

Final Annual Report

TennCare II

No. 11-W-00151/4

Demonstration Year (DY) 16

(7/1/2017 – 6/30/2018)

Executive Summary

During Demonstration Year (DY) 16, the Division of TennCare continued to pursue its mission of improving lives through high-quality, cost-effective care.

Major events for the TennCare program in DY 16 included:

- Launch of a comprehensive strategy to address opioid misuse and abuse.
- Approval and implementation of a new medication therapy management pilot project designed to optimize drug therapy and improve therapeutic outcomes for patients.
- Ongoing successes in the domain of payment reform through Tennessee's Health Care Innovation Initiative.
- Significant progress on the "systems integration services" portion of the Tennessee Eligibility Determination System (TEDS) project in collaboration with Deloitte Consulting, LLP.

Enrollees' satisfaction with care received from TennCare continued to be strong during the reporting period. Data gathered in the annual Beneficiary Survey, which is conducted by the Boyd Center for Business and Economic Research at the University of Tennessee, revealed that the level of beneficiary satisfaction had reached 95 percent, which marked the ninth straight year in which enrollee satisfaction exceeded 90 percent.

The performance of TennCare's MCOs remained strong. The 2017 HEDIS/CAHPS report identified several areas of health care effectiveness in which the MCOs outperformed both their own results from the previous year as well as the average results achieved by Medicaid programs nationwide. Improvement was evident in such notable categories as controlling high blood pressure, breast cancer screening, prenatal and postpartum care, and follow-up after hospitalization for mental illness.

A Note to the Reader

Special Term and Condition (STC) 45 of the TennCare Demonstration requires that the State submit an Annual Report documenting accomplishments, project status, quantitative and case study findings, utilization data, evaluation findings from the demonstration period to date, and policy and administrative difficulties and solutions in the operation of the demonstration.

This report is organized accordingly:

Section I:	Accomplishments
Section II:	Project Status
Section III:	Quantitative and Case Study Findings
Section IV:	Utilization Data
Section V:	Evaluation Findings from the Demonstration Period to Date
Section VI:	Policy and Administrative Issues and Solutions

Several other STCs mention items that are to be addressed in the Annual Report. These items and others have been included in the Attachments that follow the narrative section. The Attachments are as follows:

- Attachment A (“Operational Procedures Regarding Reserve Slots in CHOICES 2”) is required by STC 31.d.iv.(A).
- Attachment B (“Operational Procedures Regarding Reserve Slots in ECF CHOICES”) is required by STC 32.d.iv.(A).
- Attachment C (“Compliance Measures for HCBS Regulations”) is required by STC 42.b.
- Attachment D (“Special Terms and Conditions Report”) is an annualized version of a report that TennCare prepares quarterly.
- Attachment E (“The Impact of TennCare: A Survey of Recipients 2017”) is a report resulting from the annual Beneficiary Survey conducted since 1993.
- Attachment F presents the annual HEDIS/CAHPS report.
- Attachment G (“Quality Improvement Strategy”) is required by STC 42.c.

STC numbers in this report refer to those in effect at the conclusion of DY 16.

The period covered by the report is the Demonstration Year, which, in this case, was the period from July 1, 2017, through June 30, 2018. Events and activities that occurred after June 30, 2018, are not included in this report but will be included in next year’s Annual Report.

I. Accomplishments

Selected Statistical Successes. TennCare’s accomplishments during DY 16 were reflected in a variety of statistics from the year:

- Enrollment. The size of the TennCare population at the conclusion of DY 16 was 1,475,906.
- Enrollee Satisfaction. According to an annual survey conducted by the University of Tennessee’s Boyd Center for Business and Economic Research, the percentage of respondents expressing satisfaction with services received from TennCare during 2017 was 95 percent, which ties the highest reported satisfaction level in the 25-year history of the survey. DY 16 was the ninth straight year that enrollee satisfaction exceeded 90 percent. (See “Beneficiary Survey” in Section III for additional details.)
- Financial Performance. During this demonstration year, TennCare continued to succeed in demonstrating budget neutrality. TennCare’s medical inflation trend has remained well below trends for other Medicaid programs and commercial plans for years. According to data obtained in 2017, TennCare’s medical inflation rate was 1.8 percent, as compared with a national Medicaid rate of 4.5 percent, and a commercial rate of 6.0 percent. More information is available at <https://www.tn.gov/content/dam/tn/tenncare/documents/TennCareBudgetFY19.pdf>.
- CHOICES Rebalancing. CHOICES is TennCare’s program of managed long-term services and supports (LTSS) for individuals who are elderly or who have physical disabilities. According to TennCare’s most recent submission of CHOICES data to CMS, the number of individuals receiving Home and Community-Based Services (HCBS) on the last day of DY 16 was 12,385, which represents a 155 percent increase over the number of individuals receiving HCBS the day before CHOICES was implemented.
- Employment and Community First (ECF) CHOICES Enrollment. ECF CHOICES is TennCare’s program of managed long-term services and supports (MLTSS) for individuals with intellectual and other types of developmental disabilities. By the conclusion of DY 16 (i.e., the second year of program implementation), 2,532 individuals had been enrolled in the program and were receiving services.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Outreach. TennCare’s contract with the Tennessee Department of Health (TDH) to educate families on EPSDT benefits produced significant results during DY 16. TDH made contact with 437,194 people, distributed 321,727 sets of educational materials, and completed 4,383 home visits.
- Accuracy of Encounter Data. TennCare’s use of the Edifecs software system for encounter data allows non-compliant encounter claims to be rejected individually instead of as part of a batch. As a result, of more than 69 million encounter claims received by TennCare during DY 16, 99.54 percent were compliant with State standards (including HIPAA) upon initial submission.

Opioid Strategy. During DY 16, the Division of TennCare significantly expanded its approach to combatting opioid misuse and abuse. TennCare has worked for several years to stem the impact of the

opioid epidemic, but has redoubled its efforts by using a public health framework to enact policies and procedures that constitute a robust and comprehensive response to the issue. This multilayered approach will evolve as TennCare continues to monitor and/or identify any continued areas of opportunity. The elements of TennCare’s opioid strategy are organized into primary, secondary, and tertiary forms of prevention.

Primary Prevention. The goal of these efforts is to reduce overexposure to opioids for first-time and non-chronic users. Reducing overexposure lowers the chance that TennCare members will become newly dependent on or addicted to opioids. Examples of primary prevention include the following:

- Evaluating the relevant clinical literature and adjusting TennCare’s prescribing and authorization policies accordingly to limit the total morphine milligram equivalent (MME) and day supply for first time and non-chronic opioid users;
- Collaborating with the Tennessee governor’s office and other state agencies to support comprehensive efforts around prescriber education, prescription limits, and implementation of pain guidelines across the state;
- Improving access to non-opioid analgesics and non-pharmacologic pain treatments through TennCare’s managed care entities (MCEs); and
- Increasing targeted provider education and data transparency for outlying prescribers of controlled substances in TennCare’s provider networks.

TennCare will monitor the impact of these policies by evaluating changes in such trends as the total number of opioids prescribed, the prescription patterns for TennCare members (including dosage and day supply), and the total number of TennCare members exposed to opioids acutely.

Secondary Prevention. These efforts aim to enhance patient engagement, early detection of dependence, and evidence-based pain treatment for TennCare members chronically using opioids. TennCare in partnership with its MCEs is increasing outreach and engagement to increase connection of members to physical health, behavioral health, pain-management, and other preventative services that may be beneficial. Secondary prevention includes such techniques as—

- Using predictive clinical risk stratification to increase outreach—education and treatment options—to women of childbearing age who use opioids chronically;
- Further removing barriers to access to Voluntary Reversible Long-Acting Contraceptives (VRLACs), such as IUDs and implants, for women in both the outpatient and peripartum periods; and
- Identifying and integrating additional data sources to better target chronic opioid users for linkage to pain management services.

TennCare will track the impact of these policies by monitoring the MCOs’ member outreach and engagement efforts for at-risk women of childbearing age; the total MME and opioid usage patterns for chronic opioid users; and the utilization of VRLACs.

Tertiary Prevention. The goal of these efforts is to increase access to and support of high-quality addiction and recovery treatment services for TennCare members who are dependent, misusing, or abusing opioids and other substances. Examples of tertiary prevention include:

- Developing a baseline program description that outlines high-quality opioid use disorder (OUD) services and medication assisted treatment (MAT) for TennCare providers of MAT services;
- Partnering with TennCare MCOs to develop an MAT specialty network that meets specified access and quality standards;
- Increasing educational opportunities for MAT providers to build treatment capacity, expertise, and continued use of best practices; and
- Streamlining access to key MAT pharmacy benefits, including buprenorphine and naloxone.

TennCare will evaluate the impact of these policies by monitoring such trends as utilization of MAT and behavioral health services for OUD, the total number of MAT prescribers in the specialty network, use of buprenorphine products, and opportunities for provider education.

In addition to the three forms of prevention described above, TennCare submitted a demonstration amendment to CMS on May 25, 2018, to expand its continuum of services for combatting opioid misuse and abuse. Amendment 35 (addressed at greater length in Section II of this report) would amend the TennCare benefits package to cover residential substance use disorder (SUD) treatment services in facilities with more than 16 beds.

Additional information about TennCare's expanded opioid strategy is available at <https://www.tn.gov/tenncare/tenncare-s-opioid-strategy.html>.

Medication Therapy Management Pilot Project. In September 2017, the Division of TennCare submitted Demonstration Amendment 32 to CMS to establish a two-year pilot program in which certain TennCare enrollees would receive medication therapy management (MTM) services. MTM is a clinical service provided by licensed pharmacists, the aim of which is to optimize drug therapy and improve therapeutic outcomes for patients. Amendment 32 proposed to make MTM available to TennCare members enrolled in TennCare's health home program (Tennessee Health Link), and to members whose primary care providers participate in TennCare's patient-centered medical home (PCMH) program.

On February 1, 2018, the State received CMS approval of Amendment 32. TennCare proceeded with implementation of the MTM program by enrolling pharmacists to provide MTM services. These pharmacy providers have worked as part of the extended care teams within the Tennessee Health Link and PCMH initiatives, engaging members to actively manage their drug therapy by identifying, preventing, and resolving medication-related problems. Throughout the lifetime of the pilot program, pharmacists providing MTM services to TennCare enrollees will be particularly focused on providing their expertise to patients with the highest levels of clinical risk.

Payment Reform. In February 2013, Tennessee Governor Bill Haslam launched Tennessee's Health Care Innovation Initiative to change the way that health care is paid for in Tennessee. The State is moving from paying for volume to paying for value by rewarding health care providers for furnishing high-quality and efficient treatment of medical conditions and for helping maintain people's health over time.

The Tennessee Health Care Innovation Initiative is led by the Division of TennCare's Strategic Planning and Innovation Group. Although the initiative's goals transcend Medicaid, there is much emphasis on Medicaid leading by example. The initiative consists of strategies to reform Tennessee's health care payment and delivery system in three main domains: Primary Care Transformation, Episodes of Care, and Long-Term Services and Supports (LTSS).

Tennessee's **Primary Care Transformation** strategy supports primary care providers in promoting the delivery of preventive services and managing chronic illnesses over time. One element of this strategy that achieved considerable success during DY 16 involved collaboration between TennCare and Tennessee hospitals to coordinate the sharing of admission, discharge, and transfer (ADT) data. These data allow providers participating in TennCare's care coordination initiatives to know when their patients go to an emergency room or are admitted to or discharged from a hospital. ADT data are the most actionable, real-time electronic information in health care. While many states are working to improve the sharing and use of ADT data, Tennessee has become a leader in this area. As of the end of DY 16, 74 percent of Tennessee hospitals were sharing ADT data with TennCare, with more hospitals set to begin sharing these data in DY 17. The ADT data are delivered to primary care and behavioral health providers via TennCare's Care Coordination Tool in a usable format that—combined with other medical and pharmacy data—gives providers a workflow for prioritizing high-risk patients and highlights members' unmet medical needs. Providers have reported that this new information enables them to reach out to patients who are over-utilizing the emergency room, and to find hard-to-reach patients who may need follow-up care.

The second strategy of Tennessee's payment reform initiative is **Episodes of Care**. This strategy focuses on acute or specialist-driven health care delivered during a specified time period to treat physical or behavioral conditions such as an acute diabetes exacerbation or total joint replacement. Each episode has a principal accountable provider (sometimes referred to as the "quarterback") who is in the best position to influence the cost and quality of the episode. Episodes of care are implemented in groups or—in the terminology of the program—"waves."

Each episode is designed with significant input from stakeholders, including Tennessee providers, payers, administrators, and employers. The program organizes Technical Advisory Groups (TAGs) composed of experts in the field to provide clinical feedback on each episode's design. Episode TAG meetings are held in the spring and fall. The fall 2017 TAG meetings addressed Wave 8, which includes episodes for Acute Gastroenteritis, Acute Seizure, Appendectomy, Bronchiolitis, Colposcopy, Gastrointestinal Obstruction, Hernia Repair, Hysterectomy, Pediatric Pneumonia, and Syncope. The spring 2018 TAG meetings addressed Wave 9, comprising episodes on Cystourethroscopy and Acute Kidney and Ureter Stones. TennCare continues to seek provider feedback once an episode is implemented and makes adjustments to the design of episodes based on provider feedback.

New evidence of the effectiveness of the episodes of care program arrived during DY 16. In 2018, TennCare providers are receiving reports on 46 episodes of care. Of those episodes, 27 are in a performance period, and 19 are in a "preview" period (a one-year period of data collection and reporting that precedes the formal implementation of the episode). Estimates indicate that the Episodes of Care program saved Tennessee over \$25 million in health care costs in calendar years 2015 (when three episodes were in a performance period) and 2016 (when eight episodes were in a performance period), while maintaining or in some cases improving quality of care.

Tennessee's payment reform strategy for **Long-Term Services and Supports** comprises quality- and acuity-based payment and delivery system reform for Nursing Facility (NF) services and Home and Community-Based Services (HCBS). During DY 16, TennCare continued its work toward designing a new reimbursement methodology for NFs participating in the TennCare program to be implemented in DY 17. The new payment approach was designed to transition away from a cost-based system to a system that would take into consideration the acuity of residents served in facilities, as well as facilities' performance relative to specified quality measures. As part of an ongoing commitment to transparency,

TennCare sought broad stakeholder input throughout the development process for the new payment system, hearing directly from residents receiving NF services and their family members, as well as from staff of NFs participating in TennCare’s Quality Improvement in Long-Term Services and Supports (QuILTSS) initiative. Each of the Medicaid NFs in the State and their Resident/Family Councils were invited to complete surveys to provide feedback regarding quality-related components of the new reimbursement rule. Facility representatives also had the opportunity to discuss their experience with the QuILTSS initiative and ways in which the program could be improved, not only to aid the initiative’s goal of improving quality of care and quality of life for NF residents, but also to minimize administrative burden on facilities. As of the end of DY 16, implementation of the new reimbursement methodology was expected to take place in DY 17.

II. Project Status

Demonstration Amendment 33: Supplemental Payment Pools for Tennessee Hospitals. On February 7, 2018, TennCare submitted Demonstration Amendment 33 to CMS. Amendment 33 concerned the supplemental payments that TennCare makes to Tennessee hospitals to help offset the costs these facilities incur in providing uncompensated care. With Amendment 33, TennCare asked that CMS revisit certain changes imposed on the supplemental payment structure during the most recent renewal of the TennCare Demonstration in 2016.

The proposal contained in Amendment 33 consisted of three components:

- Restoration of approximately \$90 million to the maximum amount TennCare is authorized to pay to hospitals each year for uncompensated care costs;
- Continuation of a special funding pool—which was scheduled to end on June 30, 2018—that supports clinics operated by Meharry Medical College; and
- Extending the implementation period of a new hospital payment structure that was scheduled to take effect on July 1, 2018.

By the end of the DY 16, TennCare and CMS were working on a path to address the issues raised by the State without the need for a formal demonstration amendment. The State expected to formally withdraw Amendment 33 from further consideration once the details of the new arrangement had been finalized.

Demonstration Amendment 34: Program Modifications. Amendment 34 was a contingency plan—based on amendments from prior years—to address the budgetary challenges that would have arisen if the Tennessee General Assembly did not renew a non-recurring hospital assessment. Amendment 34 outlined several significant benefit limits to be imposed on non-exempt adults, including—

- A combined annual limit of eight days per person for inpatient hospital and inpatient psychiatric hospital services;
- An annual limit on non-emergency outpatient hospital visits of eight occasions per person;
- A combined annual limit on health care practitioners’ office visits of eight occasions per person;
- An annual limit on lab and X-ray services of eight occasions per person; and
- Elimination of coverage for occupational therapy, speech therapy, and physical therapy.

TennCare held a public notice and comment period on Amendment 34 from March 6 through April 5, 2018. As was the case in previous years, however, the General Assembly renewed the hospital assessment by the conclusion of the legislative session, thereby eliminating any funding gap and, as a result, the need for Amendment 34 to be submitted to CMS.

Demonstration Amendment 35: Substance Use Disorder Services. On May 25, 2018, the State submitted Amendment 35 to CMS. Amendment 35 would amend the TennCare benefits package to cover residential substance use disorder (SUD) treatment services in facilities with more than 16 beds. The federal government classifies facilities with more than 16 beds as “institutions for mental diseases” (IMDs), and federal law prohibits the expenditure of federal Medicaid dollars for services delivered to adults in these facilities.

Until the 2016 managed care rule, TennCare’s MCOs were able to cover residential treatment services in IMDs in lieu of providing these services in facilities that were not IMDs, if the MCO determined that such care was medically appropriate and cost-effective as compared to services in Tennessee’s Medicaid State Plan. However, the 2016 managed care rule limits this option to treatment stays of no more than 15 days per calendar month, in effect creating a gap in the State’s benefit package for SUD treatment.

In light of this new federal restriction, TennCare sought authority through Amendment 35 to cover residential SUD treatment services in facilities that meet the definition of an IMD when medically necessary and appropriate. TennCare’s proposal would allow enrollees to receive short-term services in IMDs beyond the 15-day limit in federal regulation, up to 30 days per admission.

As of the conclusion of DY 16, CMS’s review of Amendment 35 was ongoing.

Demonstration Amendment 36: Family Planning Providers. In the final month of DY 16, TennCare initiated a public notice and comment period for a demonstration amendment growing out of Tennessee’s 2018 legislative session. Specifically, the Tennessee General Assembly passed legislation establishing that it is the policy of the state of Tennessee to favor childbirth and family planning services that do not include elective abortions within the continuum of care or services, and to avoid the direct or indirect use of state funds to promote or support elective abortions.

Accordingly, Amendment 36 is designed to establish state-specific criteria for providers of family planning services, and to exclude any providers that do not meet these criteria from participation in the TennCare program. As specified in the legislation passed by the General Assembly, Amendment 36 would exclude any entity that performed, or operated or maintained a facility that performed, more than 50 abortions in the previous year, including any affiliate of such an entity.

The designated public notice and comment period for Amendment 36 was scheduled to run from June 13 through July 13, 2018. As of the end of DY 16, TennCare planned to submit Amendment 36 to CMS at the conclusion of the public notice period and after all public comments had been reviewed.

Technical Change to the TennCare Demonstration. On July 6, 2017, TennCare submitted to CMS a proposed modification to the State’s 1115 demonstration project. Attachment C of the TennCare Demonstration specifies limitations for private duty nursing services. The State sought to modify these limitations by making private duty nursing services available to adults aged 21 and older who are ventilator-dependent with a progressive neuromuscular disorder or spinal cord injury, and who are ventilated using noninvasive positive pressure ventilation by mask or mouthpiece for at least 12 hours

each day in order to avoid or delay tracheostomy. CMS approved the technical change on February 1, 2018.

EPSDT Outreach Programs. As noted in each of the Quarterly Progress Reports submitted during DY 16, TennCare contracts with the Tennessee Department of Health (TDH) to conduct community outreach to educate families on the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit available to children enrolled in Medicaid. These outreach activities take many forms and are offered in a variety of venues, with efforts concentrated in those areas determined at any given time to be the most effective.

Beginning in DY 15 and continuing into DY 16, TDH has gradually shifted their outreach and engagement strategy to emphasize a “one-on-one” approach, in which staff members make visits to the homes of individuals determined most likely to benefit from education on the EPSDT benefit. As a result, less emphasis has been placed on participation in local activities and events open to the general public, as such events are generally less conducive to one-on-one support, referrals, and education.

Another form of outreach into which TDH has shifted its EPSDT outreach efforts is a new program known as Community Health Access and Navigation in Tennessee (CHANT). CHANT targets TennCare-eligible and TennCare-enrolled pregnant women and children and youth under age 21, including those with special healthcare needs. The program identifies and addresses risk factors at both the individual and the community-population level. A multi-disciplinary team works with individuals who are most likely to have poor health outcomes, addresses their specific needs (medical and/or social), and measures the results. TDH is currently implementing this program gradually, with full statewide roll-out expected by the end of 2019. Data on the CHANT program will be included in future Quarterly Progress Reports and Annual Reports.

In addition to EPSDT outreach activities coordinated by TDH, TennCare’s MCOs conduct similar efforts. Reminders about services available through the EPSDT benefit occur through various modes (such as telephone calls, mailed notices, and text messages). Also, the health plans lead statewide campaigns that target children who are not current with regard to EPSDT doctor visits, members of minority populations, and adolescents.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. The purpose of the program is to provide financial incentives to Medicaid providers¹ to replace outdated, often paper-based approaches to medical record-keeping with Certified Electronic Health Record Technology (as defined by CMS) that meets rigorous criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the funding for administrative costs. Tennessee’s EHR program has issued payments for six program years to Medicaid providers meeting relevant eligibility requirements.

¹ CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (medical and osteopathic physicians, nurse practitioners, certified nurse midwives, dentists, and physician assistants who meet certain criteria) and hospitals (acute care hospitals, critical access hospitals, and children’s hospitals).

Tennessee's EHR program remained robust during DY 16 by continuing to distribute payments to some providers while educating others on the advantages of participation. Highlights from the year included the following:

- Total first-year payments to providers who had adopted, implemented, or upgraded to certified EHR technology capable of meeting CMS' "meaningful use" standards or who had achieved meaningful use of certified EHR technology for a period of 90 consecutive days exceeded \$180 million by June 30, 2018. (Since enrollment of new providers concluded on April 30, 2017, first year payments were made only in the first two quarters of DY 16.)
- Total second-year payments to providers who had received first-year payments and who subsequently achieved meaningful use for a subsequent period of 90 consecutive days surpassed \$58 million by the conclusion of DY 16.
- Total third-year, fourth-year, fifth-year, and sixth-year payments to providers who had demonstrated ongoing meaningful use of EHR technology increased by almost 23 percent during the year, growing from approximately \$37,600,000 as of June 30, 2017, to more than \$46,150,000 as of June 30, 2018.
- Nearly 1,100 Tennessee providers received incentive payments during DY 16.

These achievements would not have been possible without TennCare's multilayered approach to proactive outreach and communication to providers throughout the state. Various facets of this outreach effort included meetings, technical assistance calls, webinars, onsite visits, a dedicated section of the TennCare website, and newsletters.

Population Health. Population Health (PH) is a healthcare management approach implemented by TennCare to promote improved health outcomes for the TennCare member population. Key benefits of Population Health include—

- Emphasis on preventative care;
- Identification of risky behaviors likely to lead to disease in the future (such as poor eating habits, physical inactivity, and drug use);
- Assistance to enrollees in discontinuing such activities; and
- Interventions to assist enrollees who already have a complex chronic condition.

The PH program replaced the much more limited "Disease Management" model, which had typically served about 250,000 individuals. By contrast, the conclusion of DY 16 saw 1,327,005 TennCare enrollees—90 percent of the enrollee population—receiving PH services.

Special Terms and Conditions. A summary of activities that occurred with respect to the Special Terms and Conditions is presented in Attachment D.

Enrollment information. STC 46.b. requires that the State include enrollment reporting by Eligibility Group and by Type for the TennCare population. Table 1 summarizes that information.

**Table 1
Enrollment Counts for DY 16**

State Plan and Demonstration Populations	Total No. of TennCare Enrollees			
	Jul - Sep 2017	Oct - Dec 2017	Jan - Mar 2018	Apr - Jun 2018
EG1 Disabled, Type 1 State Plan eligible	145,778	143,789	142,906	142,555
EG9 H-Disabled, Type 2 Demonstration Population	240	252	261	278
EG2 Over 65, Type 1 State Plan eligible	245	350	414	446
EG10 H-Over 65, Type 2 Demonstration Population	44	57	54	66
EG3 Children, Type 1 State Plan eligible	762,486	778,248	788,561	765,641
EG4 Adults, Type 1 State Plan eligible	399,788	418,520	428,261	410,901
EG5 Duals, Type 1 State Plan eligibles and EG11 H-Duals 65, Type 2 Demonstration Population	148,941	149,247	149,080	148,475
EG6E Expan Adult, Type 3 Demonstration Population	302	269	209	131
EG7E Expan Child, Type 3 Demonstration Population	810	897	865	1,042
EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX	0	0	0	0
Med Exp Child, Title XXI Demonstration Population	4,394	4,529	4,236	4,827
EG12E Carryover, Type 3, Demonstration Population	1,839	1,731	1,666	1,544
TOTAL	1,464,867	1,497,889	1,516,513	1,475,906

III. Quantitative and Case Study Findings

Beneficiary Survey. Every year since 1993, the Boyd Center for Business and Economic Research (BCBER) at the University of Tennessee in Knoxville has conducted a survey of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—to assess their opinions about health care. Respondents provide feedback on a range of topics, including demographics (age, household income, family size, etc.), perceptions of quality of care received, and behavior relevant to health care (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.).

During DY 16, BCBER published a summary of the results of the most recent survey titled “The Impact of TennCare: A Survey of Recipients, 2017”. Although the findings of a single survey must be viewed in context of long-term trends, several results from the report are noteworthy:

- Satisfaction with TennCare remained high. Ninety-five percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction tied for the highest in the program’s history and was the fourth time in seven years that this peak had been attained. In addition, 2017 was the ninth straight year in which survey respondents had reported satisfaction levels exceeding ninety percent.
- The uninsured rate in Tennessee remained relatively low. Although the percentage of respondents classifying themselves as uninsured rose from 5.5 percent in 2016 to 6.0 percent in 2017, the 2017 mark was nonetheless the fourth lowest level in the 25-year history of the survey. Furthermore, the percentage of individuals classifying their children as uninsured fell from 1.8 percent in 2016 to 1.5 percent in 2017, tying the all-time lowest level established in 2015.
- TennCare families sought care from physicians more frequently than the Tennessee population as a whole. Thirty-three percent of heads of households with TennCare reported seeing a doctor weekly or monthly, and seventeen percent reported doing so for their children. By contrast, only fourteen percent of all heads of households reported seeing a doctor weekly or monthly, and only eight percent reported doing so for their children.

In summary, the report notes, “TennCare continues to receive positive feedback from its recipients, with 95 percent reporting satisfaction with the program. This positive feedback is a strong indication that TennCare is providing satisfactory medical care and meeting the expectations of those it serves.” BCBER’s report may be viewed in its entirety online at <http://cber.haslam.utk.edu/tncare/tncare17.pdf>.

HEDIS/CAHPS Report. The annual report of HEDIS/CAHPS data—titled “Comparative Analysis of Audited Results from TennCare MCOs”—was released in August 2017. The full name for HEDIS is “Healthcare Effectiveness Data Information Set,” and the full name for CAHPS is “Consumer Assessment of Health Plans Surveys.” This report, which is presented in Attachment F and posted on the TennCare website at <https://www.tn.gov/content/dam/tn/tenncare/documents/hedis17.pdf>, provides data that enables the State to compare the performance of its MCOs against national norms and benchmarks and to compare performance among MCOs.

Improved statewide performance was noted for an array of child health measures, with many also exceeding the HEDIS 2016 Medicaid National Average. Higher success rates were achieved in all of the following categories:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (including “BMI Percentile”, “Counseling for Nutrition”, and “Counseling for Physical Activity”)
- Immunizations for Adolescents (“Meningococcal”, “Tdap/Td”, and “Combination 1”)
- Lead Screening in Children
- Appropriate Testing for Children with Pharyngitis
- Asthma Medical Ratio (all child sub-categories)
- Appropriate Treatment for Children with Upper Respiratory Infection
- Prenatal and Postpartum Care

- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits

Improvement was also evident in a variety of health categories applicable to adults, including Adult BMI Assessment, Use of Spirometry Testing in the Assessment and Diagnosis of COPD, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Controlling High Blood Pressure, Persistence of Beta-Blocker Treatment After a Heart Attack, Statin Therapy for Patients with Diabetes, Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis, and Adults' Access to Preventive/Ambulatory Health Services. Categories related to women's health showed higher outcomes as well, with improved results in the areas of Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening in Women (both "16-20 years" and "21-24 years"), and Non-Recommended Cervical Cancer Screening in Adolescent Females.

HEDIS 2017 was the eighth year of statewide reporting of behavioral health measures following the integration of medical and behavioral health services among TennCare's health plans. Results superior to those in 2016 were achieved in the behavioral health categories of Follow-Up After Hospitalization for Mental Illness, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, Diabetes Monitoring for People With Diabetes and Schizophrenia, and Adherence to Antipsychotic Medications for Individuals with Schizophrenia. In some categories in which improvement was not seen relative to 2016 (Follow-Up Care for Children Prescribed ADHD Medication; Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia; Metabolic Monitoring for Children and Adolescents on Antipsychotics, 6-11 years), performance nonetheless exceeded the 2016 Medicaid National Average.

With regard to the CAHPS portion of the 2017 report, the performance of the MCOs was strong, especially in comparison to benchmarks established in 2016 for Medicaid programs nationwide. CAHPS data in the report was organized into three major areas: Adult Medicaid Survey Results, Child Medicaid Survey Results (General Population), and Child Medicaid Survey Results (Children with Chronic Conditions). Each of these three major categories contained several subcategories (e.g., "Getting Needed Care," "Getting Care Quickly," "How Well Doctors Communicate," etc.) in which the health plans were rated. Of these 32 subcategories, the MCOs outperformed the national average in 31. The only subcategory in which the MCOs did not exceed the national average was "Shared Decision Making" within the broader category of Child Medicaid Survey Results (Children with Chronic Conditions). In that instance, the performance of TennCare's health plans was 0.68 percent lower than the national average.

IV. Utilization Data

Utilization information is taken from encounter data submitted by the Managed Care Organizations. It is maintained on a rolling basis reflecting a one-quarter lag.

Key indicators tracked by TennCare and the measures for each indicator for FYs 2016-2018 are presented in Table 2.

Table 2
Key Indicators Tracked by TennCare, FYs 2016-2018

METRIC	FY 2016	FY 2017	FY 2018
Member Months (FTE)	1,499,252	1,506,504	1,442,280
COST INDICATORS			
PMPM – Physician	\$86	\$89	\$96
PMPM – Facilities	\$122	\$123	\$129
PMPM – Rx (before rebate)	\$69	\$69	\$70
UTILIZATION MEASURES			
Hospital Days/1000	584	573	582
Hospital Admissions (excluding mental health events)/1000	110	108	107
ER Visits/1000	951	916	872
Prescriptions/1000	10,460	10,421	10,437

Source: TennCare’s Office of Healthcare Informatics

All utilization measures are calculated per 1,000 Full Time Equivalent (FTE) members.

V. Evaluation Findings from the Demonstration Period to Date

On December 16, 2016, CMS approved the State’s application to extend the TennCare Demonstration through June 30, 2021. The Special Terms and Conditions accompanying the approval outlined the manner in which the TennCare Demonstration would be evaluated, namely by focusing on TennCare’s CHOICES and Employment and Community First CHOICES programs, as well as “the state plan and demonstration populations enrolled in those programs.”

One of the requirements applied to TennCare’s evaluation efforts was that a draft evaluation design be submitted by the State to CMS within 120 days following the date on which the extension application had been approved. Accordingly, on April 17, 2017, the State submitted its draft design, which included five program objectives related to the CHOICES program, five program objectives related to the Employment and Community First CHOICES program, and appropriate data elements for each of the ten objectives. The central issue addressed by the design and its accompanying objectives is how the CHOICES and Employment and Community First CHOICES managed LTSS programs compare with various fee-for-service LTSS programs operated by the State in the past and present.

The five objectives related to the CHOICES program as described in the State’s draft evaluation design are as follows:

1. Expand access to HCBS for older adults and adults with physical disabilities.
2. Rebalance TennCare spending on long-term services and supports to increase the proportion that goes to HCBS.

3. Provide cost-effective care in the community for persons who would otherwise require nursing facility care.
4. Provide HCBS that will enable persons who would otherwise be required to enter nursing facilities to be diverted to the community.
5. Provide HCBS that will enable persons receiving services in nursing facilities to be able to transition back to the community.

The five objectives related to the Employment and Community First CHOICES program as described in the State's draft evaluation design are as follows:

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

When DY 16 concluded, the State and CMS were working to finalize the evaluation design. In the meantime, data related to the ten objectives above has been furnished by the State to CMS in the quarterly progress reports required by STC 44 and in the CHOICES and Employment and Community First CHOICES data reports required by STC 42.d.iv. Data collection processes for the CHOICES program reflected in the evaluation design have been ongoing since the program's inception. Data collection processes for the Employment and Community First CHOICES program reflected in the evaluation design also commenced at program launch, subject to methodological limitations described in the document. Currently, only quality of life data collection processes have not yet begun, but are expected to be initiated in 2019. Once the evaluation design is approved, TennCare should be well positioned to carry out the proposed evaluation.

VI. Policy and Administrative Issues and Solutions

Status of the Health Care Delivery System Under the TennCare Demonstration. TennCare's health care delivery system remained fiscally sustainable and responsive to enrollee needs during DY 16. Indicators of the soundness of TennCare's approach to health care included the following:

- Financial Performance of the Demonstration. TennCare's financial performance is an important dimension of the program's success. The demonstration continues to operate well under its budget neutrality ceiling, avoiding billions of dollars in costs identified in the "without waiver" scenario outlined in the State's last application to extend the demonstration. According to data provided by the Kaiser Family Foundation on the average state Medicaid trend, the size of TennCare's budget has consistently been lower than the national average for state Medicaid programs. Had the demonstration's budget grown at the average state rate, the program would now be more than \$1 billion more costly in State Fiscal Year 2018-2019, requiring hundreds of

millions in additional funding from both state and federal governments. The flexibility afforded by the demonstration has allowed the TennCare program to innovate (e.g., payment and delivery system reform, new initiatives in MLTSS) while holding the share of state funding for TennCare at a nearly constant level. As noted in a recent study by the Pew Charitable Trusts, Tennessee outperformed 46 other states in managing the growth of the share of state dollars required to fund Medicaid programs from 2000 to 2016.²

- **Enrollee Appeals.** Data concerning appeals filed by TennCare enrollees was included in each of the Quarterly Progress Reports submitted during DY 16. A total of 142,881 appeals were filed from July 2017 through June 2018. Of those appeals, approximately 94 percent were related to eligibility, 5.6 percent were related to medical services, and 0.4 percent were related to LTSS. During the same time period, 143,816 appeals were resolved or withdrawn without the need for a hearing. (Some of the appeals that were resolved or withdrawn during DY 16 had been filed during DY 15.)
- **Enrollee Grievances.** During DY 16, TennCare MCOs received a total of 1,418 enrollee grievances. The categories of grievances, as well as the percentage of grievances belonging to each category, are as follows:

**Table 3
Grievance Categories and Percentages**

Category of Grievance	Percentage of Total Grievances
Access and Availability	28%
Attitude and Service	28%
Billing and Financial Issues	12%
Quality of Care	31%
Quality of Practitioner Office Site	1%

Each time an enrollee contacted the state or an MCO to voice a complaint, the grievance was logged, and steps were taken to address the enrollee’s concern. TennCare and the MCOs review issues, complaints, and grievances raised by enrollees to inform quality improvement efforts. The relatively low incidence of complaints within the TennCare population (1,418 grievances filed when TennCare enrollment exceeded 1.46 million people in all four quarters of the demonstration year) is consistent with the level of satisfaction reported by TennCare enrollees. As noted in Section III of this report (under the heading of “Beneficiary Survey”), 95 percent of individuals participating in the annual survey conducted by the University of Tennessee expressed satisfaction with care received from TennCare.

Community Engagement for TennCare Beneficiaries. In 2018, the Tennessee General Assembly enacted Public Chapter No. 869. This state law directs TennCare to submit a demonstration amendment to authorize the creation of reasonable work and community engagement requirements for non-pregnant, non-elderly, non-disabled adults enrolled in the TennCare program who do not have dependent children under the age of six. During DY 16, TennCare began the process of planning and designing a community engagement initiative in accordance with this state law, including discussions

² <http://pew.org/1Etrxxk>

with multiple stakeholders to inform the design process. The formal public notice process for this demonstration amendment and its actual submission to CMS are anticipated to occur during DY 17.

Tennessee Eligibility Determination System. The Tennessee Eligibility Determination System (or “TEDS”) is the name of the system that will be used by the State to process applications and identify persons who are eligible for TennCare and CoverKids (the State’s separate CHIP program).

TennCare initiated the TEDS project in 2012. After partnering initially with the Northrop Grumman Corporation, the State ultimately adopted a new approach to the undertaking. Three separate contracts were procured to address the functions of technical advisory services (awarded to KPMG, LLP), strategic program management office services (awarded to Public Consulting Group, Inc.), and systems integration services (awarded to Deloitte Consulting, LLP).

Deloitte is responsible for the project’s central tasks of designing, developing, implementing, maintaining, and operating a rules-based Medicaid eligibility determination system that will make eligibility determinations and redeterminations, potentially in real time; receive application data; interface with federal data sources (such as the Federally Facilitated Marketplace and the Internal Revenue Service); and mail notices to enrollees.

Significant progress on the TEDS project was achieved during DY 16. During the first half of the demonstration year, Deloitte and TennCare collaborated first on formal design documents for the system, and then on systems integration test scripts (used to verify that TEDS performs according to expectations). In the second half of the demonstration year, preparations moved on to systems integration testing, which ensures that various TEDS components perform effectively and appropriately in conjunction with one another, and user acceptance testing, in which TennCare staff members tried out various functions of the system in a simulated environment to determine whether the system was functioning as needed.

As of the end of DY 16, the first pilot phase of TEDS implementation was planned for late 2018.

Wilson v. Gordon Suit. *Wilson v. Gordon* is a class action lawsuit filed against TennCare by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit, which is being heard by the U.S. District Court for the Middle District of Tennessee, alleges federal noncompliance in the Medicaid application and appeals process TennCare has been using since implementation of the Affordable Care Act.

In the fall of 2016, the State filed a Motion to Decertify the Class and Dismiss the Case. The basis of the motion was that processes used by TennCare and CMS for Medicaid applications and application appeals in Tennessee had evolved substantially. The State argued that there were no remaining members in the Plaintiff class originally certified by the District Court, and that any eligibility issues arising in 2016 and thereafter were completely different from the issues that originally prompted the *Wilson* suit.

Oral argument and supplemental briefing on the State’s Motion took place during the first half of Calendar Year 2017. On November 9, 2017, Plaintiffs and Defendants jointly requested that a pretrial conference scheduled for late November 2017 and a trial scheduled for December 2017 be postponed until the District Court had ruled on the Motion to Decertify the Class and Dismiss the Case. This request was granted on November 14, 2017.

In the final month of DY 16, Judge William L. Campbell, Jr. denied the State's Motion to Decertify the Class and Dismiss the Case on the grounds that there were still members in the Plaintiff class. As a result of this decision, the case was scheduled to proceed to trial on October 9, 2018.

Throughout DY 16, the State continued to comply with all orders issued by the District Court in the *Wilson* suit.

Roan and Shackelford v. Long Suit. This lawsuit was filed against TennCare in December 2017 by the Tennessee Justice Center and the Legal Aid Society of Middle Tennessee and the Cumberland. The litigation, which is being heard by the U.S. District Court for the Middle District of Tennessee, concerns limitations placed by TennCare on private duty nursing services for individuals aged 21 and older. The purpose of the limitations—approved by CMS in 2008—is to ensure that private duty nursing expenditures are managed in a medically appropriate yet financially sustainable manner.

When a child enrolled in TennCare receives private duty nursing services in excess of the limits applicable to adult enrollees, the enrollee's MCO works with the child and his family prior to the child's 21st birthday to help transition the individual to a different level of benefits that best meets his needs (and that can include long-term services and supports). In *Roan and Shackelford v. Long*, two plaintiffs with disabilities who received private duty nursing services as children challenged TennCare's ability to implement limits on the services they received as adults. Plaintiffs Alison Roan and Tristen Shackelford alleged that TennCare's limits violated the Americans with Disabilities Act (ADA) and sought an injunction prohibiting TennCare from reducing the services they were receiving. The State timely filed a response to the Motion for Preliminary Injunction, as well as a Motion to Dismiss and a Notice of Constitutional Question.

By the conclusion of DY 16, the plaintiffs' Motion for Preliminary Injunction had been scheduled to be heard on November 20-21, 2018. The sole issue to be addressed at the hearing is whether TennCare must continue to provide private duty nursing services 24 hours a day for the plaintiffs while the case is pending. In addition, on June 21, 2018, plaintiff Alison Roan filed a Notice of Voluntary Dismissal in the case, effectively ending her participation in the litigation. The basis for the dismissal was that Ms. Roan's health condition had declined and, as a result, she could not safely be cared for at home, even with 24-hour-per-day private duty nursing services. The Court signed an Order dismissing Ms. Roan from the case. Nonetheless, the claims filed by plaintiff Tristen Shackelford remain pending, meaning that the lawsuit will proceed.

Quality Improvement Strategy. As required by federal law³ and the State's Demonstration agreement with CMS,⁴ TennCare has developed a strategy for evaluating and improving the quality and accessibility of care offered to enrollees through the managed care network. TennCare submitted its annual update of the strategy—titled *2017 Update to the Quality Assessment and Performance Improvement Strategy*—to CMS on December 20, 2017.

In addition to laying out the measures of quality assurance already in place, the report outlines TennCare's goals and objectives relative to quality and access for the year to follow. Furthermore, a variety of best practices (such as the Population Health program and collaborative work groups among

³ 42 U.S.C. § 1396u-2(c)(1)(A)

⁴ STC 42.c. of the TennCare Demonstration

TennCare and the MCOs) and challenges (like lack of member engagement) are detailed in the concluding section of the report, as is the positive impact of the State Innovation Model (SIM) grant awarded to Tennessee by the Centers for Medicare and Medicaid Innovation. The document is included as Attachment G of this report.

Public Forum on the TennCare Demonstration. In compliance with the federal regulation at 42 CFR § 431.420(c) and the Special Terms and Conditions of the TennCare Demonstration, the State hosted a public forum in Nashville on December 14, 2017. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The December 14 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address at which comments would be accepted.

In this forum, TennCare received one set of comments, concerning Employment and Community First CHOICES, the State's managed long-term services and supports program for individuals with intellectual and other types of developmental disabilities. Specifically, the comments acknowledged improvements that had been made to the program by the State, while also identifying areas of additional opportunity. These comments will be used to inform future program planning.

ATTACHMENT A

**OPERATIONAL PROCEDURES REGARDING
RESERVE SLOTS IN CHOICES GROUP 2**

Required by STC #31.d.iv.(A)

Operational Procedures for CHOICES Group 2 Reserve Capacity

Pursuant to STC #31.d.iv. (A), (“**Reserve Capacity**”) of the Special Terms and Conditions set forth in the current TennCare Section 1115 Demonstration Waiver, the State will reserve a specified number of slots in CHOICES Group 2 for:

- Individuals being discharged from a Nursing Facility (NF); and
- Individuals being discharged from an acute care setting who are in imminent risk of being placed in a NF setting absent the provision of Home and Community-Based Services (HCBS).

Once all other available (i.e., unreserved) slots have been filled, individuals who meet specified criteria (including new applicants seeking to establish Medicaid eligibility in an institutional category as well as current SSI-eligible individuals seeking enrollment into CHOICES Group 2) may be enrolled into reserved slots in accordance with the following procedures:

- The Area Agency on Aging and Disability (AAAD) or the Managed Care Organization (MCO), as applicable, must complete and submit a Reserve Capacity Enrollment Justification form to the TennCare Division of Long-Term Services and Supports (LTSS), along with supporting documentation.
- The Reserve Capacity Enrollment Justification form will require confirmation of the NF or hospital, as applicable, from which the person is being discharged, and in the case of a hospital discharge, a written explanation of the applicant's circumstances that warrant the immediate provision of NF services unless HCBS are immediately available. This explanation will include such factors as:
 - The reason for the acute care stay
 - The current medical status of the individual
 - Specific types of assistance needed by the individual upon discharge (medical as well as functional)
 - A description of the applicant's natural support system as it relates to discharge needs.
- The TennCare Division of LTSS will review the form and supporting documentation in order to determine whether the person meets specified criteria for enrollment into a reserved slot.
- If documentation is sufficient to demonstrate that the individual meets specified criteria for a reserved slot, TennCare will notify the submitting entity and proceed with the enrollment process, including determination of categorical/financial eligibility (for new Medicaid applicants) and application of federal post-eligibility provisions.
- If documentation is not sufficient to demonstrate that the individual meets specified criteria for a Reserve Capacity slot, TennCare will notify the submitting entity and place the person on a waiting list for Group 2 once unreserved capacity is available. TennCare shall provide notice of the determination to the applicant, which will include the right to request a fair hearing regarding any valid factual dispute pertaining to the State's decision.

ATTACHMENT B

**OPERATIONAL PROCEDURES REGARDING
RESERVE SLOTS IN ECF CHOICES**

Required by STC #32.d.iv.(A)

Operational Procedures for Employment and Community First CHOICES Reserve Capacity

Pursuant to STC #32.d.iv.(A) ("**Reserve Capacity**") of the Special Terms and Conditions set forth in the current TennCare Section 1115 Demonstration Waiver, the State will reserve a specified number of slots in Employment and Community First (ECF) CHOICES for:

- Individuals with an intellectual disability who have an aging caregiver, as defined in State law;
- Individuals in emergent circumstances as defined in TennCare rule;
- Individuals with multiple complex health conditions as defined in TennCare rule;
- Individuals with significant medical or behavioral needs who require services available in ECF CHOICES to sustain current family living arrangements; and
- Individuals requiring planned transition to community living due to the caregiver's poor and declining health.

These groups were identified in partnership with stakeholders including:

- The Arc of Tennessee;
- The Tennessee Council on Developmental Disabilities;
- The Tennessee Disability Coalition;
- Disability Rights Tennessee (Protection and Advocacy); and
- The Statewide Independent Living Council of Tennessee.

For DY 16, TennCare shall reserve 350 slots within the ECF CHOICES Groups 4, 5, and 6 Enrollment Targets. These slots are available only as specified below. Due to the limited availability of new state appropriations for DY 17 and in order to further develop the capacity of community providers to deliver home and community-based services and supports, any increases in the Enrollment Targets for ECF CHOICES Groups 4, 5, and 6 during DY 17 will be Reserve Capacity slots.

Reserve capacity groups established at the program's outset include:

Individuals with an intellectual disability who have an aging caregiver, as defined in State law

Pursuant to State law (TCA § 33-5-112), individuals who have an intellectual disability and have aging caregivers (currently defined by Tennessee statute as caregivers age 75 or older) will be eligible for enrollment into ECF CHOICES, subject to Medicaid and program eligibility criteria.

Individuals in emergent circumstances as defined in TennCare rule

An emergent situation will be defined as one that meets one or more of the criteria below and for which enrollment into ECF CHOICES is the most appropriate course, as determined through an interagency committee review process, including both TennCare and the Department of Intellectual and Developmental Disabilities (DIDD). The review will include consideration of other options, including the relative costs of such options. Discharge from another service system (DCS, DMHSAS, etc.) shall not be deemed an emergent situation unless other emergent criteria are met and unless diligent and timely efforts to plan and prepare for discharge and to facilitate transition to community living without long-term services and supports available in ECF CHOICES have been made, and it is determined through the

interagency committee review process that enrollment in ECF CHOICES is the most appropriate way to provide needed supports.

Emergent criteria shall be as follows:

- The person's primary caregiver is recently deceased, and there is no other caregiver available to provide needed long-term supports.
- The person's primary caregiver is permanently incapacitated, and there is no other caregiver available to provide needed long-term supports.
- Services/supports in ECF CHOICES are urgently needed because of the recent loss of the person's living arrangement, including (as applicable) caregiver supports provided in that living arrangement that will not be available to the person going forward.
- There is clear evidence of serious abuse, neglect, or exploitation in the current living arrangement; the person must move from the living arrangement to prevent further abuse, neglect or exploitation; and there is no alternative living arrangement available.
- Enrollment into ECF CHOICES is necessary in order to facilitate transition out of a long-term care institution, i.e., a NF or a private or public ICF/IID into a more integrated community-based setting.
- The person is being discharged from an acute care setting and is at imminent risk of being placed in a NF setting absent the provision of HCBS or has applied for admission to a NF and been determined via the PASRR process to be inappropriate for NF placement. TennCare may require confirmation of the NF or hospital discharge and, in the case of hospital discharge, written explanation of the applicant's circumstances that warrant the immediate provision of NF services unless HCBS are immediately available.
- An adult's transition upon aging out of state custody, discharge from an inpatient psychiatric hospital (including regional mental health institute), or release from incarceration is *contingent* on the availability of services and supports in ECF CHOICES because other appropriate services/supports are not available, and the services available in ECF CHOICES (including covered physical and behavioral health services) will be sufficient to safely meet the person's needs in the community.
- The person is an adult age 21 or older enrolled in ECF CHOICES Group 4 (Essential Family Supports), ECF CHOICES Group 5 (Essential Supports for Employment and Independent Living), or the Section 1915(c) Self-Determination Waiver and has recently experienced a significant change in needs or circumstances. TennCare has determined via a Safety Determination that the person can no longer be safely served within the array of benefits available in ECF CHOICES Group 4 (Essential Family Supports) or 5 (Essential Supports for Employment and Independent Living) or the Self-Determination Waiver, as applicable, the person meets NF Level of Care, and must be transitioned to ECF CHOICES Group 6 (Comprehensive Supports for Employment and Community Living) in order to sustain community living in the most integrated setting.
- The health, safety, or welfare of the person or others is in immediate and ongoing risk of serious harm or danger; other interventions including Behavioral Health Crisis Prevention, Intervention and Stabilization services, where applicable, have been tried but were not successful in minimizing the risk of serious harm to the person or others without additional services available in ECF CHOICES; and the situation cannot be resolved absent the provision of such services available in ECF CHOICES.

Individuals with multiple complex health conditions as defined in TennCare rule

Reserve capacity will be established for a limited number of individuals who have multiple complex chronic or acquired health conditions that present significant barriers or challenges to employment and community integration, and who are in urgent need of supports in order to maintain the current living arrangement and delay or prevent the need for more expensive services, and for which enrollment into ECF CHOICES is the most appropriate way to provide needed supports, as determined through an interagency committee review process, including both TennCare and DIDD. The review will include consideration of other options, including the relative costs of such options.

Additional reserve capacity groups identified in partnership with stakeholders since the program's implementation include:

Individuals with significant medical or behavioral needs who require such supports to sustain current family living arrangements

Reserve capacity will be established for a limited number of individuals living at home with family who have significant medical or behavioral support needs that family caregivers are struggling to meet, and the sustainability of the current living arrangement is at significant risk. Services available through ECF CHOICES would help to support and sustain the current living arrangement and the continuation of natural caregiving supports, delaying the need for more expensive services.

Individuals requiring planned transition to community living due to the caregiver's poor and declining health

Reserve capacity will be established for a limited number of adults age 21 and older living at home with family whose primary caregiver is in poor and declining health, placing the long-term sustainability of the current living arrangement at significant risk. Planned transition to community living in the most independent and integrated setting appropriate is needed in order to avoid a potential crisis situation in the near future.

Individuals with a developmental disability who have an aging caregiver, as defined in State law

Pursuant to State law (TCA § 33-5-112), individuals who have a developmental disability and have aging caregivers (currently defined by Tennessee statute as caregivers age 80 or older) will be eligible for enrollment into ECF CHOICES, subject to Medicaid and program eligibility criteria.

Operational Procedures:

Unlike reserve capacity slots established for CHOICES Group 2 participants, reserve capacity slots in ECF CHOICES will be used as persons meeting specified criteria are identified and determined eligible to enroll.

Reserve capacity slots may be set aside for certain groups as defined herein, e.g., individuals with an intellectual or developmental disability who have an aging caregiver, as defined and required under State law, children aging out of State custody, etc.

Except for individuals with an intellectual or developmental disability who have an aging caregiver, as defined in State law, review and selection of persons who meet criteria for reserve capacity slots will be determined by an interagency review committee, including both TennCare and DIDD. A Potential Applicant for ECF CHOICES may apply for enrollment into a reserve capacity slot only if determined through the interagency committee review process that applicable reserve capacity criteria are met, and

that enrollment into ECF CHOICES is the most appropriate way to provide needed supports. Such review shall include consideration of other options, including the relative costs of such options.

TennCare will require confirmation that an Applicant meets applicable reserve capacity criteria. Except for individuals with an intellectual or developmental disability who have an aging caregiver, as defined in State law, documentation shall be provided via a form developed by TennCare, along with medical evidence that is submitted by the MCO or DIDD, as applicable, to the interagency review committee.

Only Applicants determined by the interagency review committee to meet specified reserve capacity criteria (including new Applicants seeking to establish eligibility in the ECF CHOICES 217-Like Group or the Interim ECF CHOICES At-Risk Group as well as current SSI-eligible individuals seeking enrollment into ECF CHOICES) may be enrolled into reserve capacity slots.

Once all reserve capacity slots set aside for a particular purpose have been filled, persons who meet such criteria shall not proceed with the enrollment process, but shall remain on the Referral List for ECF CHOICES, unless they qualify to enroll in an open priority group.

If a Potential Applicant does not meet criteria for a reserve capacity slot, the Potential Applicant shall not proceed with the enrollment process, but shall remain on the referral list for ECF CHOICES.

For purposes of transparency, reserve capacity criteria, including the operational procedures pertaining thereto, are set forth in TennCare Rule 1200-13-01 through the rulemaking process.

ATTACHMENT C

COMPLIANCE MEASURES FOR HCBS REGULATIONS

Required by STC #42.b.

COMPLIANCE WITH HCBS REGULATIONS

Regulation	Topic	Actions
42 CFR 440.180(a)	Description and requirements for HCBS	<ol style="list-style-type: none"> 1. Attachments D and G of the approved TennCare Demonstration and the State Rules for TennCare Long-Term Care Programs (1200-13-01) define the HCBS benefits that are available through the CHOICES and ECF CHOICES programs and delineate when services may be provided to a CHOICES or ECF CHOICES member. Where appropriate, service definitions identify “services not included” as specified in (c)(3) of the regulation. TennCare Rules are available for review at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-01.20180730.pdf 2. Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization delineates HCBS available to CHOICES and ECF CHOICES enrollees, the scope of such services, and contractor requirements for the authorization and initiation of such services. The Contractor Risk Agreement also sets forth reporting requirements by which TennCare monitors the Managed Care Organizations’ compliance and penalties to remediate non-compliance. A sample contract is available for review at https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf. 3. Provider Agreements between the Managed Care Organizations and network providers delineate the type and scope of services that each provider may provide and requirements for qualified staff.
42 CFR 441.301(c); (1) (2) (3) (4) (5) (6)	Contents of request for a waiver: (1) Person-centered planning process (2) Person-centered service plan (3) Review of the person-centered service plan (4) Home and community-based settings (5) Settings that are not home and community-based (6) Home and community-based settings: compliance	<ol style="list-style-type: none"> 1. Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization delineates requirements for the person-centered planning process. A sample contract is available for review at the link provided above. 2. Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization delineates requirements for the person-centered support plan. MCOs use a person-centered support plan template prescribed by TennCare. The Contractor Risk Agreement also sets forth reporting requirements by which TennCare monitors the Managed Care Organizations’ compliance and penalties to remediate non-compliance. 3. The Division of TennCare conducts routine audits of

Regulation	Topic	Actions
	and transition	<p>enrollee records to ensure compliance with the person-centered planning requirements. Penalties to remediate non-compliance are delineated in the Contractor Risk Agreement. Additional quality monitoring and improvement strategies for person-centered planning are set forth in the integrated Quality Improvement Strategy, a copy of which is Attachment G to this report.</p> <p>4. [Applicable to (4)-(6) of the Regulation] Tennessee’s required Statewide Transition Plan (STP) received final approval from CMS on April 13, 2016. The STP delineates the State’s process for assuring compliance with the HCBS settings rule, including the method for assuring Medicaid-reimbursed HCBS are provided in compliant settings; the process for determining settings that are not home and community-based in nature; and the transition process, which encompasses transition to compliance, as well as transition of individuals from a non-compliant setting to a compliant setting of their choice, when applicable. The plan was updated as of July 31, 2018, to reflect completion of the heightened scrutiny review process, including public comments regarding the posting of settings for which evidence has been submitted to CMS. This updated plan is available for review at https://www.tn.gov/content/dam/tn/tenncare/documents/StatewideTransitionPlanUpdated73118.pdf The State’s progress in implementing the STP and achieving full compliance is detailed in the document entitled <i>Statewide Transition Plan and Heightened Scrutiny Milestone Tracking Quarterly Report</i>, which reflects transition status as of June 30, 2018, and which was previously submitted to CMS.</p>
42 CFR 441.302; (a) (c) (d) (g) (j)	State assurances: (a) Health and Welfare (c) Evaluation of need (d) Alternatives (g) Institutionalization absent waiver (j) Day treatment or partial hospitalization	<ol style="list-style-type: none"> 1. The State Rules for TennCare Long-Term Care Programs (1200-13-01) define the standards for HCBS providers. These Rules are available for review at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-01.20180730.pdf 2. Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization includes <ol style="list-style-type: none"> a. Critical Incident reporting requirements; b. Mandatory elements for all provider

Regulation	Topic	Actions
		<p>agreements;</p> <ul style="list-style-type: none"> c. Credentialing requirements to ensure a network of qualified providers; d. Requirements pertaining to initial and annual Level of Care assessments; e. Mandatory elements of a CHOICES or ECF CHOICES assessment and person-centered support plan, including risk assessment/planning, as applicable; and f. Maximum timelines for the assessment, development of the person-centered support plan, and service initiation for potential and new CHOICES or ECF CHOICES members. <ol style="list-style-type: none"> 3. Provider Agreements between the Managed Care Organizations and network providers include critical incident reporting requirements. 4. Cost neutrality calculations ensure that an individual's needs can be met safely and effectively at a cost that is less than or equal to care provided in a NF. If the individual's needs cannot safely and effectively be met with HCBS at a cost that is less than or equal to the same Level of Care in a NF, the individual is eligible for—and may elect to receive services in—a NF. 5. Level of Care is confirmed for each CHOICES and ECF CHOICES member through standard PAE processes, requirements for supporting medical documentation, and annual recertification to assure no changes in the Level of Care. 6. Freedom of Choice education appears in materials used by the single point of entry, and in the Freedom of Choice election form (applicable for CHOICES), member handbook, and TennCare website. 7. Please refer to the integrated Quality Improvement Strategy in Attachment G of this report for a list of measures used to verify the State Assurances.
<p>42 CFR 441.303;</p> <ul style="list-style-type: none"> (a) (c) (d) (e) 	<p>Supporting documentation required:</p> <ul style="list-style-type: none"> (a) Description of safeguards (c) Description of agency plan for evaluation (d) Description of plan to inform enrollees (e) Description of post- 	<ol style="list-style-type: none"> 1. The Single Point of Entry or the Managed Care Organization facilitates CHOICES or ECF CHOICES Level of Care assessments through the completion of a PAE (PreAdmission Evaluation or Level of Care application). TennCare determines Level of Care. On an annual basis, each PAE in use by a Medicaid participant must be reviewed by the Managed Care Organization to verify that the individual still meets Level of Care.

Regulation	Topic	Actions
	eligibility treatment of income	<ol style="list-style-type: none"> 2. Please refer to the integrated Quality Improvement Strategy in Attachment G of this report for a list of measures used to verify the State Assurances. These data are reported to CMS annually. 3. The State Rules for the Department of Health, Division of Healthcare Facilities delineate specific licensure requirements for nursing facilities, assisted care living facilities, and Adult Care Homes-Level 2. https://publications.tnsosfiles.com/rules/1200/1200-08/1200-08.htm The State Rules for the Department of Mental Health and Substance Abuse Services delineate specific licensure requirements for Community Living Supports, as defined in the three-page document following this table. 4. Post-eligibility treatment of income is delineated in State Rules for TennCare Technical and Financial Eligibility (1200-13-20). These Rules are available for review at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-20.20180513.pdf.
42 CFR 441.310	Limits on Federal financial participation	<ol style="list-style-type: none"> 1. The Contractor Risk Agreement between the Division of TennCare and the Managed Care Organizations allows the Managed Care Organizations to contract only with licensed facilities that are eligible to participate in Medicaid. 2. Managed Care Organizations may not provide reimbursement for Room and Board, as is delineated in State Rules for TennCare Long-Term Care Programs (1200-13-01-.02). 3. CHOICES services do not include prevocational, educational, or supported employment services. Where appropriate, ECF CHOICES service definitions specify that services may not be provided under the ECF CHOICES program if such benefits would be available either under special education and related services as defined in section 602 of the Education of the Handicapped Act (20 U.S.C. 1401) or under vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Licensure and Quality Oversight of Community Living Supports and Community Living Supports-Family Model Providers

Providers of Community Living Supports (CLS) and Community Living Supports-Family Model (CLS-FM) are licensed by the Department of Intellectual and Developmental Disabilities (DIDD) pursuant to statutory requirements set forth in Tennessee Code Annotated, Title 33, and in Chapter 0940-05 of the Rules of the Department of Mental Health and Substance Abuse Services, including:

0940-05-24 MINIMUM PROGRAM REQUIREMENTS FOR MENTAL RETARDATION RESIDENTIAL HABILITATION FACILITIES

0940-05-26 MINIMUM PROGRAM REQUIREMENTS FOR MENTAL RETARDATION PLACEMENT SERVICES FACILITIES

0940-05-28 MINIMUM PROGRAM REQUIREMENTS FOR MENTAL RETARDATION SEMI-INDEPENDENT LIVING FACILITIES

0940-05-32 MINIMUM PROGRAM REQUIREMENTS FOR MENTAL RETARDATION SUPPORTED LIVING SERVICES FACILITIES

The specific type of licensure will depend on the level of services/reimbursement for individuals supported in the home, as well as certain factors that are explicit in the statutory and regulatory requirements. For example:

- CLS1 is provided to CHOICES members who are primarily independent or who have family members and other (i.e., non-CHOICES) paid or unpaid supports, but need limited intermittent CLS supports to live safely in a community housing situation—generally less than 21 hours per week—and do not need overnight staff or direct support staff to live on-site for supervision purposes. A primary staff member or other support staff must be on-call on a twenty four (24) hour per day basis when assistance is needed.
 - *The CLS1 provider is licensed by the Department of Intellectual and Developmental Disabilities (DIDD) as Mental Retardation Semi-Independent Living Services Facility in accordance with licensure regulations.*
- CLS2 is provided to CHOICES members who require minimal to moderate support on an ongoing basis, but can be left alone for several hours at a time and do not need overnight staff or direct support staff to live on-site for supervision purposes. A primary staff member or other support staff must be on-call on a twenty four (24) hour per day basis.
 - *The CLS2 provider is also licensed by the Department of Intellectual and Developmental Disabilities (DIDD) as Mental Retardation Semi-Independent Living Services Facility in accordance with licensure regulations.*

This is the licensure type for Semi-Independent Living services currently provided under the State's Section 1915(c) waiver authority for individuals with intellectual and developmental disabilities. CLS 1 and CLS 2 benefits are comparable to the Semi-Independent Living benefit

currently provided under the State's Section 1915(c) waiver authority to individuals with intellectual and developmental disabilities.

- CLS3 is provided to CHOICES members with higher acuity of need who are likely to require supports and or supervision twenty four (24) hours per day due to the following reasons: advanced dementia or significant cognitive disability that impacts the member's ability to make decisions, perform activities of daily living or instrumental activities of daily living, including behaviors which place the member or others at risk; significant physical disabilities that require frequent intermittent hands-on assistance with activities of daily living including toileting, transfers, and mobility; complex health conditions and compromised health status requiring medication assistance and daily nurse oversight and monitoring and/or daily skilled nursing services as needed for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc. Individuals authorized to receive CLS3 must have the appropriate level of professional and support staffing based on their needs, including up to 24/7 when appropriate.
 - *The CLS3 provider is licensed as a Mental Retardation Supported Living or Residential Habilitation Facilities provider by the Department of Intellectual and Developmental Disabilities (DIDD) in accordance with licensure requirements.*

This is the licensure type for Supported Living and Residential Habilitation services, including Medical Residential services, currently provided under the State's Section 1915(c) waiver authority for individuals with intellectual and developmental disabilities.

- The levels of support for Community Living Supports-Family Model are the same, but all are delivered in an adult foster home setting where the person lives in the home of a family who is the paid caregiver.
 - *The CLS-FM provider is licensed by the Department of Intellectual and Developmental Disabilities (DIDD) as Mental Retardation Placement Services Facility.*

This is the licensure type for providers of Family Model Residential Services currently provided under the State's Section 1915(c) waiver authority for individuals with intellectual and developmental disabilities.

CLS and CLS-FM benefits in the Employment and Community First CHOICES program use the same licensure types.

It is important to understand that licensure standards establish the minimum standards that facilities must meet in order to be licensed. These include background checks of all staff.

Additional program and quality requirements are set forth in TennCare rules, MCO contracts, and provider agreements.

In addition to annual licensure surveys, TennCare contracts with the Department of Intellectual and Developmental Disabilities (DIDD), the operating agency for the state's three Section 1915(c) waivers for individuals with intellectual disabilities, to conduct quality monitoring surveys of providers of CLS and CLS-FM services. TennCare has built on a well-developed quality strategy that has been hailed by the

Centers for Medicare and Medicaid Services in recent evidentiary reviews of the 1915(c) waivers as a “model of best practices” to establish performance measures and processes for discovery, remediation, and ongoing data analysis and quality improvement regarding CLS services. In addition to providing data specific to the quality of these services offered in the CHOICES and ECF CHOICES programs, this ensures that TennCare has a comprehensive perspective of quality performance and strategies for quality improvement across the LTSS system as a whole.

In addition to annual licensure surveys and annual quality monitoring surveys, MCO Care or Support Coordinators are required to conduct periodic onsite visits of each person receiving CLS or CLS-FM services, including specific monitoring specified by TennCare, to ensure that services are being provided appropriately and that the members’ needs are met.

TennCare contracts with Area Agencies on Agency and Disability to ensure the availability of Ombudsman services for individuals receiving CLS and CLS-FM services. This includes periodic in-person assessment of the quality of services being received, as well as the member’s satisfaction with the services and with quality of life, using a standardized assessment tool.

Finally, TennCare participates in National Core Indicators to assess quality of life, community integration, and person-centered services for CHOICES and, beginning in 2019, ECF CHOICES members. NCI also uses a standardized assessment tool to monitor quality of services and quality outcomes for seniors and adults with disabilities and individuals with I/DD receiving HCBS, including those in CLS and CLS-FM settings.

ATTACHMENT D

SPECIAL TERMS AND CONDITIONS REPORT

STC Activity Report—DY 16

TennCare maintained compliance with all Special Terms and Conditions during Demonstration Year 16. Specific actions and deliverables are detailed below.

STCs #6 and #7: The State submitted three demonstration amendments to CMS:

- Amendment 32 proposed to establish a two-year pilot project in which certain TennCare enrollees would receive a medication therapy management benefit in addition to the traditional TennCare benefits package. The State submitted Amendment 32 on September 6, 2017, and CMS issued written approval on February 1, 2018.
- Amendment 33 was a request for modifications to the STCs governing the supplemental payment structure used to offset costs that Tennessee hospitals incur by providing uncompensated care. The State submitted Amendment 33 on February 7, 2018, and CMS was still reviewing the proposal as DY 16 concluded.
- Amendment 35 would allow the State to pay for short-term substance use disorder services in facilities classified as institutions for mental diseases for up to 30 days per admission. The State submitted Amendment 35 to CMS on May 25, 2018, and CMS was still reviewing the proposal as DY 16 concluded.

STC #10: On November 14, 2017, the State notified the public of its intention to host a public forum in which comments on the progress of the TennCare Demonstration would be accepted. The State held the forum on December 14, 2017, and included a summary of comments received there in the Quarterly Report submitted to CMS on March 1, 2018.

STC #15: Public notice concerning demonstration amendments was provided to Tennessee newspapers and posted on TennCare's website as follows:

- Demonstration Amendment 32: July 28, 2017
- Demonstration Amendment 33: December 1, 2017
- Demonstration Amendment 34: March 6, 2018
- Demonstration Amendment 35: April 20, 2018
- Demonstration Amendment 36: June 13, 2018

Amendments 34 and 36 were not submitted to CMS during DY 16. Amendment 34 identified program reductions that would be necessary if the Tennessee General Assembly did not renew the annual hospital assessment. The fee was ultimately renewed, however, thereby eliminating the need to submit Amendment 34 to CMS. Amendment 36 would allow the State to establish reasonable standards for providers of family planning services in the TennCare Demonstration. The State's public notice and comment period regarding Amendment 36 had not concluded by the end of DY 16, meaning that submission to CMS would occur during DY 17.

STC #29: TennCare's "Cost-Effective Alternatives" policy—BEN 08-001—outlines services TennCare MCOs may provide as cost-effective alternatives to covered Medicaid services. The document is available on the TennCare website at

<https://www.tn.gov/content/dam/tn/tenncare/documents2/ben08001.pdf>.

STC 29 requires the State to demonstrate annually that the use of CEAs is cost-effective and reimbursed in accordance with federal managed care regulations. With respect to this requirement, the State offers the following assurance:

With the exception of TennCare Select, all TennCare MCOs have entered a full risk agreement and are paid on a capitated basis. Incentives for risk MCOs are aligned in such a way that there is no logical reason an at-risk MCO would pay for a non-covered service unless it is determined to be a cost-effective alternative to a covered service.

All TennCare MCO Contracts require compliance with applicable policies and regulations—including the Special Terms and Conditions of the TennCare Demonstration—regarding utilization and payment of cost-effective alternative services. Further, in accordance with terms of the TennCare Select contract, the State is in receipt of a report demonstrating the use of TennCare-approved alternative services and their cost-effectiveness.

The MCO Contracts require and contain capitation payment rates that have been reviewed and certified by actuaries and have been determined to be actuarially sound.

STC #31.d.ii: On May 1, 2018, the State submitted to CMS an enrollment target range for CHOICES Group 2 for Demonstration Year 17. The range was 9,400 – 10,500.

STC #31.d.iv.(A): Each Quarterly Progress Report submitted during DY 16 provided data on enrollment in all three CHOICES groups, enrollment targets for CHOICES 2 and 3, and the number of reserve capacity slots being held for CHOICES Group 2. The operational procedures for determining individuals for whom CHOICES Group 2 reserve capacity slots are to be held are included as Attachment A. The State originally submitted these procedures to CMS on February 2, 2010, and has subsequently included the procedures as an attachment to each Annual Report.

STC #32.d.ii: On May 1, 2018, the State submitted to CMS enrollment target ranges for all three ECF CHOICES benefit groups for Demonstration Year 17. The range identified for Essential Family Supports (ECF CHOICES Group 4) was 875 – 900; the range identified for Essential Supports for Employment and Independent Living (ECF CHOICES Group 5) was 1,465 – 1,575; and the range identified for Comprehensive Supports for Employment and Community Living (ECF CHOICES Group 6) was 360 – 525.

STC #32.d.iv.(A): Each Quarterly Progress Report submitted during DY 16 provided enrollment totals, enrollment targets, and the number of reserve capacity slots being held for all three ECF CHOICES groups. The operational procedures for determining individuals for whom ECF CHOICES reserve capacity slots are to be held are included as Attachment B. The State originally submitted these procedures to CMS on October 28, 2016, and has subsequently included the procedures as an attachment to each Annual Report.

STC #39: The State requested approval by CMS of Statewide MCO Contract Amendment 7 and TennCare Select Contract Amendment 42 on December 1, 2017. In addition, the State requested approval by CMS of Statewide MCO Contract Amendment 8 and TennCare Select Contract Amendment 43 on May 30, 2018.

STC #42.b: A description of the steps taken to ensure compliance with the HCBS regulations identified in this STC is included as Attachment C. The State reviews—and, as needed, updates—this description each year and includes a copy with each Annual Report. In accordance with the 2014 HCBS settings rule, the State submitted a statewide transition plan to CMS on February 1, 2016, and—based on CMS feedback—an amended version of the document on March 23, 2016. CMS approved the State's transition plan on April 13, 2016.

STC #42.c.iv: The State submitted the document titled *2017 Update to the Quality Assessment and Performance Improvement Strategy* to CMS on December 20, 2017.

STC #42.d.iv: The State addressed data and trends of the designated CHOICES and ECF CHOICES data elements in each of the Quarterly Progress Reports and the Annual Report. Electronic copies of the CHOICES point-in-time data and annual aggregate data were submitted to CMS on September 29, 2017, and June 29, 2018. Electronic copies of the ECF CHOICES point-in-time and annual aggregate data were submitted to CMS on June 29, 2018.

STC #43: The State participated in formal Monthly Calls with CMS on October 26, 2017; January 25, 2018; March 22, 2018; April 26, 2018; May 31, 2018; and June 28, 2018. All other Monthly Calls were cancelled by joint agreement of CMS and the State.

STC #44: The State submitted Quarterly Progress Reports to CMS on August 29, 2017; November 29, 2017; March 1, 2018; and May 30, 2018.

STC #45: The State submitted a Annual Report to CMS on October 27, 2017. In addition, the State submitted the annual report concerning Title XXI Medicaid Expansion Children to CMS on December 28, 2017.

STC #46.b: Enrollment information was reported to CMS by Eligibility Group and Type in the Quarterly Progress Reports and the Annual Report.

STC #49: Member months were reported to CMS by Eligibility Group and Type in each Quarterly Progress Report.

STC #54.c: On March 30, 2018, the State submitted to CMS a new distribution methodology for the uncompensated care payments that were scheduled to go into effect on July 1, 2018.

ATTACHMENT E

THE IMPACT OF TENNCARE: A SURVEY OF RECIPIENTS, 2017

ATTACHMENT F

**2017 ANNUAL HEDIS/CAHPS REPORT: COMPARATIVE ANALYSIS
OF AUDITED RESULTS FROM TENNCARE MANAGED CARE ORGANIZATIONS**

ATTACHMENT G
QUALITY IMPROVEMENT STRATEGY
Required by STC 42.c.