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

June 22, 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 an amendment for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on March 6, 2026. The proposal has a control name of TN_VBP.Fee_AMC_Amend_ 20250101-20251231.

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

- Uniform percentage increase for professional services at an academic medical center for rating periods covering January 1, 2025 through December 31, 2025, incorporated in the capitation rates through a separate payment term amount up to $15,741,366.

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.

Based on CMS's preliminary determination, the SDP proposal with the control name of TN_VBP.Fee_AMC_Renewal_20250101-20251231 likely qualified for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21). CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of $15,741,366 for the grandfathered SDP named TN_VBP.Fee_AMC_Renewal_20250101-20251231 submitted on September 20, 2024 (as specified in item 4 of the applicable SDP preprint form) cannot increase and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal of this SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

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: 2026.06.22 15:56:27 -04'00'

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, 2025 - December 31, 2025
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, 2025
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: $15,741,366
   a. Identify the estimated federal share of this state directed payment: $10,189,386
   b. Identify the estimated non-federal share of this state directed payment: $5,551,980

   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:

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:

The magnitude of the increase is being updated. Question 19b is being changed as a result.

☐ 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 total value-based payments (comprised of quarterly infrastructure investments and quality payments based on performance metrics) are commensurate with the difference between the eligible providers contracted Medicaid rates and a statewide average commercial rate (ACR). The statewide ACR was developed by gathering commercial allowed amounts per CPT similar to the CMS fee-for-service guidance "Medicaid Qualified Practitioner Services – Methodologies for Enhanced Payment Made to Physicians and Practitioners Associated with Academic Medical Centers and Safety Net Hospitals and Upper Payment Calculation". The commercial allowed amounts were used to calculate a physician practice plan specific ACR using Medicaid managed care data instead of fee-for-service data. The statewide ACR was calculated using a weighted average of the practice-specific ACRs.
The quarterly infrastructure payments are one component of this payment arrangement. Due to the costs associated with providers implementing and executing the quality improvement initiatives requested, these payments will be provided to eligible providers quarterly. These amounts will be calculated using current period in-network utilization data. The total annual subpool of funding available for the quarterly payments (70% of total pool) is divided into four equal quarterly installments. Each quarter, the state will collect current period utilization data from the MCOs and use the ratios of utilization to distribute payments proportionally to the providers, resulting in a uniform percentage increase for that quarter. In order to earn these quarterly payments, providers will be held accountable for quality improvement activities that the state has designed to support the ultimate achievement of the quality objectives used to measure performance for the other subpool. Providers that fail to complete the quality improvement activities, or fail to complete them adequately, may have all or a portion of their payments reduced.
The second payment component under the proposed value-based payment arrangement is contingent on the providers' ability to implement a population health approach to improving outcomes and deliver efficient and effective care for focused populations as indicated by their performance on the measures listed in table 1.A of the preprint. The payments under the second component will come from the annual quality incentive pool. This pool will be determined retrospectively using in-network utilization data under the contract. The amount of available funding for quality incentive pool will be calculated based on the difference between total provider payments (MCO reimbursement and the aforementioned quarterly payments) and average commercial reimbursement.
This payment approach will result in plan payment being made based on actual utilization under the contract. Under the proposed payment arrangement, eligible providers will receive quarterly infrastructure payment in recognition of the need to develop and

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).

This quality program was developed to improve lives by providing additional support through high-quality cost-effective care using an outcome value-based payment for physician practice plans affiliated with Tennessee's public medical schools, Quillen East Tennessee State University (ETSU) and University of Tennessee – University Clinical Health (UCH) ("the Institutions"). The key areas of focus are population health and care coordination, behavioral health, maternal health, and pediatric health.

This quality program aligns with TennCare's Quality Strategy goals to ensure appropriate access to high- quality, cost-effective care and demonstrable improvement in health outcome measures. Areas of focus under TennCare's Quality Strategy include the goals of improving the health of mother and infants, increasing use of preventive care services for all members to reduce risk of chronic health conditions, integrating patient-centered holistic care including non-medical risk factors into population health coordination, and providing additional support and follow-up for patients with behavioral health needs. This program's quality metrics were chosen to support the aforementioned TennCare Quality Strategy goals. In addition, the program supports the Governor's initiative of "Tennessee Strong Families" and a 2022 Agency Priority of increasing maternal health access with a particular focus on the high-risk maternity population.

Under this payment arrangement, eligible providers are paid in recognition of both their infrastructure investments and their performance on quality metrics to shift the focus from volume to value, consistent with TennCare's mission to provide high-quality cost-effective care.

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 A, Table 1A						
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 following describes the methodology which will be used to set thresholds.

For those measures which are from the CMS Core Measure Set or HEDIS measures, performance targets were created based on the proximity of baseline rates to the 25th, 50th, 75th, or 90th percentile for that measure nationally. For example, if the Institution's baselines are greater than 5 points below the 25th percentile, then the target is set for 25th percentile. If the baseline is within 5 points, then the next milestone (50th percentile) is set as the target. For the custom metrics, the performance targets were set to be the maximum baseline rate for the measure plus 5%.

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?

Each year, the provider's performance on the quality measures is evaluated and compared to set performance targets to see if the performance on that measure met or exceeded the set target. The percent of total measures that met or exceeded the set target is used to calculate the "benchmark payment" portion of the total quality payment.

Should the provider not meet the target, but still show significant improvement (based on the below table), the provider will be eligible for an incremental improvement bonus payment. Out of the measures that did not meet the set target, the percent that showed significant improvement is used to calculate the incremental improvement bonus payment.

The total payment is a combination of the payment for measures that met the threshold and the incremental improvement bonus payment.

Table for calculating significant improvement:
Baseline Rate (%) Minimum Effect Size (i.e. Minimum Percentage Point Increase)
0% - 59% 6%
60% - 74% 5%
75% - 84% 4%
85% - 92% 3%
93% - 96% 2%
97% - 99% 1%

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

There are three (3) custom measures included in the program: 1) ED utilization, 2) Primary Care Utilization- pediatric, and 3) Primary Care Utilization - adult. Each of the measures were developed to support the priority areas of Population Health and to align with the goals and objectives in the TennCare Quality Strategy.

ED utilization is similar to the retired HEDIS measure (EDU) as a measure to observe the rate of emergency department use of the member population. Primary care physician utilization was developed to track preventive care utilization. The health care utilization measures (emergency department, primary care, and plan all cause readmission), one of which is HEDIS, provide a broader picture of the utilization patterns of the population and areas of opportunity for the Institutions.

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.

In order to ensure that the state is supporting programs that are operationally and financially compatible with agency goals, the state has opted to view this program on a year by year basis. This preprint is for year 7 (or year 2 of the updated version of this arrangement) of the program; however, slight improvements and modifications are made year over year.

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?)

57.98%

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).

Lump sum settlements paid out quarterly after receiving utilization data

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

This directed payment is based on an estimate of the upper payment limit (UPL) for the associated providers. To calculate the estimated UPL, the state collected data to determine what the average commercial rate (ACR) is and then collects data on historical TennCare MCO reimbursement in order to determine the gap between reimbursement and the UPL. The total program size is set equal to the estimated UPL. TennCare believes investing in these providers at the UPL is appropriate because the funds will be used to achieve the quality outcomes outlined elsewhere in this preprint.

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).

Academic affiliated providers who were participating in a value-based payment arrangement prior to the approval of the state's most recent waiver

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.

The state is working with academic-affiliated providers that have a history of being proactive in initiating value-based procedures and supporting the core mission of the Medicaid program. TennCare is committed to continue this program with these providers/institutions as they have invested in their programs and have committed to leveraging health strategies to support increased care coordination and care management.

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.

The total size of the value-based payments was developed using a weighted average of each eligible providers' average commercial rate. In this calculation, each provider was treated equally relative to their Medicaid volume. The measures used to recognize the quality improvement initiative work, data reporting adherence, and the same terms of performance will be the same for the class of in-network 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. Academic affiliated physicians practice groups	56%	44%			100%
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: Average Commercial Rate

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 compared annual cost data that was gathered from the providers per CPT code that are relevant to this payment structure. We examined Medicaid payments by each MCO for those services and compared that to what the providers were paid from their top five commercial payers in order to calculate the average commercial rate. In turn, the state was then were able to establish what percentage Medicaid is paying of their ACR.

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

CMS allows states to pay up to the UPL for fee-for-service, so the state is approximating that methodology (under managed care).

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?

Please see Attachments B & C

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_20250101-20251231_Certification _20240930	09/30/2024	Yes	40-45
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.

As CMS indicated in several question sets in previous rating periods for directed payment programs that operate utilizing a set pool amount, this program more easily operates as a separate payment term, thus the state is now intends to utilize that payment mechanism. Given the CMS's prior approval of such an arrangement, the state has opted to continue to operationalize this program in this way.

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. ETSU	healthcare practice affiliated with a public me	$ 2,128,078.30	No	n/a	Yes
ii. UCH	healthcare practice affiliated with a public me	$ 2,293,090.65	No	n/a	Yes
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.

There are no written agreements between the state Medicaid agency and the institutions related to the non-federal share of this payment arrangement.

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/documents2/2023QualityStrategy.pdf
- **b.** The effective date of quality strategy. December 26, 2023

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	Obj. 1.2 Increase the use of postpartum services	6
b. Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions	Obj. 2.3 Increase child immunizations Obj. 2.8 Reduce rate of hospital readmissions	6
c. Goal 5: Provide additional support and follow-up for patients with behavioral health care needs	Obj. 5.Improve follow-up after hospitalization for mental illness in adults Obj. 5.2 Improve follow-up after hospitalization for mental illness in children	7
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.

TennCare will continue to engage in an upper payment limit initiative with the Institutions. This initiative leverages the combination of primary and specialist physicians in the groups and their academic affiliations to improve the effectiveness and quality of care for TennCare members particularly in population health and care coordination, prevention, behavioral health needs, and focused engagement for maternity and pediatric care.

The Plans will:
- Leverage population health strategies to support increased care coordination and care management for attributed TennCare members across outpatient primary care, specialty care, and behavioral health care and in addition to emergency care.
-Address early prevention and screening for the pediatric and maternity populations. This includes leading efforts to develop clinical pathways and engagement opportunities to increase use of preventive and immunization services for the attributed maternity and pediatric populations.
In consideration of the need to retain and train additional staff, the level of coordination of care necessary to achieve the underlying goals, and the multi-faceted approach required to make quality improvements, a multi-year payment arrangement is in place. The first five years of the arrangement (January 2019 – December 2023) focused on implementation of quality initiatives and requisite data reporting, with baseline evaluation and year over year incremental improvement.
Year 6 of the arrangement introduced realignment with TennCare's Quality strategy and associated quality metrics, new quality initiatives, baseline evaluation, and necessary data reporting. This year's arrangement focuses on implementation of the new quality initiatives and associated quality metrics.

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. See Attachment A, Table 8.A.				
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 the attached evaluation findings (Tennessee's Evaluation Findings for TN_VBP.Fee_AMC_Renewal, Contract Rating Year 2025).

Section 438.6(c) Preprint Addendum Tables

Overview

This addendum to the Section 438.6(c) preprint file allows States to add rows to the eight tables in the preprint: Please use this workbook if States need additional rows than what is provided in the preprint. States may also use the Workbook Tables 1.A. - 8.A. in lieu of completing Tables 1 - 8 in the preprint.

Directions

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into all addendum Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 1.A, please delete Tabs 2.A - 8.A

CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

Addendum Table Organization

The addendum tables are organized by tab. Within the tables, States will find data elements with specific drop-downs that CMS has pre-selected to standardize data provided by States in the preprint.

Table 1.A	Payment Arrangement Provider Performance Measures
Table 2.A	Provider Payment Analyses
Table 3.A	Actuarial Rate Certification(s)
Table 4.A	IGT Transferring Entities
Table 5.A	Health Care-Related Provider Tax/Assessment(s)
Table 6.A	Health Care-Related Provider Tax/Assessment Waivers
Table 7.A	Payment Arrangement Quality Strategy Goals and Objectives
Table 8.A	Evaluation Measures, Baseline and Performance Targets

Identifying Information	Column1
State/Territory (Select from dropdown menu):	Tennessee

PREPRINT SUBSECTION IIA: VALUE-BASED PAYMENT/DELIVERY SYSTEM REFORM
ADDENDUM TABLE 1.A. PAYMENT ARRANGEMENT PROVIDER PERFORMANCE MEASURES

Directions

1. In Table 1.A below, use the rows to add more measure(s) to Table 1 that the State will tie to provider performance under this value-based payment or delivery system reform arrangement (provider performance measures). States may also use Table 1.A in lieu of completing Table 1 in the preprint. Input data only in beige cells in columns B - H.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 1 in the preprint, please delete Tabs 2.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 1.A: Payment Arrangement Provider Performance Measures

Column↑	Measure Name and NQF # (if applicable)	Measure Steward/Developer	Baseline Year	Baseline Statistic	Performance Measurement Period	Performance Target	Notes
			Year	Percent		Percent	
a.	Antidepressant Medication Management (NQF #0105)	National Committee for Quality Assurance	CY 2018	ETSU: 41% UCH: 19%	Years 1-5	≥40%	Retired after 2023 because the measure steward announced that measure will retire in 2025.
b.	Asthma Medication Ratio (NQF #1800)	National Committee for Quality Assurance	CY 2018	ETSU: 67% UCH: 48%	Years 1-5	≥81%	Established new baseline and threshold for Years 6-7
c.	Childhood Immunization Status – Combo 10 (NQF #0038)	National Committee for Quality Assurance	CY 2018	ETSU: 57% UCH: 14%	Years 1-5	≥42%	Established new baseline and threshold for Years 6-7
d.	Comprehensive Diabetes Care: BP Control (<140/90 mmHg) (NQF #0061)	National Committee for Quality Assurance	CY 2018	ETSU: 65% UCH: 55%	Years 1-5	≥56%	Retired after 2023 because both institutions met the performance target in MY 2022.
e.	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed (NQF # 0055)	National Committee for Quality Assurance	CY 2018	ETSU: 59% UCH: 51%	Years 1-5	≥51%	Retired after 2023. NCQA recommends all three measures (0061, 0055, and 0059) for diabetes. Since program is retiring 0061 and 0059, 0055 was removed as well.
f.	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (NQF #0059)	National Committee for Quality Assurance	CY 2018	ETSU: 50% UCH: 54%	Years 1-5	≤47%	Retired after 2023 because both institutions met the performance target in MY 2022.
g.	Child and Adolescent Well-Care Visits Ages 3-11 (NQF # 1516)	National Committee for Quality Assurance	CY 2019	ETSU: 58% UCH: 66%	Years 2-5	≥65%	Retired after 2023 due to measure reduction.
h.	Child and Adolescent Well-Care Visits Ages 12-17 (NQF # 1516)	National Committee for Quality Assurance	CY 2019	ETSU: 53% UCH: 60%	Years 2-5	≥57%	Retired after 2023 due to measure reduction.
i.	Child and Adolescent Well-Care Visits Ages 18-21 (NQF # 1516)	National Committee for Quality Assurance	CY 2019	ETSU: 40% UCH: 50%	Years 2-5	≥39%	Retired after 2023 due to measure reduction.
j.	Well-Child Visits in the First 30 Months of Life: First 15 Months (NQF # 1392)	National Committee for Quality Assurance	CY 2019	ETSU: 55% UCH: 47%	Years 2-5	≥61%	Retired after 2023 due to measure reduction.
k.	Well-Child Visits in the First 30 Months of Life: 15-30 Months (NQF # 1392)	National Committee for Quality Assurance	CY 2019	ETSU: 64% UCH: 50%	Years 2-5	≥71%	Retired after 2023 due to measure reduction.
l.	Immunizations for Adolescents – Combination 2 (NQF #1407)	National Committee for Quality Assurance	CY 2018	ETSU: 32% UCH: 24%	Years 1 – 5	≥26%	Retired after 2023 to focus efforts on CIS 10 which aligns with Quality Strategy.
m.	Chronic Opioid Users with Decreased Usage	State-defined	CY 2018	ETSU: 18% UCH: 24%	Years 2-3	≥34%	After Year 3, this measure was replaced with Use of Opioids at High Dosage in Persons without Cancer
n.	Use of Opioids at High Dosage in Persons without Cancer (NQF # 2940)	National Committee for Quality Assurance	CY 2020	ETSU: 8% UCH: 4%	Years 4-5	≤ 4%	Retired after 2023 due to measure reduction and one institution meeting threshold.
o.	Concurrent Use of Opioids and Benzodiazepines (NQF #3389)	Other (specify in "Notes" column)	CY 2018	ETSU: 17% UCH: 9%	Years 2-5	≤9%	Measure steward is PQA, Inc. Retired after 2023.
p.	Initiation of Opioid Abuse or Dependence Treatment	State-defined	CY 2018	ETSU: 29% UCH: 23%	Years 2-5	≥39%	Retired after 2023 due to measure reduction and one institution meeting threshold.
q.	Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence, 30-day rate (NQF #3488)	National Committee for Quality Assurance	CY 2018	ETSU: 13% UCH: 12%	Years 2-5	≥18%	Established new baseline and threshold for years 6-7
r.	Prenatal and Postpartum Care: Postpartum Care (NQF #1517)	National Committee for Quality Assurance	CY 2018	ETSU: 65% UCH: 56%	Years 2-5	≥66%	Established new baseline and threshold for years 6-7
s.	Prenatal and Postpartum Care: Postpartum Care for Women with OUD	State-defined	CY 2018	ETSU: 51% UCH: 53%	Years 2-5	≥66%	Retired after 2023 due to measure reduction.
t.	Prenatal and Postpartum Care: Timeliness of Prenatal Care (NQF #1517)	National Committee for Quality Assurance	CY 2018	ETSU: 98% UCH: 95%	Years 2-5	≥84%	Retired after 2023 because both institutions met the performance target in MY 2022.
u.	Plan-All Cause Readmission (NQF #1768)	National Committee for Quality Assurance	CY 2018	ETSU: 21% UCH: 24%	Years 2-5	≤17%	Established new baseline and threshold for years 6-7
v.	ED Utilization (per 1,000 member months)	State-defined	CY 2018	ETSU: 54 UCH: 53	Years 2-5	≤44	Established new baseline and threshold for years 6-7
w.	Asthma Medication Ratio (AMR), (NQF #1800)	National Committee for Quality Assurance	CY 2022	ETSU: 66.26% UCH: 56.25%	Years 6 -7	≥65.61%	Establishing new baseline and threshold for years 6-7
x.	Statin Therapy for Patients with Cardiovascular Disease (SPC)	National Committee for Quality Assurance	CY 2022	ETSU: 67.78% UCH: 69.23%	Years 6 -7	≥71.05%	Establishing new measure for years 6-7
y.	Prenatal and Postpartum Care: Postpartum Care (PPC), (NQF #1517)	National Committee for Quality Assurance	CY 2022	ETSU: 72.93% UCH: 63.89%	Years 6 -7	≥73.97%	Establishing new baseline and threshold for years 6-7
z.	Childhood Immunization Status – Combo 10 (CIS), (NQF #0038)	National Committee for Quality Assurance	CY 2022	ETSU: 27.63% UCH: 4.32%	Years 6 -7	≥37.64%	Establishing new baseline and threshold for years 6-7
aa.	Follow-up after Hospitalization for Mental Illness, 7-day rate (FUH), (NQF# 0576)	National Committee for Quality Assurance	CY 2022	ETSU: 39.86% UCH: 38.81%	Years 6 -7	≥44.29%	Establishing new measure for years 6-7
bb.	Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence, 30 day rate (FUA), (NQF #3488)	National Committee for Quality Assurance	CY 2022	ETSU: 30.23% UCH: 13.79%	Years 6 -7	≥27.75%	Establishing new baseline and threshold for years 6-7
cc.	Inpatient Utilization (IPU)	National Committee for Quality Assurance	CY 2022	N/A	Years 6 -7	N/A	Removing measure from proposal because measure steward is retiring the measure.
dd.	Plan-All Cause Readmission (NQF #1768)	National Committee for Quality Assurance	CY 2022	ETSU: 1.2945 UCH: 0.9370	Years 6 -7	≤1.0604	Establishing new baseline and threshold for years 6-7. Measure was previously reported as a percentage. The state has updated the metric to be reported as the ratio of observed to expected readmissions to align with the HEDIS definition of the metrics, which allows for use of national benchmarks for setting performance target.
ee.	ED Utilization (per 1,000 member months)	State-defined	CY 2022	ETSU: 23.51 UCH: 27.51	Years 6 -7	≤22.51	Establishing new baseline and threshold for years 6-7
ff.	Follow-up after Hospitalization for Mental Illness, 30-day rate (FUH), (NQF# 0576)	National Committee for Quality Assurance	CY 2022	ETSU: 59.72% UCH: 60.00%	Years 6 -7	≥65.38%	Establishing new measure for years 6-7
gg.	Statin Therapy for Patients with Diabetes Disease (SPD)	National Committee for Quality Assurance	CY 2022	ETSU: 68.13% UCH: 66.14%	Years 6 -7	≥72.3%	Establishing new measure for years 6-7
hh.	Primary Care Utilization Pediatric (0-20)	State-defined	CY 2022	N/A	Years 6 -7	N/A	Measure will be reporting only.
ii.	Primary Care Utilization Adult (21+)	State-defined	CY 2022	N/A	Years 6 -7	N/A	Measure will be reporting only.

PREPRINT SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS
ADDENDUM TABLE 8.A. EVALUATION MEASURES, BASELINE AND PERFORMANCE TARGETS

Directions

8. Use Table 8.A below to add each measure the State intends to use in the evaluation of this payment arrangement, including (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. States may also use Table 8.A in lieu of completing Table 8 in the preprint. Input data only in beige cells in columns B - F.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 8 in the preprint, please delete Tabs 1.A - 7.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 8.A: Evaluation Measures, Baseline and Performance Targets

Column1	Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes
		Year	Percentage	Percentage	
i.	Prenatal and Postpartum Care: Postpartum Care (NQF #1517)	CY 2022	ETSU: 72.93% UCH: 63.89%	Increase the use of postpartum services by 1% over 1 year	TennCare Quality Strategy Objective 1.2. New baselines were established for Year 6.
ii.	Childhood Immunization Status – Combo 10 (NQF #0038)	CY 2022	ETSU: 27.63% UCH: 4.32%	Increase childhood immunizations by 3% over 5 years	TennCare Quality Strategy Objective 2.3. New baselines were established for Year 6.
iii.	Follow-up after Hospitalization for Mental Illness, 7-day rate (FUH) (NQF #0576)	CY 2022	ETSU: 39.86% UCH: 38.81%	Improve follow-up after hospitalization for mental illness in adults by 3% over 5 years	TennCare Quality Strategy Objective 5.1, 5.2. New baselines were established for Year 6.
iv.	Plan-All Cause Readmission (NQF #1768)	CY 2022	ETSU: 1.2945 UCH: 0.9370	Reduce the ratio of hospital readmissions to <1 over 1 year	TennCare Quality Strategy Objective 2.8. New baselines were established for Year 6.