% margin of error, 90% confidence level and the response distribution of the previous audit.<br><br>Frequency: Semi-annually<br><br>Remediation: TennCare is responsible for semi-annual member record review and review/analysis of data. MCO 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 and Employment and Community First CHOICES 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 Contractor Risk Agreement. | Data Source: Member Record Review<br><br>Sampling Approach: Stratified, with strata comprised of CHOICES Groups 2 and 3 and Employment and Community First CHOICES members enrolled in each of the MCOs per region serving the CHOICES and/or Employment and Community First CHOICES population. A 90% confidence level, based on a 10% margin of error, will be achieved. Any records used previously in a semi-annual audit will be excluded.<br><br>Frequency: Annually in October<br><br>Remediation: 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. |
| **Goal 4: LTSS Person Centered Support Plan Composite** | | |
| **Domain** | **Performance Measure** | **Measurement Method** |
| Service Plan | Number and percent of CHOICES Group 2 and 3 and Employment and Community First CHOICES member records reviewed in which a PCSP, was developed as specified by the Contractor Risk Agreement or by TennCare protocol. | Data Source: Member Record Review<br><br>Sampling Approach: Stratified, with strata comprised of CHOICES Groups 2 and 3 and Employment and Community First CHOICES members enrolled in each of the MCOs per region serving the CHOICES and/or Employment and Community First HCBS population. A 90% confidence level, based on a 10% margin of error, will be achieved. Any records used previously in a semi-annual audit will be excluded.<br><br>Frequency: Annually in October<br><br>Remediation: 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. |

| 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 and Employment and Community First CHOICES member records reviewed in which the PCSPs were reviewed and updated prior to the member's annual review data. | Data Source: Member record review<br><br>Sampling Approach: Stratified, with strata comprised of CHOICES Group 2 and 3 and Employment and Community First members enrolled in each of the MCOs per region serving the CHOICES and/or Employment and Community First CHOICES HCBS population. A 90% confidence level, based on a 10% margin of error, will be achieved. Any records used previously in a semi-annual audit will be excluded.<br><br>Frequency: Annually in October<br><br>Remediation: 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. |
| **Goal 6: Plans of Care reflect member goals, needs and preferences.** | | |
| **Domain** | **Performance Measures** | **Measurement Method** |
| Service Plan | Number and percent of CHOICES Groups 2 and 3 and Employment and Community First CHOICES member records reviewed whose PCSPs clearly identify the member's goals, needs and preferences and include services and supports that are consistent with the member's goals, needs and preferences. | Data Source: Member record review<br><br>Sampling Approach: Stratified, with strata comprised of CHOICES Group 2 and 3 and Employment and Community First CHOICES members enrolled in each of the MCOs per region servicing the CHOICES and/or Employment and Community First CHOICES HCBS population. A 90% confidence level, based on a 10% margin or error, will be achieved. Any records used previously in a semi-annual audit will be excluded.<br><br>Frequency: Annually in October<br><br>Remediation: 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. |

| **Goal 7: Employment and Community First CHOICES members of working age participate in an employment informed choice process to help them understand and explore individual integrated employment and self-employment options.** | | |
|---|---|---|
| **Domain** | **Performance Measure** | **Measurement Method** |
| Service Plan | Number and percent of Employment and Community First CHOICES member records reviewed in which there is signed documentation that indicates the employment informed choice process was completed for individuals needing community integrated supports and/or independent living skills training services, or that employment services were authorized and initiated concurrently with community integrated supports and/or independent living skills training services. | Data Source: Member record review<br><br>Sampling Approach: Employment and Community First CHOICES members enrolled in each of the MCOs per region serving the population. The sample population for the Employment Informed Choice audit is drawn based on the total number of Employment and Community First CHOICES working-age members who are not currently working or receiving employment supports and are eligible for, and want to receive, Community Integration Support Services and/or Independent Living Skills Training services. Sample size for the audit is based on a 10% margin of error, 90% confidence level and the response distribution of the previous audit.<br><br>Frequency: Semi-annually<br><br>Remediation: 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. |

| **Goal 8: 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 and Employment and Community First 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/or Employment and Community First CHOICES, as applicable, and delivery of HCBS. | Data Source: Provider record review<br><br>Sampling Approach: Stratified, with strata comprised of HCBS providers contracted with each of the MCOs serving the CHOICES Group 2 and 3 population and/or Employment and Community First CHOICES population. The sample for the Provider Qualifications audit is derived from the total number of contracted HCBS providers. Sample size for the audit is based on a 10% margin of error, 90% confidence level and the response distribution of the previous audit.<br><br>Frequency: Annually<br><br>Remediation: 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. |
| **Goal 9: CHOICES Group 2 and 3 and Employment and Community First CHOICES members (or their family member/authorized representative, as applicable) receive education/information at least annually about how to identify and report instances of abuse, neglect, and exploitation.** | | |
| **Domain** | **Performance Measure** | **Measurement Method** |
| Health and Welfare | Number and percent of CHOICES Group 2 and 3 and Employment and Community First 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. | Data Source: Member record review<br><br>Sampling Approach: Stratified, with strata comprised of CHOICES Group 2 and Employment and Community First members enrolled in each of the MCOs per region serving the CHOICES and Employment and Community First population. Sample size will be based on the first auditing year's sampling error in order to achieve a 90% confidence level with a 10% margin of error. Any records used previously in a semi-annual audit will be excluded.<br><br>Frequency: Annually in October<br><br>Remediation: 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. |

| **Goal 10: 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. | Data Source: Sample record review<br><br>Sampling Approach: Stratified, with strata comprised of reported incidents for CHOICES Group 2 and 3 and Employment and Community First CHOICES members enrolled in each of the MCOs per region. For CHOICES, sample size will be based on the first auditing year's sampling error in order to achieve a 90% confidence level with a 10% margin of error. In the first year of Employment and Community First CHOICES, sample size will consist of all records, up to 25 per stratum. For following years, of Employment and Community First CHOICES, the sample size will be based on the first auditing year's sampling error in order to achieve a 90% confidence level with a 10% margin of error.<br><br>Frequency: Semi-annually<br><br>Remediation: 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. |
| **Goal 11: CHOICES and Employment and Community First CHOICES members are informed of and afforded the right to request a Fair Hearing when services are denied, reduced, suspended, or terminated.** | | |
| **Domain** | **Performance Measure** | **Measurement Method** |
| Participant Rights | Number and percent of CHOICES Group 2 and 3 and Employment and Community First member records reviewed in which HCBS were denied, reduced, suspended, or terminated as evidenced in the PCSP (as applicable) and, consequently, member was informed of and afforded the right to request a Fair Hearing as determined by the presence of a notice of action. | Data Source: Member record review<br><br>Sampling Approach: Stratified, with strata comprised of reported incidents for CHOICES Group 2 and 3 and Employment and Community First members enrolled in each of the MCOs per region serving the CHOICES and Employment and Community First CHOICES HCBS population. Sample size will be a subset of the sample used in Sub-Assurance 2.<br><br>Frequency: Semi-annually in April and October<br><br>Remediation: 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. |

**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***

TennCare contracts with the Boyd Center for Business and Economic Research at the University of Tennessee, Knoxville 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.

***CHOICES and ECF CHOICES Baseline Data and Annual CHOICES and ECF CHOICES Baseline Data Reports***

The CHOICES and ECF CHOICES Baseline Data and Annual CHOICES and ECF CHOICES Baseline Data Reports are submitted to CMS in June and September of each year pursuant to STC 42.d.

Point in time CHOICES and ECF CHOICES enrollment data are derived from monthly ***Medicaid Management Information Systems (MMIS) Enrollment Reports*** for each program.

CHOICES and ECF CHOICES enrollment and expenditures across the baseline and each demonstration year are derived from an analysis of MCO encounter data submissions by the Health Care Informatics group in the TennCare Fiscal Division.

Enrollment of individuals with I/DD in other (i.e., non-MLTSS) LTSS programs and services and expenditures for other (i.e., non-MLTSS) LTSS programs and services for individuals with I/DD is derived from an analysis of MMIS fee-for-service claims by the Health Care Informatics group in the TennCare Fiscal Division.

Employment data is derived from TennCare's analysis of aggregated data collected through individual ***Employment Data Surveys*** conducted with each working age adult receiving LTSS on an annual basis by the entity responsible for support coordination in each LTSS program.

Quality of life data is derived from an analysis of data collected through the administration of the ***National Core Indicators*** (or a comparable survey tool).

### *Development and Review of Quality Strategy*

***CMS Requirement: Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy. (42 CFR § 438.202(b))***

***CMS Requirement: Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final. (42 CFR § 438.202(b))***

**Steps for revising the TennCare Quality Strategy include:**

- Collaboration with appropriate divisions within TennCare, with the Division of Quality Improvement holding responsibility for creating the draft.
- Review of the draft by TennCare's Chief Medical Officer.
- After a final draft is completed, the Quality Strategy will be posted on TennCare's website for public review.
- After the designated time frame has elapsed, a final report will be developed including appropriate recommendations made during the public review period.

***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." (42 CFR § 438.202(d))***

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

# SECTION II: ASSESSMENT

***Quality and Appropriateness of Care***

***CMS Requirement: Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs. This must include the state's definition of special health care needs. (42 CFR § 438.204(b)(1)).***

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

- TennCare requires all MCOs to be NCQA accredited. MCOs are required, by contract, to provide TennCare with the entire accreditation survey and associated results. They are also required to submit to TennCare their annual NCQA Accreditation update.
- 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 TennCare.
- QSource conducts Performance Measure Validation (PMV) on an annual basis for two HEDIS metrics chosen by TennCare.

  The MCOs are contractually required to submit a variety of reports to various divisions within TennCare. The reports include performance improvement projects (PIPs), Population Health, EPSDT, dental, CHOICES care coordination, annual quality improvement/utilization management (QI/UM) descriptions, evaluations and work plans, provider satisfaction surveys, dual eligible care coordination, etc. These reports are reviewed throughout the.
- EQRO, Qsource conducts an Annual Quality Survey (AQS) for each MCO, the Dental Benefits Manager, and the Pharmacy Benefits Manager; that evaluates contractual requirements related to quality.
- Annual audits are conducted related to compliance with federal requirements for Abortions, Sterilizations, and Hysterectomies (ASH).
- Quality Improvement and Long Term Services and Supports staff conduct MCO audits related to compliance with the federal Special Terms and Conditions for TennCare's CHOICES program and the Employment and Community First CHOICES programs.
- Collaborative workgroups with all MCOs are held periodically. These workgroups address issues related to Quality Redesign, EPSDT outreach, Emergency Department diversion, and high risk maternity.
- Periodic meetings are held collaboratively with both MCOs and Dual Eligible Special Needs Populations Plans (D-SNPs) to discuss improved opportunities for coordinating care.

CMS Requirement: Detail the methods or procedures the state uses to identify the age, race, ethnicity, sex, primary language, and disability statuses for each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment. (42 CFR § 438.340(b)(6))

TennCare has taken steps to identify the age, race, ethnicity, sex, primary language, and disability statuses for each enrollee at the time of enrollment. Eligibility for TennCare and other Medicaid programs is determined by TennCare and the Federally Facilitated Marketplace (FFM). The application includes questions about age, race,

ethnicity, sex, primary language, and disability statuses and instructs the applicant that responses to the race and ethnicity questions are voluntary.

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

The MCOs and their providers and subcontractors that provide services to members participate in TennCare's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, disabilities, and diverse cultural and ethnic backgrounds regardless of a member's gender or sex status. This includes the MCOs emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing services to members with physical or mental disabilities.

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

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 address healthcare disparities identified through data collection and requires them to include the methodology utilized for collecting the data as well as interventions taken to enhance the accuracy of the data collected. Additionally, TennCare is directly working to reduce healthcare disparities through contractually requiring its MCOs to provide essential networks and services required to address disparity issues. These requirements include:

- Ensuring an adequate medical provider network of appropriately credentialed providers increasingly committed to evidence-based practices to improve access to care and higher quality outcomes.
- Requiring opt-out Population Health services to be available to all TennCare members while providing intensive case management to those high-risk members who choose to opt-in to certain aspects of the program.
- Proactively promoting health screenings and preventive healthcare services to all TennCare members.
- Providing care coordination and direct support services for CHOICES HCBS enrollees. CHOICES care 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.
- Collaborating with TennCare to develop and implement TennCare member and provider social and health needs surveys (CARE surveys). The 2017 TennCare child and adult social and health needs surveys were available in English, Spanish, Arabic, Chinese, and Vietnamese languages. The TennCare child and

adult member surveys captured data on eleven (11) social and health needs categories. The provider survey collected information in six (6) areas, including access to community resources, community stigmas, and learning opportunities that would improve health outcomes. For more information about the social and health needs surveys, please, see Attachment V: 2017 CARE Action Plan.

For 2018, TennCare's social and health needs goals are to help improve our communities by:

**C**= Connecting members with community resources (like food pantries and housing help);

**A**= Acting for better health by teaching members about their care needs;

**R**=Reducing stigma often felt by those that are in need of help; and

**E**= Empowering members to take the steps needed for better health.

The CARE Workgroup designed the 2018 on-line member and provider surveys to include information about community resources and how to overcome stigma. The social and health needs surveys were renamed the CARE surveys to reflect the goals of the project.

The CARE member survey will be available in English, Spanish, Arabic, Mandarin Chinese, and Vietnamese. The member and provider survey formats are accessible to individuals with disabilities and will protect the privacy and health care data of survey responders.

On July 11, 2018, the CARE Workgroup held a meet-and-greet with several state agencies and community resource organizations. This meeting helped further the Workgroup's goal for building connections between health and social resource organizations. To continue fostering the collaborative efforts, each participant received an attendee contact list.

At the beginning of the year, the Workgroup was creating a statewide community resource list. Since July, the Workgroup is exploring an initiative with the United Way to help improve the 2-1-1 community resource finder database.

**Coordination of Care for Dual Eligible Members**

Since withdrawing from the Financial Alignment Demonstration in late 2012; Tennessee leverages Medicare Part C authority and the D-SNP platform, to help align members in the same health plan for Medicare and Medicaid benefits. TennCare utilizes the MIPPA agreement to require activities designed to support improved coordination of benefits across both programs—for aligned members as well as members enrolled in a non-aligned D-SNP.

To promote member alignment in MCO and D-SNP enrollment, TennCare has employed the following strategies:

- Procurement: during the last Medicaid procurement (for contract term beginning 2015), all plans were required to have a statewide companion D-SNP or to include in their proposals a plan for establishing a statewide companion D-SNP by 2016. All three MCOs now have fully operational statewide D-SNPs. Additionally; United HealthCare operates a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) specific to the CHOICES population, which went live January 1, 2018. On January 1, 2019, United HealthCare will go live with a D-SNP specific to ECF CHOICES. The contractual requirements for this D-SNP are equivalent to a FIDE SNP. However, because the ECF CHOICES program is not yet capitated, and because ECF CHOICES does not contain an institutional benefit, the plan will not technically be a FIDE

SNP.

- Member Reassignment: With the implementation of the new statewide Medicaid contracts, TennCare reassigned members to new MCOs in each grand region of the state to equalize membership enrollment across all MCOs. A key priority in the statewide implementation was reassignment to a Medicaid MCO that would achieve alignment with the member's D-SNP enrollment. Reassignment notices included explanations to help selected members understand why they might want to proceed with reassignment to aligned enrollment, rather than opting to remain with their current Medicaid MCO.
- MIPPA Contracting: While TennCare will continue to maintain MIPPA agreements with current D-SNPs, TennCare will not contract with any new D-SNPs that are not contracted (through a competitive procurement process) to also provide Medicaid benefits.
- Member Education: A process has been implemented for sending educational letters to Medicaid members in advance of their attaining Medicare eligibility to encourage them to enroll in an aligned D-SNP.
- Hardship: Going forward, the hardship criteria will be modified to include requests that would result in alignment with the member's D-SNP.
- Default Enrollment: All of TennCare's aligned D-SNPs have been approved by CMS and are actively engaged in default enrollment. TennCare has been working with the contracted Medicaid plans that have companion D-SNPs to support them in default enrollment of Medicaid enrollees attaining Medicare eligibility pursuant to federal requirements. Prospective Medicare enrollment dates derived from the MMA file submission process are submitted to assist them in identifying their members attaining Medicare eligibility. Upon notification of a Medicaid member's prospective Medicare eligibility date, the State also sends a letter to the member informing them of their upcoming Medicare enrollment and the benefits of enrolling in an aligned D-SNP.

The State is engaging in a number of quality improvement efforts relative to default enrollment. First, the State is participating in a CMS pilot along with Arizona to test the efficacy of a new CMS Prospective Duals File. The purpose of the pilot is to assess whether the new file will provide more timely information on individuals under age 65 becoming eligible for Medicare on the basis of disability to ensure there is time to effectuate the required notice provisions for default enrollment. Second, the State continuously monitors and analyzes the D-SNP Alignment report to determine whether alignment is increasing among plans that have both D-SNP and Medicaid lines of business. Third, the State has built in continuity of care provisions into the MIPPA Agreement for D-SNPs relating to members enrolled through default enrollment. These requirements include a 30 day continuity of care period for all FBDEs seamlessly enrolled (regardless of providers' network participation), extended as necessary to allow time for completion of Health Risk Assessment, network contracting, or seamless transition to network providers. Additionally, D-SNPs are required to develop a provider network that specifically targets substantial overlap of D-SNP providers with its TennCare MCO to ensure seamless access to care for FBDE members who are enrolled through default enrollment into the D-SNP plan. Finally, the State requires, as part of its regular Default Enrollment Report from D-SNPs, information on continuity of care for Primary Care Providers and certain Specialists for members enrolled through default enrollment. The list of Specialists was developed through consultation with medical officers from the respective plans to include types of specialists where continuity would be of high concern. These Specialist types are: Cardiologists, Gastro-Intestinal Physicians, Pulmonologists, Endocrinologists, Nephrologists, Oncologists/Radiation, Infectious Disease,

Rheumatologists, and Wound Care Specialists. Finally, TennCare is also participating in a study conducted by Vanderbilt University Medical Center with funding from ASPE to evaluate how participation in aligned arrangements impacted utilization of services across both the Medicaid and Medicare programs.

- Coordination of Benefits: TennCare exchanges full Medicaid enrollment files with all D-SNPs to ensure they are aware of the member's Medicaid MCO assignment. Medicare enrollment data is also provided to Medicaid MCOs for the same purposes. MIPPA agreements specify strengthened coordination requirements for D-SNPs, including 1)Integrating the Medicare Health Risk Assessment and Plan of Care with the Medicaid Comprehensive Assessment and Person-Centered Support Plan for Medicaid recipients in the ECF CHOICES or CHOICES program; (2) Discharge planning, including education for caregivers upon discharge and medication reconciliation; (3)Care transitions; and (4) Use of long-term services and supports, including requirements for D-SNPs to identify candidates appropriate for Medicaid LTSS programs and make timely referrals to the appropriate MCO. Medicare data, including D-SNP encounter data required by the Medicaid Agency, is also provided to the MCOs for care coordination purposes. Additionally, D-SNPs are required to exchange daily inpatient admission and discharge reports, including observation stays, to help facilitate timely discharge planning. Finally, the MIPPA agreement requires the submission of a Quarterly Dual Coordination Report, a Quarterly Default Enrollment Report (for aligned D-SNPs), a Quarterly D-SNP Appeals and Grievances Report, and a clinical audit of a sample of individuals with multiple re-admissions during a quarterly period conducted by TennCare LTSS staff. The audit samples members identified in the Quarterly Dual Coordination Report having multiple readmissions during a quarter to determine whether adequate coordination occurred to reduce preventable readmissions.

**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 formulation strategy 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 are currently 3,326 active beneficiaries locked into a pharmacy and 951 ineligible persons still subject to the Lock-In (should they regain eligibility) due to being arrested or convicted of TennCare Fraud, Drug Sales or TennCare Doctor Shopping.

- ***Prescriber Identification*** – TennCare has developed a unique and innovative algorithm to identify prescribers who are potentially prescribing opioids and other controlled substances 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.

**Opioid Utilization**

The TennCare Pharmacy Advisory Committee adopted criteria to curb potential over utilization and/or misuse of psychotropic medications in enrollees diagnosed with I/DD. TennCare's pharmacy division is working closely with the Pharmacy Benefits Manager to address over prescribing and misuse of opioids by adopting portions of the Centers for Disease Control's opioid prescribing guidelines.

**Voluntary Reversible Long Acting Contraceptives (VRLAC)**

The TennCare Pharmacy Division implemented an outpatient clinic or medical practice VRLAC pilot project on August 1, 2016 with Bayer Pharmaceuticals and EnTrusRx (Fred's) Specialty Pharmacy. The project allows physicians to obtain VRLACs (IUD – intrauterine contraceptive devices) on a consignment basis to insert at a scheduled appointment thus avoiding a follow-up visit by the enrollee. By allowing same day access to VRLACs, the goal is to readily accommodate TennCare enrollees who desire long-acting contraceptives to prevent unintended or closely spaced pregnancies. Additionally, the pilot project could potentially reduce Neonatal Abstinence Syndrome (NAS) births, abortions, and unused IUD prescriptions because an enrollee was unable to return for a VRLAC placement office visit. The initial pilot included twenty-five (25) medical practices in the first month. At the one (1) year mark, thirty-seven (37) outpatient clinics and medical practices, representing seventy-nine (79) practitioners, are participating in the pilot project and a third IUD product was introduced. The ultimate goal of the project is to offer VRLAC products on a consignment basis to all interested practitioners state-wide.

Additionally, in Q4 of 2017, with full support from TennCare, each MCO launched an initiative to allow for increased access to post-partum VRLACs including both IUDs and implants. Each MCO now allows hospital billing for the VRLAC device and practitioner professional insertion fee billing to be added to the standard Diagnosis Related Group (DRG) bundled fee for labor and delivery.

## National Performance Measures

***CMS Requirement: Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders. (42 CFR § 438.204(c))***

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

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

Performance goals are based on improvement to or maintenance of the following national benchmarks: HEDIS 25th, 50th, and 75th percentiles, and CAHPS Quality Compass national benchmarks.

**Child Health Quality Measures**

| Measure Name | 2016 Baseline | 2018 Update | 2019 Goal |
|---|---|---|---|
| **Timeliness of Prenatal Care** | 76.34% | 76.94% | 85.19% |
| **Childhood Immunization Status** | | | |
| DTaP/DT | 76.91% | 75.28% | 79.52% |
| IPV | 91.23% | 75.28% | 94.70% |
| MMR | 88.46% | 87.78% | 90.93% |
| HiB | 88.77% | 87.90% | 91.00% |
| Hepatitis B | 92.14% | 91.78% | 93.67% |
| VZV | 88.52% | 87.57% | 91.17% |
| Pneumococcal Conjugate | 79.20% | 77.49% | 79.88% |
| Hepatitis A | 87.18% | 86.84% | 89.29% |
| Rotavirus | 69.62% | 70.95% | 69.91% |
| Influenza | 42.86% | 42.54% | 51.34% |
| Combination 2 | 74.27% | 73.13% | 75.47% |
| Combination 3 | 71.88% | 70.55% | 76.50% |
| Combination 4 | 70.27% | 70.24% | 73.24% |
| Combination 5 | 57.87% | 59.11% | 58.36% |
| Combination 6 | 37.28% | 37.63% | 43.65% |
| Combination 7 | 57.32% | 58.91% | 62.04% |
| Combination 8 | 37.02% | 37.54% | 42.23% |
| Combination 9 | 31.78% | 33.04% | 36.68% |
| Combination 10 | 31.64% | 32.94% | 35.88% |
| **Adolescent Immunization Status** | | | |
| Meningococcal | 67.84% | 71.28% | 75.69% |
| Tdap/Td | 81.80% | 84.08% | 86.26% |
| Combination 1 | 67.13% | 70.63% | 73.15% |
| **Weight Assessment and Counseling for Nutritional and Physical Activity for Children/Adolescents** | | | |
| BMI Percentile (3 - 11 years) | 71.33% | 78.27% | 77.48% |
| BMI Percentile (12 - 17 years) | 65.74% | 74.90% | 67.47% |
| Counseling for Nutrition (3 - 11 years) | 62.76% | 69.94% | 63.00% |
| Counseling for Nutrition (12 - 17 years) | 54.98% | 63.17% | 58.33% |
| Counseling for Physical Activity (3 - 11 years) | 53.08% | 60.97% | 53.36% |
| Counseling for Physical Activity (12 - 17 years) | 54.47% | 61.89% | 56.34% |

| | | | |
|---|---|---|---|
| **Chlamydia Screening** | 51.19% | 53.41% | 57.64% |
| **Well-Child Visits in the First 15 Months of Life: Six or More Visits** | 57.63% | 66.86% | 59.76% |
| **Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life** | 68.01% | 72.61% | 72.02% |
| **Adolescent Well-Care Visits** | 42.34% | 53.14% | 49.15% |
| **Child and Adolescent Access to Primary Care Practitioners** | | | |
| 12-24 months | 91.77% | 95.44% | 96.28% |
| 25 months – 6 years | 85.15% | 86.73% | 88.46% |
| 7 – 11 years | 91.15% | 91.21% | 91.42% |
| 12 – 19 years | 87.78% | 88.07% | 90.06% |
| **Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication** | | | |
| Initiation Phase | 49.26% | 45.98% | 49.07% |
| Continuation and Follow-Up Phase | 63.14% | 57.89% | 58.36% |
| **Follow-Up After Hospitalization for Mental Illness** | | | |
| 7 day follow- up | 55.95% | 35.05% | 56.78% |
| 30 day follow-up | 70.63% | 57.24% | 75.28% |
| **Medication Management for People with Asthma – 75%** | | | |
| Ages 5-11 | 26.87% | 26.88% | 32.80% |
| Ages 12-18 | 26.63% | 29.57% | 28.99% |
| **Consumer Assessment of Health Plans – Child Medicaid Survey** | | | |
| Getting Needed Care (Always + Usually) | 86.60% | 87.85% | 88.70% |
| Getting Care Quickly (Always + Usually) | 91.58% | 91.74% | 93.28% |
| How Well Doctors Communicate (Always + Usually) | 93.79% | 94.47% | 95.26% |
| Customer Service (Always + Usually) | 89.23% | 90.01% | 91.13% |
| Shared Decision Making (Yes) | 80.49% | 80.09% | 82.94% |
| Rating of All Health Care (9+10) | 70.94% | 71.47% | 73.75% |
| Rating of Personal Doctor (9+10) | 76.89% | 77.96% | 79.50% |
| Rating of Specialist Seen Most Often (9+10) | 75.96% | 74.98% | 78.60% |
| Rating of Health Plan (9+10) | 73.62% | 76.85% | 76.35% |
| **Consumer Assessment of Health Plans – Children With Chronic Conditions** | | | |
| Getting Needed Care (Always + Usually) | 87.93% | 90.10% | 89.93% |
| Getting Care Quickly ( Always + Usually) | 93.57% | 94.83% | 95.07% |
| How Well Doctors Communicate (Always + Usually) | 94.22% | 94.62% | 95.64% |
| Customer Service ( Always + Usually) | 89.79% | 89.35% | 91.65% |
| Shared Decision Marking (Yes) | 85.83% | 84.00% | 87.98% |
| Rating of All Health Care (9+10) | 69.52% | 69.70% | 72.37% |
| Rating of Personal Doctor (9+10) | 75.45% | 75.75% | 78.11% |
| Rating of Specialist Seen Most Often (9+10) | 72.87% | 76.35% | 75.62% |
| Rating of Health Plan (9+10) | 69.18% | 73.84% | 72.04% |
| Access to Specialized Services (Always + Usually) | 80.20% | 77.81% | 82.66% |
| FCC-Doctor or Nurse Who Knows Child (Yes) | 90.95% | 91.25% | 92.71% |
| Coordination of Care (Yes) | 77.58% | 82.23% | 80.16% |
| FCC – Getting Needed Information (Always + Usually) | 91.11% | 91.58% | 92.85% |
| Access to Prescription Medicines (Always + Usually) | 92.63% | 94.05% | 94.23% |

**Adult Quality Measures:**

| Measure Name | 2016 Baseline | 2018 Update | 2019 Goal |
|---|---|---|---|
| **Adult BMI Assessment** | 82.46% | 90.94% | 83.45% |
| **Breast Cancer Screening** | 54.47% | 53.81% | 58.34% |
| **Cervical Cancer Screening** | 55.60% | 62.15% | 61.05% |
| **Chlamydia Screening in Women Ages 21-24** | 54.61% | 57.70% | 61.21% |
| **Follow-Up After Hospitalization for Mental Illness** | | | |
| 7 Day Follow-Up | 55.95% | 35.05% | 56.78% |
| 30 Day Follow-Up | 70.63% | 57.24% | 75.28% |
| **Controlling High Blood Pressure** | 55.10% | 57.18% | 57.53% |
| **Comprehensive Diabetes Care: Hemoglobin A1c Testing** | 82.59% | 85.39% | 86.20% |
| **Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)** | 43.23% | 37.12% | 42.22% |
| **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment** | | | |
| Initiation of AOD Treatment | 33.36% | 41.82% | 37.61% |
| Engagement of AOD Treatment | 8.70% | 13.42% | 9.83% |
| **Prenatal and Postpartum Care: Postpartum Care Rate** | | | |
| Timeliness of Prenatal Care | 76.34% | 79.21% | 85.19% |
| Postpartum Care | 55.57% | 60.31% | 62.77% |
| **Antidepressant Medication Management** | | | |
| Effective Acute Phase Treatment | 47.75% | 47.07% | 50.51% |
| Effective Continuation Phase Treatment | 32.19% | 30.60% | 34.02% |
| **Flu Vaccinations for Adults Ages 18-64** | 36.92% | 41.75% | 39.04% |
| **Annual Monitoring of Patients on Persistent Medications** | | | |
| Ace Inhibitors or ARBs | 90.46% | 91.31% | 92.01% |
| Diuretics | 90.92% | 91.87% | 91.78% |
| **Medical Assistance with Smoking and Tobacco Use Cessation** | | | |
| Advising Smokers and Tobacco Users to Quit | 77.05% | 78.72% | 79.41% |
| Discussing Cessation Medications | 43.01% | 45.14% | 46.70% |
| Discussing Cessation Strategies | 38.28% | 40.82% | 42.50% |
| % Current Smokers | 37.28% | 36.73% | 39.60% |
| **Consumer Assessment of Health Plans Survey – Adult** | | | |
| Getting Needed care (Always + Usually) | 82.45% | 83.90% | 84.80% |
| Getting Care Quickly (Always + Usually) | 82.14% | 83.01% | 84.50% |
| How Well Doctors Communicate (Always + Usually) | 90.13% | 91.22% | 91.96% |
| Customer Service (Always + Usually) | 88.88% | 89.47% | 87.11% |
| Shared Decision Making (Yes) | 77.06% | 78.48% | 79.66% |
| Rating of All Health (9+10) | 52.70% | 55.20% | 55.81% |
| Rating of Personal Doctor (9+10) | 64.24% | 67.03% | 67.22% |
| Rating of Specialist Seen Most Often (9+10) | 67.25% | 67.91% | 70.16% |
| Rating of Health Plan (9 + 10) | 58.71% | 62.52% | 61.77% |

## *Monitoring and Compliance*

***CMS Requirement: Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). Some examples of mechanisms that may be used for monitoring include, but are not limited to: Member or provider surveys; HEDIS results; Report cards or profiles; Required MCO/PIHP reporting of performance measures; Required MCO/PIHP reporting on performance improvement projects; Grievance/Appeal logs, etc. (CFR § 438.204(b)(3))***

### NCQA Accreditation

Each MCO must obtain and maintain NCQA accreditation, and failure to obtain and/or maintain accreditation is considered to be a breach of the Contractor Risk Agreement (CRA) and will result in termination of the Agreement. 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, at which point it is reviewed by staff to determine areas of deficiency. If the reviewer deems necessary, a Corrective Action Plan may be required.

### LTSS Distinction

Effective January 1, 2019. MCOs will also be required to achieve LTSS Distinction as part of their NCQA Accreditation process no later than December 31, 2019. NCQA's LTSS Distinction designates that an MCO meets certain evidence-based standards in the coordination of LTSS in areas such as conducting comprehensive assessments, managing care transitions, performing person-centered assessments and planning and managing critical incidents. Two of TennCare's MCOs—Blue Care and Amerigroup—were the first in the country to achieve this distinction; United HealthCare is expected to complete the process in 2019.

### Quarterly and Annual Reports from Managed Care Contractors

All MCCs are required to submit a variety of reports to TennCare throughout the year. 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. Information from the reports is used by program staff to help monitor compliance with program requirements. Examples of reports include Population Health, EPSDT Outreach, Behavioral Health, Nursing Facility Diversion Activities, CHOICES Care Coordination, CHOICES and Employment and Community First CHOICES Member Complaints, and Provider Satisfaction.

### HEDIS results

Annually each MCO is required to submit all HEDIS measures designated by NCQA as relevant to Medicaid, with an exception for dental measures. 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, as well as a PIP in the area of EPSDT. The two clinical PIPs must include one in the area of behavioral health that is relevant to one of the Population Health programs for bipolar disorder, major depression, or schizophrenia, and one in the area of either child health or perinatal (prenatal/postpartum) health. One of the three non-clinical PIPs must be in the area of long-term services and supports. 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 conducts the survey and provides a detailed written report of findings for each MCO. If an MCO scores less than 100% on any element, a Corrective Action Plan must be submitted within two weeks of receipt of the findings. Both the EQRO and TennCare staff review the Corrective Action Plans to ensure the MCCs take appropriate action. Follow-up on the plans is conducted by the TennCare Division of Quality Improvement.

**Site visits/collaborative work groups**

Both the Division of Quality Improvement and the Behavioral Health Operations Unit conduct periodic site visits to learn about and monitor various aspects of MCC activities. On a semi-annual basis, or more frequently if needed, TennCare staff meet with each MCO to receive updates on different initiatives and special projects. The Division of Quality Improvement meets with the Quality Directors on a monthly basis to discuss issues, projects, etc. and participates on multiple workgroups facilitated by the Tennessee Department of Health. Other workgroups that TennCare Behavioral Health staff participates in include TDMHSAS Planning and Policy Council, State Epidemiological Outcomes Workgroup, Tennessee Interagency Council on Homelessness, Tennessee Suicide Prevention Network (TSPN) Zero Suicide Initiative Task Force, Children's Cabinet state-wide, multi-agency Collaboration Pilot, Department of Children's Services/TennCare Select Coordination of Care Meeting, and Tennessee Association of Mental Health (TAMHO) Finance and Administration meetings.

**Audits/Medical Record Reviews**

Either annually or semi-annually the following Medical Record Reviews (MRRs) are conducted by the EQRO, the Division of Quality Improvement or the Division of Long-Term Services and Supports:

- A sample of provider records is reviewed to determine compliance with Abortion, Sterilization, and Hysterectomy (ASH) federal regulations.

**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 physical, behavioral health and LTSS. The report must summarize the provider survey methods and findings and must provide an analysis of opportunities for improvement. An additional CHOICES and Employment and Community First CHOICES survey of providers is also required. This report must address results for CHOICES and employment and Community First CHOICES long term services and supports providers. It also must include a summary of survey methods and findings as well as n analysis of opportunities for improvement.

**Customer Satisfaction Surveys**

- Annually each MCO must conduct a CAHPS survey utilizing a vendor that is certified by NCQA. The surveys conducted are the CAHPS Adult Survey, the CAHPS Child Survey, and the CAHPS Children with Chronic Conditions Survey. The data is then submitted to both TennCare and the EQRO, which provides analyses of the data as well as a written report.
- TennCare contracts with The University of Tennessee Boyd Center for Business and Economic Research to conduct an annual survey of 5,000 Tennesseans to gather information on their 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.
- In 2015, TennCare began contracting with NASUAD to participate in the National Core Indicators – Aging and Disability (NCI-AD) consumer satisfaction survey for older adults and adults with disabilities. TennCare contracts with the nine Area Agencies on Aging and Disability to conduct the face-to-face interviews that inform the NCI-AD results. 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. TennCare oversamples in order to be able to compare performance between MCOs and shares the results with its MCOs, with results separated by MCO and overall, to inform MCO quality improvement strategies. TennCare requires the MCOs to present on negative and positive trends, and to create action plans for improvement, the efficacy of which are evaluated the following year when new NCI-AD results are received.
- For Employment and Community First CHOICES, TennCare plans to utilize the original NCI survey (developed for persons with I/DD) to assess the quality of life of each person with I/DD enrolled in ECF CHOICES. Implementation of this survey in ECF CHOICES has been delayed because NASDDDS (the National Association of State Directors of Developmental Disabilities Services) has been unwilling to contract with TennCare (a State Medicaid Agency) to allow participation in the NCI. We hope to resolve this issue in order for NCI surveys to commence in 2019. If not, a comparable quality of life instrument will be used.

**Prior approval of all member materials**

The Division of Quality Improvement, in conjunction with Managed Care Operations staff and Member Communications, reviews all member materials that have clinical information included. Staff reviews information for clinical accuracy, culturally appropriate information, and appropriateness of clinical references. LTSS staff in conjunction with MCO staff reviews all member materials related to the CHOICES and the Employment and Community First 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 TDCI TennCare Quality Oversight Division is considered to be a Health Oversight Authority under the guidelines of the Health Insurance Portability and Accountability Act. As such the release of protected health information without authorization is permitted under 45 CFR § 164.512 for the purposes of regulation. The TennCare Oversight Division is required to:

- Act upon licensure applications;
- Examine HMOs at least once every five years (examinations are currently conducted once every two years);
- Review and analyze quarterly and annual financial reports filed by the TennCare HMOs;
- Process eligible requests for independent review of denied TennCare provider claims;
- Review and either approve or disapprove material modifications to organization documents, including but not limited to, provider agreements, subcontracts, evidences of coverage, marketing materials, and any other item that would materially change the operations of the HMO;
- 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**

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

**LTSS Quality Monitoring**

TennCare's LTSS Division has an established quality monitoring system, including reports and audits; to monitor the quality and appropriateness of care delivered to members in the CHOICES and Employment and Community First CHOICES programs. The quality monitoring system aligns with the quality components of the Medicaid Managed Care Rule specified in 42 C.F.R. § 438.330. Specifically, TennCare's LTSS Division monitors MCO performance through: (1) assessing care between settings; (2) comparing services and supports with those in the member's plan; (3) incorporating MCOs into efforts to prevent, detect, and remediate critical incidents; and (4) assessing member quality of life, rebalancing, and community integration activities. The following sections detail reports and audits TennCare's LTSS Division employs to help monitor these four quality components.

**Assessing Care between Settings**

LTSS monitors member care between settings – meaning members transitioning from institutional to community settings, transitioning to specific types of community-based residential alternatives regardless of whether the

member is coming from an institutional or community setting, or transitioning from the community to an institutional setting –through a variety of reports and audits. This section walks through methods related to assessing care between settings and how TennCare LTSS uses this information to address quality concerns with care transitions and improve care transition outcomes.

**Transitioning from an Institutional Setting to the Community**

TennCare LTSS maintains multiple reports and tracking systems to monitor quality outcomes for individuals transitioning from an institutional setting to the community for the CHOICES and ECF CHOICES programs.

For CHOICES, TennCare LTSS receives the **Nursing Facility to Community Transition Report**, which tracks CHOICES members who transition from a nursing facility to the community, and also tracks members who could potentially move from a nursing facility to a community setting. For ECF CHOICES, TennCare LTSS receives the **Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) to Community Transition Report**, which tracks the members who transition from a nursing facility or from an ICF/IID to the community. This report also tracks members who could potentially be moved from one of these institutions to a community setting. Upon receipt of these reports, TennCare LTSS staff review transitions or potential transitions identified during the reporting period including the settings to which care has transitioned, community tenure and readmissions, and use the reports to help identify potential barriers or delays to successful transition, and actions that may be taken by the MCOs or by TennCare to improve transitions of care from the institution to the community.

For Both CHOICES and ECF CHOICES, TennCare LTSS receives **the Housing Profile Assessment Report**, which includes the housing needs of members waiting to transition from an institutional setting or members who are post-transition from an institutional setting and includes wait times, transition barriers, monthly income, housing options, and locations chosen. Additionally, this report includes members receiving housing supplements, and members participating in the State's (MFP) Non-Profit Affordable Housing Development Grant Initiative.

Finally, for ECF CHOICES, each MCO reports data on their members in the subacute or IDD population who are in Regional Mental Health Institutes and are appropriate for community transition on the **Regional Mental Health Institute to Community Transition Grid** so that consistent data points can be collected in terms of the number of individuals who are discharged, the type of LTSS or Behavioral health program utilized, any readmissions, and the summary information for the transition process for a particular individual. TennCare works closely with MCOs and with the RMHIs to identify potential barriers and opportunities for improvements with transitions from this care setting. These collaborations have led to streamlined enrollment processes, specialized transitional rates of reimbursement for Community Living Supports, and a proposed amendment to the TennCare demonstration to implement a new benefit group entitled "Intensive Behavioral Community Transition and Stabilization Services" targeted to helping adults with I/DD who have co-occurring psychiatric conditions or extremely challenging behavior support needs transition safely into integrated community-based settings.

**Transitioning to Community Living Supports or Community Living Supports-Family Model Benefits**

The State maintains two community-based residential alternative benefits called Community Living Supports (CLS) and Community Living Supports-Family Model (CLS-FM). CLS allows up to 4 older adults and adults with disabilities to receive residential services that encompass a continuum of support options that supports each resident's independence and full integration into the community, ensures each resident's choice and rights. CLS-

FM is similar but operates through an adult foster care model. Both of these settings predominantly house individuals who have transitioned from an institutional setting or would otherwise be in an institutional setting. To ensure the quality of services in these residences, the State has several reports, audits, and strategic partnerships in place.

**A CHOICES and ECF CHOICES CLS and CLS-FM Placement Report** tracks members from each MCO who are receiving CLS and CLS-FM and contains detailed information about members who are new to CLS services.

The State contracts with the Area Agencies on Aging and Disability (AAAD) to provide Ombudsman services in CLS and CLS-FM residences. An Ombudsman meets face-to-face with each member to offer advocacy and support, provide education regarding their rights (including choice) and the identification and prevention of abuse, neglect, and/or financial exploitation, and assist members in the resolution of complaints relating to CLS or CLS-FM. Additionally, the AAAD provide TennCare with a **CHOICES and ECF CHOICES CLS and CLS-FM Ombudsman Report** and **CLS and CLS-FM Pre and Post-Transition Survey**, which track AAAD CLS Ombudsman activities to ensure they are being conducted as required by TennCare and collect member data on choice of setting and roommate selection, if applicable, member needs, preferences, and goals, person-centered planning, member rights, respect, and dignity, and safety and security, respectively. Finally, TennCare receives a **Quality Monitoring Survey of CLS and CLS-FM Providers** to assess the provider's role in: (1) supporting individuals to make informed choices during the process of provider selection; (2) the provider's ability to provide an effective orientation to individuals, which includes information about their services and rights; and (3) the provider's willingness and ability to accept referrals and begin the service in a timely manner.

**Transitioning from the Community to an Institutional Setting**

TennCare maintains reports and a related audit to monitor individuals living in the community who have short-term institutional stays (STS). **The CHOICES and ECF CHOICES Nursing Facility (NF) and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Short-Term Stay Report** provides information on members who have utilized the STS benefit. The report tracks the length of stay, the NF or ICF/IID at which the stay occurred, anticipated discharge date, and provides details if the member will stay longer than 90 days. **The Short-Term Stay (STS) Audit** addresses MCO performance related to verification of Nursing Facility level of care prior to admission for a STS, 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.

In addition, for CHOICES, TennCare LTSS receives a **Nursing Facility Diversion Report** that describes MCO efforts and successes at delaying or preventing nursing facility placement for members wishing to remain in the community. MCOs also identify systematic barriers so the State can continue to increase community living opportunities for members in choosing this option.

**Comparing Services and Supports with Those in the Member's Plan**

TennCare requires that MCOs develop a Person-Centered Support Plan (PCSP) for each CHOICES and ECF CHOICES member that reflects the member's individual needs, preferences, interests, strengths, risk areas, supports, services, health status, background, and goals. To ensure that services and supports are provided consistent with the member's PCSP TennCare employs several reports, surveys, and audits.

For ECF CHOICES, TennCare receives a **Service Initiation Report** that details services that have not been initiated and the reasons for the delays. Additionally, this report tracks services that are being received, timeliness of

initiation, and services that have yet to be authorized. The MCOs participate in monthly calls with TennCare LTSS to discuss the report data and identify opportunities for improvement.

For CHOICES and ECF CHOICES, a **Late and Missed Visit Report** tracks late and missed visits for personal care, attendant care, and home-delivered meals in CHOICES, and personal assistance and supportive home care in ECF CHOICES to determine when workers are not providing services pursuant to a member's PCSP.

For CHOICES and ECF CHOICES, a **Utilization Report** tracks members who have been without long-term services for periods of longer than 30-59 days, 60-89 days, and more than 90 days. This report also details why a member has not received services and when services are expected to begin.

Finally, TennCare conducts **CHOICES and ECF CHOICES New and Existing Member Record Review Audits**, which address identification of services in the PCSP, MCO authorization of services, and timely initiation of services. Additionally, this audit addresses the referral, intake and enrollment processes, MCO response time and documentation and for ECF CHOICES, MCO performance related to completion of required processes to help members understand and explore individual integrated employment and self-employment options. The audit takes a deep dive into a sample of PCSPs to determine whether MCOs are delivering all services in each individual's PCSP.

**Incorporating MCOs into Efforts to Prevent, Detect, and Remediate Critical Incidents**

TennCare maintains two distinct systems for preventing, detecting, and remediating adverse occurrences to its members – the Critical Incident system in CHOICES and the Reportable Event Management system in ECF CHOICES. In CHOICES, providers investigate critical incidents and MCOs are responsible for remediation based on the findings of those investigations. In ECF CHOICES, TennCare contracts with the Department of Intellectual and Developmental Disabilities (DIDD) for investigations of abuse, neglect, and exploitation, and providers assume investigative responsibility for lesser allegations. In both systems, TennCare maintains three reports and two audits to receive notification of these occurrences and any identified trends to assist MCOs and DIDD with prevention strategies. Additionally, TennCare continues its efforts to evolve the systems in both programs to allow for dignity of risk.

For CHOICES, TennCare receives a **CHOICES Critical Incident Report** that tracks all critical incidents by incident type, setting, and the provider/staff accused of being responsible for the incident.
The report includes a narrative describing the MCO's analysis of critical incidents for the reporting period, including trends and patterns; opportunities for improvement; and strategies implemented by the MCO to reduce the occurrence of incidents and improve the quality of CHOICES HCBS.

Similarly, for ECF CHOICES, TennCare receives an **ECF CHOICES Reportable Event Report** that tracks all reportable events, and reportable events determined to be critical incidents, reported by incident type and tier, setting, and the provider/staff accused of being responsible for the incident. It also includes details on the trends and findings of reportable events, opportunities for improvement, and the development and implementation of strategies and actions taken to reduce the occurrence of and prevent future events/incidents for ECF CHOICES members.

For CHOICES and ECF CHOICES, TennCare receives a **Fiscal Employer Agent Report** that tracks critical incidents, reportable events, and reportable events determined to be critical incidents that involved CHOICES, ECF CHOICES, and DIDD members who are consumer-directing or self-directing their services.

Finally, TennCare conducts three audits related to these occurrences – a **CHOICES Critical Incident Audit**, **ECF**

**CHOICES Reportable Event Audit**, and **DIDD Reportable Event Audit** – to address MCO and DIDD determinations, documentation, responsiveness, and investigations of critical incidents/reportable events within specified timeframes. The audits also assess MCO and DIDD activities to identify trends and patterns and opportunities for improvement, and their progress on development and implementation of strategies to reduce the occurrence of events/incidents to improve the quality of CHOICES and ECF CHOICES services.

**Assessing Member Quality of Life, Rebalancing, and Community Integration Activities**

TennCare has been engaged in a statewide LTSS system transformation effort across Medicaid programs, including Section 1915(c) and 1115 waiver service delivery systems, that serve over 40,000 people in institutional and home and community based service settings, with the goal of transforming the entire LTSS system to one that is person-centered and that aligns policies, practices, and payments with system values and outcomes. TennCare, in collaboration with a statewide System Transformation Leadership Group comprised of LTSS stakeholders, has identified key drivers of systems transformation that impact the collective populations served by Tennessee's LTSS programs. The system transformation efforts take into account that transformation occurs at the person or individual level, the interpersonal level, and at the system or program level. Tennessee recognizes that the advancement made at the system level will impact a broader culture transformation where older adults and people with disabilities enjoy the rights, valued roles, and quality of life that other citizens strive to realize.

A consistent theme of these system transformation drivers is the opportunity to align program policies and practices with quality efforts that improve quality of life and satisfaction for individuals served. Key tools leveraged by system transformation to inform strategies include National Core Indicator - Aging and Disability Survey, LTSS quality monitoring tools, Individual Experience Assessment survey results, and reports and audits.

**Assessing Member Quality of Life**

There are two reports and three surveys that TennCare uses to assess member quality of life in CHOICES and ECF CHOICES.

For CHOICES and ECF CHOICES**,** TennCare receives a **Point of Service Satisfaction Report**, which provides data on member satisfaction with MCO and provider supports, entered and recorded directly by members into the electronic visit verification system. Additionally, TennCare receives a **CHOICES and ECF CHOICES Member Complaint Report**, which tracks the total number of member complaints overall and by specified categories (Quality of Care, Attitude and Service, Billing and Financial Issues, and other) and the number and percentage of complaints with/without timely notification and resolution.

In addition to the preceding reports, TennCare engages in robust survey processes to assess member quality of life. The first survey process TennCare uses specific to CHOICES members is the **National Core Indicators – Aging and Disability Survey.** TennCare contracts with the State's nine Area Agencies on Aging and Disability to conduct the NCI-AD survey for its CHOICES members, and provides MCO-specific feedback on member quality of life to MCOs based on the results of the survey. TennCare LTSS reviews survey results with the MCOs and requires that each MCO develop and submit a plan detailing strategies for addressing opportunities for improvement identified by survey results. MCO plans also include an update on implementation of the previous year's plan.

The second survey, which applies to CHOICES, ECF CHOICES, and the State's three 1915(c) HCBS Waivers, is the **Individual Experience Assessment (IEA) Survey**. At each member's annual visit, a Care or Support Coordinator or Case Manager or Independent Support Coordinator, as applicable to the particular program, conducts an IEA Survey, which is a tool developed by TennCare using the HCBS Settings Rule Exploratory Questions from CMS. The

survey is intended to measure each individual's level of awareness of and access to rights provided in the HCBS Settings Rule, freedom to make informed decisions, community integration, privacy requirements, and other member experience expectations. This data is entered into an electronic system that TennCare uses to aggregate and analyze data by MCO and by provider. A related report, the **CHOICES and ECF CHOICES HCBS Regulatory Report**, tracks IEA survey results collected by the MCOs. The MCOs are required to review IEA survey responses for all Medicaid recipients receiving HCBS and investigate each "No" response that indicates a rights restriction. MCOs must then investigate these responses to determine if the restriction indicated has gone through the HCBS Settings Rule modifications procedure, and the restriction is appropriately included in the member's Person-Centered Support Plan. If the restriction has not gone through the modification process and is not supported in the person-centered support plan, the MCOs remediate the individual concerns by working with the provider and the person supported and his or her representative, if applicable. In addition, as part of ongoing monitoring of compliance with the HCBS Settings Rule, the MCOs are required to identify trends relating to member concerns with particular providers or provider settings and report those issues to TennCare along with steps for remediation to address those concerns. The TennCare's review and analysis of this data informs targeted technical assistance as well as overall ongoing systems transformation efforts.

The final survey relating to member quality of life for CHOICES and ECF CHOICES members is the **Quality Monitoring Survey.** TennCare, through its contractor the Department of Intellectual and Developmental Disabilities (DIDD), conducts Quality Monitoring Surveys of certain ECF CHOICES providers. The survey assesses providers in several quality areas including, choice and decision-making, opportunities for integrated work, relationships and community membership, and rights, respect, and dignity. TennCare will begin conducting Quality Monitoring Surveys of CHOICES CLS providers in 2019.

**Rebalancing**

To assess rebalancing efforts in the State, TennCare maintains the CHOICES and ECF CHOICES **Baseline Data Reports** , which include clear performance measures pertaining to rebalancing LTSS expenditures that are tracked from program implementation and on an ongoing basis.

**Employment and Community Integration Activities**

TennCare assesses employment – meaning desire for employment, services relating to employment, and outcomes – as well as community integration activities in a number of ways.

One of those methods is the previously mentioned **Quality Monitoring Survey**. This survey contains a portion that assesses whether and to what extent the provider ensures the services being delivered encourage and support members to pursue and work in integrated individualized employment or self-employment making at least minimum wage. Additionally, another portion of the survey assesses whether and to what extent the provider ensures the individuals they support have opportunities for developing and maintaining meaningful relationships with others who do not have disabilities, who are not also receiving HCBS services, and who are not paid to provide supports. This includes ensuring individuals have opportunities to be valued members of their communities and to fill valued social roles in their communities. Finally, the survey measures whether and to what extent the provider's service delivery model promotes the development and maintenance of natural supports that can enable individuals to be less dependent on paid services and supports.

For ECF CHOICES, TennCare receives an **Employment Report** that tracks the number of ECF CHOICES members who are actively engaged in integrated, competitive employment, as well as member wages and job types. The report also identifies members who have completed the Employment Informed Choice process. Additionally, the

report was revised in 2018 to capture the following information for members who are not currently engaged in competitive, integrated, employment: members entering ECF CHOICES through an employment priority group, members with an employment goal in their PCSP, and members with at least one pre-employment service authorization.

TennCare LTSS uses this data to monitor the quality of the MCO person-centered planning process and appropriate implementation of the ECF CHOICES program. TennCare LTSS staff discuss this data with MCO Employment Specialists during regular meetings.

For CHOICES and ECF CHOICES, each member's Care or Support Coordinator will conduct an **Individual Employment Data Survey** at routine intervals. The survey measures the number of TennCare members currently working in competitive, integrated employment, and the number of members who are not currently working who have an interest in working or volunteering. The survey is also used as a care and support coordination tool for discussing employment during the person-centered planning process. This data is entered into an electronic system that TennCare can use to aggregate and analyze data by MCO and by provider.

Finally, TennCare conducts an **Employment Informed Choice Audit.** This audit addresses MCO performance related to completion of required processes to help members understand and explore individual integrated employment and self-employment options. Compliance with this standard is also monitored through the quarterly MCO submission of the Employment and Community First CHOICES Employment Report specified above.

**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.

**Patient Centered Dental Home**

DentaQuest, TennCare's contracted Dental Benefits Manager (DBM), has established a patient-centered dental home (PCDH) for all TennCare members. A PCDH is defined as a place where a child's oral health care is delivered in a comprehensive, continuously accessible, coordinated and family centered way by a dentist participating in the TennCare program. TennCare members can either choose their dental home dentist or be assigned a dentist. Individual primary care dentists must be able to access their roster of dental home assignments through their provider web portal established by the DBM. One of the primary reasons for establishing a PCDH is to ensure that all enrollees truly have access to a participating primary care dentist who is identified through member assignment. Provider acceptance and engagement of member assignments is essential to the success of the program for TennCare beneficiaries. Key to evaluating success is the development of reports that track patient engagement, quality of care and provider performance. The Provider Performance Report (PPR) is an individual confidential report card sent to participating primary care dentists on a quarterly basis. The PPR is a provider educational tool to afford providers in the network the opportunity to see how their practice compares with their peers and the overall network average in cost, access, and preventive care. It is anticipated that sharing confidential feedback with providers through the PPR will result in a shift by those performing under the network benchmark or mean to modify their practice pattern to meet or exceed network benchmarks. This will further encourage movement of the needle in a positive direction on quality and cost. Additional member assignments to a dental home will be based upon the PPR as well as other provider utilization reports. This will ensure that TennCare members have access to dental home providers demonstrating a commitment to providing the highest quality care. The dental home model is key component of TennCare's overall vision to transform the TennCare dental program from a surgical/dental restorative program to a more balanced program that emphasizes prevention and control of oral diseases through minimally-invasive treatment resulting in improved oral health and quality of life for members.

## External Quality Review

***CMS Requirement: Include a description of the state's arrangements for an annual, external, independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time. (42 CFR § 438.204(d))***

Tennessee contracts with Qsource to provide External Quality Review (EQR) activities. The services to be provided under this contract include multiple tasks and deliverables that are consistent with applicable federal EQR regulations and protocols for Medicaid Managed Care Organizations and state-specific requirements 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 the TennCare Section 1115 Waiver.

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

***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 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 Improvement staff as well as all MCOs and the DBM.
- Analysis of the National Core Indicators – Aging and Disabilities Survey.

- Assisting the Division of Quality Improvement with its strategic planning sessions and Quality Strategy development.
- Providing technical assistance to MCCs on a variety of topics including HEDIS and CAHPS reporting.

***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). (42 CFR § 438.360(b))***

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* | |
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| **2018 State Standards** | **2018 NCQA Accreditation Standards** |
| **CRA § 2.11.1.5.-2.11.1.5.1-4 (E/W, Middle, & TCS)** | **QI 3B Affirmative Statement** |
| The contractor may not prohibit or other-wise 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:<br>• The member's health status or medical, behavioral health, or long-term care treatment options, including alternative treatment that may be self-administered;<br>• Any information the member needs in order to decide among all relevant treatment options;<br>• The risks, benefits, and consequences of treatment or non-treatment; or<br>• 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. | Contracts with practitioners include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations. |
| **CRA § 2.18.3-2.18.3.1.4 (E/W, Middle, & TCS)** | **NET 1A – Availability of Practitioners RR 3, Element B, Interpreter Services** |
| As required by 42 CFR 438.206, the CONTRACTOR and its Providers and Sub-contractors that are providing services pursuant to this Contract shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, disabilities, and diverse cultural and ethnic backgrounds regardless of an enrollee's gender, sexual orientation, or gender identify. This includes the CONTRACTOR emphasizing the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services with physical or mental disabilities. | Element A: Availability of Practitioners<br>• Assesses the cultural, ethnic, racial and linguistic needs of its members<br>• Adjusts the availability of practitioners within its network, if necessary<br><br>Based on the linguistic need of its subscribers, the organization provider interpreter or bilingual services in its Member Services Department and telephone functions. |

| CRA § 2.8.4.3.2 | PHM1-6 |
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| The CONTRACTOR shall develop and operate the "opt out" health risk management program per NCQA standard PHM.1 for disease management. Program services shall be provided to eligible members un-less they specifically ask to be excluded. | ***PHM1: PHM Strategy***<br>The organization has a cohesive plan of action for addressing members' needs across the continuum of care.<br><br>The strategy describes:<br><br>1. Goals and population targeted for each of the four areas of focus<br>2. Programs or services offered to members<br>3. Activities that are not direct member interventions<br>4. How member programs are coordinated<br>5. How members are informed about available PHM programs<br><br>***PHM2: Population Identification***<br>The organization integrates the following data to use for population health management functions:<br>1. Medical and behavioral claims or encounters<br>2. Pharmacy claims<br>3. Health appraisal results<br>4. Laboratory results<br>5. Advanced data sources<br><br>***PHM 1: Element B***<br>The organization informs members eligible for programs that include interactive contact:<br>1. How to use the services<br>2. How members become eligible to participate<br>3. How to opt in or opt out |

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| | ***PHM2: Population Identification***<br>The organization assesses the needs of its population and determines actionable categories for appropriate intervention.<br><br>***PHM1 and 2: PHM Strategy***<br>Element A: The strategy describes:<br>Activities that are not direct member interventions.<br>1. Data and information sharing with practitioners.<br><br>***PHM 2: Data Integration***<br>The organization systematically collects, integrates, and assesses member data to inform population health programs :<br>1. Medical and behavioral claims or encounters<br>2. Pharmacy claims<br>3. Laboratory results.<br>4. Health appraisal results<br>5. Electronic Health records<br>6. Health services within the organization<br>7. Advanced data sources<br><br>***PHM 5: Experience with Case Management***<br>At least annually, the organization evaluates experience with its complex case management program by:<br>1. Obtaining feedback from members<br>2. Analyzing member complaints<br><br>***PHM 6: Population Health Management Impact***<br>At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:<br>1. Quantitative results for relevant clinical, cost/utilization and experience measures.<br>2. Comparison of results with a benchmark or goal.<br>3. Interpretation of results. |

| CRA § 2.8.4.7.3 | QI 5 Complex Case Management |
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| The CONTRACTOR shall develop and implement the Complex Case Management Program according to NCQA standard PHM 2 for complex case management. | ***PHM 2: Element B- Population Assessment***<br>The organization annually:<br>Assesses the characteristics and needs of its member population and relevant subpopulations<br>1. Assess the needs of children and adolescents<br>2. Asses the needs of individuals with disabilities<br>3. Assess the needs of individuals with serious and persistent mental illness (SPMI)<br><br>***PHM 2: Program Description***<br>The description of the organization's complex case management program includes:<br>1. Evidence used to develop the program<br>2. Criteria for identifying members who are eligible for the program<br>3. Services offered to members<br>4. Defined program goals<br>5. How case management services are integrated with the services of others involved in the member's care<br><br>***PHM 2: Population Identification***<br>The organization integrates the following data to use for population health management functions:<br>1. Medical and behavioral claims or encounters<br>2. Pharmacy claims<br>3. Laboratory results<br>4. Health appraisals results<br>5. Electronic health records<br>6. Health services program within the organization<br>7. Advanced data sources<br><br>***PHM 5: A- Access to Case Management***<br>The organization has multiple avenues for members to be considered for complex CM services, including:<br>1. Medical management program referral.<br>2. Discharge planner referral.<br>3. Member of caregiver referral<br>4. Practitioner referral |

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| | ***PHM 5: B- Case Management Systems***<br>The organization uses CM systems that support:<br>1. Evidence-based clinical guidelines or algorithms to conduct assessment and management<br>2. Automatic documentation of the staff member's ID and date, and time of action on the case or when interaction with the member occurred<br>3. Automated prompts for follow-up, as required by the case management plan.<br><br>***PHM 5: C- Case Management Process***<br>The organization's complex case management procedures address the following:<br>1. Initial assessment of members' health status, including condition-specific issues<br>2. Documentation of clinical history, including medications<br>3. Initial assessment of the activities of daily living<br>4. Initial assessment of behavioral health status, including cognitive functions<br>5. Initial assessment of social determinants of health<br>6. Initial assessment of life-planning activities<br>7. Evaluation of cultural and linguistic needs, preferences, or limitations<br>8. Evaluation of visual and hearing needs, preferences, or limitations<br>9. Evaluation of caregiver resources and involvement<br>10. Evaluation of available benefits<br>11. Evaluation of community resources<br>12. Development 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<br>13. Identification of barriers to a member meeting goals or complying with the plan<br>14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals<br>15. Development of a schedule for follow-up and communication with members<br>16. Development and communication of member self-management plans<br>17. A process to assess members' progress against case management plans for members |

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| | ***PHM 5: Element D- Initial Assessment:***<br>An NCQA review of the organization's Complex Case Management files demonstrates that the organization follows its' documented processes for:<br>1. Initial assessment of member health status, including condition-specific issues<br>2. Documentation of clinical history, including medications<br>3. Initial assessment of activities of daily living<br>4. Initial assessment of behavioral health status, including cognitive functions<br>5. Initial assessment of psychosocial issues<br>6. Evaluation of cultural and linguistic needs, preferences or limitations<br>7. Evaluation of visual and hearing needs, preferences or limitations<br>8. Evaluation of caregiver resources and involvement<br>9. Evaluation of available benefits<br>10. Evaluation of available community resources<br>11. Assessment of life-planning activities<br><br>***PHM 5: Element E- Case Management-Ongoing Management***<br>The NCQA review of a sample of organization's complex case management files that demonstrates that the organization follows its documented processes for:<br>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 complex case management program<br>2. Identification of barriers to meeting goals and complying with the plans<br>3. Development of schedules for follow-up and communication with members.<br>4. Development and communication of member self-management plans<br>5. Assessment of progress against case management plans and goals, and modification as needed.<br><br>***PHM 5: Element F- Experience with Case Management***<br>At least annually, the organization evaluates experience with its complex case management program by:<br>1. Obtaining feedback from members<br>2. Analyzing member complaints |

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| | ***PHM 6: A- Population Health Management Impact***<br>At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:<br>1. Quantitative results for relevant clinical, cost/utilization and experience measures<br>2. Comparison of results with a benchmark or goal<br>3. Interpretation of results<br><br>***PHM 6: B–Improvement and Action***<br>The organization uses results from the PHM impact analysis annually:<br>1. Identify opportunities for improvement<br>2. Act on one opportunity for improvement |
| **CRA § 2.14.1.6 - 2.14.1.6.5** | **UM 2A – Clinical Criteria for UM Criteria** |
| The UM program shall have criteria that:<br>• Are objective and based on medical, behavioral, health and/or long-term care evidence, to the extent possible.<br>• Are applied based on individual need.<br>• Are applied based on an assessment of the local delivery system.<br>• Involve appropriate practitioners in developing, adopting, and reviewing them; and<br>• Are annually reviewed and updated as appropriate. | The organization uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying criteria:<br>The organization:<br>1. Has written UM decision-making criteria that are objective and based on medical evidence<br>2. Has written policies for applying the criteria based on individual needs<br>3. Has written policies for applying the criteria based on an assessment of the local delivery system<br>4. Involves appropriate practitioners in developing, adopting and reviewing criteria<br>5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate<br>The organization has written policies for applying the criteria based on an assessment of the local delivery system.<br>Involves appropriate practitioners in developing, adopting, and reviewing criteria.<br>Annually review the UM criteria and the procedures for applying them, and updates the criteria when appropriate. |

| CRA § 2.14.1.8 (E/W, Middle and TCS) | UM 4 - Appropriate Professionals |
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| 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. | Qualified licensed health professionals assess the clinical information used to support UM decisions.<br>*Element A*: The organization has written procedures:<br>• Requiring appropriately licensed professionals to supervise all medical necessity decisions<br>• Specifying the type of personnel responsible for each level of UM decision-making.<br>*Element C*: The organization uses a physician or other health care professional, as appropriate, to review any non-behavioral healthcare denial based on medical necessity.<br>*Element D*: The organization uses a physician or appropriate behavioral health care practitioner, as appropriate, to review any behavioral healthcare denial of care based on medical necessity.<br>*Element E*: The organization uses a physician or a pharmacist to review pharmacy denials based on medical necessity.<br>*Element F*: Use of Board-Certified Consultants<br>The organization:<br>• Has written procedures for using board-certified consultants to assist in making medical necessity determinations<br>• Provides evidence that organization uses board-certified consultants for medical necessity determinations. |
| **CRA § 2.14.1.10** | **UM 4G – Affirmative Statement about Incentives** |
| The CONTRACTOR shall 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. | The organization distributes a statement to all members and to all practitioners, providers, and employees who make UM decisions, affirming the following:<br>1. UM decision making is based only on appropriateness of care and service and existence of coverage.<br>2. The organization does not specifically reward practitioners or other individual for issuing denials of coverage.<br>3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. |

| CRA § 2.14.1.11 | UM 4G – Affirmative Statement about Incentives |
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| The CONTRACTOR shall assure, consistent with 42 CFR § 438.6(h), 42 CFR § 422.208 and § 422.210, that compensation to individuals or entities that conduct UM activities is for the individual or entity not structured so as to provide incentives to deny, limit, or discontinue medically necessary covered services to any member. | The organization distributes a statement to all members and to all practitioners, providers, and employees who make UM decisions, affirming the following:<br>1. UM decision making is based only on appropriateness of care and service and existence of coverage.<br>2. The organization does not specifically reward practitioners or other individual for issuing denials of coverage.<br>3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. |
| **CRA § 2.15.1.2** | **QI 2B – Informing Members** |
| The CONTRACTOR shall make all information about its QM/QI program available to providers and members. | The organization annually makes information about its QI program available to members. |
| **CRA § 2.27.2 & 2.27.5.7 (E/W, Middle, & TCS)** | **MED 5 Element B – Privacy and Confidentiality** |
| In accordance with HIPAA/HITECH regulations, the CONTRACTOR shall, at a minimum:<br>Make available to TENNCARE enrollees the right to amend their PHI 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; 2.26.1.3; 2.26.1.4; 2.26.1.5; 2.26.1.6 | CR 8 – Elements A, C, and E |
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| 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 and as specified in Contract Section D.5.<br><br>• The CONTRACTOR shall evaluate the prospective subcontractor's ability to per-form the activities to be delegated.<br>• 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 sub-contractor's performance is inadequate.<br>• Effective with any new subcontracts or upon the next amendment to existing subcontracts, the CONTRACTOR shall include a requirement that the sub-contract may be terminated by the CONTRACTOR for convenience and without cause upon a specified number of day's written notice.<br>• The CONTRACTOR shall monitor the subcontractors' performance on an on-going basis and subject it to formal review, on at least an annual basis consistent with NCQA standards and state MCO laws and regulations.<br>• The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the subcontractor shall take corrective action as necessary.<br>• If the subcontract is for purposes of providing or securing the provision of covered services to enrollees, the CONTRACTOR shall ensure that all requirements described in Section A.2.12 of this Contract are included in the subcontract and/or a separate provider agreement executed by the appropriate parties. | *CR 8A Delegation Agreement-*<br>The written delegation agreement:<br>1. Is mutually agreed upon<br>2. Describes the delegated activities and the responsibilities of the organization and the delegated entity<br>3. Requires at least semiannual reporting of the dele-gated entity to the organization<br>4. Describes the process by which the organization evaluates the delegated entity's performance<br>5. Specifies that the organization retains the right to approve, suspend, and terminate individual practitioners, providers and sites, even if the organization delegates decision making.<br>6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.<br><br>*CR 8A Factor 5 Right to Approve, Suspend and Terminate-*<br>No additional explanation required.<br><br>*CR 8E Opportunities for Improvement-*<br>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 opportunities for improvement, if applicable. |

***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 42 CFR § 438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under 42 CFR § 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*** |
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| **42 CFR § 438.206 AVAILABILITY OF SERVICES** |
| 42 CFR § 438.206(b)(1) Maintains and monitors a network of appropriate providers |
| The Contractor Risk Agreement (CRA) between TennCare and the MCOs addresses provider networks in section 2.11 including primary care providers, specialty service providers, prenatal care providers, behavioral health services, long-term services & supports providers, and safety net providers; credentialing and other certification; and network notice requirements.<br>CRA § 2.12 addresses provider agreements.<br>CRA § 2.18 addresses customer service for members, including member services toll-free phone line, interpreter/translation services, cultural competency, and member involvement with behavioral health services.<br>CRA Attachment III addresses general access standards and CRA Attachment IV addresses specialty network standards. CRA Attachment V addresses access and availability for behavioral health services. |
| 42 CFR § 438.206(b)(2) Female enrollees have direct access to a women's health specialist |
| CRA § 2.11.4.1 states that a sufficient number of providers must be enrolled in the TennCare program so that prenatal or other medically necessary covered services are not delayed or denied to pregnant women at any time, including during their presumptive eligibility period. Additionally, the CONTRACTOR shall make services available from non-contract providers, if necessary, to provide medically necessary covered services to a woman enrolled in the CONTRACTOR's MCO. |
| 42 CFR § 438.206(b)(3) Provides for a second opinion from a qualified health care professional |
| CRA 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 shall arrange for a member to obtain one from a non-contract provider. The second opinion shall be provided at no cost to the member. |

| 42 CFR § 438.206(b)(4) Adequate and timely coverage of services not available in network |
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| CRA § 2.11.1.9 States if the MCO is unable to provide medically necessary covered services to a particular member using contract providers, it must adequately and timely cover these services for that member using non-contract providers, for as long as the provider network is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the member can be safely transferred, the CONTRACTOR may transfer the member to an appropriate contract provider as specified in § A.2.9.4. |
| 42 CFR § 438.206 (b)(5) Out of network providers coordinate with the MCO or PIHP with respect to |
| CRA § 2.13.12-15 address circumstances under which out-of-network providers may seek payment from the MCO. It states the following:<br>• 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;<br>• 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<br>• The MCO shall only pay for covered long-term care services for which the member was eligible and that were authorized by the MCO in accordance with the requirements of this contract. |
| 42 CFR § 438.206(b)(6) Credential all providers as required by 438.214 |
| CRA § 2.11.9 addresses credentialing of both contract and non-contract providers.<br>CRA § 2.11.9.1.1 states the MCCs shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.<br>CRA § 2.11.9.2.1 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. An independent relationship exists when the CONTRACTOR selects and directs its members to see a specific provider or group of providers.<br>CRA § 2.11.9.2.2 states that all credentialing applications shall 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. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the CONTRACTOR. |

| 42 CFR § 438.206(c)(1)(i) Providers meet state standards for timely access to care and services |
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| 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:<br><u>Primary Care Physician or Extender</u><br>• Suburban/Rural/Frontier – 30 miles/45 minutes.<br>• Urban – 20 miles/30 minutes.<br>• Patient Load – 2,500 or less for physician; one-half this for a physician extender.<br>• 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.<br>• Documentation/Tracking requirements:<br>• Documentation – Plans must have a system in place to document appointment scheduling times.<br>• 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.<br><u>Specialty Care and Emergency Care</u><br>• 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.<br><u>Hospitals</u><br>• Transport access will be the usual and customary, not to exceed 30 miles/45 minutes, except in rural areas where access distance may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.<br><u>Long-Term Care Services</u><br>• Long-Term Care Services: Transport access to licensed Adult Day Care providers, ≤ 20 miles travel distance and ≤ 30 minutes travel time for TennCare enrollees in urban areas, ≤ 30 miles travel distance and ≤ 45 minutes travel time for TennCare enrollees in suburban areas ≤ 60 miles travel distance and ≤ 90 minutes travel time for TennCare enrollees in rural/frontier areas, except where community standards and documentation shall apply.<br><u>General Optometry Services:</u><br>• Transport access will be the usual and customary, not to exceed 30 miles/45 minutes, except in rural areas where community standards and documentation shall apply.<br>• 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.<br><u>All Other Services</u><br>• Usual and customary as defined by TennCare.<br><u>Access to specialty care</u> (CRA Attachment IV)<br>• The MCO shall have provider agreements with providers practicing the following specialties: Allergy,Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult, child, and adolescent), and Urology.<br>• Travel access must not exceed 60 miles/90 minutes for at least 75% of non-dual members.<br>• Travel access must not exceed 90 miles/120 minutes for all non-dual members. |

Access for Behavioral Health Services (CRA Attachment V)

- *Psychiatric Inpatient Hospital Services* – Travel does not exceed 90 miles/120 minutes for at least 90% for all Child and Adult members. Maximum time for admission/appointment is 4 hours (emergency involuntary), 24 hours (involuntary), and 24 hours (voluntary).
- *24 Hour Psychiatric Residential Treatment* – Not subject to geographic access standards. Maximum time for admission/appointment is within 30 calendar days.
- *Outpatient Non-MD Services* – Travel access not exceed 30 miles/45 minutes for at least 75% of Child and Adult members, and 60 miles/60 minutes for all Child and Adult members. Maximum time for admission/appointment is within 10 business days; if urgent, within 48 hours.
- *Intensive Outpatient [may include day treatment (adult), intensive day treatment (children/adolescents), or Partial Hospitalization]* – Travel access does not exceed 90 miles/90 minutes for at least 75% of Child and Adult members, and 120 miles/120 minutes for all Child and Adult members. Maximum time for admission/appointment is within 10 business days; if urgent, within 48 hours.
- *Inpatient Facility Services (Substance Abuse)* – Travel access does not exceed 90 miles/120 minutes for all Child and Adult members. Maximum time for admission/appointment is within 2 calendar days; for detoxification-within 4 hours in an emergency and 24 hours for non-emergency.
- *24 Hour Residential Treatment Services (Substance Abuse)* – Not subject to geographic access standards. Timeframe: within 10 business days.
- *Outpatient Treatment Services (Substance Abuse)* – Travel access does not exceed 30 miles/30 minutes for 75% of Child and Adult members, and 45 miles/45 minutes for all Child and Adult members. Timeframe: within 10 business days; within 24 hours for detoxification.
- *Intensive Community Based Treatment Services*– Not subject to geographic access standards. Timeframe: within seven calendar days.
- *Tennessee Healthlink Services* – Not subject to geographic access standards. Timeframe: within 30 calendar days.
- *Psychosocial Rehabilitation (may include Supported Employment, Illness Management & Recovery, Peer Recovery services, or Family Support service)* – Not subject to geographic access standards. Timeframe: within ten business days.
- *Supported Housing* – Not subject to geographic access standards. Timeframe: within 30 calendar days.
- *Crisis Services (Mobile)* – Not subject to geographic access standards. Timeframe: face-to-face contact within 2 hours for emergency situations and 4 hours for urgent situations.
- *Crisis Stabilization* – Not subject to geographic access standards. Timeframe: within 4 hours of referral.

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

CRA section 2.12.9.64 require that providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees.

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

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

| 42 CFR § 438.206(c)(1)(iv-v) Mechanisms/monitoring to ensure compliance by providers. Monitor network providers regularly to determine compliance. |
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| Each MCO has a provider services unit that monitors the network for compliance with certain standards. TennCare has contracted with Qsource, TennCare's EQRO, to conduct a quarterly provider data validation (PDV) survey. The purpose of this activity is to determine the accuracy of the provider data files submitted by the TennCare MCCs and to use the results as a proxy to determine the extent to which providers are available and accessible to TennCare members. The survey is conducted using a hybrid methodology developed to maximize response rates. The survey consists of telephone calls and facsimile follow-up protocol as necessary. The validation tool was programmed into a Microsoft Access database and pre-populated with data elements from the MCC provider files. Qsource attempts to contact providers up to three times by telephone. |
| Providers were also notified of a toll-free number to allow the provider to call back if the time was not convenient. The following standards are monitored through this survey.<br>• Valid Telephone Number<br>• Contract Status with MCC<br>• Provider Address<br><br>• MCC Data Accuracy - Provider Credentialed Specialty/Behavioral Health Service Code.<br>• Provider Panel Status (Open/Closed)<br>• 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.<br>• 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?<br>• Primary Care Services<br>• Prenatal Care Services |
| 42 CFR § 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, disabilities and diverse cultural and ethnic backgrounds regardless of an enrollee's gender, sexual orientation, or gender identity. Additionally, the 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 (i.e., weight management and tobacco cessation), self-monitoring, co-morbidities, cultural beliefs, depression screening, and appropriate communication with providers. |

| 42 CFR § 438.207 ASSURANCES OF ADEQUATE CAPACITY AND SERVICES |
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| 42 CFR § 438.207(b)(1) Offer an appropriate range of preventive, primary care, and specialty services |
| CRA § 2.7.5.1 states, "The Contractor shall provide preventive services which include, but are not limited to, initial and periodic evaluations, family planning services, prenatal care, laboratory services, and immunizations in accordance with TennCare Rules and Regulations."<br><br>CRA § 2.7.5.2.1 states, "The Contractor shall provide or arrange for the provision of medically necessary prenatal care to members beginning on the date of their enrollment in the MCO. This requirement includes pregnant women who are presumptively eligible for TennCare, enrollees who become pregnant, as well as enrollees who are pregnant on the effective date of enrollment in the MCO. The requirement to provide or arrange for the provision of medically necessary prenatal care shall include assistance in making a timely appointment for a woman who is presumptively eligible and shall be provided as soon as the Contractor becomes aware of the enrollment." For a woman in her second or third trimester, the appointment shall occur as required in Section A.2.11.4.2. In the event a member enrolling in the CONTRACTOR's MCO is receiving medically necessary prenatal care services the day before enrollment, the CONTRACTOR shall comply with the requirements in Sections A.2.9.2.2 and A.2.9.2.3 regarding prior authorization of prenatal care.<br><br>CRA § 2.7.6.1.1 requires that the MCOs provide EPSDT services (TennCare Kids) to members under age 21. CRA § 2.7.6.3.1-2 further requires that the MCO provide periodic comprehensive child health assessments, meaning, "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth." At a minimum, these screens must include periodic and interperiodic screens and be provided at intervals which meet reasonable standards set forth in the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. See the response for 42 CFR § 438.207(b)(2) (below) for further standards of care. |
| 42 CFR § 438.207(b)(2) Maintain network of providers sufficient in number, mix, and geographic distribution |
| CRA Attachments III, IV and V outline standards that the MCOs have to meet.<br>(See Attachments I, II and III of this document to see the full set of standards.) |
| **42 CFR § 438.208 COORDINATION AND CONTINUITY OF CARE** |
| 42 CFR § 438.208(b)(1) Each enrollee has an ongoing source of primary care appropriate to his or her needs |

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

- Access Suburban/Rural/ Frontier: 30 miles/45 minutes
- Access Urban: 20 miles/30 minutes
- Patient Load: 2,500 or less for physician; one-half this for a physician extender
- Appointment/Waiting Times: Usual and customary practice, not to exceed three weeks from date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.
- Documentation/Tracking requirements:
  - Health plans must have a system in place to document appointment scheduling times.
  - Tracking – Plans must have a system in place to document the exchange of member information if a provider other than the primary care provider (i.e., school-based clinic or health department clinic) provides health care.

| 42 CFR § 438.208(b)(2) All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP |
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| The MCOs are responsible for the management, coordination, and continuity of care for all their TennCare members and shall develop and maintain policies and procedures to address this responsibility. For CHOICES and ECF CHOICES members, these policies and procedures shall specify the role of the Care Coordinator/are coordination or Support Coordinator/support coordination team, as applicable, in conducting these functions (CRA § 2.9.1). Additionally, MCOs coordinate with other state and local departments and agencies to ensure that coordinated care is provided to members (CRA § 2.9.16). |
| 42 CFR § 438.208(b)(3) Share with other MCOs, PIPHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services |
| MCOs shall use their Population Health and CHOICES care coordination and Employment and Community First CHOICES support coordination programs to support the continuity and coordination of covered physical health, behavioral health, and long-term services and supports, and to support collaboration between providers (CRA § 2.9.9.8). |
| 42 CFR § 438.208(b)(4) Protect enrollee privacy when providing care |
| The MCOs shall comply with all applicable HIPAA and HITECH requirements including, but not limited to, the following (CRA § 2.27.2.1-4):<br>• Compliance with the Privacy Rule, Security Rule, and Notification Rule<br>• The creation of and adherence to sufficient Privacy and Security Safeguards and Policies<br>• Timely reporting of violations in the access, use, and disclosure of PHI<br>• Timely reporting of privacy and/or security incidents |

| 42 CFR § 438.208(c)(1) State mechanisms to identify persons with special health care needs |
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| CRA § 2.9.16.1-7 requires MCOs to coordinate with other state and local departments and agencies to ensure that coordinated care is provided to members. This includes, but is not limited to, coordination with:<br>• *Tennessee Department of Mental Health & Substance Abuse Services (TDMHSAS)* and *Tennessee Department of Intellectual & Developmental Disabilities (DIDD)* for the purpose of interfacing with and assuring continuity of care and for coordination of specialized services in accordance with federal PASRR requirements;<br>• *Tennessee Department of Children's Services (DCS)* for the purpose of interfacing with and assuring continuity of care;<br>• *Tennessee Department of Health (DOH)* for the purposes of establishing and maintaining relationships with member groups and health service providers;<br>• *Tennessee Department of Human Services (DHS) and DCS Protective Services Section,* for the purposes of reporting and cooperating in the investigation of abuse and neglect;<br>• *Tennessee Department of Intellectual Disabilities Services (DIDD),* for the purposes of coordinating physical and behavioral health services with HCBS available for members who are also enrolled in a Section 1915(c) HCBS waiver for persons with intellectual disabilities, and for purposes of ECF CHOICES, including intake, Reportable Event Management, and quality monitoring;<br>• *Area Agencies on Aging and Disability (AAADs)* regarding intake of members new to both TennCare and CHOICES, and assisting CHOICES members in Groups 2 and 3 with the TennCare eligibility redetermination process;<br>• *Tennessee Department of Education (DOE)* and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;<br><br>MCOs are responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers to manage the care of students with special needs. The State has implemented a process, referred to as TennCare Kids Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for payment. If a school-aged member, needing medical services, is identified by the CONTRACTOR by another means, the CONTRACTOR shall request the IEP from the appropriate school system. (CRA § 2.9.16.7.1) |
| 42 CFR § 438.208(c)(2) Mechanisms to assess enrollees with special health care needs by appropriate health care professionals |
| 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). |
| 42 CFR § 438.208(c)(3) If applicable, treatment plans developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state standards |
| Not Applicable |

| 42 CFR § 438.208(c)(4) Direct Access to specialists for enrollees with special health care needs |
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| The MCOs shall establish and maintain a network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical and behavioral health needs of its members (adults and children) without excessive travel requirements. (CRA § 2.11.3.2.1) TENNCARE will monitor CONTRACTOR compliance with specialty network standards on an ongoing basis. TENNCARE will use data from the monthly Provider Enrollment File required in CRA § A.2.30.8.1), to verify compliance with the specialty network requirements. TENNCARE will use these files to confirm the CONTRACTOR has a sufficient number and distribution of physician specialists and in conjunction with MCO enrollment data to calculate member to provider ratios. TENNCARE will also periodically phone providers listed on these reports to confirm that the provider is a contract provider as reported by the CONTRACTOR. TENNCARE shall also monitor appeals data for indications that problems exist with access to specialty providers. (CRA § 2.11.3.3.1) |
| **42 CFR § 438.210 COVERAGE AND AUTHORIZATION OF SERVICES** |
| 42 CFR § 438.210(a)(1) Identify, define, and specify the amount, duration, and scope of each service. |
| See Attachment IV for covered benefits. |
| 42 CFR § 438.210(a)(2) Services are furnished in an amount, duration, and scope that is no less than those furnished to beneficiaries under fee-for-service Medicaid. |
| All covered benefits are provided if medically necessary through a capitated arrangement with the MCCs. |
| 42 CFR § 438.210(a)(3)(i) Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. |
| CRA § 2.6.3.1 relates to Medical Necessity Determinations. It states that the MCCs may establish procedures for the determination of medical necessity and for the use of medically appropriate cost effective alternative benefits. The CONTRACTOR may also limit benefits for the purpose of utilization control in accordance with NCQA standards, as long as (1) the furnished benefits can reasonably achieve the purpose for which they are furnished, and as long as (2) the benefits furnished for enrollees with chronic conditions (or who require LTSS) are authorized in a manner that reflects the enrollee's ongoing need for such benefits. See 42 CFR § 438.3(e)(2) and 42 CFR § 438.210(a)(4). |
| 42 CFR § 438.210(a)(3)(ii) No arbitrary denial or reduction in service solely because of diagnosis, type of illness or condition |
| CRA § 2.6.3.2 shall use written criteria based on sound clinical evidence to make utilization decisions. The written criteria shall specify procedures for appropriately applying the criteria. The criteria must satisfy NCQA standards. The CONTRACTOR shall apply objective and evidence-based criteria and take individual circumstances and the local delivery into account when determining the medical appropriateness of health care services and § 2.6.3.3 The CONTRACTOR shall ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. The CONTRACTOR shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. |
| 42 CFR § 438.210(a)(3)(iii) Each MCO/PIHP may place appropriate limits on a service, such as medical necessity. |

CRA § 2.6.3.1 through 2.6.3.3 state the MCCs may not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The MCCs must not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

42 CFR § 438.210(a)(5) Specify what constitutes "medically necessary services".

CRA § 2.6.3 relates to Medical Necessity Determinations. It states that the MCCs may establish procedures for the determination of medical necessity with the determination being made on a case- by-case basis and in accordance with the definition of medical necessity defined in TCA 71-5-1944 and TennCare rules and regulations governing medical necessity, which are delineated at 1200-13-16. Specifically, to be medically necessary, the benefit must meet each of the following criteria:

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

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

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

CRA § 2.14.1.8 states that MCOs shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making. They must also have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional that has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional that has appropriate expertise in providing long-term care services.

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

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

| 42 CFR § 438.210(b)(3) Any decision to deny or reduce services is made by an appropriate health care professional. |
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| CRA § 2.14.1.8states that MCOs shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorizations and decision making. They shall also have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services. |
| 42 CFR § 438.210(c) Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.<br>42 CFR § 438.210(d) Provide for the authorization decisions and notices as set forth in CFR § 438.210(d).<br>42 CFR § 438.210(e) Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services. |
| CRA § 2.14.7, Notice of Adverse Benefit Determination Requirements, require MCOs to: CRA § 2.14.7.1 In accordance with 42 CFR § 438.210(c), the CONTRACTOR must notify the requesting provider, and give the enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The Notice of Adverse Benefit Determination must meet the requirements set forth in CRA § A.2.19.2.<br><br>CRA § 2.14.7.2 The CONTRACTOR shall comply with all member notice provisions in TennCare rules and regulations.<br><br>CRA § 2.14.7.3 The CONTRACTOR shall issue appropriate notice prior to any CONTRACTOR-initiated decision to reduce or terminate CHOICES or non-CHOICES nursing facility services and shall comply with all federal court orders, and federal and state laws and regulations regarding members' transfer or discharge from nursing facilities.<br>• Clearly document and communicate the reasons for each denial of a prior authorization request in a manner sufficient for the enrollee to understand the denial basis and decide about requesting reconsideration of or appealing the decision;<br>• Comply with all member notice provisions in TennCare rules and regulations; and<br>• Issue appropriate notice prior to any contractor-initiated decision to reduce or terminate CHOICES or non-CHOICES nursing facility services and shall comply with all federal court orders, and federal and state laws and regulations, regarding members' transfer or discharge from nursing facilities. |

***Structure and Operations Standards***

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

| ***STATE STRUCTURE & OPERATIONS STANDARDS AS REQUIRED BY 42 CFR, PART 438, SUBPART D*** |
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| **42 CFR § 438.214 Provider Selection** |
| 42 CFR § 438.214(a) Written Policies and procedures for Selection and Retention of Providers. |
| CRA § 2.11.1.3.3 states the MCO must have in place written policies and procedures for the selection and retention of providers. These policies and procedures must not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment. |
| 42 CFR § 438.214(b)(1) Uniform credentialing and recredentialing policy that each MCO/PIHP must follow. |
| *CRA § 2.11.9.1 - Credentialing of Contract Providers:*<br>• 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.<br>• 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.<br>• 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.<br>*CRA § 2.11.9.2 - Credentialing of Non-Contract Providers*<br>• 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.<br>• 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.<br>• 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 § 2.11.9.3 - Credentialing of Behavioral Health Entities*

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

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

CRA § 2.20.1.8 states, "The contractor, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR § 1002) on exclusion and debarment screening. 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 |
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| 42 CFR § 438.218 Incorporate the requirements of 438.10 |
| CRA § 2.17 incorporates the responses to 42 CFR § 438.10. Primary language is identified by the enrollment contractor at the time of each person's application for TennCare services. If the primary language is omitted from the enrollment files received by the MCO, the MCO staff then collects the information during new member calls. Requirements for the MCOs are as follows:<br>• 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.<br>• 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.<br>• 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.<br>• All written member materials contain language and communication taglines and civil rights notices, which inform members that free oral interpretation is available for any language, free written translation and auxiliary aids or services are available upon request, and how to ask for help with their services. The language taglines are printed in the top 17 prevalent non-English languages in Tennessee. The taglines also comply with the 18 point font requirements.<br>• Electronic information and services are readily accessible and incorporate the Section 508 guidelines and Web Content Accessibility Guidelines (WCAG) 2.0 AA. The MCOs may provide member materials electronically or on their websites as long as it meets the following requirements: (1) the material/information must be placed on the MCO's website in a location that is prominent and readily accessible for applicants and members to link to from the MCO's home page; (2) the material/information must be provided in a format that can be electronically saved and printed; and (3) if a member or applicant requests that the MCO mail them a copy of the material/information, the MCO must mail free of charge the material/information to them within five (5) days of that request.<br>• 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.<br>• The contractor must use the approved Glossary of Required Spanish Terms in the Spanish translation of all member materials.<br>• 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 § 2.17.4.6 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 or support coordinator assignment for ECF 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 and ECF CHOICES members, by CHOICES group and ECF CHOICES group.
- Provide information regarding ECF CHOICES as specified in a template provided by TennCare.
- Description of TennCare cost sharing or patient liability responsibilities including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts. Further, the information shall specify the instances in which a member may be billed for services, and shall indicate that the member may not be billed for covered services except for the amounts of the specified TennCare cost sharing or patient liability responsibilities and explain the member's right to appeal in the event that they are billed for amounts other than their TennCare cost sharing or patient liability responsibilities. The information shall also identify the potential consequences if the member does not pay his/her patient liability, including loss of the member's current nursing facility provider, disenrollment from CHOICES or ECF CHOICES, and, to the extent the member's eligibility depends on receipt of long-term care services, loss of eligibility for TennCare.
- Information about preventive services for adults and children, including TennCare Kids; a listing of covered preventive services; and notice that preventive services are at no cost and without cost sharing responsibilities.
- Procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-contract providers. The handbook shall advise members that if they need a service that is not available from a contract provider or MCO, for certain reasons, including, moral or religious reasons, they will be referred to a non-contract provider and any copayment requirements would be the same as if this provider were a contract provider.

- Information on the CHOICES program, including a description of the CHOICES groups; eligibility for CHOICES; enrollment in CHOICES, including whom to contact at the MCO regarding enrollment in CHOICES; enrollment targets for Group 2 and Group 3 (excluding Interim Group 3), including reserve capacity and administration of waiting lists; and CHOICES benefits, including benefit limits, the individual cost neutrality cap for Group 2, and the expenditure cap for Group 3.
- Information on the ECF CHOICES program including a description of the ECF CHOICES groups, eligibility for ECF CHOICES , enrollment in ECF CHOICES including who to contact at the MCO regarding enrollment in ECF CHOICES, and ECF CHOICES benefits including benefit limits and the individual expenditure caps for ECF CHOICES.
- Information on care coordination for CHOICES members, including but not limited to the role of the care coordinator, level of care assessment and reassessment, comprehensive assessment and reassessment, and care planning, including the development of a plan of care for members in CHOICES Groups 2 and 3.
- Information on support coordination for ECF CHOICES members, including but not limited to the role of the support coordinator, level of care assessment and reassessment, needs assessment and reassessment, and care planning, including the development of a person centered support plan.
- Information on the right of CHOICES and ECF 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 and ECF 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 and ECF 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. Also included are the language and communication taglines, which inform members that free oral interpretation is available for any language, free written translation and auxiliary aids or services are available upon request, and how to ask for help with their services. The language taglines are printed in the top 17 prevalent non-English languages in Tennessee. In accordance with the regulations, the taglines comply with the 18 point font requirements.
- Information about the Long Term Care Ombudsman Program

- Information about the CHOICES and ECF CHOICES consumer advocate, including but not limited to the role of the consumer advocate in the CHOICES and Employment and Community First CHOICES program and how to contact the consumer advocate for assistance.
- Information about how to report suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 et seq.) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 et seq. and TCA 37-1-601 et seq.), including the phone numbers to call to report suspected abuse/neglect.
- Complaint and appeal procedures.
- Notice that in addition to the member's right to file an appeal directly to TennCare for adverse actions taken by the MCO, the member shall have the right to request reassessment of eligibility related decisions directly to TennCare.
- Written policies on member rights and responsibilities, pursuant to 42 CFR § 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs.
- Written information concerning advance directives as described in 42 CFR § 489 Subpart I and in accordance with 42 CFR § 422.128.
- Notice that enrollment in the contractor's MCO invalidates any prior authorization for services granted by another MCO but not utilized by the member prior to the member's enrollment into the contractor's MCO and notice of continuation of care when entering the contractor's MCO as described in § 2.9.2 of this Agreement.
- Notice to the member that it is his or her responsibility to notify the MCO, TennCare, and Department of Human Services (DHS) (or for SSI eligibles, SSA) each and every time the member moves to a new address and that failure to notify DHS (or for SSI eligibles, SSA) could result in the member not receiving important eligibility and/or benefit information.
- Notice that a new member may request to change MCOs at any time during the 45 calendar day period immediately following their initial enrollment in an MCO, subject to the capacity of the selected MCO to accept additional members and any restrictions limiting enrollment levels established by TennCare. This notice must include instructions on how to contact TennCare to request a change.
- Notice that the member may change MCOs at the next choice period and shall have a 45 calendar day period immediately following the enrollment, as requested during said choice period, in a new MCO to request to change MCOs, subject to the capacity of the selected MCO to accept additional enrollees and any restrictions limiting enrollment levels established by TennCare. This notice shall include instructions on how to contact TennCare to request a change.
- Notice that the member has the right to ask TennCare to change MCOs based on hardship, the circumstances which constitute hardship, explanation of the member's right to file an appeal if such request is not granted, and how to do so.
- Notice of the enrollee's right to terminate participation in the TennCare program at any time with instructions to contact TennCare for termination forms and additional information on termination.
- TennCare and MCO member services toll-free telephone numbers, including the TennCare hotline, the MCO's member services information line, and the MCO's 24/7 nurse triage/advice line with a statement that the member may contact the MCO or TennCare regarding questions about the TennCare program, including CHOICES and ECF CHOICES, as well as the service/information that may be obtained from each line.
- Information educating members of their rights and necessary steps to amend their data in accordance with HIPAA regulations and state law.
- Directions on how to request and obtain information regarding the "structure and operation of the MCO" and "physician incentive plans."
- Information that the member has the right to receive information on available treatment options

and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

- Information that the member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Information on appropriate prescription drug usage.
- Any additional information required in accordance with NCQA's Standards and Guidelines for the Accreditation of MCOs.

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

- The MCO must distribute information regarding general provider directories to new members within 30 calendar days of receipt of notification of enrollment in the MCO or prior to the member's enrollment effective date. Such information must include how to access the provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider's participation in the network. Members receiving a hard copy of the provider directory must be advised that the network may have changed since the directory was printed and told how to access current information regarding participating providers.
- The MCO must provide information regarding the CHOICES or ECF CHOICES provider directory to each CHOICES or ECF CHOICES member as part of the face-to-face visit (for members enrolled through the SPOE) or face-to-face intake visit (for current members) as applicable, but not more than 30 days from notice of CHOICES enrollment. Such information shall include how to access the CHOICES or ECF CHOICES provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider's participation in the network. Members receiving a hard copy of the CHOICES or ECF CHOICES provider directory shall be advised that the network may have changed since the directory was printed, and how to access current information regarding the MCO's participating providers.
- The MCO is also responsible for maintaining updated provider information in an online searchable electronic general provider directory and an online searchable electronic CHOICES and ECF CHOICES provider directory. A PDF copy of the hard copy version will not meet this requirement. The online searchable version of the general provider directory and the CHOICES or ECF CHOICES provider directory shall be updated on a daily basis during the business week. In addition, the MCO must make available upon request, in hard copy format, a complete and updated general provider directory to all members and an updated CHOICES or ECF CHOICES provider directory to CHOICES or ECF CHOICES members. The hard copy of the general provider directory and the CHOICES or ECF CHOICES provider directory shall be updated at least on an annual basis. Members receiving a hard copy and/or accessing a PDF version of the hard copy on the MCO's website of the general provider directory or the CHOICES provider directory must be advised that the network may have changed since the directory was printed and told how to access current information regarding participating providers, including the searchable electronic version of the general provider directory and the CHOICES or ECF CHOICES provider directory as well as the member services line.
- Provider directories (including the general provider directory, the CHOICES provider directory and the Employment and Community First CHOICES provider directory) and any revisions thereto, must be submitted to TennCare for written approval prior to distribution to enrollees. The text of the directory must be in the format prescribed by TennCare. In addition, the provider information used to populate the provider directory must be submitted as a TXT file or such format as otherwise approved in writing by TennCare and be produced using the same extract process as the actual provider directory.

- The MCO must develop and maintain a general provider directory, which shall be made available to all members. The provider directory must be posted on the MCC website and provided in hard copy upon request of the member. Members must be advised in writing regarding how to access the provider directory, including the right to request a hard copy and to contact the member services line to inquire regarding a provider's participation in the network. Members receiving a hard copy of the provider directory must be advised that the network may have changed since the directory was printed and told how to access current information regarding participating providers. The online version of the provider directory shall be updated on a daily basis. The general provider directory must include the following: names, locations, telephone numbers, web site; office hours, and non-English languages spoken and cultural capabilities by contract PCPs and specialists; whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment; identification of providers accepting new patients; identification of whether or not a provider performs TennCare Kids screens; Specialty, as appropriate; hospital listings, including locations of emergency settings and post-stabilization services, with the name, location, and telephone number of each facility/setting; and a prominent notice that CHOICES or ECF CHOICES members should refer to the CHOICES or ECF CHOICES provider directory for information on long-term services and supports providers.

**42 CFR § 438.224 Confidentiality**

42 CFR § 438.224 Individually identifiable health information is closed in accordance with Federal privacy requirements.

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

**42 CFR § 438. 226 Enrollment and Disenrollment**

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

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

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

| 42 CFR § 438.228 Grievance Systems |
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| 42 CFR § 438.228(a) Grievance system meets the requirements of § 438 (F) |
| 42 CFR § 438.228(b) If applicable, random State reviews of notice of action designation to ensure notification of enrollees in a timely manner |
| CRA § 2.19.3 outlines all requirements related to appeals as stated below:<br>• 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.<br>• 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.<br>• 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.<br>• The MCO must identify the appropriate internal individual or body having decision-making authority as part of the appeal procedure.<br>• 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.<br>• Upon request, the MCO must provide members a TennCare approved appeal form(s).<br>• The MCO must provide reasonable assistance to all appellants during the appeal process.<br>• 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.<br>• 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.<br>• Neither the MCO nor TennCare shall prohibit or discourage any individual from testifying on behalf of a member.<br>• 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.<br>• 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.<br>• 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. |

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| • 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.<br>• 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.<br>• 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.).<br>• 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** |
| 42 CFR § 438.230(c)(1i) Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities |
| In accordance with contractual requirements, MCOs must monitor all delegated functions to ensure that they are in compliance with all regulations (CRA 2.26.1). |
| 42 CFR § 438.230(b)(1) Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform. |
| All MCOs must evaluate prospective subcontractors' ability to perform the activities to be delegated in accordance with contractual requirements (CRA 2.26.1.1). |
| 42 CFR § 438.230(b)(2)(i)(ii) Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. |
| MCOs must require that all delegated agreements be in writing and specify the activities and report responsibilities delegated to the subcontractor. Contracts require that delegation may be revoked or sanctions applied if the subcontractor's performance is inadequate (CRA § 2.26.1.2). |
| 42 CFR § 438.230(b)(3) Monitoring of subcontractor performance on an ongoing basis |
| MCOs must monitor all subcontractors on an ongoing basis and subject them to formal review, on at least an annual basis, consistent with NCQA standards and state MCO laws and regulations (CRA § 2.26.1.4). |
| 42 CFR § 438.230(b)(4) Corrective action for identified deficiencies or areas for improvement |
| MCOs must identify deficiencies or areas for improvement and require subcontractors to take corrective action as necessary (CRA § 2.26.1.5). |

### *Measurement and Improvement Standards*

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

| ***STATE MEASUREMENT & IMPROVEMENT STANDARDS AS REQUIRED BY 42 CFR, PART 438, SUBPART D*** |
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| **42 CFR § 438.236 Practice Guidelines** |
| 438.236(b) Practice guidelines: 1) are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate. |
| CRA § 2.15.4 states that the MCO must utilize evidence-based clinical practice guidelines 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.<br><br>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 |
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| 438.240(a) Each MCO and PIHP must have an ongoing quality assessment and performance improvement program. |
| CRA Section 2.15 addresses the Quality Assessment and Performance Improvement standards for the MCOs. They must:<br>• Receive and maintain accreditation from NCQA.<br>• Have a written program that clearly defines its quality structures and processes and assigns responsibility to appropriate individuals.<br>• Use NCQA standards as a guide and include a plan for improving patient safety.<br>• Address physical health, behavioral health, and long-term care services.<br>• Be accountable to the MCC Board of Directors and executive management team.<br>• Have substantial involvement of a designated physician and designated behavioral health practitioner.<br>• Have a Quality Improvement (QI) Committee that oversees the QI functions.<br>• Have an annual work plan.<br>• Have dedicated staff as well as data and analytical resources.<br>• Evaluate the program annually and update as appropriate.<br>• Make all information available to providers and members.<br>• Make performance data available to providers and members.<br>• 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.<br>• Take appropriate action to address service delivery, provider, and other QI issues as they are identified.<br>• 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.<br>• Collect data on race and ethnicity.<br>• Include QM/QI activities to improve healthcare disparities identified through data collection.<br>• 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.<br>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. Beginning in 2017, a PIP in the area of EPSDT is also required. CMS protocols must be followed for all PIPs. |

| 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. |
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| 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:<br>• Pre-admission certification process for non-emergency admissions;<br>• A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity.<br>• 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.<br>• Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and<br>• Prospective review of same day surgery procedures.<br>• The UM Program, including the UM Program description, associated work plan and annual evaluation shall address Emergency Department (ED) utilization and ED diversion efforts. (CRA 2.14.1.3).<br>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).<br>Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease or, in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services (CRA 2.14.1.8). |

MCOs must not place maximum limits on the length of stay for members requiring hospitalization and/or surgery. MCOs may not employ, and shall not permit others acting on their behalf to employ, utilization control guidelines or other quantitative coverage limits, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history (CRA 2.14.1).

MCOs must have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition (CRA 2.14.1.10).

438.240(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 multiple ways. The first is the NCQA Accreditation Review that occurs for all health plans every three years. The second review is done annually by the EQRO and includes the following:

- Policies and procedures ensuring coordination between physical, behavioral health, and long-term care (LTC) services by including the following key elements:
  - Screening for behavioral health needs
  - Referral to physical health, behavioral health, and LTC providers
  - Screening for LTC needs
  - Confidentiality
  - Exchange of information
  - Assessment
  - Treatment plan development
  - Collaboration
  - Case management (CM) and Population Health (PH)
  - Provider training
  - Monitoring implementation and outcomes
  - Encourages PCPs and other providers to use state-approved behavioral health screening tool
- Processes in place to 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 and Employment and Community First CHOICES members, through the same process used for identification of non-CHOICES and Employment and Community First CHOICES members and the CHOICES non-Employment and Community First CHOICES care coordination process or Employment and Community First CHOICES support coordination process.
- Processes to 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 or Employment and Community First support coordinator will receive notification of the member's participation, information collected about the member, and educational materials given to the member.
- Processes to identify CHOICES and Employment and Community First CHOICES member needs when they are in transition between MCOs. Must ensure that a comprehensive assessment is immediately conducted, the plan of care is updated, and the changes in services are implemented within 10 days of the MCO becoming aware of the change in needs.
- Processes for ensuring that members transitioning from a nursing facility to a community based residential alternative or to live with a relative or other caretaker, the care coordinator or support coordinator, as applicable, makes contact with the member within the first 24 hours of transition and visits the member in his/her new residence within seven days of transition.
- Processes to assure the MCO conducts a CHOICES or Employment and Community First CHOICES level of care assessment at least annually and within five business days of awareness of a change in a member's functional or medical status that could potentially affect eligibility.

Quality Improvement staff receives many different reports from the health plans that are due at various times of the year. These include, but are not limited to:

- EPSDT Annual Community Outreach Plan and subsequent quarterly reports.
- Annual Quality Report that outlines major initiatives conducted by the health plan.
- Population Health Program reports – both quarterly and annually.
- 24/7 Nurse Line reports

Additionally there are collaborative workgroups that address specific topics and includes individuals from all health plans; monthly meetings with the MCO Quality Director's; and site visits with the health plans at least annually.

**42 CFR 438.242 Health Information Systems**

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

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

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

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

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

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

# SECTION IV: IMPROVEMENT AND PARTICIPATION IN PCMH

***Interventions with Goals***

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

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

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

| PLANNED INTERVENTIONS' ALIGNMENT WITH QUALITY STRATEGY GOALS AND OBJECTIVES | |
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| **GOAL: ACCESS TO CARE** | |
| **OBJECTIVE** | **INTERVENTION** |
| Adult's access to preventive/ ambulatory health services | Distribution of Member Materials:<br>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. QI staff works closely with the MCOs regarding continual quality improvement of materials developed. |
| Children & adolescents' access to primary care | MCC EPSDT (TennCare Kids) Collaborative:<br>The Division of Quality Improvement 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. |
| Children and adults visit doctor/clinic when first seeking care as opposed to hospital/ED | Strategic Planning:<br>Annually, the Division of Quality Improvement staff, in collaboration with Qsource and the Division of Healthcare Informatics, reviews and analyzes all data coming in to the Division of Quality Improvement 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 2017, staff expanded strategies to address excessive Emergency Department utilization and continued these through 2017. The strategies included: |

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| | • Identified opportunities for improvement that eliminated the MCO self-report in lieu of an automated ED claims report along with individual medical record reviews for the top 5 ED utilizers by health plan and region; |
| | • Changed medical record reviews from semi-annually to quarterly for timelier results;<br>• Added additional fields to the ED database in order to trend the data by member and to compare member utilization rankings from quarter to quarter;<br>• Placed a strong focus on members who appear in multiple quarterly reports as high utilizers and those that did not receive outreach attempts from the MCOs;<br>• Enhanced the sampling methodology;<br>• Established a target population of the top five ED utilizers for each MCO by region and began auditing MCO records for these individuals; and<br>• Continued conducting medical record reviews and determining if appropriate interventions were conducted by the MCOs.<br>• In 2017, QI continued medical record reviews of the top five ED utilizers for each MCO by region on a quarterly basis with a focus on case management outreach to members. A MCO ED Diversion Collaborative and Operational Workgroup was established in late 2017 to allow the MCO's to collaborate and share best practices to encourage appropriate utilization of the Emergency Department |
| Adolescent Access to Care | The Adolescent Screening Workgroup is a collaboration of the MCOs, the Dental Benefits Manager, and the Tennessee Department of Health. Workgroup members are tasked with implementing approaches to raising adolescent screening rates, for members ages 12-20 across the State. Adolescents have the lowest screening rates of all ages. The workgroup meets bi-monthly, with conference calls held between meetings as necessary. Screening campaigns continued in 2017, with a total of 8418 screens performed between August 2016-August 2017. Total Dental Screens was 138. |

| GOAL: QUALITY OF CARE | |
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| Diabetes | TennCare has included the HEDIS Comprehensive Diabetes Care Measures for Retinal Eye Exams, Nephropathy, and Blood Pressure <140/90 in the list of measures for which the MCOs can receive a pay for performance incentive. Likewise, the MCOs have included this measure in their Provider Pay for Performance program. |
| Timeliness of Prenatal Care | TennCare has included the HEDIS Timeliness of Prenatal Care Measure in the list of measures with which the MCOs can receive a pay for performance incentive. Likewise, the MCOs have included this measure in their Provider Pay for Performance program.<br><u>Department Of Health Perinatal Advisory Committee</u>:<br>The Quality Improvement Clinical Quality Review Manager participates on the Department of Health's Perinatal Advisory Committee. The committee continues to meet on a semi-annual basis to address Neonatal Abstinence Syndrome, Post-neonatal Follow-up, Baby and Me Tobacco Free, Safe Sleep, Breastfeeding, the Tennessee Infant Mortality Reduction Strategic Plan, Certificate of Need Changes, Mothers' Milk Bank of Tennessee, and issues identified by the Regional Perinatal Centers. A new workgroup is reviewing and revising the Educational Objectives for Nurses. |
| Breast and Cervical Cancer Screening | <u>Breast and Cervical Cancer Screening Program</u>:<br>This program provides breast and cervical cancer screening to eligible women and diagnostic follow-up tests for those with suspicious results. Women diagnosed with breast or cervical cancer or pre-cancerous conditions for these cancers are enrolled for treatment coverage through TennCare. The mission of the program is to reach and serve lower income uninsured or underinsured women for these basic preventive health screening exams. |
| Quality of Care Concerns | <u>Quality of Care Concerns and Critical Incident Process:</u><br>The Division of Quality Improvement receives notification of quality of care concerns regarding enrollees that are sent directly to TennCare. These concerns are addressed in a variety of ways – through calls to the person submitting the concern, correspondence with the MCOs, or referrals to other agencies. Quality of care concerns may also be received from other Divisions within TennCare. Home Health Agency (HHA) critical incidents are also sent directly to TennCare from the MCOs. These incidents are investigated and addressed through action taken by the agency involved or through other State agencies, action taken by the MCOs, corrective action as indicated, and follow-up actions. Quality of Care Concerns and Critical incidents related to the LTSS population are forwarded to the TennCare LTSS Division, for notification purposes. |

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| Child Health | <u>Asthma Medication Management Project</u>:<br>TennCare staff participates in a statewide asthma workgroup. The goal of the workgroup is to reduce the number of Emergency Department (ED) visits for children that are due to asthma related complications. The workgroup is convened by the Department of Health and is composed of TennCare staff as well as staff from MCOs, hospitals, pharmacy and the Department of Health. Subcommittees work on various issues such as enhanced care coordination and enhanced asthmas education. The data extraction unit is the Children's Hospital Alliance of Tennessee (CHAT) and is focusing on data extractions for acute asthma repeat encounters at 30 days and 6 months. The goal for this unit is to develop evidence-based clinical pathway guidelines for asthma encounters. Another group involved in this project is the Pediatric Healthcare Improvement Initiative for Tennessee (PHIT) and is focused on education. This group has completed a series of training videos for providers dealing with identification and diagnosing asthma, determination of severity and control, developing a partnership and action plan for asthma treatment, both acute and maintenance. All subgroups are working to coordinate and educate providers and develop stakeholder care coordination for children with asthma. The ultimate goal is to develop a statewide asthma plan that includes stakeholders from both the medical community and school communities.<br><br><u>Episodes of Care Strategy:</u><br>The Tennessee Health Care Innovation Initiative Episodes of Care strategy includes an Attention Deficit and Hyperactivity Disorder (ADHD) episode. The ADHD episode revolves around patients who are diagnosed with ADHD. The trigger event is either a professional claim with a primary diagnosis of ADHD, or a professional claim with a primary diagnosis for ADHD specific symptoms and a secondary diagnosis code for ADHD, along with a procedure code that is for assessments and testing, case management, evaluation and management code, or therapy visits. Only care with a primary diagnosis of ADHD, or a primary diagnosis of ADHD specific symptoms and a secondary diagnosis from among the ADHD trigger codes, as well as a specific list of medications, are included in the episode spend. The Quarterback of the episode is the specific health care provider deemed to have the greatest accountability for the quality and cost of care for the patient. The ADHD episode begins on the day of the triggering visit and extends or an additional 79 days. TennCare has included a measure for increasing the ratio for EPSDT screenings to 80% in the list of measures for which the MCOs can receive a pay for performance incentive. |

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| | Activities Related to Child Health Conducted by Individual MCOs:<br>• The HEDIS Compliance Impact Report uses claims data to show non- compliant measures at a member level. As a result a monthly report is created to identify members who were missing required immunizations two months prior to their 13th birthday. A brochure entitled *"Protecting Teens and Young Adults*" is then sent to both male and female members who were on this report.<br>• The Pregnancy Identification List compiles all pregnant members based on claims data, pharmacy data and obstetric authorizations.<br>• The *"Taking Care of Baby and Me"* program provides pregnant members prenatal packets offering healthcare information, MCO contact information for assistance in scheduling appointments or transportation, and an incentive (gift card) to members when their doctor sends written verification to the MCOs indicating the member has been seen. |

| **GOAL: SATISFACTION** | |
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| Consumer Satisfaction | CAHPS Survey:<br>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. |

| GOAL: IMPROVE HEALTHCARE | |
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| Comprehensive Diabetes Care | As part of TennCare's Population Health Program all members are stratified, according to associated risks, into levels of care that have specific interventions associated with them. Diabetes is one of the diagnoses that are categorized into either the Health Risk Management (HRM) group or the Chronic Care Management Group (CCM). Pregnant women who have diabetes are placed into a High Risk Maternity Program. If the member is in the HRM group they will receive one to four non-interactive contacts, offer of individual support for self-management, 24/7 nurse line, offer of health coaching, and offer of weight management and/or tobacco cessation assistance. If the member is in the CCM group, they receive monthly coaching calls with a face to face visit as appropriate, clinical reminders, development of a plan of care, and after hours' assistance if needed.<br>The following are other interventions conducted by TennCare Managed Care Organizations.<br>• Diabetic self-management care plans for topics such as foot care, signs and symptoms of hyper/hypoglycemia, management of co-morbidities, management of diabetes when they are ill.<br>• Members who are identified with health risk behaviors are directed to local community resources.<br>• Members identified with psychosocial issues receive education on their condition and treatment plan. They are provided access to transportation and receive assistance with any identified barriers.<br>• Depression screening.<br>• Education on types of questions to ask their Primary Care Physician (PCP)<br>• Interactive web-based health tools that members may use to track, chart, and respond to clinical and wellness parameters, such as blood glucose.<br>• Availability of home monitoring services.<br>• Member outreach calls to diabetic members that are no-compliant to discuss and encourage recommended screenings.<br>• Mobile Diabetic Retinal Eye Exams,<br>• Member mailings.<br>• Member incentives.<br>• Medical Record Documentation Audits of providers.<br>• Rapid Cycle Improvement Projects related to Diabetes. |

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| F/U after hospitalization for mental illness | MCO Monitoring:<br>The contracted MCOs are required to submit a *Post-Discharge Services* 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 *Post-Discharge Services* report. |
| EPSDT (TennCare Kids) screening | Community Outreach:<br>All federal requirements will continue to be met. Each MCO must submit to TennCare a comprehensive EPSDT outreach plan annually by August 15 for the Federal Fiscal Year. The following information must be included in each plan:<br>• Methodology for developing the plan to include data assessments conducted, policy and procedure reviews, and any other research that may have been conducted;<br>• Outreach efforts that include both written and oral communications as well as both rural and urban areas of the state;<br>• Outreach efforts to teens;<br>• Interim evaluation criteria;<br>• Annual evaluation criteria.<br>Each plan must be resubmitted quarterly with updates on their progress. A Year-End Update of the Plan shall be due no later than 60 days following the federal fiscal year.<br>While the MCOs are expected to develop a comprehensive outreach plan, other outreach criteria also remain as contractual requirements. They are as follows:<br>• Ability to conduct EPSDT outreach in formats appropriate to members who are blind, deaf, illiterate or have Limited English Proficiency (LEP).<br>• New member calls if screening rate is below 90%;<br>• Minimum of six (6) outreach contacts per member per calendar year;<br>• Method for notifying families when screenings are due |

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| | • Follow-up for members who do not receive their screenings timely;<br>• Two attempts to re-notify families if no services were used within a year;<br>• Must have outreach activities informing pregnant women, prior to their expected delivery date, about the availability of EPSDT services for their children and to offer these services for the children when they are borne.<br>Currently, all of the MCOs hire Spanish-speaking bilingual outreach staff, if available, for community outreach events targeting the Hispanic TennCare population. These events promote the importance of preventive health care and educate members about how to access their benefits and improve their health outcomes by properly utilizing available health care resources. |
| Collaborative Workgroup | <u>Collaborative Workgroup with TennCare Select for Children in State Custody</u>:<br><br>The TennCare Division of Behavioral Health Operations leads quarterly workgroup meetings with the Department of Children's Services addressing the issues and initiatives affecting children in foster care. This workgroup includes representatives from the Division of TennCare and TennCare Select/ BlueCare. These meetings focus on issues such as immediate eligibility, using out of state providers, safety admissions to hospitals, and the Resource Parent Mailing List. The group also discusses initiatives such as behavioral health training for pediatricians; Adverse Childhood experiences (ACEs) trainings, new intensive in-home services for children in state custody and programs to help close gaps in care. |

### *Other Interventions Affecting All Goals and Objectives*

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

TennCare has been providing performance incentives, based on improvement to specific HEDIS measures, to the MCOs for several years. As a result of the Quality Redesign meetings conducted in 2015, 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 and will continue for at least three years. These measures were selected because all three (3) MCOs scored below the 25th percentile of the National Medicaid Average. The MCOs intend to 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 80% or above.

**Quality Improvement Collaborative Meetings**

Qsource facilitates three meetings per year that are attended by TennCare and MCCs. Each meeting is organized around several quality improvement topics and features keynote presentations, panel discussion, and breakout session. TennCare works with Qsource to bring in local and regional providers and public health experts to inform attendees about innovations in healthcare and healthcare delivery. 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)***

TennCare's LTSS division believes that one of the most effective tools to drive quality improvement lies in value-based purchasing approaches.

TennCare LTSS value-based purchasing initiative is called **Quality Improvement in Long-Term Services and Supports (QuILTSS).**

QuILTSS is a value-based purchasing initiative to promote the delivery of high quality long-term services and supports, focusing on the performance measures that are most important to people who receive these services

and their families—that most directly impact the member's experience of care. This initiative rewards providers that improve member experience of care and promote a person-centered care delivery model.

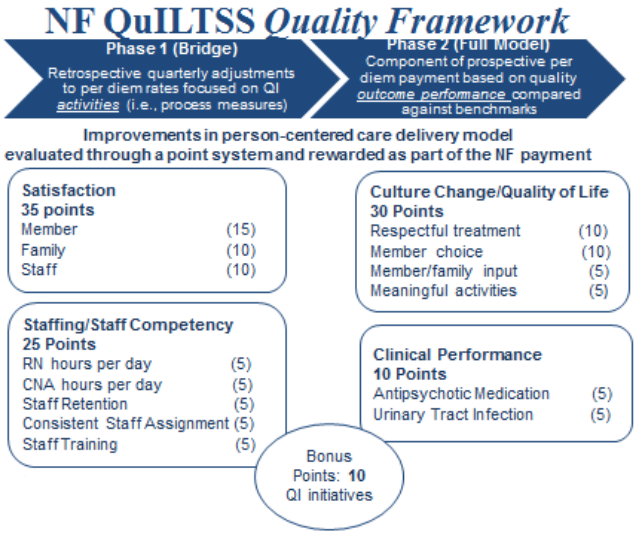
The State was awarded a State Quality and Value Strategies grant from the Robert Wood Johnson Foundation that helped to provide technical assistance to the initiative through a contract between Princeton University and Lipscomb University's School of TransformAging.

With respect to QuILTSS for nursing facilities, legislation brought by the nursing facility industry during the 2013-2014 legislative sessions and passed by the General Assembly modified a longstanding nursing home bed tax into a nursing home assessment fee, effective July 1, 2014, generating additional revenues to support changes to the nursing facility reimbursement structure. The new law included provisions for acuity- and quality-based based payments, with 20% *of the new monies* generated by the fee designated for quality-based adjustments to facilities cost-based per diem rates during the initial bridge payment year.

Implementation of QuILTSS for nursing facilities occurred in two phases: phase one - the "bridge" payment process, with quarterly retroactive adjustments to facilities' per diem rates based largely on facilities' quality improvement activities (i.e. process measures); and phase two - the full VBP model with a transition to quality as a component of the prospective per diem rate based on nursing facility performance on specified quality measures compared against state and national benchmarks. The rule signaling the end of phase 1 (retrospective payments) and the beginning of the new prospective quality – and acuity- adjusted reimbursement system was implemented August 1, 2018 with an effective date of July 1, 2018. In addition to quality informed aspects of the nursing reimbursement methodology, a specified amount of the funding for nursing facility services will be set aside during each fiscal year for purposes of calculating a quality-based component of each nursing facility provider's per diem payment (i.e., a quality incentive component). At implementation, the amount of funding set aside for the quality-based component will be no less than forty million dollars ($40 million) or four percent (4%) of the total projected fiscal year expenditures for nursing facility services, whichever is greater. In each subsequent year, the amount of funding set aside for the quality-based component will increase at two (2) times the rate of inflation, and will then increase or decrease at a rate necessary to ensure that the quality-based component of the reimbursement methodology remains at ten percent (10%). The quality-based component of each nursing provider's per diem payment will be calculated based on the facility's volume of Medicaid resident days and the percentage of total quality points earned for each measurement period.

To date, submissions have been completed utilizing a web-based tool, redundant review process, and a reconsideration committee composed of external stakeholders. The quality metrics set forth in the QuILTSS *Quality Framework* have remained consistent since the inception of the initiative.

**Figure1: Nursing Facility QuILTSS Quality Framework**




***Value-Based Purchasing Initiative for Enhanced Respiratory Care (ERC)***

Effective July 1, 2016, TennCare revised its reimbursement structure for ERC services in a nursing facility, using a point system to adjust rates based on the facility's performance on key performance indicators (e.g., rates of liberation, decannulation, infection, unplanned hospitalization and death; and the use of advanced technology to improve quality of care and quality of life). An analysis of quality outcome and technology performance measurement data is conducted bi-annually on audited data submitted by each facility. This analysis serves two purposes: (1) it allows TennCare to monitor and improve the quality of ERC services in Tennessee; and (2) it allows TennCare to establish the rates of reimbursement that will be provided as an add-on payment to the established per diem rate for a nursing facility contracted by one or more TennCare MCOs to receive ERC reimbursement. Facilities demonstrating better performance (i.e., high overall quality outcome and technology scores) are placed into higher quality tiers, which in turn offer higher rates of ERC reimbursement. Facilities are therefore incentivized to undertake activities which will enhance resident outcomes in order to receive higher reimbursement rates. TennCare has experienced a 25% reduction in expenditures for these services while yielding significant improvements in quality outcomes for members.

TennCare has contracted with Vanderbilt University Medical Center to conduct an evaluation of the ERC Quality Improvement Initiative. The evaluation will determine at a minimum the impact of the ERC program on: (1) Medicaid utilization and expenditures for ERC services and for related hospitalizations and nursing home use; (2) ERC care processes and care deliver, including, but not limited to, the use of equipment and technology; and (3) patient outcomes related to ERC services.

**Quality and Acuity-Based Payments for HCBS:**

HCBS payments will also be adjusted to incorporate the same quality metrics when they apply across service delivery settings, along with modified and additional quality metrics specific to HCBS. These changes will reward providers that improve the member's experience of care and promote a person-centered care delivery model.

The Employment and Community First CHOICES MLTSS program is designed to promote integrated employment and community living as the first and preferred outcome for individuals with intellectual and developmental

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

As these approaches have been successful, TennCare began planning to cross-walk many of these lessons learned into proposed amendments to each of the Section 1915(c) waivers that will introduce pre-employment services with outcome-based reimbursement approaches and incentivize and reward best practice job coaching through tiered and phased payment structure. The goal is to realign existing waiver funds with desired outcomes by investing substantially more resources in higher rates for services that achieve competitive, integrated employment and reducing reimbursement for services that do not support desired outcomes, including facility-based programs. Ultimately, these changes were designed to help move individuals towards employment and increased community integration, and provide more flexibility for individuals served. The amendments were posted for public comment May 2018, submitted to CMS July 2018, approved by CMS in September 2018, and will be implemented in 2019, upon readiness of the Department of Intellectual and Developmental Disabilities (the operating agency for these waivers) to implement these changes in their new information system.

***Workforce Development***

TennCare LTSS has identified that one of the most critical elements of LTSS quality involves developing a comprehensive strategy to address the workforce crisis - recruiting, training, and retaining professionals to deliver LTSS direct care services. TennCare LTSS has engaged in a multi-year initiative, retaining subject matter experts and leaders at the national and state levels to inform a comprehensive approach. In addition, TennCare LTSS has actively engaged the stakeholder community, including members and providers, to better understand barriers and challenges related to the direct support workforce.

First, as part of our federal SIM grant, TennCare is investing in the development and launch of a comprehensive competency-based workforce training and development program for deployment through secondary and post-secondary vocational technical, trade schools, and community colleges.
By offering college credit and a specialized certificate embedded in multiple degree paths, the program will provide an education path for direct support professionals, with opportunity to both learn and earn by acquiring shorter term, stackable credentials with clear labor market value that are recognized and portable across service settings. It will also provide a career path for direct support professionals, as they continue to build competencies to access more advanced jobs and higher wages. A registry for search by individuals, families, providers and matching based on needs/interests of a person needing support will help to align competencies with member needs and interests, improving the overall member experience.

We have partnered with the Tennessee higher education system to implement the Workforce Development training program through Tennessee's Colleges of Applied Technology and Community Colleges, awarding 18 hours of post-secondary credit and a post-secondary credential, and to leverage State last-dollar funding scholarship programs to cover the cost of the training for direct service workers. The training will be piloted through the end of 2018 and beginning of 2019, with anticipated implementation targeted in 2019

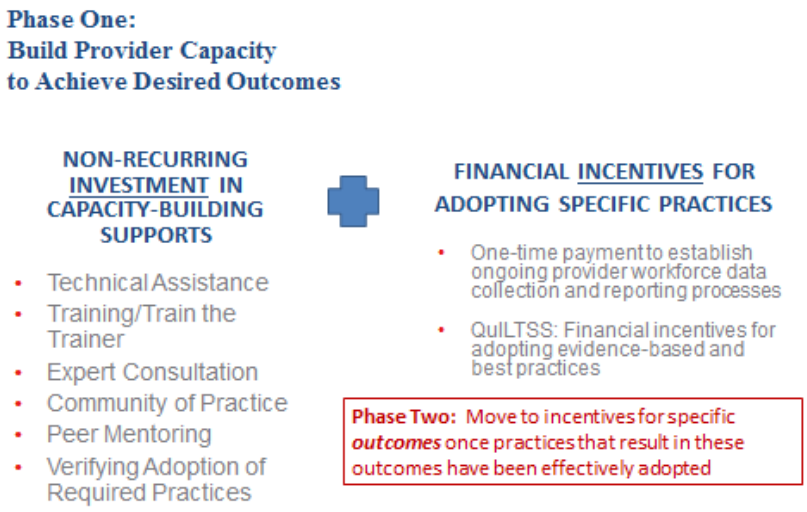
The direct support professional training programs consist of credentialing programs to support direct support workers with experience in the field as well as a pre and early training program to support workers who are new to the field. In addition, TennCare LTSS is developing programs to support self-direction of routine health care tasks, such as diabetes management and medication administration, with potential future trainings focusing on additional conditions or areas of expertise, such as dementia or specialized behavior support needs.

In addition to the QuILTSS workforce development efforts, escalating workforce challenges across HCBS programs led to the development of a more comprehensive strategy, including alternative VBP approaches, to directly address the direct service workforce crisis. TennCare plans to utilize a combination of SIM and Money Follows the Person (MFP) state rebalancing funds to enhance and facilitate access to home and community-based services (HCBS) programs for people with intellectual and developmental disabilities by addressing the direct service workforce shortage through data-driven and evidence-based strategies.

The new comprehensive approach to workforce development encompasses an array of provider capacity-building investments and workforce development incentives. Investments include engaging national Subject Matter Experts (SMEs) at the University of Minnesota's Institute on Community Integration to assist in establishing processes for the collection and use of workforce-related data at provider and system levels to target and measure improvement efforts over time, and to provide training and technical assistance to providers to support adoption of evidence-based and best practices that have been shown to result in more effective recruitment, increased retention, and better outcomes for people served.

Value-based payment strategies will then be implemented to incentivize the provider adoption of ***practices*** that will lead to desired ***outcomes***, including data collection, reporting, and use at the provider level and adoption of evidence-based and best practice approaches to workforce recruitment/retention as well as organization culture/business model changes. Incentives will also be aligned at the worker level by implementing pass-through incentive payments to ensure wages are increased as DSWs increase their level of training and competency and upon completing the certification program. VBP approaches will transition to financial incentives for specific workforce and quality of life *outcomes* once practices expected to result in the outcomes have been effectively adopted. The strategy will initially be implemented in Employment and Community First CHOICES; however many providers participate across programs, thus spreading the impact of this work. Ultimately, we hope to expand the approach across HCBS programs and authorities.

**Figure 2: Phases to Address Workforce Crisis**




***Tennessee Asthma Coalition***

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 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).

In 2017, TennCare staff continues to participate in a statewide asthma coalition with the goal of reducing ER visits for children due to asthma related complications. The group includes medical professionals from across the state, Managed Care Organizations, hospitals, pharmacists, and health department personnel. The group has formed subcommittees dealing with enhancing care coordination and enhancing asthma education. The ultimate goal is to develop a statewide asthma plan that includes stakeholders from both the medical and school communities. The asthma coalition is currently taking steps to formalize by becoming a non-profit organization, enabling the coalition to have an online presence.

***Clinical Practice Guidelines***

MCOs are contractually required to utilize evidence-based clinical practice guidelines in their Population Health Programs. These guidelines must be 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 their 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, excluding dental measures. The MCOs 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 D-SNP 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. Beginning in 2017, a PIP in the area of EPSDT is also required. CMS protocols must be followed for all PIPs.

***Strategic Planning***

Annually, the Division of Quality Improvement staff, in collaboration with Qsource and the Division of HealthCare Informatics, review and analyze all data coming in to the Division of Quality Improvement through MCC reporting and other areas. At that time, and in subsequent meetings, decisions are made about areas of performance that need additional emphasis.

***Population Health***

In December 2011, Quality Improvement staff began leading discussions with the MCOs about moving from a disease management model 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 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; and
- Addressing upstream causes of poor health (e.g., nutrition, physical inactivity, substance abuse).

Under the new Population Health model, the entire TennCare population for each MCO is identified/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 Level 1 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 the population but have complex needs outside of chronic conditions . Members may also be identified as potentials for CM by trigger lists or referrals.

As part of the evaluation process, all MCOs are required to conduct Rapid Cycle Improvement (RCI) projects. Some of the RCI's that were successful included changing or improving member behavior with a focus on completing appropriate diabetic screenings; decreasing the rate of "unable to contact" members in a given county by six percent; and improving the health of members by successful weight management. There were also some RCIs that were attempted and were not successful. These include attempting to improve the retention of enrollees in Chronic Care Management; and improving the ability of members to track and update their own personal health care information via a web portal device.

***MCO Provider Agreements***

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

***Grants***

Money Follows the Person – The State will conclude its successful participation in the MFP demonstration program effective December 31, 2018. The State is ending the program because once the State draws down the remaining administrative funds and program match owed to the State, there will be no funds remaining. The State will exhaust its approved funding by the end of this calendar year. Importantly, Tennessee has exceeded its stated target of transitioning 2,225 individuals under the demonstration. As of June 30, 2018, Tennessee has successfully transitioned 2,381 individuals out of institutions under the demonstration. (Note that these are individuals who have been institutionalized at least 90 days, and do not encompass the entirety of nursing facility-to-community transitions under the State's LTSS programs.)

Despite the program ending, one notable project funded by the MFP project occurring during 2018 and into 2019 concerns TennCare contracting with five non-profit home developers that are members of the Neighborworks America Alliance. Neighborworks is a congressionally chartered corporation that consists of over 200 nonprofit housing development agencies charged with furthering affordable housing and community development across the country. In Tennessee, there are five nonprofit home developers who are Neighborworks members. The State contracted with these nonprofit developers to support the development of accessible and affordable homes in the five largest metropolitan areas in the State to assist in the transition of individuals who receive LTSS to the community.

As a result of this contract with the Neighborworks developers, 10 homes in total, will be completed in 2019.The homes will be located in Memphis, Nashville, Knoxville, Johnson City, and Chattanooga. Upon completion of all the homes, 25 CHOICES and ECF CHOICES members, who would either be placed in an institutional setting or would be at risk of placement in an institutional setting, will have the opportunity to live and be supported in an accessible and affordable home in the community.

***State Innovations Models Initiative: Model Test Award***

In 2015, TennCare was awarded a State Innovations Model (SIM) Model Test grant by the Centers for Medicare and Medicaid Innovation (CMMI). This grant supports the Tennessee Health Care Innovation Initiative which includes three strategies: Primary Care Transformation, Episodes of Care, and Long-Term Services and Supports. The State's Primary Care Transformation strategy includes an aligned TennCare Patient Centered Medical Home (PCMH) model, a Tennessee Health Link program for TennCare members with the highest behavioral health needs, as well as a shared Care Coordination Tool that allows providers to identify and track the closure of gaps in care linked to quality measures. Episodes of Care focuses on improving the quality and cost of health care delivered in association with acute or specialist-driven health care events such as a surgical procedure or an inpatient hospitalization. TennCare's LTSS strategy focuses on improving quality and shifting payment to outcomes-based measures for NF and HCBS services and for Enhanced Respiratory Care services. 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. The Tennessee Health Care Innovation Initiative will further advance the vision of improved quality of services from the perspective of the member. The Tennessee Health Care Innovation Initiative continues to be a strong priority for TennCare.

### *Intermediate Sanctions*

| CFR 438.204(e) For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 C.F.R. Part 428, Subpart I. |
|---|
| CRA E.29.1 Addresses Intermediate Sanctions:<br>• 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:<br>o Fails substantially to provide medically necessary covered services;<br>o Imposes on members cost sharing responsibilities that are in excess of the cost sharing permitted by TennCare;<br>o Acts to discriminate among enrollees on the basis of health status or need for health care services;<br>o Misrepresents or falsifies information that it furnishes to CMS or to the State;<br>o Misrepresents or falsifies information furnished to a member, potential member, or provider;<br>o Fails to comply with the requirements for physician incentive plans as listed in 42 CFR 438.6(h);<br>o Has distributed directly, or indirectly through any agent or independent contractor, marketing or member materials that have not been approved by the State or that contain false or materially misleading information; and<br>o Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.<br>• 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:<br>o Liquidated damages;<br>o Suspension of enrollment in the contractor's MCO;<br>o Disenrollment of members;<br>o Limitation of contractor's service area;<br>o Civil money penalties as described in 42 CFR 438.704;<br>o Appointment of temporary management for an MCO as provided 42 CFR 438.706<br>o Suspension of all new enrollment, including default enrollment, after the sanction's effective date;<br>o Suspension of payment for members enrolled after the sanction's effective date and until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or<br>o Additional sanctions allowed under federal law or state statue or regulation that address areas of non-compliance;<br>o Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or<br>o Additional sanctions under federal law or state statute or regulation that address areas of non-compliance. |

| Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems. |
| --- |
| Each Division of TennCare is responsible for recommending sanctions on an MCO if any of the following are identified. The Division of Managed Care Operations reviews all recommendations for sanctions and has the final responsibility for either approving or disapproving them. Once sanctions are approved, the MCO involved is notified that the sanctions will be imposed. Liquidated damages may be assessed for a variety of quality of care issues, including:<br>• 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;<br>• Failure to perform specific responsibilities or requirements that pose threats to TennCare integrity, but which do not necessarily imperil patient care;<br>• Failure to perform specific responsibilities or requirements that result in threats to the smooth and efficient operation of the TennCare Program<br>• Failure to meet performance standards<br>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.<br><br>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.<br><br>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 health care needs; foster care children; or dual eligibles.***

| Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying enrollees in this population. |
|---|
| 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 |

**LTSS Service Delivery Initiatives**

TennCare's LTSS Division has several current and future-facing service delivery quality initiatives, which are expanded upon below. These include, amending the State's 1915(c) HCBS Waiver to focus on and incentivize the expansion of employment services and day services that promote community integration; to implement improved, community-facing HCBS in the CHOICES program; and the launching of a statewide System Transformation Initiative for LTSS and the convening of a System Transformation Leadership Group composed of members, MCOs, providers, TennCare and DIDD staff, and other stakeholders, for the purposes of transforming the LTSS delivery system to be more person-centered.

Regarding improvements to the State's 1915(c) HCBS Waivers, the State recently received CMS approval of amendments encompassing series of improvements to employment and day services, which will be implemented in 2019. At a high level, these changes include: establishing separate service categories, with unique service definitions and provider qualifications, for each type of employment and day service currently provided; re-organizing the reimbursement rates to better align services with outcomes; adding Supported Employment-Individual Services that support providers to assist more waiver participants to obtain individualized, competitive integrated employment; establishing quality incentive payments for providers of Supported Employment-Individual Employment Support where waiver participants are engaged in certain levels of competitive integrated employment; and encouraging lower waiver participant to staff ratios through the reimbursement structure. The goal is to realign existing waiver funds with desired outcomes by investing substantially more resources in higher rates for services that achieve competitive, integrated employment and reducing reimbursement for services that do not support desired outcomes, including facility-based programs. Ultimately, these changes were designed to help move individuals towards employment and increased community integration, and provide more flexibility for individuals served.

In 2019, TennCare LTSS intends to explore amendments to its 1115 Waiver regarding its CHOICES program to further enhance employment and community integration. Primarily, through modifications to Personal Care and Attendant Care services, TennCare LTSS intends to reinforce flexibility regarding where these services are performed, so that workers follow members into the community to support them at places of work or at

community activities based on member needs and preferences, ensuring their full access to employment and community participation.

To examine the service delivery structure as a whole across its MLTSS and fee-for-service LTSS programs, TennCare has initiated a System Transformation Leadership Group (STLG). The STLG is composed of members, MCOs, providers, TennCare and DIDD staff, and other stakeholders, who routinely meet to advance crucial areas of quality improvement in the areas of policy and regulation, quality service array, workforce development, value-based payment reform, and the use of data to drive system improvements and gauge the effectiveness of the group's work. A sample of some of the main initiatives of the group are: engaging with advocacy groups to further supported decision-making in place of more restrictive legal options, examining and amending critical incidents systems through the lens of dignity of risk to remove restrictive and burdensome requirements; exploring the expansion of consumer-directed services; and identifying expanded options for community transportation.

***TennCare Patient Centered Medical Homes (PCMH)***

PCMH is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities of and practice standards of primary care providers, and the overall value of health care delivered to the TennCare population.

Tennessee has built on the existing PCMH efforts by providers and payers in the State to create a robust PCMH program that features alignment across payers on critical elements. TennCare's three health plans launched a statewide aligned PCMH program with 29 organizations on January 1, 2017. As of November 1, 2018 the PCMH program includes 67 primary care organizations caring for over 440,000 TennCare members at over 400 sites throughout the State.

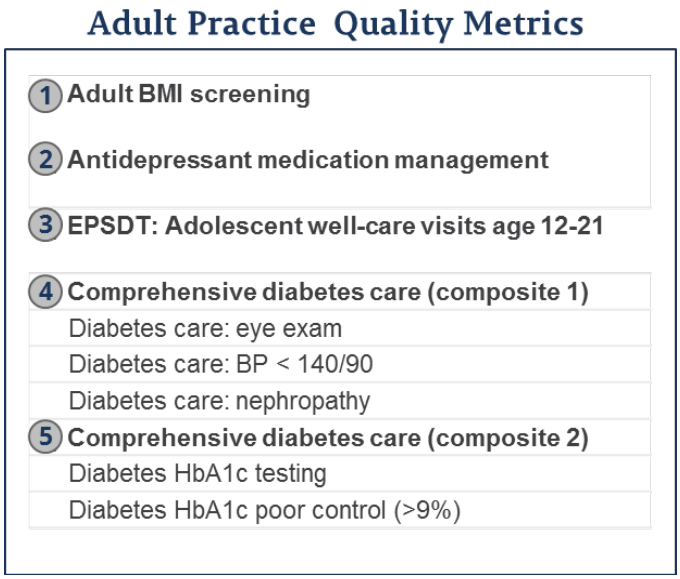
PCMH providers commit to member centered access, team based care, Population Health management, care management support, care coordination, performance measurement and quality improvement. Participating providers receive training and technical assistance, quarterly reports with actionable data, and access to the Care Coordination Tool. To date, 88% of hospitals and licensed hospital beds statewide are submitting admissions, discharge, and transfer data. PCMH providers are compensated with ongoing financial support and an opportunity for an annual outcome payment based on quality and efficiency performance.

## Family Practice Quality Metrics

1. **Adult BMI screening**
2. **Antidepressant medication management**
3. **Comprehensive diabetes care (composite 1)**
   - Diabetes eye exam
   - Diabetes BP < 140/90
   - Diabetes nephropathy
4. **Comprehensive diabetes care (composite 2)**
   - Diabetes HbA1c testing
   - Diabetes HbA1c poor control (> 9%)
5. **Asthma medication management**
6. **Immunization composite metric**
   - Childhood immunizations
   - Immunizations for adolescents
7. **EPSDT screening rate (Composite for youngest kids)**
   - Well-child visits first 15 months
   - Well-child visits at 18, 24, & 30 months
8. **EPSDT: Well-child visits ages 3-6 years**
9. **EPSDT Screening (Composite for older kids)**
   - Well-child visits ages 7-11 years
   - Adolescent well-care visits age 12-21
10. **Weight assessment and nutritional counseling**
    - BMI percentile
    - Counseling for nutrition

## Pediatric Practice Quality Metrics

1. **EPSDT screening rate (composite for older kids)**
   - Well-child visits ages 7-11 years
   - Adolescent well-care visits age 12-21
2. **Asthma medication management**
3. **Immunization composite metric**
   - Childhood immunizations
   - Immunizations for adolescents
4. **EPSDT screening rate (composite for younger kids)**
   - Well-child visits first 15 months
   - Well-child visits at 18, 24, & 30 months
   - Well-child visits ages 3-6 years
5. **Weight assessment and nutritional counseling**
   - BMI percentile
   - Counseling for nutrition




Efficiency measures for TennCare's PCMH program are as follows:

- Ambulatory care – ED visits
- Inpatient admissions

***Tennessee Health Link***

The primary objective of Tennessee Health Link is to coordinate health care services for TennCare members with the highest behavioral health needs.

TennCare has worked closely with providers and TennCare's three health plans to create a program to address the diverse needs of people these members. A Health Link Technical Advisory Group of Tennessee clinicians and practice administrators was convened in 2015 to develop recommendations in several areas of program design including, quality measures, sources of value, and provider activity requirements. The design of Health Link was also influenced by federal Health Home requirements.

Through better coordinated behavioral and physical health services, the Health Link program is meant to produce improved member outcomes, greater provider accountability and flexibility when it comes to the delivery of appropriate care for each individual and improved cost control for the state. Health Link providers are encouraged to ensure the best care setting for each member, offer expanded access to care, improve treatment adherence, and reduce hospital admissions. In addition, the program is built to encourage the integration of physical and behavioral health, as well as, mental health recovery, giving every member a chance to reach his or her full potential for living a rewarding and increasingly independent life in the community.

Health Link providers commit to providing comprehensive care management, care coordination, referrals to social supports, member and family support, transitional care, health promotion, and Population Health management. Participating providers receive training and technical assistance, quarterly reports with actionable data, and access to the Care Coordination Tool. These providers are compensated with financial support in the form of activity payments and an opportunity for an annual outcome payment based on quality and efficiency performance.

The Health Link program began statewide on December 1, 2016.


Efficiency measures for Tennessee Health Link are as follows:

- Ambulatory care – ED visits
- Inpatient admissions – total inpatient

# SECTION VI: CONCLUSIONS AND OPPORTUNITIES

| ***Identify any successes that the state considers to be best or promising practices:*** |
|---|
| The TennCare MCOs have successfully transitioned from Disease Management to Population Health (PH). All 1.45 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. 2017 and 2018 evaluation data showed positive results for a number of the measures. These are listed in a previous section of this document.<br><br>**TennCare's Behavioral Health Crisis Prevention, Intervention and Stabilization Services: "Systems of Support" (SOS)** was designed in collaboration with and delivered by contracted MCOs to provide a model of service delivery intended to build the capacity of the system to better support individuals with I/DD who experience challenging behavior, which creates more effective Systems of Support. The primary goal is to assist the person in achieving greater independence, community participation and improved quality of life, and a higher degree of stability and community tenure. The model includes: person-centered assessments; development of person-centered Crisis Prevention and Intervention Plans (CPIP); training of paid and unpaid caregivers to equip them to provide positive behavior supports and identify, address, and prevent potential crisis events; development of community linkages and cross-system supports based on the individualized needs of each member and the member's CPIP; 24/7 crisis intervention/stabilization response; referral to therapeutic respite or inpatient services, only when necessary, engagement/coordination with therapeutic respite or inpatient providers to plan and prepare for transition back to community living arrangement as soon as appropriate.<br><br>SOS was designed with a value-based reimbursement approach that aligns the monthly case rate to support improvement and increased independence over time as the provider is successful in helping paid or unpaid caregivers increase their capacity to provide needed support in order to prevent and/or manage crises.<br><br>Claims-based performance measures include ED visits for behavioral health crises, inpatient psychiatric hospitalization, behavioral respite utilization, total service expenditures, and intensity/cost of HCBS. Non-claims based performance measures include use of psychotropic medications, number of crisis events requiring intervention by SOS provider, in-person assistance by the SOS provider, out-of-home placement (including length of out-of-home placement), community tenue – days/periods without institutionalization or out-of-home placement, stability in living arrangements, participation in community activities, integrated competitive employment, perceived quality of life, and satisfaction with services.<br><br>Two analyses of claims-based performance measurement data found substantial reductions in three broad categories: Crisis Respite (CR), Emergency Department (ER) and Psychiatric In-Patient (PI). The second examination was conducted on SOS participants form January 1, 2105 – April 30, 2018 examining their claims across three periods: prior to admission to the SOS model, during participation in the SOS model, and after discharged from the SOS model. Results of this analysis will be used to establish an additional VBP component for reimbursement structure around claims based measures. |

During the 2017 AQS, the MCOs achieved 100% compliance of the majority of accessed elements. The MCOs were commended for demonstrating strength in their dedication to Early and Periodic Screening, Diagnostic, and Treatment standard. MCOs were praised for their innovative ways to outreach members.

In addition each MCO continued to participate in the statewide collaborative work groups with TennCare and other MCOs. These collaborations remain important strengths for 2017 and have improved how the MCOs educate and conduct outreach to members and providers by presenting a unified message on topics such as adolescent outreach and increasing the number of adolescent well-child visits.

Innovation has always been a priority throughout TennCare. Consistent with its mission "to continuously improve the health and satisfaction of TennCare enrollees," the Division of Quality Improvement works closely with health plan representatives to foster such innovation and encourage adoption of evidence-based practices statewide. In 2017, each MCC demonstrated a strong commitment to quality improvement and best practices across a range of programs. During the various activities monitored by the EQRO, the following activities were identified as promising practices:

Performance Measure Validations

- Continual use of standard and nonstandard supplemental data sources for HEDIS 2017 reporting.
- Ongoing efforts to increase electronic claims submissions from providers
- Excellent processes for tracking and trending all sources of HEDIS data
- Commitment to achieving a more sophisticated internal body of knowledge of the HEDIS reporting process
- Robust audit procedures in place to ensure accuracy

Performance Improvement Projects

- Dedication to ensuring compliance across all PIPs
- Detailed analyses of PIPs maturing to subsequent re-measurement years
- Ongoing multidisciplinary barrier analyses to determine the effectiveness of implemented interventions
- Thorough, comprehensive results covering all required criteria
- Complete measurement descriptions & corresponding documentation of results and significance of findings
- Extensive interpretation of results that illustrated the effectiveness of the improvement activities

Annual Network Adequacy and Benefit Delivery Review

- Improvements to the overall credentialing and re-credentialing process
- Staff training to improve knowledge of documentation requirements
- High compliance with provider to member ratios and geographical-across standards
- Ongoing provider education to improve member outcomes
- Excellent scores related to provider & member benefit notification
- Implementation of the Employment and Community First CHOICES program using the same network of providers and standardized forms and procedures

Annual Quality Survey

- Continued commitment to participating in the statewide collaborative workgroups with TennCare and other MCCs
- Continued commitment to monitoring EPSDT services
- High ratings on Quality Performance standards and Performance Activity Standards
- Ongoing and improved outreach to members and providers

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

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

For dual eligible beneficiaries, one of the greatest challenges lies in the coordination of benefits across two complex health insurance programs for individuals who are more likely to have multiple chronic health conditions as well as functional limitations requiring the provision of LTSS. Hospital ADT feeds now allow TennCare to at least be informed when a dual eligible beneficiary is admitted to or leaves a hospital, but the current care coordination tool provides the information only to PCMH or HealthLink providers, and not to health plans, who for individuals receiving LTSS perform critical care coordination functions that can help to facilitiate transition to the most integrated setting appropriate, and with the right post discharge care and supports to help sustain community tenure and avoid readmission.

With respect to individuals receiving LTSS more broadly, the greatest challenge lies in addressing what has become a national workforce shortage in direct care staff to provided needed care—especially in home and community based settings. Without an adequate supply of well-trained staff, it is impossible to deliver high quality LTSS to individuals who need them to ensure their health and safety and their quality of life on a day-to-day basis. Escalating workforce challenges across HCBS programs led to the development of an alternative value-based payment approach in HCBS to directly address the direct service workforce crisis (in addition to the development and implementation of a comprehensive, competency-based workforce development program). The new comprehensive approach to workforce development encompasses an array of provider capacity-building investments and workforce development incentives. Investments include engaging national Subject Matter Experts (SMEs) at the

University of Minnesota's Institute on Community Integration to assist in establishing processes for the collection and use of workforce-related data at provider and system levels to target and measure improvement efforts over time, and to provide training and technical assistance to providers to support adoption of evidence-based and best practices that have been shown to result in more effective recruitment, increased retention, and better outcomes for people served. Value-based payment strategies will then be implemented to incentivize the provider adoption of ***practices*** that will lead to desired ***outcomes***, including data collection, reporting, and use at the provider level and adoption of evidence-based and best practice approaches to workforce recruitment/retention as well as organization culture/business model changes. Incentives will also be aligned at the worker level by implementing pass-through incentive payments to ensure wages are increased as DSWs increase their level of training and competency and upon completing the certification program. VBP approaches will transition to financial incentives for specific workforce and quality of life *outcomes* once practices expected to result in the outcomes have been effectively adopted. The strategy will initially be implemented in Employment and Community First CHOICES; however many providers participate across programs, thus spreading the impact of this work. Ultimately, we hope to expand the approach across HCBS programs and authorities.

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

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

With the implementation of the Care Coordination Tool, Tennessee will be able to provide the ability for health care providers to coordinate patients across multiple payers and plan types (i.e., Medicaid, Medicare and Commercial plans). The solution, once implemented will produce risk scores; prioritize patients and activities based on their risk scores; track gaps in care; allow for view of prescription fill information; produce care plans; allow users to track completion of tasks attributed to the care plans and the patient's needs; utilize eCommunication to foster greater coordination across the Care Team; and support the work of both Patient Centered Medical Home and Health Link care models. Opportunities also include the ability to provide a greater quality of care to patients in a timelier manner.

The implementation of a Clinical Knowledge Module, that includes hospital admission, discharge information and transfer information (ADT), will standardize the clinical information loaded from the ADT feeds. Once hospitals are on-boarded Tennessee will begin to collect and co-locate ADT feeds to begin building a clinical database for the State Health Information Exchange (HIE) that will address gaps in care and reduce hospital admissions.

Through the Quality Apps project, the state will have the ability to collect clinical quality data that cannot be acquired from processed medical billing claims. Ultimately, these Quality Apps will provide all payers, beginning with the State's Medicaid participating MCOs, with the necessary information to reimburse providers for high quality health outcomes.

***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 six Meaningful Use Modified Stage 2 measures could be met with various implementations of Direct. The state currently has nearly 5,000 DIRECT secure messaging users. Over the past three years, EHR system adoption measured by the number of providers participating in the EHR Provider Incentive Program, through either Medicare or Medicaid has grown by almost 20%, to 10,951 at the end of August 2016. Combined with Medicare EHR registrations, this means that approximately 39% of the eligible provider types in Tennessee (including hospitals) have registered for the EHR Incentive Program. Since the inception of the program, TennCare has made 4,843 payments to unique providers, totaling a little more than $253.5 million.

***EHR and Meaningful Use***

TennCare's Quality Improvement 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 Improvement Meaningful Use Unit is in their fifth 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, 2014, 2015 and 2016. We are in the process of closing out the attestation period for payment year 2017.

On August 2, 2018, the Centers for Medicare and Medicaid Services (CMS) finalized the final rule for the FY 2019 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System that includes policies that rebrand the meaningful use programs as the Promoting Interoperability (PI) program, and changes to the program with a core emphasis on reducing burden and placing a strong emphasis on measures that require advancing health data exchange among providers.

The rule finalizes an EHR reporting period of a minimum of any continuous 90-day period in each of calendar years 2019 and 2020 for new and returning participants attesting to CMS or their state Medicaid agency. Importantly, the final rule reiterates the mandates that require providers to use 2015 edition certified EHR technology (CEHRT) starting in 2019. Requiring providers to use the most updated version of certified EHR technology aligns with the federal agency's mission to promote the use of application programming interfaces (APIs), which can help to streamline the flow of clinical information between providers, patients, and healthcare facilities. Additional changes to the program include more closely aligning the eCQMs reported for MU with those reported for under the Merit-based Incentive Payment System.

Though the MU Unit is still in the process of reviewing attestations for PY 2017, 656 Eligible Professionals (EPs) have already successfully attested to MU. To date no providers have attested to Stage 3. In order to provide more technical aid and education resources to Eligible Professionals reporting public health measures and specialized registries, MU staff has strengthened their partnership with the Tennessee Department of Health. The MU staff has reduced return rates on attestations by providing additional technical assistance on attestation issues that do not require a return for correction but a simple verification of the issue.

***Grants that support State HIT/EHR development or enhancement***

The state of Tennessee has received grants from the Office of the National Coordinator (ONC), CMS, and SAMSHSA/MITRE to further HIT and HIE across the state. ONC granted $11.7 million for HIE advancement over a four year period (February 2010 to February 2014). These funds have assisted in upgrading the state's immunization system, electronic lab reporting, a state DIRECT HISP implementation, the statewide roll-out to providers of DIRECT technology, and ePrescribing adoption, as well as operations and improvement of the program. CMS has granted the state a HIT/HIE IAPD grant of $25,551,041. $12,184,496 of these funds is intended to fund administration of the CMS Provider Incentive Program and HIE program in Tennessee as well as updates to the State's incentive program registration system. $13,366,543 of these funds is intended to fund HIE projects, including providing State HIE Core services, allowing access to clinical data contained in Medicaid claims to both providers and Medicaid recipients, development of regional HIE organizations, and assisting provider practices in attainment of meaningful

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.

***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.

In 2015, TennCare was awarded a State Innovations Model (SIM) Model Test grant by the Centers for Medicare and Medicaid Innovation (CMMI) . This grant supports the Tennessee Health Care Innovation Initiative which includes three strategies: Primary Care Transformation, Episodes of Care, and Long-Term Services and Supports. The State's Primary Care Transformation strategy includes an aligned TennCare Patient Centered Medical Home (PCMH) model, a Tennessee Health Link program for TennCare members with the highest behavioral health needs, as well as a shared Care Coordination Tool that allows providers to identify and track the closure of gaps in care linked to quality measures. Episodes of Care focuses on improving the quality and cost of health care delivered in association with acute or specialist-driven health care events such as a surgical procedure or an inpatient hospitalization. TennCare's LTSS strategy focuses on improving quality and shifting payment to outcomes-based measures for NF and HCBS services and for Enhanced Respiratory Care services. 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. The Tennessee Health Care Innovation Initiative will further advance the vision of improved quality of services from the perspective of the member.

**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

  (b) Distance/Time Urban: 20 miles

  (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 miles, except in rural areas where distance may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

In addition, pursuant to 42 CFR 438.68(2), TennCare has established the following standards regarding network adequacy for MLTSS providers:

- Time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services
- Adult Day Care: Transport access to licensed Adult Day Care providers, ≤ 20 miles travel distance and ≤ 30 minutes travel time for TennCare enrollees in urban areas, ≤ 30 miles travel distance and ≤ 45 minutes travel time for TennCare enrollees in suburban areas ≤ 60 miles travel distance and ≤ 90 minutes travel time for TennCare enrollees in rural/frontier areas, except where community standards

and documentation shall apply.

Network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services

For services provided in the member's home, MCOs must ensure the following:

- **Choice of providers for every HCBS.** In general, this means a minimum of 2 contracted providers for each HCBS in every county. MCO provider files must identify MLTSS providers separately by the service(s) they are contracted to provide, and the counties in which they are contracted to provide the service. For services provided in the member's home, it does not mean that the provider has to be located in the county, but rather, have staff to serve people who live in the county, providing those services to members in their homes.
- **A sufficient number of providers to initiate services as specified in the person-centered support plan in accordance with the timeframes specified in A.2.9.6 and to ensure continuity of such services without gaps in care.** In general, the contract prescribes the specific number of days that an MCO has from the date a member is enrolled in MLTSS to complete an initial assessment, develop an initial plan of care, and initiate HCBS (in the case of ECF CHOICES, "immediately needed HCBS"). For most services, this is 10 business days. This is monitored through ongoing reporting and audit processes to ensure that each MCOs' network is adequate. In addition, TennCare monitors gaps in care through the mandated use of an electronic visit verification system and monthly appeals data.
- **For special populations--specifically individuals with I/DD, a network of providers with appropriate experience and expertise in serving people with I/DD and in achieving important program outcomes, such as employment.** Quality assurance is accomplished through monitoring of preferred contracting standards which are tracked on the provider file in order for us to ensure that the MCO's network is adequate in terms of the experience and expertise of its providers.

In the future, we also intend to incorporate quality performance as part of the network adequacy structure for LTSS. At this juncture, we are implementing quality monitoring and quality measurement processes that will allow us to identify high performing providers, and to prepare us to be able to establish a process for taking quality performance into consideration as part of the review of network adequacy for LTSS providers.

General Optometry Services:

(a) Transport 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.

- All other services not specified here shall meet the usual and customary standards for the community as determined by TENNCARE.

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

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

## SPECIALTY NETWORK STANDARDS

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

### Access to Specialty Care

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

- The CONTRACTOR shall have provider agreements with providers practicing the following specialties: Allergy, Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent), and Urology; and

- The following access standards are met:
    - Travel distance does not exceed 60 miles for at least 75% of non-dual members and
    - 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.

## 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<br>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<br>---<br>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<br>---<br>The CONTRACTOR shall contract with at least one (1) provider of service in each Grand Region (3 statewide) 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 |
| **Intensive Community Based Treatment Services** | Not subject to geographic access standards | Within 7 calendar days |
| **Intensive Community Based Treatment Services** | Not subject to geographic access standards | Within 7 calendar days |
| **Supported Housing** | Not subject to geographic access standards | Within 30 calendar days |
| **Crisis Services** (Mobile) | Not subject to geographic access standards | Face-to-face contact within 2 hours for emergency situations and 4 hours for urgent situations |
| **Crisis Stabilization** | Not subject to geographic access standards | Within 4 hours of referral |

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

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

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

| Service Type | Service Code(s) for use in position 330-331 of the Provider Enrollment |
|---|---|
| **Psychiatric Inpatient Hospital Services** | Adult - 11, 79, 85<br>Child – A1 or H9 |
| **24 Hour Psychiatric Residential Treatment** | Adult - 13, 81, 82<br>Child – A9, H1, or H2 |
| **Outpatient** MD Services (Psychiatry) | Adult – 19<br>Child – B5 |
| **Outpatient** Non-MD Services | Adult – 20<br>Child – B6 |
| **Intensive Outpatient/ Partial Hospitalization** | Adult – 21, 23,<br>62 Child - B7, |
| **Inpatient Facility**<br>**Services (Substance** | Adult – 15,<br>17 Child – |
| **24 Hour Residential Treatment**<br>**Services (Substance Abuse)** | Adult - 56<br>Child - F6 |
| **Outpatient Treatment**<br>**Services (Substance Abuse)** | Adult – 27 or<br>28 Child – D3 |
| **Tennessee Health Link Services** | Adult – 31<br>Child –D7 |
| **Intense Community Based Treatment Services** | Adult 66 or 83<br>Child D3 or D4 |
| **Psychiatric Rehabilitation Services:** | |
| **Psychosocial Rehabilitation** | 42 |
| Supported Employment | 44 |
| Peer Recover Service | 88 |
| Illness Management & Recovery | 91 |

| | |
|---|---|
| **Family Support Services** | 49 |
| **Supported Housing** | 32 and 33 |
| **Crisis Services (Mobile)** | Adult - 37, 38, 39<br>Child - D8, D9, E1 |
| **Crisis Respite** | Adult – 40<br>Child – E2 |
| **Crisis Stabilization** | Adult 41 |

**A.2.6.1 CONTRACTOR Covered Benefits**

2.6.1.1 The CONTRACTOR shall cover the physical health, behavioral health and long-term care services/benefits outlined below. Additional requirements for behavioral health services are included in Section A.2.7.2 and Attachment I.

2.6.1.2 The CONTRACTOR shall integrate the delivery of physical health, behavioral health and long-term care services. This shall include but not be limited to the following:

2.6.1.2.1 The CONTRACTOR shall operate a member services toll-free phone line (see Section A.2.18.1) that is used by all members, regardless of whether they are calling about physical health, behavioral health and/or long-term care services. The CONTRACTOR shall not have a separate number for members to call regarding behavioral health and/or long-term care services. The CONTRACTOR may either route the call to another entity or conduct a "warm transfer" to another entity, but the CONTRACTOR shall not require an enrollee to call a separate number regarding behavioral health and/or long-term care services.

2.6.1.2.2 If the CONTRACTOR's nurse triage/nurse advice line is separate from its member services line, the CONTRACTOR shall comply with the requirements in Section A.2.6.1.2.2 as applied to the nurse triage/nurse advice line. The number for the nurse triage/nurse advice line shall be the same for all members, regardless of whether they are calling about physical health, behavioral health and/or long-term services, and the CONTRACTOR may either route calls to another entity or conduct "warm transfers," but the CONTRACTOR shall not require an enrollee to call a separate number.

2.6.1.2.3 As required in Section A.2.9.6, the CONTRACTOR shall ensure continuity and coordination among physical health, behavioral health, and long-term services and supports and ensure collaboration among physical health, behavioral health, and long-term services and supports providers. For CHOICES members and ECF CHOICES members, the member's Care Coordinator or Support Coordinator, as applicable, shall ensure continuity and coordination of physical health, behavioral health, and long-term services and supports, and facilitate communication and ensure collaboration among physical health, behavioral health, and long-term services and supports providers.

2.6.1.2.4 Each of the CONTRACTOR's Population Health programs (see Section A.2.8) shall address the needs of members who have co-morbid physical health and behavioral health conditions.

2.6.1.2.5 The CONTRACTOR shall provide the appropriate level of Population Health services (see Section A.2.8.4 of this Contract) to non-CHOICES and non-ECF CHOICES members with co-morbid physical health and behavioral health conditions. These members should have a single case manager that is trained to provide Population Health services to enrollees with co-morbid physical and behavioral health conditions. If a member with co-morbid physical and behavioral conditions does not have a single case manager, the CONTRACTOR shall ensure, at a minimum that the member's Population Health Care Manager collaborates on an ongoing basis with both the member and other individuals involved in the member's care. As required in Section A.2.9.6.1.9 of this Contract, the CONTRACTOR shall ensure that upon enrollment

into CHOICES or ECF CHOICES, the appropriate level of Population Health activities are integrated with CHOICES care coordination or ECF CHOICES support coordination processes and functions, and that the member's assigned Care Coordinator or Support Coordinator, as applicable, has primary responsibility for coordination of all the member's physical health, behavioral health and long-term services and supports needs. The member's Care Coordinator or Support Coordinator may use resources and staff from the CONTRACTOR's Population Health program, including persons with specialized expertise in areas such as behavioral health, to supplement but not supplant the role and responsibilities of the member's Care Coordinator/care coordination or Support Coordinator/support coordination team. The CONTRACTOR shall report on its Population Health activities per requirements in Section A.2.30.5.

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

2.6.1.2.7 The CONTRACTOR's administrator/project director (see Section A.2.29.1.3.1) shall be the primary contact for TENNCARE regarding all issues, regardless of the type of service, and shall not direct TENNCARE to other entities. The CONTRACTOR's administrator/project director shall coordinate with the CONTRACTOR's Behavioral Health Director who oversees behavioral health activities (see Section A.2.29.1.3.5 of this Contract) for all behavioral health issues and the senior executive responsible for CHOICES activities (see Sections A.2.29.1.3.7 of this Contract) for all issues pertaining to the CHOICES and ECF CHOICES programs.

2.6.1.3 CONTRACTOR Physical Health Benefits Chart

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

| SERVICE | | BENEFIT LIMIT |
|---|---|---|
| **TennCare Kids Services** | | **Medicaid/Standard Eligible, Age 21 and older:** Not covered.<br><br>**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.<br><br>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements. See Section A.2.7.6. |
| **Preventive Care Services** | | As described in Section A.2.7.5. |
| **Lab and X-ray Services** | | As medically necessary. |
| **Hospice Care** | | As medically necessary. Shall be provided by a Medicare-certified hospice. |
| **Dental Services** | | **Dental Services shall be provided by the Dental Benefits Manager or in some cases, through an HCBS waiver program for persons with intellectual disabilities.**<br><br>However, the facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR when the dental service is covered by the DBM or through an HCBS waiver program for persons with intellectual disabilities. |
| **Vision Services** | | **Medicaid/Standard Eligible, Age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.<br><br>**Medicaid/Standard Eligible, Under age 21:** Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements. |

| SERVICE | | BENEFIT LIMIT |
|---|---|---|
| **Home Health Care** | | **Medicaid /Standard Eligible, Age 21 and older:**<br>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).<br><br>**Medicaid/Standard Eligible, Under age 21:**<br>Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). |
| **Pharmacy Services** | | **Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.**<br><br>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.<br><br>Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section A.2.6.2.2). |
| **Durable Medical Equipment (DME)** | | As medically necessary.<br><br>Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations. |
| **Medical Supplies** | | As medically necessary.<br><br>Specified medical supplies shall be covered/non-covered in accordance with TennCare rules and regulations. |
| **Emergency Air And Ground Ambulance Transportation** | | As medically necessary. |
| **Non-emergency Medical Transportation** | | Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from |

| SERVICE | | BENEFIT LIMIT |
|---|---|---|
| **(including Non-Emergency Ambulance Transportation)** | | 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 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section A.1 of the Contract).<br><br>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.<br>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).<br><br>The CONTRACTOR is not responsible for providing NEMT to HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities and HCBS provided through the CHOICES program. However, as specified in Section A.2.11.1.8 in the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III), the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity. The CONTRACTOR shall be responsible for providing NEMT to dental services for ECF CHOICES members, including medical and dental services related to such dental services.<br><br>Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XI) is not a covered NEMT service, unless otherwise allowed or required by TENNCARE as a pilot project or a cost effective |

| SERVICE | | BENEFIT LIMIT |
|---|---|---|
| | | alternative service.<br><br>If the member is a child, transportation shall be provided in accordance with TennCare Kids requirements (see Section A.2.7.6.4.6).<br><br>Failure to comply with the provisions of this Section may result in liquidated damages. |
| **Renal Dialysis Services** | | As medically necessary. |
| **Private Duty Nursing** | | **Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard), when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Private duty nursing services are limited to services that support the use of ventilator equipment or other life sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Prior authorization required, as described Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).<br><br>**Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01 (for TennCare Medicaid) and 1200-13-14-.01 (for TennCare Standard) when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative. Prior authorization required as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). |
| **Speech Therapy** | | **Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.<br><br>**Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements. |

| SERVICE | | BENEFIT LIMIT |
|---|---|---|
| **Occupational Therapy** | | **Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions.<br><br>**Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements. |
| **Physical Therapy** | | **Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions.<br><br>**Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements. |
| **Organ and Tissue Transplant And Donor Organ Procurement** | | **Medicaid/Standard Eligible, Age 21 and older:** All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to:<br>Bone marrow/Stem cell;<br>Cornea;<br>Heart;<br>Heart/Lung;<br>Kidney;<br>Kidney/Pancreas;<br>Liver;<br>Lung;<br>Pancreas; and<br>Small bowel/Multi-visceral.<br><br>**Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements. Experimental or investigational transplants are not covered. |

| SERVICE | | BENEFIT LIMIT |
|---|---|---|
| **Reconstructive Breast Surgery** | | Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast shall only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast. |
| **Chiropractic Services** | | **Medicaid/Standard Eligible, Age 21 and older:** Not covered unless determined by the CONTRACTOR to be a cost effective alternative (see Section A.2.6.5).<br><br>**Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary in accordance with TennCare Kids requirements. |

2.6.1.4 CONTRACTOR Behavioral Health Benefits Chart

| SERVICE | | BENEFIT LIMIT |
|---|---|---|
| **Psychiatric Inpatient Hospital Services (including physician services)** | | As medically necessary. |
| **24-hour Psychiatric Residential Treatment** | | **Medicaid/Standard Eligible, Age 21 and older:** As medically necessary.<br><br>**Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary. |
| **Outpatient Mental Health Services (including physician services)** | | As medically necessary. |
| **Inpatient, Residential & Outpatient Substance Abuse Benefits[1]** | | **Medicaid/Standard Eligible, Age 21 and older:** Covered as medically necessary.<br><br>**Medicaid/Standard Eligible, Under age 21:** Covered as medically necessary. |
| **Behavioral Health Intensive Community Based Treatment** | | As medically necessary. |

| SERVICE | | BENEFIT LIMIT |
|---|---|---|
| **Psychiatric-Rehabilitation Services** | | As medically necessary. |
| **Behavioral Health Crisis Services** | | As necessary. |
| **Lab and X-ray Services** | | As medically necessary. |
| **Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)** | | Same as for physical health (see Section A.2.6.1.3 above). |

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

2.6.1.4.1 The CMS Managed Care Rules specify that an MCO may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K. In accordance with this requirement, this Contract identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by TENNCARE.

2.6.1.4.1.1 In accordance with 42 CFR 438.905(a), the CONTRACTOR must comply with 42 CFR Subpart K—Parity in Mental Health and Substance Use Disorder Benefits requirements for all enrollees of a MCO in states that cover both medical/surgical benefits and mental health or substance use disorder benefits under the state plan.

2.6.1.4.1.2 TENNCARE does not impose an annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to medical/surgical benefits provided to enrollees through a contract with the state, therefore, the CONTRACTOR shall not impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits, in accordance with 42 CFR 438.905(b), 42 CFR 438.905(c), and 42 CFR 438.905(e).

2.6.1.4.1.3 In accordance with 42 CFR 438.910(b)(1), the CONTRACTOR shall not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees (whether or not the benefits are furnished by the same managed care contractor).

2.6.1.4.1.4 In accordance with 42 CFR 438.910(b)(2) and as specified in the benefit charts of Section A.2.6.1.3 and A.2.6.1.4, if an enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the MCO enrollee in every classification in which medical/surgical benefits are provided.

2.6.1.4.1.5 In accordance with 42 CFR 438.910(c)(3), the CONTRATOR shall not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

2.6.1.5 Long-Term Care Benefits for CHOICES Members

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

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

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

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

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

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

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

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

| Service and Benefit Limit | Group 1 | Group 2 | Group 3 |
|---|---|---|---|
| Nursing facility care | X | Short-term only (up to 90 days) | Short-term only (up to 90 days) |
| Community-based residential alternatives | | X | (Specified CBRA services and levels of reimbursement only. See below)[1] |
| Personal care visits (up to 2 visits per day at intervals of no less than 4 hours between visits) | | X | X |
| Attendant care (up to 1080 hours per calendar year; up to 1400 hours per full calendar year only for 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 |

[1] CBRAs for which Group 3 members are eligible include only: Assisted Care Living Facility services, Community Living Supports (CLS), and Community Living Supports-Family Model (CLS-FM)

| Service and Benefit Limit | Group 1 | Group 2 | Group 3 |
|---|---|---|---|
| Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) | | X | X |
| Pest control (up to 9 units per calendar year) | | X | X |

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

2.6.1.5.3.1.1 The ninety (90) day limit shall be applied on a per admission (and not a per year) basis. A member may receive more than one short-term stay during the year; however, the visits shall not be consecutive. Further, the CONTRACTOR shall be responsible for carefully reviewing any instance in which a member receives multiple short-term stays during the year or across multiple years, including a review of the circumstances which resulted in each nursing facility admission, and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to CHOICES Group 2 or Group 3 (as applicable) is appropriate.

2.6.1.5.3.1.2 The CONTRACTOR shall monitor, on an ongoing basis, members utilizing the short-term NF benefit, and shall submit to TENNCARE on a monthly basis a member-by-member status for each Group 2 and Group 3 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 2 and Group 3 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why the benefit limit has been exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community or transition to Group 1, as applicable, including the anticipated timeline.

2.6.1.5.4 In addition to the benefit limits described above, in no case shall the CONTRACTOR exceed the member's individual cost neutrality cap (as defined in Section A.1 of this Contract) for CHOICES Group 2 or the expenditure cap for Group 3.

2.6.1.5.4.1 For CHOICES members in Group 2, the services that shall be compared against the

member's individual cost neutrality cap include the total cost of CHOICES HCBS and Medicaid reimbursed home health care and private duty nursing. The total cost of CHOICES HCBS includes all covered CHOICES HCBS and other non-covered services that the CONTRACTOR elects to offer as a cost effective alternative to nursing facility care pursuant to Section A.2.6.5.2 of this Contract including, as applicable: CHOICES HCBS in excess of specified CHOICES benefit limits, the one-time transition allowance for Group 2 and NEMT for Groups 2 and 3.

2.6.1.5.4.2 For CHOICES members in Group 3, the total cost of CHOICES HCBS, excluding minor home modifications, shall not exceed the expenditure cap (as defined in Section A.1 of this Contract).

2.6.1.5.5 CHOICES members may, pursuant to Section A.2.9.7, choose to participate in consumer direction of eligible CHOICES HCBS and, at a minimum, hire, fire and supervise workers of eligible CHOICES HCBS.

2.6.1.5.6 The CONTRACTOR shall, on an ongoing basis, monitor CHOICES members' receipt and utilization of long-term care services and identify CHOICES members who are not receiving long-term care services. Pursuant to Section A.2.30.11.4, the CONTRACTOR shall, on a monthly basis, notify TENNCARE regarding members that have not received long-term care services for a thirty (30) day period of time. The CONTRACTOR shall be responsible for immediately initiating disenrollment of any member who is not receiving TennCare-reimbursed long-term care services and is not expected to resume receiving long-term care services within the next thirty (30) days, except under extenuating circumstances which must be reported to TennCare on the CHOICES Utilization Report. Acceptable circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. Such notification and/or disenrollment shall be based not only on receipt and/or payment of claims for long-term care services, but also upon review and investigation by the CONTRACTOR as needed to determine whether the member has received long-term care services, regardless of whether claims for such services have been submitted or paid.

2.6.1.5.7 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term care services to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:

2.6.1.5.7.1 A member in Group 2 for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member' cost neutrality cap, and the member declines to transition to a nursing facility;

2.6.1.5.7.2 A member in Group 2 or 3 who repeatedly refuses to allow a Care Coordinator entrance into his/her place of residence (Section A.2.9.6);

2.6.1.5.7.3 A member in Group 2 or 3 who refuses to receive critical HCBS as identified through a needs assessment and documented in the member's PCSP; and

2.6.1.5.7.4 A member in Group 1 who fails to pay his/her patient liability and the CONTRACTOR is unable to find a nursing facility willing to provide services to the member (Section A.2.6.7.2).

2.6.1.5.7.5 A member in Group 2 or 3 who refuses to pay his/her patient liability and for whom the CONTRACTOR is either: 1) in the case of persons receiving CBRA services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the CONTRACTOR is unwilling to continue to serve the member, and the 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 PAE Tracking System. The CONTRACTOR shall also contact the member's Primary Care Provider and any contracted LTSS providers that have delivered services to the member during the previous six (6) months in order to obtain contact information that can be used to reach the member;

2.6.1.5.8.2 At least one (1) visit to the member's most recently reported place of residence except in circumstances where significant safety concerns prevent the CONTRACTOR from completing the visit, which shall be documented in writing; and

2.6.1.5.8.3 An attempt to contact the member by mail at the member's most recently reported place of residence at least two (2) weeks prior to the request to disenroll.

2.6.1.6 Long-Term Services and Supports Benefits for ECF CHOICES Members

2.6.1.6.1 In addition to physical health benefits (see Section A.2.6.1.3) and behavioral health benefits (see Section A.2.6.1.4), the CONTRACTOR shall provide long-term services and supports as described in this Section A.2.6.1.6 to members who have been enrolled into ECF CHOICES by TENNCARE, as shown in the outbound 834 enrollment file furnished by TENNCARE to the CONTRACTOR.

2.6.1.6.2 TennCare enrollees will be enrolled by TENNCARE into ECF CHOICES in accordance with criteria set forth in the approved 1115 waiver and TennCare rule.

2.6.1.6.3 The following long-term services and supports are available to ECF CHOICES members, per Group and subject to all applicable service definitions, benefit limits, and Expenditure Caps, when the services have been determined medically necessary by the CONTRACTOR.

| Benefit | Group 4 | Group 5 | Group 6 |
|---|---|---|---|
| Respite (up to 30 days per calendar year **or** up to 216 hours per calendar year only for persons living with unpaid family caregivers) | X | X | X |
| Supportive home care (SHC) | X | | |
| Family caregiver stipend in lieu of SHC (up to $500 per month for children under age 18; up to $1,000 per month for adults age 18 and older) | X | | |
| Community integration support services (subject to limitations specified in the approved 1115 waiver and TennCare Rule) | X | X | X |
| Community transportation | X | X | X |
| Independent living skills training (subject to limitations specified in the approved 1115 waiver and TennCare Rule) | X | X | X |
| Assistive technology, adaptive equipment and supplies (up to $5,000 per calendar year) | X | X | X |
| Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) | X | X | X |
| Community support development, organization and navigation | X | | |
| Family caregiver education and training (up to $500 per calendar year) | X | | |
| Family-to-family support | X | | |
| Conservatorship and alternatives to conservatorship counseling and assistance (up to $500 per lifetime) | X | X | X |
| Health insurance counseling/forms | X | | |

| Benefit | Group 4 | Group 5 | Group 6 |
|---|---|---|---|
| assistance (up to 15 hours per calendar year) | | | |
| Personal assistance (up to 215 hours per month) | | X | X |
| Community living supports (CLS) | | X | X |
| Community living supports—family model (CLS-FM) | | X | X |
| Individual education and training (up to $500 per calendar year) | | X | X |
| Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living (up to $1,500 per lifetime) | | X | X |
| pecialized consultation and training (up to $5,000 per calendar year[2]) | | X | X |
| Adult dental services (up to $5,000 per calendar year; up to $7,500 across three consecutive calendar years) | X[3] | X | X |
| Employment services/supports as specified below (subject to limitations specified in the approved 1115 waiver and in TennCare Rule) | X | X | X |
| – Supported employment—individual employment support<br>– Exploration<br>– Benefits counseling<br>– Discovery<br>– Situational observation and assessment<br>– Job development plan or self-employment plan<br>– Job development or self-employment start up<br>– Job coaching for individualized, integrated employment or self-employment<br>– Co-worker supports<br>– Career advancement | X | X | X |

2.6.1.6.4 In addition to the benefits specified above which shall be delivered in accordance with the definitions, including limitations set forth in the approved 1115 waiver and in TennCare rule, a person enrolled in ECF CHOICES may receive short-term nursing facility care, without being

[2] For adults in the Group 6 benefit group determined to have exceptional medical and/or behavioral support needs, specialized consultation services are limited to $10,000 per person per calendar year.
[3] Limited to adults age 21 and older.

required to disenroll from their ECF CHOICES group until such time that it is determined that transition back to HCBS in ECF CHOICES will not occur within ninety (90) days from admission.

2.6.1.6.5 The CONTRACTOR shall review all requests for short-term NF stays and shall authorize and/or reimburse short-term NF stays for Groups, 4, 5 and 6 members only when (1) the member is enrolled in ECF CHOICES Group 4, 5, or 6 and receiving HCBS upon admission; (2) the member meets the nursing facility level of care in place at the time of admission; (3) the member's stay in the facility is expected to be less than ninety (90) days; and (4) the member is expected to return to the community upon its conclusion. The CONTRACTOR shall monitor all short-term NF stays for Group 4, 5, and 6 members and shall ensure that the member is disenrolled from ECF CHOICES if a) it is determined that the stay will not be short-term or the member will not transition back to the community; and b) prior to exhausting the ninety (90)-day short-term NF benefit covered for ECF CHOICES Group 4, 5, and 6.

2.6.1.6.6 The ninety (90) day limit shall be applied on a per admission (and not a per year) basis. A member may receive more than one short-term stay during the year; however, the visits shall not be consecutive. Further, the CONTRACTOR shall be responsible for carefully reviewing any instance in which a member receives multiple short-term stays during the year or across multiple years, including a review of the circumstances which resulted in each nursing facility admission, and shall evaluate whether the services and supports provided to the member are sufficient to safely meet his needs in the community such that transition back to ECF CHOICES Group 4, 5 or 6 (as applicable) is appropriate.

2.6.1.6.7 The CONTRACTOR shall monitor, on an ongoing basis, members utilizing the short-term NF benefit, and shall submit to TENNCARE on a monthly basis a member-by-member status for each Group 4, 5, or 6 member utilizing the short-term NF stay benefit, including but not limited to the name of each Group 4, 5, or 6 member receiving short-term NF services, the NF in which s/he currently resides, the date of admission for short-term stay, the number of days of short-term NF stay utilized for this admission, and the anticipated date of discharge back to the community. For any member exceeding the ninety (90)-day limit on short-term NF stay, the CONTRACTOR shall include explanation regarding why the benefit limit has been exceeded, and specific actions the CONTRACTOR is taking to facilitate discharge to the community including the anticipated timeline.

2.6.1.6.8 The cost of such services shall not be counted toward the person's expenditure cap. During the short-term stay, the person's patient liability amount will continue to be calculated based on the community personal needs allowance in order to allow the person to maintain his/her community residence. Additional tracking, reporting and monitoring processes will be put in place for these services.

2.6.1.6.9 ECF CHOICES benefits will be subject to an annual per member expenditure cap. Specifically:

2.6.1.6.9.1 Individuals receiving Group 4 benefits will be subject to a $15,000 cap, not counting the cost of minor home modifications;

2.6.1.6.9.2 Individuals receiving Group 5 benefits will be subject to a $30,000 cap. The State may grant an exception for emergency needs up to $6,000 in additional services per year, but shall not permit expenditures to exceed a hard cap of $36,000 per calendar year; and

2.6.1.6.9.3 Individuals receiving Group 6 benefits will be subject to an annual expenditure cap as follows:

2.6.1.6.9.3.1 Individuals with low-to-moderate need as determined by the State will be subject to a $45,000 expenditure cap.

2.6.1.6.9.3.2 Individuals with high need as determined by the State will be subject to a $60,000 expenditure cap.

2.6.1.6.9.3.3 The State may grant an exception as follows: for individuals with DD and exceptional medical/behavioral needs as determined by the State, up to the average cost of NF plus specialized services that would be needed for persons with such needs determined appropriate for NF placement; or for individuals with ID and exceptional medical/behavioral needs as determined by the State, up to the average cost of private ICF/IID services.

2.6.1.6.10 ECF CHOICES members may, pursuant to Section A.2.9.7, choose to participate in consumer direction of eligible ECF CHOICES HCBS and, at a minimum, hire, fire and supervise workers of eligible ECF CHOICES HCBS.

2.6.1.6.11 The CONTRACTOR shall, on an ongoing basis, monitor ECF CHOICES members' receipt and utilization of long-term services and supports and identify ECF CHOICES members who are not receiving long-term services and supports. Pursuant to Section A.2.30.11.4, the CONTRACTOR shall, on a monthly basis, notify TENNCARE regarding members that have not received long-term services and supports for a thirty (30) day period of time. The CONTRACTOR shall be responsible for immediately initiating disenrollment of any member who is not receiving TennCare-reimbursed long-term services and supports and is not expected to resume receiving long-term services and supports within the next thirty (30) days, except under extenuating circumstances which must be reported to TennCare on the CHOICES and ECF CHOICES Utilization Report. Acceptable circumstances may include, but are not limited to, a member's temporary hospitalization or temporary receipt of Medicare-reimbursed skilled nursing facility care. Such notification and/or disenrollment shall be based not only on receipt and/or payment of claims for long-term services and supports, but also upon review and investigation by the CONTRACTOR as needed to determine whether the member has received long-term services and supports, regardless of whether claims for such services have been submitted or paid.

2.6.1.6.12 The CONTRACTOR may submit to TENNCARE a request to no longer provide long-term services and supports to a member due to concerns regarding the ability to safely and effectively care for the member in the community and/or to ensure the member's health, safety and welfare. Acceptable reasons for this request include but are not limited to the following:

2.6.1.6.12.1 A member in Groups 4, 5, or 6 for whom the CONTRACTOR has determined that it cannot safely and effectively meet the member's needs at a cost that is less than the member' expenditure cap;

2.6.1.6.12.2 A member in Group 4, 5, or 6 who repeatedly refuses to allow a Support Coordinator entrance into his/her place of residence (Section A.2.9.6);

2.6.1.6.12.3 A member in Group 4, 5, or 6 who refuses to receive critical HCBS as identified through a comprehensive assessment and documented in the member's PCSP; and

2.6.1.6.12.4 A member in Group 4, 5, or 6 who refuses to pay his/her patient liability and for whom the CONTRACTOR is either: 1) in the case of persons receiving CBRA services, unable to identify another provider willing to provide services to the member; or 2) in the case of persons receiving non-residential HCBS or companion care, the CONTRACTOR is unwilling to continue to serve the member, and the Division of TennCare has determined that no other MCO is willing to serve the member.

2.6.1.6.13 The CONTRACTOR's request to no longer provide long-term services and supports to a member shall include documentation as specified by TENNCARE. The State shall make any and all determinations regarding whether the CONTRACTOR may discontinue providing long-term services and supports to a member, disenrollment from ECF CHOICES, and, as applicable, termination from TennCare.

2.6.1.6.14 The CONTRACTOR may submit to TENNCARE a request to disenroll from ECF CHOICES a member who is not receiving any Medicaid-reimbursed long-term services and supports based on the CONTRACTOR's inability to reach the member only when the CONTRACTOR has exhausted all reasonable efforts to contact the member, and has documented such efforts in writing, which must be submitted with the disenrollment request. Efforts to contact the member shall include, at a minimum:

2.6.1.6.14.1 Multiple attempts to contact the member, his/her representative or designee (as applicable) by phone. Such attempts must occur over a period of at least two (2) weeks and at different times of the day and evening, including after business hours. The CONTRACTOR shall attempt to contact the member at the phone number provided in the outbound 834 enrollment file, any additional phone numbers the CONTRACTOR has on file, including referral records and case management or support coordination notes; and phone numbers that may be provided in TENNCARE's PAE Tracking System. The CONTRACTOR shall also contact the member's Primary Care Provider and any contracted providers of long-term services and supports that have delivered services to the member during the previous six (6) months in order to obtain contact information that can be used to reach the member;

2.6.1.6.14.2 At least one (1) visit to the member's most recently reported place of residence except in circumstances where significant safety concerns prevent the CONTRACTOR from completing the visit, which shall be documented in writing; and

2.6.1.6.14.3 An attempt to contact the member by mail at the member's most recently reported place of residence at least two (2) weeks prior to the request to disenroll.

A.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 A.2.6.1.3 of this Contract, 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 A.2.6.1.3 of this Contract, 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. The CONTRACTOR shall be responsible for providing HCBS to members with an intellectual or developmental disability who are enrolled in ECF CHOICES, as an alternative to services in a Nursing Facility.


# ACTION PLAN

*Social and Health Needs 2017 Survey*

**C= Community Resources**

**A= Acting for Better Health**

**R=Reducing Stigma**

**E= Empowerment**

## Social and Health Needs

It matters where you Live, Work, go to School, and Play. A gap in a person's life can stop them from connecting with opportunities to improve and empower their health.

When different groups of people have less access to jobs, health care, food, and other opportunities, this is called a disparity. Disparity means limited opportunities. Social and health needs (health disparities) are all the circumstances that cause poor health in underserved populations.

Many Americans have fewer opportunities due to:

- The area where they live (Rural vs. City);
- Race or ethnicity;
- Age;
- Disability;
- Sex/Gender;
- Income (Lack of jobs or little opportunity to earn a wage a person can live on); and
- Language spoken

Lack of choice makes a person vulnerable to having unmet social and health needs like:

- Little or poor education;
- Food (Lack access to food or healthy food);
- Poverty;
- A house with mold, lead, pests, or unsafe neighborhood;
- No access to a car, bus, or other transportation;
- High costs for health care or no access to health care;
- Language and cultural barriers; and
- High stress levels

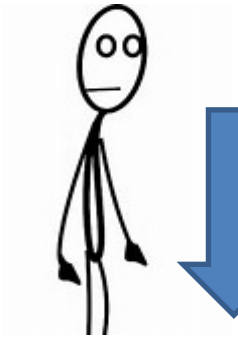
### Why is it important to reduce social and health needs?

Good health outcomes start in the communities where TennCare members live. When we develop connections through fragment health and social support systems, this leads to meaningful care coordination and person-centered care for TennCare members, which results in cost savings. Together we can help others connect to tools to improve and empower their health.

**How are Social and Health Needs Reduced?**

**Effects of Opportunity Gaps on a Person's Health**


Health Concerns: Asthma; Diabetes; and Depression



**Factors that cause health concerns**

Assess Needs of Person

Goals: People understand the connections between life & health and can take steps to improve & empower their health; fewer emergency room visits; better health outcomes for people; lower health care costs

Measure Action Plan Results/steps
Re-Assess Needs of Person

## 2017 Member and Provider Social and Health Needs Surveys

On September 12, 2017, TennCare launched on-line social and health needs surveys for TennCare members and providers. TennCare partnered with:

- Amerigroup Community Care of Tennessee ("Amerigroup");
- BlueCross BlueShield of Tennessee ("BlueCare"); and
- UnitedHealthcare Community Plan of Tennessee ("United")

to conduct an online and social media campaign that encouraged members and their providers to take the surveys. The member and provider survey webpages also contained a link to information about community resources.

### I. TennCare Member Survey

#### a. Overview

The TennCare child and adult social and health needs surveys were available in English, Spanish, Arabic, Chinese, and Vietnamese languages. The member survey captured eleven (11) social and health needs for the child and adult member populations:

1. Food needs;
2. Housing needs;
3. Utility needs;
4. Child care needs;
5. Clothing needs;
6. Transportation needs;
7. Health needs, including substance use disorders;
8. Whether or not stigma (shame or blame) was keeping members from connecting with resources;
9. Educational levels;
10. Internet access; and
11. Social demographics (age, race, gender, etc…)

The results of the child and adult member surveys were reported at a statewide level and broken down by county.

**b. Who Responded to the TennCare Member Survey?**

| | |
|---|---|
| All Adult TennCare Members | 1,680 |
| English Survey | 1,592 |
| Arabic Survey | 19 |
| Chinese Mandarin Survey | 5 |
| Spanish Survey | 59 |
| Vietnamese | 5 |

| | |
|---|---|
| All Child TennCare Members | 862 |
| English Survey | 682 |
| Arabic Survey | 27 |
| Chinese Mandarin Survey | 6 |
| Spanish Survey | 142 |
| Vietnamese Survey | 5 |

**i. Gender Status Results**

The gender response rate between the 2017 and 2016 responses were markedly different. In 2017, eighty percent (80%) of the adult member survey responders identified as female, eighteen percent (18%) identified as male, and two percent (2%) chose not to answer the question. Compared to 2016, with fifty-seven (57%) of the adult survey responders identifying as female and forty-three (43%) identifying as male.

**ii. Disability Status Results**

Although the 2016 survey question collecting the member's disability status was changed for the 2017 survey, there are a few survey results comparisons between the 2016 and 2017 data. In 2017, sixteen percent (16%) or responders identified as a person with a vision impairment or blindness compared to thirteen percent (13%) in 2016. For the 2016 survey, nine percent (9%) of survey responders identified as person who is deaf compared to zero percent (0%) in 2017. The next two (2) charts contain the 2017 and 2016 disability status survey results.

### iii. Race/Ethnicity Status Results

There were some similarities between the 2017 and 2016 race/ethnicity survey results. For example, sixty-four percent (64%) of survey responders identified as white Americans, twenty-five percent (25%) identified as black Americans in both the 2017 and 2016 surveys. There were major differences between the response rate for survey responders who identified as either Hispanic or Latino Americans. In 2017, only six percent (6%) identified as either Hispanic or Latino Americans compared to twenty-two percent (22%) in 2016. Differences were also found in the number of individuals who identified as other Americans six percent (6%) in 2017 compared to sixteen percent (16%) in 2016.

### iv. Language Results

On the 2017 survey, language data was collected in three (3) questions:

1) Member's ability to speak English (English proficiency);
2) Member's ability to read and write in English; and
3) The language the member is most comfortable speaking.

The 2017 data showed that the majority of members who responded have the ability to speak and read in English with only five percent (5%) responding that they are most comfortable speaking a language other than English. The 2016 results also showed that the majority of members spoke English.

### v. Adult Member Response by County

2017 Response to adult member question 12: What Tennessee county do you live in?

### vi. Did the member need help with taking the survey?

In 2017, there was a twelve (12) percentage point decrease in the amount of members needing help with the survey. The 2017 on-line survey was provided in a web accessible format (meaning it was able to be independently used by individuals with different range of hearing, movement, sight, and cognitive abilities) and protected member's private information. Seven percent (7%) of survey responders reported that they needed help with taking the 2017 survey.

In 2016, member's had the option of responding to the survey by mail, on-line, or by phone. Nineteen percent (19%) of the survey responders needed help with completing the survey.

### c. TennCare Member Social and Health Needs

The 2017 survey, gathered data on the underlying social and health needs for the TennCare member population[4]. Question one (1) collected data on social needs:

**Q1: In the past year, did you really need something but you weren't able to get it?**

This data also had the ability to be broken down by survey responder's language (English, Arabic, Spanish, Chinese, and Vietnamese). The below chart (Q1H) shows that eighty percent (80%) of Vietnamese adult responders, fifty-six percent (56%) of English adult responders, fifty-three percent (53%) of Arabic adult responders, and forty percent (40%) of Spanish and Chinese adults responders had at least one social need.

### Q1H: Percentage of each language group who did not need anything

In the chart below (Q1D), question one (1) was further broken down by social need. The Arabic survey responders had the highest response rate for needing food, the English responders had the second highest response, and the Vietnamese responders indicated that they did not need food assistance.

### Q1D: Percentage of language group who needed food

### d. Stigma

The 2017 survey measured whether or not stigma was keeping TennCare members from seeking medical care or prescriptions to treat their medical conditions. Stigma makes a person feel bad about something that is out of their control.

Eleven percent (11%) of TennCare members responded that stigma was keeping them from getting the health care that they needed. The chart below shows that Vietnamese and Chinese survey responders had the highest levels of stigma.

### e. Substance Use Disorders

Substance use disorders (formerly called addiction) were also measured in the 2017 survey. In this area, the survey results data was conflicting with the majority of responders reporting that they did not binge drink, use illegal drugs, or misuse prescription medication. However, other responses indicated that responders had used some form of illegal drugs or prescription medication and had a need for opioid reversal drugs or medication assisted treatment.

[4] Attachment 1 contains the adult member survey results.

## II. TennCare Provider Survey

In order to create a more in-depth picture of the social and health needs that are being experienced by the TennCare member populations, TennCare launched a provider survey. The provider survey collected information in six (6) areas:

1. Problems/barriers to care that are causing members to experience bad health;
2. Whether or not community resources were available in the provider's service areas;
3. Stigmas that are keeping members from connecting with resources;
4. Cultural and language appropriate services that are being provided to members;
5. Provider collaborations with community partners
6. Learning opportunities that would be beneficial to the provider's practices:
    - Substance use disorders
        - Treating substance exposed newborns and their families;
    - Family planning;
    - HIV/AIDS; and
    - Asthma;

The results of the survey were reported at the East, Middle, and West Tennessee regional levels. Fourteen (14) providers responded to the survey.

| Tennessee Region Served | Number of Provider Responses |
|---|---|
| East Tennessee | 8 |
| Middle Tennessee | 3 |
| East and Middle Tennessee | 2 |
| East, Middle, West Tennessee | 1 |

**a. Social and Health Needs**

Eight (8) of the fourteen (14) providers responded that there was a lack of resources to address the social and health needs in the community that their practice operates.

When asked to provide more information about the lack of community resources, providers reported the following: (Please note that many of the comments are not specific to the TennCare population)

- Lack of health insurance deductibles that they can't afford to pay;
- Lack of transportation;
- Limited resources for homeless and uninsured;
- People need more access to inexpensive healthy food that is close to where they live and they need more active lifestyles;
- Long wait list for meals-on-wheels;
- Medication copays can be unaffordable;
- Lack of affordable counseling services

**b. Stigma**

The second question on the survey asked providers "In the community that you serve what stigmas are keeping patients from seeking care/treatment?" The majority of the providers reported that mental health concerns, social and health needs, and substance use disorders are preventing people from seeking health care services.

Thirteen of the providers responded as follows:

| Stigma | Number of Provider Responses |
|---|---|
| Social and Health Needs | 6 or 46% |
| Mental Health | 6 or 46% |
| Substance Use Disorders Aging | 5 or 38% |
| Concerns/Caregiving Issues | 2 or 15% |
| HIV | 1 or 8% |

**C. Learning Opportunities**

The 2017 survey collected information on the tools providers were using to improve patient outcomes. It also gave providers the opportunity to tell us about the learning opportunities that would be useful to their practice teams in the following areas:

- Substance use disorders
    - Serving substance exposed newborns/neonatal abstinence syndrome families;
- Culturally and linguistically appropriate services (CLAS) standards;
- Family planning;
- HIV/AIDS; and
- Asthma

**i. Substance Use Disorders**

**What screening tool do you use to screen patients for substance use disorders?**

All of the nine (9) responders to this question reported having some form of a substance abuse screening tool in place. The SBIRT (Screening, Brief Intervention, and Referral to Treatment) was the tool that was most frequently used by the responders (4 out of the 9 providers).

**What educational or learning opportunities on SUD would like more information about:** Eight (8) of the providers answered this question.

| Learning Opportunity | Number of Provider Responses |
|---|---|
| Developing patient treatment plans | 5 or 63% |
| Multidimensional patient assessments | 4 or 50% |
| Referrals for positive screen | 4 or 50% |
| Narcan/Nalaxone training | 4 or 50% |

**Do you have any knowledge gaps for serving Substance Exposed Newborns/Neonatal Abstinence Syndrome families?**

| Provider Response | Number or Provider Responses |
|---|---|
| Yes | 3 or 23% |
| No | 2 or 15% |
| Not applicable | 8 or 62% |
| No response | 1 |

**ii. Culturally and linguistically appropriate services (CLAS) standards:**
Six (6) out of the eleven (11) responders reported that they would like more information about the CLAS standards.

**iii. HIV/AIDS**
**During the past year, give an estimate for the percentage of your patients that you have screened for HIV/AIDS:**

| Percentage of Patients Screened | Number of Provider Responses |
|---|---|
| 0% | 3 |
| 10% | 2 |
| 15% | 1 |
| 20% | 1 |
| 80% | 1 |
| 100% | 1 |
| Unknown | 2 |
| Not applicable | 2 |
| No response | 1 |

**Do you have any knowledge gaps for serving HIV/AIDS patients?**

| Provider Response | Number of Provider Responses |
|---|---|
| Yes | 5 or 38% |
| No | 4 or 29% |
| Not applicable | 5 or 38% |

## 2018 CARE Action Plan

The 2017 social and health needs member and provider survey results showed a need to address:

1. The lack of information in our communities about the resources that are available in the State; and
2. The stigmas that are keeping people from seeking health care.

Our 2018 goal is to help improve our communities by:

**C**= Connecting members with community resources (like food pantries and housing help);

**A**= Acting for better health by teaching members about their care needs;

**R**=Reducing stigma often felt by those that are in need of help; and

**E**= Empowering members to take the steps needed for better health.

The CARE Workgroup designed the 2018 on-line surveys to provide the survey takers with information about community resources and how to overcome stigma. The surveys were renamed the CARE surveys to reflect the goals of the project.

The CARE member survey will be available in English, Spanish, Arabic, Mandarin Chinese, and Vietnamese. The member and provider survey formats are accessible to individuals with disabilities and will protect the privacy and health care data of survey responders.

On July 11, 2018, the CARE Workgroup held a meet-and-greet with several state agencies and community resource organizations. This meeting helped further the Workgroup's goal for building connections between health and social resource organization. To continue fostering the collaborative efforts, each participant received an attendee contact list.

At the beginning of the year, the Workgroup was working towards creating a statewide community resource list. Since July, the Workgroup is exploring an initiative with the United Way to help improve the 2-1-1 community resource finder database.

**2017 Action Plan – this is an ongoing effort**

| Activity | Action Steps | Performance Indicators | Target Goal |
|---|---|---|---|
| Targeted activities to promote CLAS awareness with the health care provider community | Identify and/or develop materials and resources for MCO provider educators<br><br>Include CLAS resources on TennCare's and the MCOs' websites | Number of providers who received education on CLAS<br><br>Resources are available on TennCare's and the MCOs' websites | Help the heath care provider communities recognize barriers to services and take action to reduce those barriers |
| Make available to the health care provider community resource guides for working with individuals from Tennessee's top 15 Limited English Proficient cultures and working with individuals with disabilities | Identify and/or develop materials and resources for the health care provider community<br><br>Include the materials and resources on TennCare's and the MCOs' websites | Number of resources that have been identified and/or developed and are available to the health care provider community | Help the heath care provider communities recognize barriers to services and take action to reduce those barriers |
| Rework websites and member materials to increase member engagement and understanding of services and making health care decisions | Research organizations that have successfully improved their messaging and materials. Review our materials and revise as needed | Number of websites and materials that have been reviewed and revised as needed | Provider members with the tools and information to make healthy choices |
| Open dialogue with underserved members and with community leaders | Identify and invite members and community leaders to dialogue sessions | Dialogue sessions have occurred at least twice in each Grand Region | Learn more about issues/barriers and build partnerships that focus on barriers in those communities |

## Acknowledgements

Amerigroup Community Care of Tennessee ("Amerigroup"), BlueCross BlueShield of Tennessee ("BlueCare"), and UnitedHealthcare Community Plan of Tennessee ("United") were generous in their support and outreach efforts to promote the 2017 Social and Health Needs Survey for TennCare members and providers. These health plans are highly dedicated to promoting opportunities for improving and empowering the health of all Tennesseans.

## Amerigroup Community Care of Tennessee ("Amerigroup")

The Amerigroup Community Care of Tennessee's Cultural and Linguistic Program's mission is to help enhance the health status of its members by ensuring customer-focused and customer-driven services that are both culturally competent and linguistically appropriate.

Amerigroup Community Care of Tennessee recognizes the increasing importance of delivering culturally relevant health care benefits, solutions and education that address the diverse needs of individuals and families in the communities we serve. An interdepartmental approach and collaboration helps to ensure the implementation of culturally and linguistically appropriate health care related services to members with diverse health beliefs and practices, limited English proficiency (LEP) and variable literacy levels. In 2017, Amerigroup was awarded the Multicultural Health Care (MHC) Distinction from NCQA.

In addition to goal and measurement identification, the Quality Management (QM) department, in collaboration with other key departments, establishes an annual written evaluation of the CLAS improvement and health disparities reduction goals and measurements. The annual evaluation includes:

- A description of completed and ongoing activities for CLAS and health disparities reduction
- Trending of measures to assess performance
- Analysis of results and initiatives, including barrier analysis
- Evaluation of overall effectiveness of the program and of the interventions to address CLAS and health disparities.

At Amerigroup, one of our core values is a commitment to innovation. In order to be a truly innovative company, we must understand and address the needs of the diverse population we are privileged to serve. Our commitment to diversity and our ability to benefit and learn from our own collective backgrounds and experiences is critical to achieving our vision to be America's valued health partner.

Our Diversity & Inclusion team continues to focus on equipping leaders with the tools and information they need so we can reap the benefits of a diverse workforce. Leadership has built diversity initiatives into their 2017 goals, and leadership training is available to help make more objective decisions about talent and create a more inclusive environment. Our associates can take advantage of information and resources on the Diversity & Inclusion community online through our internal website, and they can join any of our nine Associate Resource Group (ARG) communities, groups that play such an important role in engaging associates in diversity initiatives. In our ARG communities there are professional and personal development opportunities, where associates benefit from different perspectives and innovative ideas connect culture to business decisions.

In 2017, a Diversity and Inclusion Toolbox was made available to all Amerigroup associates. These tools include a wealth of resources such as job aids, articles of interest, infographics, research and benchmarking that can help to improve the understanding and appreciation of cultural norms and differences that affect behaviors, needs, preferences and perspectives among Anthem associates, our members, clients and customers.

Amerigroup contracts with providers and other health professionals who are committed to serving a diverse population. These individuals have the ability to meet the cultural, ethnic, racial and language/communication needs of Amerigroup's members. To support this effort, training about acknowledging and respecting cultural differences (cultural competency training) is provided during orientation and on an ongoing basis in many formats (webinars, online resources in the provider portal, individual training as needed).

In addition, Amerigroup seeks to maintain a provider network that reflects the make-up of its members and can support the needs of different members. The determination of whether or not Amerigroup has enough providers is based on the languages that members speak.

Amerigroup's provider database includes languages spoken at provider offices. Information on the languages that a provider can either speak or hire interpreters for is required on the provider applications, and the information is entered into a database system, which is used to produce and update the Provider Directory. Updates to provider demographic data, including language, are entered into the database as received from provider offices. Members can use the Provider Directory to obtain information on languages spoken by provider offices, or they can contact the Customer Care Center (CCC)/Member Services.

Reducing health disparities requires systematic change that is targeted to the needs of individual members. Amerigroup-Tennessee continues to look for innovative ways to reduce disparities in care.

## BlueCross BlueShield of Tennessee (BlueCare)

Health equity is achieved when all individuals achieve their best health. BlueCare understands that, as a health care organization, it plays a significant role in achieving health equity through the ability to address opportunity gaps at the point of care. A greater risk for poor health outcomes is created when its members are faced with multiple opportunity gaps.

Researching health care opportunity gaps and changing Quality Improvement interventions is part of BlueCare's goal of creating community partnerships. These partnerships help members take the steps they need to improve their health. BlueCare's action plans work on opportunity gaps across Tennessee's geographical, ethnic, racial, and illness-based areas. These areas include the most heavily populated areas of the state and areas so rural that even the most basic services are difficult to provide. BlueCare's action plans include:

**Community Advisory Panel-** BlueCare's Community Advisory Panel is comprised of local leaders across Tennessee already engaged in working to reduce opportunity gaps in their own communities. The panel meets twice (2) a year and discusses efforts to reduce health care opportunity gaps.

**Faith-based Coalition-** BlueCare has partnered with local church leaders in efforts to improve health and quality of life for the communities it serves. The group meets two to three times per year to discuss methods of mobilizing churches to provide social and emotional support for behavior change.

**Faith-based Toolkit-** The goal of the Faith-based Toolkit ("FBTK") is to develop an intervention to increase engagement among BlueCare, members, and faith based communities and to improve the health knowledge of members within these communities.

**Learning about Opportunity Gaps-** BlueCare offers extensive training to its staff member to help reduce healthcare opportunity gaps by means of the Social Determinants Empathy Workshop™ by Consilience Group, LLC. The training is offered to all staff and required as part of the new hire training for all members facing staff.

The Social Determinants Empathy Workshop™ is designed to increase understanding of the gaps in a person's life and is needed for that person to improve their health. Another version of the workshop tailored for BlueCare, Reducing Healthcare Disparities through Trusting Relationships, is designed for staff members who work directly with members to provide resources for improved health and wellness. It highlights using empathy when working with members to create a long-term trusting relationship between health care organizations and those they serve.

**Cultural and Linguistic Need-** Reviewing data on health opportunity gaps in different health care areas serves as the basis for BlueCare's population health management programs. It also guides efforts to reduce ethnic, racial, and illness-based opportunity gaps. Several data sources are used for the review including enrollment data, United States (US) Census data and the Consumer Assessment of Healthcare Providers and Systems ("CAHPS") survey data. BlueCare is improving its ability to collect data in the five (5) specific demographic categories.

**Racial/Ethnic Health Opportunity Gap Population Assessment** is conducted to gain a deep understanding of ethnic and racial health gaps among BlueCare's complete member base.

**Partnership with NextHealth Technologies-** Through BlueCare's partnership with NextHealth Technologies, BlueCare will determine the best outreach approach to help members take the steps they need to get care. BlueCare's partnership with NextHealth is designed to improve member participation by:

i. Generating predictive insights on member behavior
ii. Defining target populations for outreach
iii. Designing customized campaigns using advanced behavior change techniques
iv. Loading, launching and tracking campaign causality

**Provider Office Screening Events-** The Provider Office Screening event intervention focuses on building connections with BlueCare network provider practices to offer TennCare Kids screening events. BlueCare has identified our providers with the largest number of TennCare Kids gaps in care. BlueCare will partner with these providers for TennCare Kids screening events.

**Limited English Proficiency Screening Events-** The Limited English Proficiency (LEP) screening event intervention focuses on building connections with BlueCare's network provider practices to offer TennCare Kids screening events. BlueCare has identified its providers with the largest number of LEP members with TennCare Kids gaps in care.

BlueCare will partner with these providers for TennCare Kids screening events. A new targeted Spanish member invitation will be mailed to each identified LEP member with a TennCare Kids gap in care.

**Provider Partnerships-** Based on recent onsite visits and conversations with BlueCare's strategic provider partners, BlueCare has become increasingly more aware of the important role that it plays in provider education for TennCare Kids services. During BlueCare's key leadership's routine face to face visits, it is educating providers on the CMS 416 reporting periods, the periodicity schedule and the frequency of visits, basic coding principles, addressing barriers with claim submission when members have other insurance, and offering more in depth coding/billing assistance through TNAAP. BlueCare will continue this approach during 2017.

**MCO Collaboration-** BlueCare Tennessee plans to partner with United Healthcare, Amerigroup, and DentaQuest for TennCare Kids screening events. All three MCOs conduct TennCare Kids outreach events for adolescents aligning those by provider groups could improve the participation rates and increase revenue for the providers. The purposes of the events are to give BlueCare Tennessee members with gaps in care the opportunity to receive TennCare Kids screenings.

**Interagency Meetings-** BlueCare attends state agency/community-based organization meetings because it helps partners to reach unanimous decisions when urgent and crucial health matters need to be discussed and brainstormed through personal interaction. For example, we meet with various Health Councils to educate members on their counties screening rates and work to establish new partnerships to combat the issue. The focus of these meetings is to:

- Increase awareness of health promotions and disease prevention
- Collaborate with health care providers to increase screening rates
- Partner with community agencies
- Combat health issues
- Support community projects and special screening events
- Promote accessible quality health care

## UnitedHealthcare Community Plan of Tennessee ("United")

Although United has an active Cultural Competency Committee, it is developing an opportunity gap (health disparities) action plan. UnitedHealth Group founded the Health Equity Services Program that brings together its business leaders from its Commercial, Medicare and Medicaid departments to create a universal approach in reducing health opportunity gaps and improving member experiences.

The main program goals are to:

- Reduce health opportunity gaps to help communities achieve improved health; and
- Embrace diversity by creating a range of activities that are designed around a person's life that will promote health and reduce health care costs.

Current program priorities include:

- Establishing the foundation for multicultural population stratification
- Understanding gaps in health and health care to develop interventions
- Refining the patient-centered approach based on member demographics, including race, ethnicity and language preferences; and
- Growing multicultural capabilities to enhance the member experience

By using the work of the Health Equity Services program, United will improve its ability to offer culturally competent care management programs and services. Currently UnitedHealthcare Community Plan of Tennessee is developing pilots for the following measures in the associated counties:

- Adolescent Well Care Visits – Shelby County (all ethnicities)
- Prenatal and Post-Partum Care – Shelby County (African American women)
- Comprehensive Diabetes Care (Eye) - Davidson County (African American, Hispanic and White ethnicities); and
- Well Child Visits in the First 15 Months of Life ( Six (6) or more visits)

United has built partnerships with Tennessee communities by participating in the following programs, which address opportunity gaps:

**School Based Programs-** United works with Healthy Kids and Teens (a vendor) to offer 12-week long fitness and nutritional education programs at schools and/or community centers across the state. These programs are open to all children at the school or center, not just United members. Since the programs are 12 weeks long, United has sessions in the spring (anytime between January and May) and in the fall (September – December).

**NHBW Teen Summit-** This summit is designed to demonstrate to young African-American women, choices made in the teen years can have a significant positive impact on their future. The program encourages young women to set goals, take care of their health and chart a course that will give them a better tomorrow. United's President/CEO was the keynote speaker at this event.

**Screening Events-** United currently has twenty-eight (28) Early and Periodic, Screening, Diagnosis, and Treatment ("EPSDT") services and other screening events scheduled in eleven (11) counties, for the first quarter of 2017. Most of these events are provider-based events or campaigns. United continues to work most efficiently and effectively in this setting; however, it also works closely with county health departments, churches, schools and other community agencies to plan and promote events in the community.

**Food Banks-** United participates with multiple food banks serving the State of Tennessee. Currently with Second Harvest Food Bank it is engaged in Northeast Tennessee, East Tennessee and Middle Tennessee. United is expanding into fourteen (14) counties for Second Harvest Food Bank, Middle/West Tennessee and five (5) counties in Middle/East Tennessee. United also partners with Chattanooga Food Bank in East Tennessee and Mid-South Food bank in West Tennessee.