DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

February 27, 2026

Stephen Smith, Director of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Stephen Smith:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Tennessee's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on September 25, 2025, and a final revised preprint was received on January 15, 2026. The proposal has a control name of TN_Fee.VBP_PC_Renewal_20260101-20261231.

CMS has completed our review of the following Medicaid managed care SDP(s):

- Uniform dollar increase, quality payment, and population-based payment for primary care services for the rating period covering January 1, 2026 through December 31, 2026, incorporated in the capitation rates through a risk-based rate adjustment up to $51,700,000.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

JOHN F. GILES JR -S

Digitally signed by JOHN F. GILES JR -S
Date: 2026.02.27 16:24:38 -05'00'

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   January 1, 2026 - December 31, 2026
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* January 1, 2026
3. Identify the managed care program(s) to which this payment arrangement will apply:
   CHOICES & non-CHOICES
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $51,700,000
   a. Identify the estimated federal share of this state directed payment: $33,170,720
   b. Identify the estimated non-federal share of this state directed payment: $18,529,280

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

01/01/18-12/31/18;01/01/19-12/31/19;01/01/20-12/31/22; 01/01/23-12/31/23; 01/01/24-12/31/24; 01/01/25-12/31/25

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☒ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☐ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

The per member per month payments are paid in order to reimburse providers for care coordination of their members. PCMH providers commit to member centered access, team based care, population health management, care management support, care coordination, performance measurement and quality improvement. Providers in the PCMH program must also obtain and/or maintain NCQA PCMH Recognition to participate in the program. Providers in the PCMH program are also eligible for outcome payments based on their performance on certain NCQA HEDIS quality and efficiency metrics. These efficiency metrics are Inpatient Utilization—General Hospital/Acute Care (IPU) and Ambulatory Care (AMB).

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☒ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☒ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☒ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

Providers participating in this program are eligible to receive an outcome payment. This payment is calculated based on performance on certain quality, efficiency and total cost of care metrics. Only the highest performing providers, those meeting the quality gate and showing improvement in either efficiency or total cost of care, will be eligible for the outcome payment. The outcome payments are distributed annually. This payment arrangement was originally designed with the support of our State Innovation Model grant. More info: https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation/patient-centered-medical-homes-pcmh.html.

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☒

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a. Please see Attachment C						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

The performance targets are set using national, statewide, and program level data. Performance for each participant and MCO is reviewed and targets are increased based on State goals and National benchmarks. For any new or modified metrics, a similar process of reviewing national, statewide, and program level data is used to set performance targets for measures. The performance targets for the efficiency metrics and total cost of care are set using statewide data.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

Organizations are eligible for outcome payments only if the organization meets the set quality gate for their specific designation (adult, family, or pediatric). Performance must meet or exceed the measure threshold (target) in order to earn a quality star. Pediatric and adult organizations are held to a total of five performance measures; they must earn three (3) stars to meet the quality gate and be eligible for an outcome payment. Family organizations are held to a total of ten performance measures; they must earn five (5) stars to meet the quality gate and be eligible for an outcome payment. This is a change for this performance year; historically pediatric and adult providers only needed to obtain two (2) stars and four (4) stars for family providers. The state expects to see improved value for the funding due to this change.

c. For state-developed measures, please briefly describe how the measure was developed?

n/a

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☒ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

Pursuant to 42 C.F.R. § 438.6(c)(3)(ii) the PMPM portion of this directed payment requires the state seek annually renew opposed to multi-year. This preprint is reflective of year 10 of the program. Tennessee's Primary Care Transformation strategy assists providers in promoting better quality care, improving population health, and reducing the cost of care. The PCMH directed payment has resulted in a robust program that, as a comprehensive care delivery model, is designed to improve the quality of primary care services for TennCare members, the capabilities of and practice standards of primary care providers, and the overall value of health care delivered to the TennCare population. Thus, TennCare envisions this program as a long-term investment to ensure optimal health outcomes for TennCare members.

15. Use the checkboxes below to make the following assurances:

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☒ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

$4 pmpm

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

MCOs pay per member per month (PMPM) payments that are risk-adjusted based on the acuity of the PCP groups membership.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

Activity payment amounts are risk-adjusted to account for differences in the degree of care coordination required for members with serious or chronic health conditions. All MCOs are using the same risk adjustment methodology, Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx), to ensure that payments are distributed fairly and appropriately to PMCHs.
All TennCare eligible members attributed to a PCMH are included in the calculation for the monthly pmpm payment. The payment is a $4.00 PMPM across all PCMH providers for each MCO - risk adjusted for acuity.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☐ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☒ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Patient Centered Medical Homes (PCMH)

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Primary care providers (PCPs) that are in the TennCare MCOs' networks are eligible to participate in this payment arrangement. Each MCO is responsible for determining which PCPs to contract with for this program.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

MCOs pay per member per month (PMPM) payments that are risk-adjusted based on the acuity of the PCP groups membership. All MCOs are using the same risk adjustment methodology, Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx), to ensure that payments are distributed fairly. The average payment is $4.00 PMPM across all PCMH providers for each MCO.
All providers in the PCMH program are measured against the same set of quality and efficiency metrics. Quality metrics are assigned state-wide benchmarks that are the same for all PCMH providers.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☐

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Primary Care Services	75.17%	2.45%			77.62%
b.					
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

a. ☒ Medicare payment/cost

b. ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*

c. ☐ Other; Please define:

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The state has taken the approach of having its actuaries compare core capitation reimbursement for professional services to Medicare, and then estimating the impact this specific directed payment would have on that reimbursement level.

*https://healthcostinstitute.org/hcci-research/comparing-commercial-and-medicare-professional-service-prices
**https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/
^https://www.genworth.com/aging-and-you/finances/cost-of-care.html

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

TennCare has created an aligned Patient Centered Medical Home (PCMH) program across the State's Managed Care Organizations (MCOs) to improve the quality of care among primary care providers in Tennessee. PCMH programs put primary care providers in the center of their patients' medical networks. From this central position, providers can ensure that their patients are receiving high quality and efficient health care. These providers are compensated with ongoing financial support and an opportunity for an annual outcome payment based on quality and efficiency performance.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

N/A - Please see Attachments A & B

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

C.3.1.5

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. Tennessee_CHOICES Non-CHOICES_20260101-20261231_Certification _20250930	10/01/2025	Yes	Page 42
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

a. ☒ An adjustment applied in the development of the monthly base capitation rates paid to plans.

b. ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.

c. ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

a. ☒ State general revenue

b. ☐ Intergovernmental transfers (IGTs) from a State or local government entity

c. ☐ Health Care-Related Provider tax(es) / assessment(s)

d. ☐ Provider donation(s)

e. ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

a. Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☐

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.tn.gov/content/dam/tn/tenncare/archive/2024QualityStrategyUpdateToPublicComment.pdf
- **b.** The effective date of quality strategy. December 4, 2024

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Goal 1: Improve the health and wellness of new mothers and infants	Objective(s): 1.3 Increase the use of well-child visits in the first 30 months	6
b. Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions	Objective(s): 2.1 Increase child and adolescent well care visits 2.3 Increase child immunizations 2.4 Improve high blood pressure control in adults 2.5 Increase cervical cancer screening in adults 2.7 Decrease emergency department utilization for children	6
c. Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care	Objective(s): 7.1 Maintain the percentage of TennCare members attributed to PCMH organizations	8
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The TennCare Quality Strategy goals and objectives listed above will be advanced by the TennCare Patient Centered Medical Home (PCMH) program through incentives tied to quality measures directly related to these objectives. Overall, the PCMH program is designed to improve the quality of primary care services for TennCare members. Organizations participating in the PCMH program must meet or exceed thresholds for these quality measures in order to receive an outcome payment. With respect to Goal 7 and maintaining the percentage of TennCare members attributed to PCMH organizations, TennCare has included a minimum attributed membership requirement of 40% for each MCO beginning January 1, 2023 the MCO statewide contract. MCOs must meet this membership requirement by having at least 40% of their overall TennCare membership attributed to a PCMH organization.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Please see Attachment C				
ii.				
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

Please see Attachments D & E. Due to overlap of quality measures from the PCMH programs with the Quality Strategy, this evaluation demonstrates the impact to the shared goals and objectives in the Quality Strategy.

Table 1: Payment Arrangement Provider Performance Measures
Program: Tennessee Patient Centered Medical Home

Measure Name and NQF (if applicable)	Measure Steward/ Developer	Baseline Year	Baseline Statistic	Performance Measurement Period	Performance Target	Notes	Measure Description
Cervical Cancer Screening (NQF #0032)	NCQA/HEDIS	2023	53.10%	Performance on measure will be collected each year beginning in 2025. Payments will be made the following year (i.e., for performance in 2025, payment will be made in 2026).	≥ 52.00%	Current baseline statistic show in using data from CY2023 and was calculated when engaged in setting thesholds for this metric. New measure in PY 2025.	% of members 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer
Blood Pressure Control for Patients With Diabetes (NQF #0061)	NCQA/HEDIS	2018	50%	Performance on measure will be collected each year beginning in 2023. Payments will be made the following year (i.e., for performance in 2023, payment will be made in 2024).	≥ 62.00%	Baseline statistic is for CY2018 PCMH Performance	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose blood pressure was adequately controlled (<140/90 mm Hg). Performance should be above or equal to threshold.
Breast Cancer Screening (NQF #2372)	NCQA/HEDIS	2022	48.77%	Performance on measure will be collected each year beginning in 2024. Payments will be made the following year (i.e., for performance in 2024, payment will be made in 2025).	>=40.00%	New measure implemented in 2024. NCQA expanded denominator from members ate 50-74 to members age 40-74. Due to this mid-year change, the threshold was reduced from 47% to 40%. Baseline still reflective of previous measure that only included members aged 50-74.	The percentage of members 40–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.
Child and Adolescent WellCare Visits Ages 12-17 years (NQF # 1516)	NCQA/Hedis	*2020	*55%	Performance on measure will be collected each year beginning in 2023. Payments will be made the following year (i.e., for performance in 2023, payment will be made in 2024).	≥ 57.00%	Measure updated in program year 2021; *Current baseline statistic show in using data from CY2019 and was calculated when engaged in setting thesholds for this metric. CY2022 performance was 55%.	The percentage of members 12-17 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year. Performance should be above or equal to threshold.
Child and Adolescent WellCare Visits Ages 18-21 years (NQF # 1516)	NCQA/Hedis	*2020	*47%	Performance on measure will be collected each year beginning in 2023. Payments will be made the following year (i.e., for performance in 2023, payment will be made in 2024).	≥ 39.00%	Measure updated in program year 2021. *Current baseline statistic show in using data from CY2019 and was calculated when engaged in setting thesholds for this metric. CY2022 performance was 27%.	The percentage of members 18-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year. Performance should be above or equal to threshold.
Child and Adolescent WellCare Visits Ages 3-11 years (NQF # 1516)	NCQA/Hedis	*2020	*62%	Performance on measure will be collected each year beginning in 2023. Payments will be made the following year (i.e., for performance in 2023, payment will be made in 2024).	≥ 65.00%	Measure updated in program year 2021. *Current baseline statistic show in using data from CY2019 and was calculated when engaged in setting thesholds for this metric. CY2022 performance was 63%.	The percentage of members 3-11 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year. Performance should be above or equal to threshold.
Childhood Immunizations Status – Combination 10 (NQF #0038)	NCQA/HEDIS	2019	32%	Performance on measure will be collected each year beginning in 2023. Payments will be made the following year (i.e., for performance in 2023, payment will be made in 2024).	≥ 42.00%	Measure updated in program year 2019; Baseline statistic is for CY2019 PCMH performance. Baseline statistic updated to 28.4% in 2022 from recent program evaluation.	The percentage children 2 years of age who had 4 DTaP, 3 polio, 1 MMR, 3 HiB, 3 HepB, 1 VZV, 4 PCV, 1 HepA, 2 or 3 RV, and 2 influenza vaccines by their second birthday. The performance should be above or equal to threshold.
Controlling High Blood Pressure (NQF #0018)	NCQA/HEDIS	2022	55%	Performance on measure will be collected each year beginning in 2023. Payments will be made the following year (i.e., for performance in 2023, payment will	≥ 60.00%	Measure updated in program year 2020; Baseline statistic calculated on PY2022.	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Eye Exam for Patients with Diabetes (NQF # 0055)	NCQA/Hedis	2018	52%	Performance on measure will be collected each year beginning in 2023. Payments will be made the following year (i.e., for performance in 2023, payment will be made in 2024).	≥ 51.00%	Baseline statistic is for CY2018 PCMH Performance	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam. Performance should be above or equal to threshold.
Glycemic Status Assessment for Patients with Diabetes-Glycemic Status <8.0%	NCQA/HEDIS	2022	45.01%	Performance on measure will be collected each year beginning in 2025. Payments will be made the following year (i.e., for performance in 2025, payment will be made in 2026).	>=47%	New measure implemented in 2024.	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following

Immunizations for Adolescents - Total rate-Combination 2 (NQF #1407)	NCQA/HEDIS	2018	30%	Performance on measure will be collected each year beginning in 2023. Payments will be made the following year (i.e., for performance in 2023, payment will be made in 2024).	≥ 26.00%	Baseline statistic is for CY2018 PCMH Performance.	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. Performance should be above or equal to threshold.
Upper Respiratory Infection (NQF #0069)	NCQA/HEDIS	2022	87%	Performance on measure will be collected each year beginning in 2025. Payments will be made the following year (i.e., for performance in 2025, payment will be made in 2026).	≥ 93.00%	New metric in 2024; Baseline statistic is for CY2022 PCMH performance.	The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.
Well-Child Visits for Age 15 Months - 30 Months (NQF # 1392)	NCQA/Hedis	2021	*65%	Performance on measure will be collected each year beginning in 2023. Payments will be made the following year (i.e., for performance in 2023, payment will be made in 2024).	≥ 71.00%	Measure updated in program year 2021. *Current baseline statistic show in using data from CY2019 and was calculated when engaged in setting thesholds for this metric. New baseline calculated in recent study indicates baseline in 2022 at 70.4%	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Children who turned 30 months old during the measurement year: Two or more well-child visits. Performance should be above or equal to threshold.
Well-Child Visits in the First 15 Months of Life (NQF # 1392)	NCQA/Hedis	2021	*52%	Performance on measure will be collected each year beginning in 2023. Payments will be made the following year (i.e., for performance in 2023, payment will be made in 2024).	≥ 61.00%	Measure updated in program year 2021. *Current baseline statistic show in using data from CY2019 and was calculated when engaged in setting thesholds for this metric. TennCare Quality Strategy Goal 1. New baseline calculated in recent study indicates baseline in 2022 at 65.4%	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Children who turned 15 months old during the measurement year: Six or more well-child visits. Performance should be above or equal to threshold.

Table 8: Evaluation Measures, Baseline, and Performance Targets
Program: Patient Centered Medical Home

The baseline statistics, when listed below, are specific to the PCMH population and may differ from the baseline provided in the Quality Strategy for the full TennCare Medicaid, CHIP, and TennCare Select population.

Measure Name and NQF (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes
Blood Pressure Control for Patients With Diabetes (NQF #0061)	2018	50%	Performance target at 62%	TennCare Quality Strategy Goal 2 Quality Metric.
Breast Cancer Screening (NQF #2372)	2022	48.77%	Threshold for PCMH program is set at 40%	TennCare Quality Strategy Goal 2 Quality Metric. New measure in PY 2024.
Cervical Cancer Screening (NQF #0032)	2023	*53.1%	Threshold for PCMH program is set at 52%	TennCare Quality Strategy Goal 2 Quality Metric. *Current baseline statistic show in using data from CY2023 and was calculated when engaged in setting thesholds for this metric. New measure in PY 2025.
Child & adolescent well-care visits: 12-17 years (NQF #1516)	2021	*55%	Increase well child visits.; Performance target at 57%	Measure updated in program year 2021; *Current baseline statistic show in using data from CY2019 and was calculated when engaged in setting thesholds for this metric. CY2022 performance was 55%. TennCare Quality Strategy Objective 2.1
Child & adolescent well-care visits: 18-21 (NQF #1516)	2021	*47%	Increase well child visits.; Performance target at 39%	Measure updated in program year 2021. *Current baseline statistic show in using data from CY2019 and was calculated when engaged in setting thesholds for this metric. CY2022 performance was 27%. TennCare Quality Strategy Objective 2.1
Child & adolescent well-care visits: 3-11 years (NQF #1516)	2021	62%	Increase well child visits.; Performance target at 65%	Measure updated in program year 2021. *Current baseline statistic show in using data from CY2019 and was calculated when engaged in setting thesholds for this metric. CY2022 performance was 63%. TennCare Quality Strategy Objective 2.1
Childhood Immunizations Status – Combination 10 (NQF #0038)	2019	32%	Increase child immunizations; Performance target set at 42%	Measure updated in program year 2019; Baseline statistic is CY2019 performance. Baseline statistic updated to 28.4% in 2022 from recent program evaluation. TennCare Quality Strategy Goal 2.
Controlling High Blood Pressure (NQF #0018)	2022	55%	Improve high blood pressure control in adults; Performance target set at 60%	Measure updated in program year 2020; Baseline statistic calculated on PY2022. TennCare Quality Strategy Goal 5, objective 2.4
Eye Exam for Patients with Diabetes (NQF # 0055)	2018	52%	Performance target set at 51%	TennCare Quality Strategy Goal 2 Quality Metric.
Glycemic Status Assessment for Patients with Diabetes-Glycemic Status <8.0%	2022	45.01%	Threshold for PCMH program is set at 47%	TennCare Quality Strategy Goal 2 Quality Metric. New measure in PY 2024
Immunizations for Adolescents - Total rate-Combination 2 (NQF #1407)	2018	30%	Increase adolescent immunizations; Performance target set at 26%	TennCare Quality Strategy Goal 2 Quality Metric.
Percentage of TennCare members attributed to TennCare PCMH organizations	2019	40.70%	Maintain the percentage of TennCare members attributed to PCMH organizations	TennCare Custom Measures; TennCare Quality Strategy Goal 7
Well-Child Visits for Age 15 Months - 30 Months (NQF # 1392)	2021	*65%	Increase well child visits in the first 30 months of life; Performance target set at 71%	Measure updated in program year 2021. *Current baseline statistic show in using data from CY2019 and was calculated when engaged in setting thesholds for this metric. TennCare Quality Strategy Goal 2. New baseline calculated in recent study indicates baseline in 2022 at 70.4%

Well-Child Visits in the First 15 Months of Life (NQF # 1392)	2021	*52%	Increase well child visits in the first 30 months of life; Performance target set at 61%	Measure updated in program year 2021. *Current baseline statistic show in using data from CY2019 and was calculated when engaged in setting thesholds for this metric. TennCare Quality Strategy Goal 2. New baseline calculated in recent study indicates baseline in 2022 at 65.4%