Division of TennCare

Tennessee Department of Finance & Administration

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Annual Monitoring Report

(For the period January – December 2023)

June 30, 2024

TennCare III Monitoring Report

Tennessee operates its Medicaid program under the authority of an 1115 demonstration known as TennCare. TennCare is a comprehensive Medicaid reform project, consisting of innovations in a number of aspects of the Medicaid program, including eligibility, benefits, and service delivery systems. The primary goals of the TennCare demonstration include providing high-quality care to enrollees, improving health outcomes for enrollees, and providing enrollees with access to safe and appropriate home- and community-based services (HCBS). As a means of advancing these goals, the TennCare demonstration authorizes a number of programmatic flexibilities, including extending eligibility to certain groups that would not be eligible for Medicaid under the State Plan; covering a more robust package of benefits than that authorized under the Medicaid State Plan; operating a single, statewide managed care service delivery system; operating a number of HCBS programs for persons with physical, intellectual, and/or developmental disabilities; and various operational efficiencies. Through the TennCare demonstration, the state demonstrates that the careful use of a single, statewide managed care service delivery system can enable the state to deliver high-quality care to all enrollees without spending more than would have been spent had the state continued its Medicaid program.

In accordance with the special terms and conditions of the TennCare demonstration, the state submits three quarterly monitoring reports to CMS each year, as well as one annual monitoring report that contains both the information typically contained in the quarterly monitoring reports for the fourth quarter of the demonstration year, as well as information included specifically for purposes of the annual monitoring report. Accordingly, this report contains information for the October-December 2023 quarter as well as information for Demonstration Year 3 (i.e., Calendar Year 2023) as a whole.

Highlights of Demonstration Year 3

The strong performance of the TennCare demonstration continued during Calendar Year 2023. During this year, Tennessee continued providing comprehensive healthcare coverage to approximately 1.7 million Tennesseans, including many Tennesseans who do not qualify for Medicaid under Tennessee's State Plan. Member experience/satisfaction surveys administered in 2023 continued to show that individuals enrolled in TennCare express high levels of satisfaction with the care they receive through the demonstration.

During 2023, coverage and benefits under the demonstration expanded in several notable ways.

Strong Tennessee Families

With regard to pregnant women, children, and families, during 2023 Tennessee increased its coverage of low-income pregnant under the demonstration, implemented a lactation supports benefit for breastfeeding mothers and infants, and implemented a policy of 12 months of continuous eligibility for children under age 19.

These policies are part of a multi-pronged, multi-year strategy to improve maternal and child health outcomes in Tennessee undertaken under the auspices of the TennCare demonstration. This strategy to support Strong Tennessee Families includes the following components:

Policy	Status as of 12/31/2023
Extend postpartum coverage from ~60 days following the end of pregnancy to a full year	Implemented April 1, 2022
Implement a dental benefit for pregnant and postpartum adults	Implemented April 1, 2022
Implement a benefit to provide lactation services and supports for breastfeeding mothers and infants	Implemented June 1, 2023
Implement 12 months of continuous eligibility for children	Implemented June 18, 2023
Increase coverage of pregnant women from 195 percent of the FPL to 250 percent of the FPL	Implemented January 1, 2024
Increase coverage of parents/caretaker relatives of dependent children from State Plan levels (based on the AFDC income levels) to 100 percent of the FPL	*Demonstration request submitted to CMS*
Cover a supply of diapers for infants and children under age 2 enrolled in TennCare	*Demonstration request submitted to CMS*

Dental Services

On January 1, 2023, Tennessee began covering dental services for all adults enrolled in the TennCare demonstration. (Previously, dental services were covered only for children under age 21, pregnant and postpartum women, and individuals enrolled in certain LTSS programs.) This marks the first comprehensive adult dental benefit in the history of Tennessee's Medicaid program.

Individuals with Disabilities

During 2023, Tennessee also expanded coverage for persons with disabilities in Tennessee—by opening up a pathway for persons at risk of needing institutional care to enroll in TennCare and receive HCBS supports (the CHOICES At Risk Demonstration Group).

Resumption of Normal Eligibility Processes

In April 2023, following the expiration of the FFCRA[1] continuous coverage requirement, Tennessee restarted its normal processes for reviewing the eligibility of individuals enrolled in TennCare following an extended pause during the COVID-19 public emergency. Throughout this year, TennCare and its partners have worked diligently to communicate information about this process to persons whose eligibility for TennCare may be impacted, to implement flexibilities intended to streamline processes where possible and minimize unnecessary coverage losses, and to ensure that Tennessee's processes operate in accordance with all federal requirements and standards.

[1] FFCRA refers to the Families First Coronavirus Response Act.

Key Dates of the Demonstration Quarter

Key dates of approval/operation for the TennCare demonstration during the October-December 2023 quarter, together with the corresponding Special Terms and Conditions (STCs), if applicable, are presented in Table 1. A summary of key activities that occurred with respect to the STCs throughout Demonstration Year (DY) 3 is presented in Attachment A to this report.

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
10/26/23	The Monthly Call for October, which would have been held on this date, was cancelled.	59
11/13/23	The state submitted to CMS Amendment 5 to the TennCare III demonstration. Amendment 5 would expand access to care for low-income parents and caretaker relatives of dependent children; cover a supply of diapers for children under age 2; and enhance HCBS available under the demonstration, with particular emphasis on supporting employment.	7
11/23/23	The Monthly Call for November, which would have been held on this date, was cancelled.	59
12/20/23	The state notified the public of its intent to adjust the expenditure caps for CHOICES Group 3 and ECF CHOICES.	6
12/21/23	The state notified the public and CMS of changes to the methodology by which uncompensated care payments are made to qualifying hospitals.	6
12/21/23	The state submitted to CMS the 2023 update to the Quality Assessment and Performance Improvement Strategy.	50
12/21/23	The state submitted to CMS the Quarterly Monitoring Report for the July – September 2023 quarter.	55
12/21/23	CMS approved Statewide MCO Contract Amendment 16 and TennCare Select Contract Amendment 52.	43
12/28/23	The Monthly Call for December, which would have been held on this date, was cancelled.	59

I. Operational Updates

Progress Towards Milestones

The TennCare III demonstration continues a number of program components from the prior iteration of the TennCare demonstration that are already in operation. In addition, TennCare III includes some new programmatic flexibilities and authorities. In terms of new flexibilities authorized under TennCare III, the state has completed various milestones, including:

- Submission of the Shared Savings Quality Measures Protocol on March 8, 2021 (approved by CMS on December 27, 2022);
- Submission of the draft Implementation Plan on April 8, 2021, and the revised Implementation Plan on August 16, 2021;
- Submission of the draft Demonstration Monitoring Protocol on June 7, 2021, and the revised Demonstration Monitoring Protocol on May 24, 2023;
- Submission of the DSIP Claiming Protocol on June 30, 2021 (approved by CMS on December 27, 2022); and
- Submission of the draft Evaluation Design on July 7, 2021, and the revised Evaluation Design on September 9, 2022.

The state has not yet implemented certain flexibilities authorized under the TennCare demonstration. For instance, the state has not implemented any new policies related to suspension of members convicted of TennCare fraud. The state will work closely with CMS prior to implementing any new policies in this area.

Resumption of Annual Eligibility Reviews

With the ending of the COVID-19 public health emergency and the Medicaid continuous coverage requirement[2], the state resumed required annual eligibility renewals in April 2023. Before this resumption began, the state worked to increase member awareness of the renewal process by implementing a multitiered outreach approach, including engaging community leaders, creating a media campaign, and direct member targeting. The process of renewing TennCare coverage is available through multiple access points and modalities, with coverage able to be renewed online; by phone, mail, or fax; or in person at any local Department of Human Services county office.

During the October-December 2023 quarter, more than 444,000 TennCare members were due for renewal. The numbers below—gathered during March 2024—reflect the outcomes for those renewals due during the quarter, as well as the cumulative totals for the first nine months of the state's renewal process.

Table 2
Renewal Numbers for October-December 2023

		October 2023	November 2023	December 2023	Cumulative (Apr-Dec 2023)
	Auto-renewed	60,402	53,367	47,631	467,113

[2] See Section 6008 of the Families First Coronavirus Response Act.

		October 2023	November 2023	December 2023	Cumulative (Apr-Dec 2023)
Member's eligibility renewed	Responded and approved	23,251	22,609	18,425	247,256
Member found ineligible	Responded and ineligible – referred to federal marketplace	10,184	9,862	7,169	84,885
	Failed to return required renewal packet	33,897	39,271	44,024	276,922
	Failed to return required requested additional information	1,666	2,331	2,472	17,760
Eligibility determination pending		10,759	22,659	34,037	85,080
Total		140,159	150,099	153,758	1,179,016

The state submits data to CMS on the status of its renewal work on a monthly basis in accordance with the Consolidated Appropriations Act, 2023, and related CMS guidance. The state also posts information about the renewal process, including updated monthly numbers as well as information for members and other stakeholders, on the TennCare website; information about the status of the renewal process will also be included in subsequent Monitoring Reports.

Additional Program Developments

During DY 3, the state continued to seek approval for a set of demonstration amendments that would expand coverage and benefits under the demonstration. Details are as follows:

Demonstration Amendment 1 (Services for Persons with Intellectual Disabilities). CMS continued to review a demonstration amendment designed to improve the alignment between the various types of care that certain TennCare enrollees with intellectual disabilities receive. Currently, these enrollees receive their medical/surgical and behavioral health care from MCOs through the managed care program authorized under the demonstration, and their LTSS outside of managed care. Demonstration Amendment 1 would entail the following modifications to the TennCare program:

- Integration of services for members with intellectual disabilities into the TennCare managed care program[3];
- Transitioning the care of children receiving Supplemental Security Income (SSI) benefits from the TennCare Select health plan to one of the other health plans that serves TennCare members; and
- Assigning to the TennCare Select health plan certain inmates of public institutions who receive inpatient services in a setting located outside the public institution.

As of the end of DY 3, the state was awaiting CMS approval of Amendment 1.

Demonstration Amendment 2 (Coverage of Adopted Children). On April 8, 2022, the state submitted a proposed demonstration amendment to CMS to extend TennCare coverage to children adopted from state custody in Tennessee who do not otherwise qualify for Medicaid (i.e., do not qualify for IV-E adoption assistance or non-IV-E adoption assistance). Extending TennCare coverage to these children would remove a potential barrier to adoption, as well as promote greater continuity of care for these children as they transition from foster care to permanent homes. Amendment 2 remained under CMS review as of the end DY 3.

Public Notice and Comment Period on Demonstration Amendment 5 (Supporting Strong Families). On November 13, 2023, the state submitted a new demonstration amendment to CMS. Amendment 5 would enhance coverage, benefits, and supports for TennCare members via the following program changes:

- Expanding access to care for low-income parents and caretaker relatives of dependent children by aligning TennCare's income standard for these individuals with the federal poverty level (i.e., 100 percent of the FPL);
- Covering a supply of 100 diapers per month for TennCare-enrolled children under age 2; and
- Enhancing the HCBS available under the demonstration, with particular emphasis on supporting employment.

[3] Specific services to be integrated are intermediate care facility services for individuals with intellectual disabilities (ICF/IID services) and 1915(c) waiver home- and community-based services (HCBS).

CMS held a federal public comment period on Amendment 5 from November 24 through December 23, 2023. All comments received by CMS during the comment period were supportive of the proposal. As of the end of DY 3, Amendment 5 remained under CMS review.

Policy or Administrative Difficulties in Operating the Demonstration

There were no significant administrative difficulties in operating the demonstration during DY 3. The state continued to await CMS approval of the demonstration amendments described above.

Key Challenges During DY 3

There were no significant challenges associated with operating the demonstration during DY 3. The state continued to conduct eligibility renewals, as discussed above under the heading of "Resumption of Annual Eligibility Reviews."

Key Achievements During DY 3

During DY 3, the state obtained approval of two demonstration amendments while also continuing to expand the availability of TennCare services to eligible Tennesseans by covering more benefits and enrolling new populations.

Approval of Demonstration Amendment 3. On October 20, 2023, CMS approved Amendment 3. Amendment 3 codifies certain enhancements to the HCBS available under the TennCare demonstration via the CHOICES and Employment and Community First (ECF) CHOICES programs. The specific changes approved by CMS in Amendment 3 are:

- Increasing the expenditure caps for individuals in CHOICES Group 3 and in ECF CHOICES to reflect targeted increases in reimbursement rates for certain services;
- Providing a temporary, one-time exception to the CHOICES and ECF CHOICES expenditure caps to support families who routinely provide unpaid supports for family members with disabilities; and
- Adding Enabling Technology as a benefit in CHOICES (until March 31, 2025) and ECF CHOICES (on an ongoing basis), up to $5,000 per member per year.

On October 27, 2023, the state provided formal acknowledgement of the approval and accepted the terms and conditions on which the approval was conditioned.

Approval of Demonstration Amendment 4. On August 4, 2023, CMS approved Amendment 4 to the TennCare III demonstration. The purpose of Amendment 4 was to address the following modifications to the demonstration, consistent with feedback from CMS:

1. Determining budget neutrality for the TennCare demonstration using a per member per month (PMPM) cap arrangement;
2. Revising the demonstration expenditure authorities while continuing to recognize savings produced to the federal government by the state as a mechanism for reinvestments in the TennCare program; and

3. Removing the expenditure authority for pharmacy and associated pharmacy flexibilities from the demonstration.

The approval of Amendment 4 allows Tennessee to continue pursuing the expansion of coverage and benefits achieved under the TennCare III demonstration.

Expanded Coverage for Pregnant Women. On October 27, 2023, the state notified CMS of its intention to cover more pregnant women through the TennCare demonstration. Specifically, the state proposed to raise the income threshold for pregnant women to qualify for TennCare coverage from 195 percent of the federal poverty level to 250 percent of the federal poverty level. The planned program change subsequently took effect on January 1, 2024, and was projected to increase program enrollment by approximately 2,400 people.

Lactation Support Services. On June 1, 2023, the state began covering lactation support services for new mothers enrolled in TennCare. Lactation support services include education, counseling, and assistance for common breastfeeding issues, along with skilled, evidence-based care for more complex lactation issues. Research consistently shows that breastfeeding has a variety of health benefits for mothers and infants, including lower risk of ear infections, sudden infant death syndrome, obesity, type 1 diabetes, and asthma. Breastfeeding can have a positive economic impact on families as well, as formula can be a significant expense for families. The new lactation support benefit will help bolster breastfeeding as an option for families who want to breastfeed their infant but who need additional supports to do so successfully. As of the end of DY 3, a total of 576 lactation support services claims had been paid by the state on behalf of 441 mothers enrolled in the TennCare program.

Continuous Eligibility for Children. On June 18, 2023, the state began providing 12 months of continuous eligibility for children under age 19 enrolled in TennCare. Under this policy, children who qualify for TennCare will generally receive 12 months of coverage and then be reevaluated at the end of the year, without taking into account short-term fluctuations in income that might occur during the year. Continuous eligibility reduces administrative burden for families and reduces the number of children who experience temporary, short-term lapses in coverage.

Dental Services for All Adult Members. Effective January 1, 2023, the state began covering dental services for all adults enrolled in TennCare. (Previously, dental services had been covered for children under age 21, pregnant and postpartum women, and certain adults receiving long-term services and supports.) Dental benefits covered for adults age 21 and older include services from nearly 20 categories, including—but not limited to—diagnostic x-rays and exams, preventive cleanings, restorative (fillings), crowns, partial dentures, complete dentures, tooth extractions, and palliative treatment. Implementation of these services was preceded by extensive communication with providers, changes to the state's dental benefits management contract, a public notice and comment period, and formal notification to CMS on November 1, 2022. As of the end of DY 3, a total of 90,124 unique members had received 775,518 unique dental services.

Re-Opening of CHOICES At Risk Demonstration Group. CHOICES, which provides managed long-term services and supports (MLTSS) for persons who are elderly or who have physical disabilities, consists of three benefit groups. CHOICES Groups 1 and 2 provide assistance to individuals who meet Tennessee's level of care criteria for nursing facility care and receive either LTSS in a nursing facility (Group 1) or home- and community-based services (HCBS) in lieu of nursing facility care (Group 2). CHOICES Group 3, by contrast, consists of adults who do not meet Tennessee's level of care criteria for nursing facility care but who, absent additional supports, are considered at risk of needing institutional care. These individuals receive a targeted package of HCBS intended to prevent or delay the need for nursing facility care.

Under the terms of the TennCare demonstration, CHOICES Group 3 is open to individuals who are eligible for Medicaid as SSI recipients and to non-Medicaid-eligible individuals who qualify in the CHOICES At Risk Demonstration Group. The CHOICES At Risk Demonstration Group provides a pathway for individuals who are not otherwise eligible for Medicaid to be eligible for TennCare and to receive CHOICES Group 3 HCBS. The CHOICES At Risk Demonstration had been closed to new enrollment since June 30, 2015. On June 8, 2022, the state announced its intent to re-open the group to 1,750 new enrollees beginning on October 1, 2022. As of the end of DY 3, a total of 891 new individuals had been enrolled in CHOICES Group 3 through the At Risk Demonstration Group.

Katie Beckett/Medicaid Diversion Program. On November 23, 2020, the state launched a new Katie Beckett/Medicaid Diversion program as part of the TennCare Demonstration. The program provides services and supports for children under age 18 with disabilities and/or complex medical needs who are not eligible for traditional Medicaid because of their parents' income or assets.

The state's program contains two principal parts:

- **Katie Beckett (Part A)** – Children with the most severe needs receive the full TennCare benefits package, as well as essential wraparound home and community based services. These individuals are subject to monthly premiums, which are determined on a sliding scale based on the member's household income.
- **Medicaid Diversion (Part B)** – Individuals in this group receive a specified package of essential wraparound services and supports, including premium assistance. These services are intended to prevent or delay the need for traditional Medicaid supports.

In addition, the program includes provisions to ensure continued coverage for children who are already enrolled in TennCare, who meet the criteria for enrollment in Katie Beckett (Part A), but for whom there is no Katie Beckett (Part A) slot available.

The Katie Beckett/Medicaid Diversion program began accepting self-referral forms from interested families on November 23, 2020. As of the end of DY 3, a total of 3,033 children were enrolled in the program, with 174 enrolled in Katie Beckett (Part A), 2,859 children enrolled in Medicaid Diversion (Part B), and no one enrolled in Continued Eligibility (Part C). See additional discussion of TennCare's Katie Beckett/Medicaid Diversion program below.

Issues or Complaints Identified by Beneficiaries

Eligibility Appeals. Table 3 presents a summary of eligibility appeal activity throughout DY 3. The increase in appeal activity over the last three quarters reflects the resumption of eligibility redeterminations following the end of the COVID-19 public health emergency. It should be noted that appeals (whether related to eligibility, medical services, or LTSS) may be resolved or taken to hearing in a quarter other than the one in which they are initially received by TennCare.

Table 3
Eligibility Appeals for Demonstration Year 3

	Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023
No. of appeals received	5,207	14,294	28,417	27,065
No. of appeals resolved or withdrawn	5,443	9,165	24,390	25,985
No. of appeals taken to hearing	721	910	2,498	4,340
No. of hearings resolved in favor of appellant	14	14	34	63

Medical Service Appeals. Table 4 below presents a summary of the medical service appeals handled throughout DY 3.

Table 4
Medical Service Appeals for Demonstration Year 3

	Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023
No. of appeals received	3,712	3,754	3,611	3,303
No. of appeals resolved	1,664	1,998	1,958	1,960
• Resolved at the MCC level	464	568	498	521
• Resolved at the TSU level	134	131	117	184
• Resolved at the LSU level	1,066	1,299	1,343	1,255
No. of appeals that did not involve a valid factual dispute	1,681	1,675	1,583	1,424
No. of directives issued	347	311	344	345
No. of appeals resolved by fair hearing	1,080	1,348	1,359	1,273
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	425	500	489	466
Appeals that went to hearing and were decided in the state's favor	578	751	817	728

	Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023
Appeals that went to hearing and were decided in the appellant's favor	63	48	37	61

By way of explanation:

- The "MCC" level is the level of the Managed Care Contractors. MCCs sometimes reverse their decisions or develop new recommendations for addressing an issue after reviewing an appeal.

- The "TSU" level is the TennCare Solutions Unit. The TSU is a unit within TennCare that reviews requests for hearings. The TSU might overturn the decision of the MCC and issue a directive requiring the MCC to approve provision of the service under appeal. Alternatively, if, following review, TennCare agrees with the MCC's decision, the appeal typically proceeds to TennCare's Legal Solutions Unit (LSU), where it is scheduled for administrative hearing before an Administrative Law Judge.

- The "LSU" level is the Legal Solutions Unit. This unit within TennCare ensures that enrollees receive those procedural rights to which they are entitled under the law. LSU represents TennCare and its MCCs at administrative hearings and takes those steps necessary to ensure that such appeals come to a timely resolution.

LTSS Appeals. The following table provides information regarding certain appeals administered by TennCare's Long-Term Services and Supports Division during DY 3 (e.g., appeals of PreAdmission Evaluation denials, appeals of PreAdmission Screening and Resident Review determinations, etc.).

Table 5
Long-Term Services and Supports Appeals for Demonstration Year 3

	Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023
No. of appeals received	72	80	75	91
No. of appeals resolved or withdrawn	48	51	47	63
No. of appeals set for hearing	26	29	27	33
No. of hearings resolved in favor of appellant	0	0	0	0

Grievances. Details of grievances received and resolved by TennCare's managed care contractors (MCOs, DBM, and PBM) during DY 3 are included as Attachment B to this Annual Monitoring Report. Each time an enrollee contacted the state or a managed care contractor to voice a complaint, the grievance was logged, and steps were taken to address the enrollee's concern.

TennCare and the managed care contractors review issues, complaints, and grievances raised by enrollees to inform quality improvement efforts. It should be noted that grievances may be resolved in a quarter other than the one in which they are received.

Audits, Investigations, or Lawsuits that Impact the Demonstration

Since the state's previous Annual Monitoring Report, the findings of two audits of the Division of TennCare have been released: a Payment Error Rate Measurement (PERM) audit conducted by CMS for Reporting Year 2023, and a Single Audit conducted by the Tennessee Comptroller of the Treasury for the period of July 1, 2022, through June 30, 2023. Details of these audits are as follows:

PERM Audit by CMS

The PERM audit conducted by CMS identifies improper payments made by Medicaid programs by focusing on three elements: fee-for-service claims, managed care capitation payments, and eligibility determinations and resulting payments. The purpose of the audit, according to CMS, is "to produce a national-level improper payment rate for Medicaid and the Children's Health Insurance Program (CHIP) in order to comply with the requirements of the Payment Integrity Information Act (PIIA) of 2019."

CMS' audit determined that Tennessee's Medicaid estimated federal improper payment rate for Reporting Year 2023 (5.61 percent) was lower than the combined national Medicaid estimated federal improper payment rate (8.58 percent) and the combined Cycle 2 Medicaid estimated federal improper payment rate (6.26 percent) for the same period. Within those rates, however, Tennessee's Medicaid estimated federal improper payment rate for fee-for-service claims (8.67 percent) was higher than the national Medicaid payment rate for fee-for-service claims (6.90 percent) and the Cycle 2 Medicaid payment rate for fee-for-service claims (5.13 percent). The primary error types within Tennessee's fee-for-service claims were—

- No documentation;
- Document(s) absent from record;
- Procedure coding; and
- Number of units.

The types of services in which these errors were found were—

- Day Habilitation/Adult Day Care/Foster Care or Waiver Programs/School Based Services;
- Laboratory/X-ray/Imaging Services;
- Nursing Facility/Chronic Care Services or Intermediate Care Facilities;
- Personal Support Services; and
- Psychiatric/Mental Health/Behavioral Health Services.

It is worth noting that the PERM audit indicated that Tennessee had "no managed care processing review errors." This finding is especially important, since the number of managed care claims

processed by Tennessee is far greater than the number of fee-for-service claims. The PERM audit summary report is included as Attachment C to this report.

Single Audit by the Tennessee Comptroller of the Treasury

Each year, a Single Audit for the State of Tennessee is conducted by the Tennessee Comptroller of the Treasury. The scope of the audit is broad, encompassing "the financial statements of the governmental activities, the business-type activities, the aggregate discretely presented component units, each major fund, and the aggregate remaining fund information of the State of Tennessee," as well as "the related notes to the financial statements, which collectively comprise the State of Tennessee's basic financial statements." The 2023 Single Audit included findings related to several state agencies, including state universities (Austin Peay University, Tennessee State University, the University of Memphis, and the University of Tennessee), the Tennessee Housing Development Agency, the Tennessee Wildlife Resources Agency, and the Tennessee Departments of Agriculture, Economic and Community Development, Education, Finance and Administration, Human Services, Labor and Workforce Development, Mental Health and Substance Abuse Services, and Military. There were no findings within the Single Audit related to the TennCare demonstration.[4] The 2023 Single Audit Report for the State of Tennessee is included as Attachment D to this report.

During DY 3, the Division of TennCare was also involved in several lawsuits. Details of these suits appear below. It should be noted that this list does not include probate matters related to estate recovery or matters governed by the Tennessee Uniform Administrative Procedures Act (e.g., administrative appeals pending before the agency or on appeal in state court).

A.M.C., et al. v. Smith Lawsuit. On March 19, 2020, the Tennessee Justice Center filed a federal lawsuit on behalf of a proposed class of plaintiffs against the Division of TennCare. The lawsuit alleges statutory and constitutional deficiencies with TennCare's eligibility redetermination process and the Tennessee Eligibility Determination System. Another allegation within the suit is that TennCare is violating the Americans with Disabilities Act by not providing reasonable accommodations, thereby preventing disabled individuals from participating in the TennCare program. Plaintiffs filed two motions with the court: one for class certification that was affirmed, and one for preliminary injunction that was denied. In November 2023, a bench trial was conducted. Post-trial briefs were submitted by the parties in March 2024, and a decision is expected sometime in Calendar Year 2024.

EMCF v. TennCare Lawsuit. In September 2018, Emergency Medical Care Facilities, P.C., filed a complaint for declaratory judgment and injunctive relief against the Division of TennCare in Davidson County Chancery Court. The suit relates to a $50 cap imposed by the agency on payment for emergency room physician services determined to be non-emergent. The parties filed cross-motions for summary judgment, and, on September 1, 2020, the Chancellor granted

[4] There was one finding related to CoverKids, the state's separate CHIP program, which is administered by the Division of TennCare. The audit found that "management did not address the division's CoverKids eligibility process deficiencies, resulting in $31,499 in federal and state questioned costs."

summary judgment to EMCF on their claim that the $50 cap was void. EMCF then voluntarily dismissed their remaining claims pertaining to the determination of payment for the services in question. The state filed an appeal, and, on October 7, 2021, the Court of Appeals ruled in the state's favor and reversed the trial court's ruling. The Court of Appeals found that the reimbursement limit fell within the internal management exception of a rule and was not subject to rulemaking requirements. On May 25, 2023, the Tennessee Supreme Court reversed the Court of Appeals and held that the $50 cap should have been promulgated as a rule under the state's administrative procedures act.

Erlanger Health System v. TennCare Lawsuit. This declaratory order action was commenced against the state regarding the applicability and validity of two TennCare rules that set the reimbursement rates for emergency services provided to TennCare enrollees by non-contract hospitals. TennCare's Commissioner's Designee issued a declaratory order upholding the rules being challenged by Erlanger, and on November 12, 2021, Erlanger filed a Petition for Judicial Review of the declaratory order in Chancery Court. A second case challenges the State Plan Amendments (SPAs) containing the same reimbursement rates. On August 24, 2023, the Chancery Court ruled against TennCare and held the rules and SPAs to be invalid. The state has appealed these rulings, and the appeals are currently pending with the Court of Appeals.

McCutchen et al. v. Becerra Lawsuit. In 2021, the Tennessee Justice Center, acting on behalf of 14 individual plaintiffs, filed a federal lawsuit challenging CMS' approval of the TennCare III demonstration. On August 5, 2021, the state intervened in the litigation. The McCutchen suit was subsequently stayed pending the outcome of a federal comment period on the TennCare III demonstration. In December 2023, Plaintiffs filed their Second Amended Complaint, which reduced the number of claims and individual plaintiffs, and the litigation is now proceeding.

Rhythm Health Tennessee, Inc. v. State Protest Committee, et al. Lawsuit. On September 12, 2022, Rhythm Health Tennessee, Inc., filed a Petition for Writ of Certiorari in the Davidson County Chancery Court against several parties, including TennCare, the state's Central Procurement Office, and the State Protest Committee. The petition challenges the Protest Committee's decision to deny the bid protest by Rhythm and uphold TennCare's award of its Managed Care Organization (MCO) contracts. Briefing on the matter is expected to conclude in July 2024, with a decision expected thereafter.

Unusual or Unanticipated Trends

There were no unusual or unanticipated trends during DY 3. The state conducted eligibility renewals for three of the four quarters of DY 3 after an extended pause during the COVID-19 public health emergency, the eventual result of which is expected to be a decrease in the number of individuals enrolled in the TennCare program. This resumption of normal eligibility processes was accompanied by a corresponding increase in the number of eligibility-related appeals during the second half of DY 3.

Legislative Updates

The Tennessee General Assembly passed a number of pieces of legislation with implications for the TennCare program during the first two quarters of DY 3. Most significantly, the General Assembly appropriated funding for such agency priorities as implementing continuous eligibility for children enrolled in TennCare, expanding access to care for low-income parents and caretaker relatives of dependent children, and covering diapers for children under age 2. In addition, assessments used to help fund various aspects of the TennCare program (i.e., the hospital assessment, the nursing facility assessment, and the ground ambulance provider assessment) were renewed for another year.

In addition, the Tennessee General Assembly held a special legislative session on public safety in August 2023, but no significant legislation affecting the TennCare program was passed.

Public Forums

In compliance with the federal regulation at 42 CFR § 431.420(c) and the Special Terms and Conditions of the TennCare III demonstration, the state hosted a public forum on June 23, 2023. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

Individuals interested in participating in the meeting had the option to attend in person or to access the event electronically. Furthermore, the June 23 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address at which comments would be accepted. A total of six sets of comments were received. Among the ideas expressed in the comments were the following:

- Praise for recent TennCare initiatives, such as coverage of dental benefits for adult members and providing 12 months of postpartum coverage.
- Concerns about network adequacy, especially in such domains as home health, dental care, mental health care (particularly for individuals with intellectual and developmental disabilities), HCBS in the ECF CHOICES program, and prenatal care in rural areas.
- Support for increased delivery of mental health services in school-based settings.
- A desire for more information about the recent resumption of eligibility redeterminations.
- Concerns about the quality and consistency of case management and care coordination services, especially within the CHOICES and ECF CHOICES programs.
- The importance of timely provider reimbursement by TennCare's MCOs.
- The need for higher reimbursement rates for LTSS providers (including for providers of lower levels of care and for transportation providers in the ECF CHOICES program).
- Support for coverage of sedation services as part of the new adult dental benefit.

Copies of the written comments received during the 2023 public forum process were included as an attachment to the Quarterly Monitoring Report for April-June 2023.

Enrollment and Member Month Data

Information about TennCare enrollment by category throughout DY 3 is presented in Table 6. Totals for each EG category during the July-September 2023 quarter have been revised based on modifications to the process by which enrollment is calculated.

Table 6
Enrollment Counts for Demonstration Year 3

Demonstration Populations	Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023
EG1 Disabled	135,221	135,310	137,427	132,537
EG9 H-Disabled	1,089	1,100	971	982
EG2 Over 65	334	329	318	330
EG10 H-Over 65	32	27	36	28
EG3 Children	883,891	894,188	893,312	873,241
EG4 Adults	567,712	581,583	572,341	526,847
EG5 Duals and EG11 H-Duals 65	171,822	176,289	180,031	178,787
EG6E Expan Adult	0	0	0	0
EG7E Expan Child	1,373	1,588	2,591	3,463
EG8, Med Exp Child	0	0	0	0
Med Exp Child, Title XXI Dem Pop	11,927	11,365	14,420	18,061
EG12E Carryover	1,022	969	925	878
EG13 Katie Beckett	161	166	171	180
EG14E Medicaid Diversion	2,429	2,558	2,732	2,952
EG15 Continued Eligibility	0	0	0	0
EG16 MEC Additions	–	–	4,946	9,904
TOTAL*	1,777,013	1,805,472	1,810,221	1,748,190

*** Unique member counts for reporting quarter, with at least one day of eligibility. To avoid duplication, the member counts are based on the last eligibility group (EG) of the quarter.**

The majority of TennCare's enrollment consists of Type 1 EG3 children and Type 1 EG4 adults, with 80 percent of TennCare members appearing in one of these categories.

Table 7 below presents the member month reporting by eligibility group for each month in the final quarter of DY 3.

Table 7
Member Month Reporting for October – December 2023

Eligibility Group	October 2023	November 2023	December 2023	Sum for Quarter Ending 12/31/23
EG1 Disabled	134,591	132,678	129,967	397,236
EG2 Over 65	271	266	275	812
EG3 Children	865,417	852,030	844,132	2,561,579
EG4 Adults	516,606	485,970	468,737	1,471,313
EG5 Duals	167,378	165,993	163,357	496,728
EG6E Expan Adult	0	0	0	0
EG7E Expan Child	2,786	2,958	3,272	9,016
EG8 Med Exp Child	0	0	0	0
EG9 H-Disabled	949	960	965	2,874
EG10 H-Over 65	28	28	25	81
EG11 H-Duals	7,084	7,090	7,064	21,238
Med Exp Child, Title XXI Demo Pop	15,166	16,273	17,616	49,055
EG12E Carryover	890	867	850	2,607
EG13 Katie Beckett	174	176	178	528
EG14E Medicaid Diversion	2,790	2,854	2,914	8,558
EG15 Continued Eligibility	0	0	0	0
EG16 MEC Additions	6,672	8,231	9,854	24,757
TOTAL	1,720,802	1,676,374	1,649,206	5,046,382

Information and Data about the CHOICES Program

CHOICES is TennCare's program of managed long-term services and supports for individuals who are elderly and/or have physical disabilities. Implemented in 2010, CHOICES offers nursing facility services (CHOICES 1) and home- and community-based services (CHOICES 2 and 3) to eligible individuals via the state's managed care program. During the October-December 2022 quarter, the state re-opened enrollment in CHOICES 3 to certain individuals who would not otherwise be eligible for Medicaid. These individuals may receive CHOICES 3 benefits by enrolling in the CHOICES At Risk Demonstration Group, which had been closed from June 30, 2015, through September 30, 2022.

As required by STC 33.d., the state offers the following table delineating CHOICES enrollment in each quarter of DY 3, as well as information about the number of available reserve slots. The operational procedures by which slots are reserved for members of CHOICES 2 and CHOICES 3 are included as Attachment E to this Annual Monitoring Report.

Table 8
CHOICES Enrollment and Reserve Slots
for Demonstration Year 3

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Being Held as of the End of Each Quarter			
		Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023
CHOICES 1	Not applicable	14,316	14,433	14,280	14,029
CHOICES 2	11,000	9,256	9,102	8,878	8,759
CHOICES 3 (SSI recipients)	To be determined	2,166	2,120	2,098	2,069
CHOICES 3 (members of the CHOICES At Risk Demo Group)	1,750[5]	320	517	729	891
Total CHOICES	Not applicable	26,058	26,172	25,985	25,748
Reserve Capacity	300	300	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STC 52 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 52.d. requires the state to submit to CMS periodic statistical reports about the use of LTSS by TennCare members. Twenty separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and June 2023.

Taken together, the reports depict a program evolving according to the characteristics of LTSS recipients, with institutional care available to individuals with the highest acuity of need, and HCBS available to individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point-in-time data revealed declining use of NF services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 14,317 individuals on June 30, 2022. According to annual aggregate data contained in the reports, this downward trend was even more pronounced for new LTSS recipients, 81 percent of whom had been admitted to NFs in the year prior to implementation of the CHOICES program, as compared with 63 percent admitted to NFs in the twelfth year of CHOICES. Furthermore,

[5] An enrollment target of 1,750 has been established for the CHOICES at Risk Demonstration Group within CHOICES 3; individuals eligible for Medicaid as SSI recipients who qualify for CHOICES Group 3 benefits do not count against this enrollment target. The target of 1,750 is based on legislative appropriations.

nursing facility expenditures in the year prior to CHOICES implementation accounted for more than 90 percent of total LTSS expenditures, whereas the percentage was approximately 80 percent twelve years later. In addition, transitions of individuals from NFs to HCBS settings increased over time as well, with 129 such transitions occurring during the year prior to CHOICES implementation, and 505 transitions happening in the twelfth year of the program.

By contrast, appropriate use of HCBS by TennCare members grew significantly during these years. The aggregate number of members accessing HCBS increased from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 13,940 after CHOICES had been in place for twelve full fiscal years. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 11,779 by June 30, 2022. The percentage of LTSS expenditures devoted to HCBS grew as well, rising from 9.75 percent in the year prior to CHOICES, to 20.40 percent after the CHOICES program had been in place for twelve years.

Selected elements of the aforementioned CHOICES data are summarized in Table 9.

Table 9
Changes in Use of HCBS by Persons Who Are Elderly or Disabled (E/D) Before and After CHOICES Implementation

Annual Aggregate Data			Point-in-Time Data		
No. of TennCare members accessing HCBS (E/D), 3/1/09 – 2/28/10	No. of TennCare members accessing HCBS (E/D), 7/1/21 – 6/30/22	Percent increase over a twelve-year period	No. of TennCare members accessing HCBS (E/D) on the day prior to CHOICES implementa-tion	No. of TennCare members accessing HCBS (E/D) on 6/30/22	Percent increase from the day prior to CHOICES implementa-tion to 6/30/22
6,226	13,940	124%	4,861[6]	11,779	142%

MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds during DY 3 is detailed in Table 10.

[6] The total of 4,861 comprises 1,479 individuals receiving HCBS (E/D) in Middle Tennessee on February 28, 2010 (the day prior to CHOICES implementation in that region), and 3,382 individuals receiving HCBS (E/D) in East and West Tennessee on July 31, 2010 (the day prior to CHOICES implementation in those regions).

Table 10
CHOICES Transition Allowances
for Demonstration Year 3

Grand Region	Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023
East	$10,158	$7,406	$6,116	$9,819
Middle	$7,288	$6,211	$16,676	$9,934
West	$13,134	$9,626	$19,485	$13,802
Statewide Total	$30,580	$23,243	$42,277	$33,555

Information and Data about the Employment and Community First CHOICES Program

Designed and implemented in partnership with people with intellectual and developmental disabilities, their families, advocates, providers, and other stakeholders, ECF CHOICES is the first managed LTSS program in the nation that is focused on promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for people with intellectual and other types of developmental disabilities.

As required by STC 34.d., the state offers the following table delineating ECF CHOICES enrollment throughout DY 3, as well as information about enrollment targets and the number of available reserve slots. It should be noted that the number of filled reserve slots does not include slots in a "held" status that have been assigned to a person but for whom actual enrollment is pending an eligibility determination. The operational procedures by which slots are reserved for members of ECF CHOICES are included as Attachment F to this Annual Monitoring Report.

Table 11
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots
for Demonstration Year 3

	Statewide Enrollment Targets and Reserve Capacity[7]	Enrollment and Reserve Slots Filled as of the End of Each Quarter			
		Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023
ECF CHOICES 4	1,834	1,771	1,732	1,708	1,691

[7] Statewide enrollment targets and reserve capacity were adjusted to reflect new appropriation authority, effective July 1, 2022. A total of 300 reserve capacity slots were added to ECF CHOICES Groups 4, 5, 6, 7, and 8. The distribution of these slots reflects 15 additional slots in Group 4, 60 additional slots in Group 5, 200 additional slots in Group 6, 10 additional slots for Group 7, and 15 additional slots for Group 8. Of the 15 slots allocated for Group 8, a total of 5 were assigned to Group 7. Furthermore, because of the higher expected cost of benefits in Group 8, it was possible to convert the remaining 10 slots from Group 8 to a total of 15 slots for Group 6. In the October-December 2023 quarter, a total of 11 FMAP Group 4 slots were moved back to Group 6; 3 FMAP Group 5 slots were moved back to Group 6; 3 DD Aged Caregiver reserve capacity slots were moved from Group 5 to Group 6; 2 Priority Group slots were moved from Group 4 to Group 6; 5 Priority Group slots were moved from Group 5 to Group 4; and 3 Priority Group slots were moved from Group 5 to Group 6.

	Statewide Enrollment Targets and Reserve Capacity[7]	Enrollment and Reserve Slots Filled as of the End of Each Quarter			
		Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023
ECF CHOICES 5	2,552	2,468	2,431	2,374	2,326
ECF CHOICES 6	1,814	1,637	1,690	1,738	1,808
ECF CHOICES 7	50	16	14	12	13
ECF CHOICES 8	50	24	24	26	27
Total ECF CHOICES	6,300[8]	5,916	5,891	5,858	5,865
Reserve capacity	3,950	3,512	3,500	3,498	3,515
Waiver Transitions[9]	Not applicable	85	90	87	88

Data and trends of the designated ECF CHOICES data elements: STC 52.d. requires the state to provide CMS periodic statistical reports about the ECF CHOICES program. To date, the state has submitted baseline data for the year-long period preceding implementation of ECF CHOICES, as well as six years' worth of post-implementation data. In comparing the baseline data with the post-implementation data, several notable trends emerged:

- The number of individuals with developmental disabilities other than intellectual disabilities who received HCBS through the TennCare program grew from 0 to 2,321.
- Average LTSS expenditures for individuals with intellectual or developmental disabilities fell from $94,327 per person to $88,965 per person, representing a 5.7 percent decrease.
- The percentage of working age adults with intellectual or developmental disabilities who are enrolled in HCBS programs, employed in an integrated setting, and earning at or above the minimum wage grew from 14.3 percent to 17.8 percent.

Since 2021, the state has made significant investments in reducing the referral list for ECF CHOICES. As ECF CHOICES gains enrollment capacity, these trends toward individuals with intellectual and developmental disabilities living independently in the community are expected to accelerate.

[8] Budget reconciliation of slots in Quarter 1 opened 52.5 reserve capacity slots to fully fund 6,300 slots defined as the upper limit. These upper limits provide flexibility to move slots as needed, based on the needs of program applicants.

[9] Waiver transitions are instances in which an individual enrolled in a 1915(c) HCBS waiver program is transferred into the ECF CHOICES program. Since these individuals have an independent funding source (i.e., the money that would have been spent on their care in the 1915(c) program), their enrollment in ECF CHOICES does not count against the enrollment target. Waiver transition numbers are cumulative since the program began. Group 6 enrollment includes some of these transitions that do not count against the enrollment target.

Information and Data about the Katie Beckett, Medicaid Diversion, and Continued Eligibility Groups

The state's Katie Beckett, Medicaid Diversion, and Continued Eligibility groups provide services and supports for children under age 18 with disabilities and/or complex medical needs who are not eligible for traditional Medicaid because of their parents' income or assets. Although the state has long provided Katie Beckett program services to certain TennCare members via its three section 1915(c) HCBS waivers and the ECF CHOICES program, the availability of these services expanded with the implementation of the new Katie Beckett/Medicaid Diversion program on November 2, 2020.

The state offers services to eligible children through a traditional Katie Beckett program (also called "Part A"), in which members receive the full TennCare benefits package plus essential wraparound HCBS. In addition, the demonstration includes a Medicaid Diversion component (also called "Part B"), which furnishes a specified package of essential wraparound services and supports, including premium assistance. In addition, a Continued Eligibility element of the state's program ensures that children who would otherwise lose TennCare eligibility because slots in the Katie Beckett program are not available for them are able to remain eligible for the full TennCare benefits package.

As required by STC 35.c., the state offers the following table delineating Katie Beckett, Medicaid Diversion, and Continued Eligibility enrollment throughout DY 3, as well as information about enrollment targets and the number of available reserve slots. The operational procedures by which slots are reserved for members of the Katie Beckett and Medicaid Diversion groups are included as Attachment G to this Annual Monitoring Report.

Table 12
Katie Beckett, Medicaid Diversion, and Continued Eligibility Enrollment and Reserve Slots for Demonstration Year 3

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of Each Quarter			
		Jan – Mar 2023	Apr – Jun 2023	Jul – Sep 2023	Oct – Dec 2023
Katie Beckett	300	157	164	161	174
Medicaid Diversion	4,000[10]	2,402	2,544	2,646	2,859
Continued Eligibility	N/A	0	0	0	0
Reserve capacity	300	157	164	161	174

[10] The previous enrollment target of 2,700 for the Medicaid Diversion group increased to 4,000 as a result of budget rebalancing during the third quarter of DY 3.

Data and trends of the designated Katie Beckett/Medicaid Diversion data elements: STC 52.d. requires the state to provide CMS periodic statistical reports about the Katie Beckett and Medicaid Diversion groups. The state anticipates submitting baseline data for these groups soon, with trend data to follow on an annual basis thereafter.

Steps Taken to Ensure Compliance with Regulations Governing HCBS Settings

The state's Transition Plan—delineating the state's process for assuring compliance with the HCBS settings rule—has been fully implemented. The state submitted its final Statewide Transition Plan Quarterly Status Report to CMS on April 11, 2019, affirming that all identified settings had achieved full compliance by March 17, 2019. The state continues to monitor ongoing compliance with the HCBS Settings Rule, as described in each Annual Monitoring Report.

Beginning in March 2020, certain aspects of compliance with the HCBS Settings Rule have been affected by stay-at-home orders and social distancing expectations resulting from the COVID-19 public health emergency. On April 30, 2020, an emergency amendment to the state's 1115 demonstration was submitted to CMS. One component of the amendment was a request to temporarily provide services in alternative settings, including settings that do not comply with the HCBS settings requirement at 42 CFR § 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time. The purpose of the request was to minimize the spread of infection during the COVID-19 pandemic. This amendment was approved and incorporated into the STCs as Attachment K to the TennCare demonstration on June 19, 2020. A request to extend the approved Attachment K was subsequently submitted as the public health emergency continued. The extension of Attachment K was approved by CMS for six months following the end of the COVID-19 public emergency.

A more comprehensive description of the steps taken to ensure compliance with the regulations governing HCBS settings is included as Attachment H to this Annual Monitoring Report.

Health and Welfare of HCBS Recipients

The state's system for assuring the health and welfare of TennCare members receiving HCBS is outlined in Attachment I to this Annual Monitoring Report.

II. Performance Metrics

Progress Toward Goals and Targets in the Monitoring Protocol

STC 55 requires the state to submit to CMS a draft Monitoring Protocol no later than 150 days after the January 8, 2021, start date of the TennCare III approval period. The purpose of the Monitoring Protocol is to define the quantitative and qualitative elements the state will use in its Quarterly and Annual Monitoring Reports to chart progress toward fulfillment of the goals and targets of the TennCare III demonstration. On June 7, 2021, the state submitted its draft Monitoring Protocol to CMS. CMS, in turn, provided feedback on the document on May 31, 2022,

and the state submitted a revised version of the document that addressed CMS' input on May 24, 2023.

Impact of the Demonstration in Providing Insurance Coverage

As noted in Section I of this report, the TennCare III demonstration was furnishing health care coverage to 1,748,190 Tennesseans as of the end of DY 3. This total represents 25 percent of the 6.9 million residents living in Tennessee.

Impact of the Demonstration in Ensuring Access to Care

Ensuring Access Through Contractual Means

TennCare's managed care entities (MCEs) are contractually required to furnish available, accessible, and adequate numbers of contracted providers for the delivery of TennCare-covered services (including medical, behavioral, long-term services and supports, dental, and pharmacy). The state uses specialized software to monitor enrollee access to care and to ensure that access requirements contained in the MCEs' contracts are fulfilled. If a deficiency in an MCE's provider network were to be identified, the MCE would be notified and a Corrective Action Plan would be required to address the deficiency. Financial penalties would then be assessed by the state if the Corrective Action Plan were determined to be inadequate.

Measuring Access Through Provider Data Validation

In December 2023, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the final quarter of DY 3. The EQRO took a sample of provider data files from TennCare's MCCs[11] and reviewed each for accuracy in the following categories:

- Active contract status
- Provider address
- Provider specialty / behavioral health service code
- Provider panel status
- Services for children
- Services for adults (MCO only)
- Primary care services (MCO only)
- Prenatal care services (MCO only)
- Availability of routine care services
- Availability of urgent care services

The validity of such information is one measure of providers' availability and accessibility to TennCare members. The EQRO's report demonstrated generally strong performance by the MCCs, especially in the categories of "services for children" (93.18 percent accuracy), "primary care services" (92.58 percent accuracy) and "prenatal care services" (98.31 percent accuracy).

[11] TennCare's Pharmacy Benefits Manager (PBM) was not included in the survey.

Progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Qsource's report concluded that the MCCs "achieved high accuracy rates" for the fourth quarter of Calendar Year 2023.

Impact of the Demonstration in Improving Health Outcomes and Ensuring Quality of Care

HEDIS/CAHPS Report

Recently, the annual report of HEDIS/CAHPS data—titled "Comparative Analysis of Audited Results from TennCare MCOs for Measurement Year (MY) 2022"—was released. The full name for HEDIS is "Healthcare Effectiveness Data Information Set," and the full name for CAHPS is "Consumer Assessment of Healthcare Providers and Systems." This report, which is presented in Attachment J and posted on the TennCare website, provides data that enables the state to compare the performance of its MCOs against national norms and benchmarks and to compare performance among MCOs.

Improved statewide performance was noted for certain child health measures this year, with higher success rates achieved in all of the following categories:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Counseling for Nutrition
- Counseling for Physical Activity
- Childhood Immunization Status – Influenza
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 months – 17 years)
- Postpartum Care
- Well-Child Visits in the First 30 Months of Life
- Child and Adolescent Well-Care Visits

Improvement was also evident in a variety of health categories applicable to adults, including Asthma Medical Ratio (both "19-50 years" and "51-64 years"); Controlling High Blood Pressure; Statin Therapy for Patients with Cardiovascular Disease; Cardiac Rehabilitation 18-64 Years; Hemoglobin A1c Control for Patients With Diabetes; Eye Exam for Patients With Diabetes; Blood Pressure Control (<140/90 mm Hg); Kidney Health Evaluation for Patients With Diabetes; Appropriate Treatment for Upper Respiratory Infection (18-64 years); Comprehensive Diabetes Care ("HbA1c Poor Control"); and Use of Opioids at High Dosage.

Categories related to women's health showed higher outcomes as well, with improved results in the areas of Statin Therapy for Patients with Cardiovascular Disease ("Females 40-75 Years") and Non-Recommended Cervical Cancer Screening in Adolescent Females.

HEDIS MY 2022 was the fourteenth year of statewide reporting of behavioral health measures following the integration of medical and behavioral health services among TennCare's health plans. Results superior to those in the preceding measurement period were achieved in the

behavioral health categories of Antidepressant Medication Management (both "Effective Acute Phase Treatment" and "Effective Continuation Phase Treatment"); Follow-Up Care for Children Prescribed ADHD Medication (both "Initiation Phase" and "Continuation and Maintenance Phase"); Follow-Up After High-Intensity Care for Substance Use Disorder (both "7-Day Follow-Up" and "30-Day Follow Up") for Individuals 18-64 years; Pharmacotherapy for Opioid Use Disorder: 16-64 Years; Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications; Diabetes Monitoring for People with Diabetes and Schizophrenia; Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia; Adherence to Antipsychotic Medications for Individuals With Schizophrenia; Metabolic Monitoring for Children and Adolescents on Antipsychotics (eight of nine subcategories); and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: 12-17 years.

With regard to the CAHPS portion of the MY 2022 report, the performance of the MCOs was generally strong, and was comparable to the results achieved in the preceding measurement period. CAHPS data in the report was organized into three major areas: Adult Medicaid Survey Results, Child Medicaid Survey Results (General Population), and Child Medicaid Survey Results (Children with Chronic Conditions). Each of these three major categories contained several subcategories (e.g., "Getting Needed Care," "Getting Care Quickly," "How Well Doctors Communicate," etc.) in which the health plans were rated in terms of the national percentile achieved. The MY 2022 ratings of the MCOs generally fell into the top two national percentiles: "greater than 75th percentile" and "25th to 75th percentile".

<u>Innovative Measures to Improve Health and Ensure Quality</u>

The state has a variety of innovative programs designed to improve the health of TennCare members. Information about three of those programs—Patient Centered Medical Home, Health Starts Provider Partnerships, and BESMART—appears below.

Patient-Centered Medical Home Program. The Patient-Centered Medical Home (PCMH) program is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities and practice standards of primary care providers, and the overall value of health care delivered to the TennCare population.

Members attributed to a PCMH receive team-based care, care coordination services leading to improved quality and health outcomes, greater emphasis on primary and preventative care, and improved care coordination with behavioral health providers. Participating providers receive ongoing financial support to assist with practice transformation, technical assistance, opportunities to attend webinars and conferences throughout the year, quarterly reports with actionable data, and access to a web-based application (known as the Care Coordination Tool) that allows providers to identify and track closure of gaps in care linked to specific quality measures. To ensure that the principles of the PCMH model are actually incorporated into health care furnished to TennCare members, participating providers are required to maintain or achieve National Committee for Quality Assurance (NCQA) PCMH recognition for all of their practice sites.

The PCMH program began with the first group of participating provider organizations on January 1, 2017. As of the most recent count, approximately 697,000 TennCare members are attributed to one of 81 PCMH-participating organizations, and there are 499 sites associated with these organizations across the state. PCMH providers receive ongoing quality support via one-on-one coaching, webinars, and collaboratives. For instance, PCMH organizations recently participated in a learning collaborative to reduce unnecessary utilization of the emergency department.

Health Starts. The state's Health Starts Provider Partnerships program launched on April 1, 2021. The goal of these partnerships is to improve quality of care for TennCare members by addressing social risk factors in the TennCare population. The partnership program currently involves over 30 provider groups across Tennessee, including patient-centered medical homes, long-term services and supports providers, hospitals, and behavioral health providers. An expansion to include two large, integrated hospital systems began during the demonstration year. For its fourth cohort beginning soon, the Partnerships program will engage two hospital obstetrics sites. With the increased focus on the hospital setting, the state aims to enrich its understanding of how social risk factors can be addressed and care coordination leveraged as a means to improve health of members. The state is working with each provider partner to screen members for social risk factors, refer them to community resources based on identified needs, and close the loop on referrals to verify that member needs are met.

Thus far, the Partnerships program has impacted over 44,000 unique members and identified needs across various domains, including transportation, housing, utility assistance, and childcare. The state is utilizing findings and data from the first three years of program implementation to inform future quality improvement initiatives related to addressing Tennesseans' social risk factors. Recently, the Health Starts Initiative expanded to encompass efforts related to community health workers. TennCare has contracted with the Tennessee Community Health Worker Association (TNCHWA) to support two critical components of the CHW strategy: (1) the development of CHW program standards that emphasize high-quality CHW programs and (2) to serve as the accreditation entity for CHW programs. Additionally, eight provider organizations across the state received funding to implement CHW program standards developed by the Tennessee Community Health Worker Association. These grantees also receive technical support to hire and retain CHWs using evidence-based principles to ensure TennCare members receive high-quality CHW services. All grantees will continue this work in the year ahead by applying for CHW Organization accreditation facilitated by TNCHWA and by outlining how their organization plans to continue integrating CHWs into their care models after the grant period ends. The CHW Infrastructure Grants will expand to include up to 15 more organizations in State Fiscal Year 2025.

In other Health Starts news, the state selected the organization findhelp as the vendor for its closed-loop referral system, Tennessee Community Compass (TCC). TCC is a free, statewide tool connecting Tennesseans to local, community-based resources to address health and social needs. The tool will help TennCare MCOs and providers screen for social needs; create referrals to community resources based on identified needs using the resource directory; and provide opportunities for CBOs, MCOs, and providers to track the outcome of the referrals. Data from

the system will be used by the state to enhance the strategic direction of Health Starts. TCC will launch with two large integrated hospital systems in State Fiscal Year 2025.

BESMART Program. The buprenorphine-enhanced supportive medication-assisted recovery and treatment (or "BESMART") program is a core component of the state's strategy to address the opioid epidemic in Tennessee. The BESMART program is a network of high-quality buprenorphine clinicians who provide a coordinated set of services to help TennCare members in their recovery journeys. Buprenorphine therapy is an evidence-based, FDA-approved treatment for opioid use disorder that combines medication and behavioral health supports. The BESMART program includes services such as a psychosocial assessment and development of a treatment plan, individual and group counseling, peer recovery services, care coordination, and opioid-agonist therapy.

The BESMART Program officially launched on January 1, 2019, and has continued to grow and serve more Tennesseans. As of March 2019, there were approximately 100 high-quality BESMART providers contracted with TennCare MCOs to treat 2,000 members. By December 2023, the number of BESMART providers had increased to 525, and the number of unique members served per month had grown to 26,443. Additionally, buprenorphine covered by TennCare remains in the top five controlled substances by claims, meaning that TennCare pays for more buprenorphine to treat opioid use disorder than for short-acting opioids to treat pain.

The focus that TennCare has placed on combatting the opioid epidemic through treatment and other major prevention efforts has also shown tremendous success in reducing the number of newborns with neonatal abstinence syndrome (NAS), or signs and symptoms of opioid withdrawal as an infant due to opioid exposure during the pregnancy. In 2018, the NAS rate in the TennCare population was 23.99 NAS births per 1,000 live births, as compared with the 2021 rate, which was 21.35 NAS births per 1,000 live births. A decline from the 2018 NAS rate has been achieved for three consecutive years.

Beneficiary Survey

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

During the fourth quarter of DY 3, BCBER published a summary of the results of the most recent survey titled "The Impact of TennCare: A Survey of Recipients, 2023". Although the findings of a single survey must be viewed in context of long-term trends, several results from the report are noteworthy:

- Satisfaction with TennCare remained high. Ninety-five percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction tied for the highest satisfaction level in the program's history, and 2023 was the fifteenth straight year in which survey respondents had reported satisfaction levels exceeding 90 percent.
- The uninsured rate in Tennessee barely changed. The reported percentage of uninsured children ticked up from 2.3 percent in 2022 to 2.5 percent in 2023. Furthermore, the reported percentage of uninsured adults rose slightly from 9.0 percent in 2022 to 9.1 percent in 2023. The overall uninsured rate reported in 2023 was 7.7 percent, up marginally from the 2022 reported uninsured rate of 7.5 percent.
- More TennCare recipients with illness were able to see a doctor on the same day or the next day. The percentage of respondents with TennCare who obtained an appointment from a primary care physician on the same day or the next day rose from 32 percent in 2022 to 39 percent in 2023.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 95 percent reporting satisfaction with the program. This positive feedback is a strong indication that TennCare is providing satisfactory medical care and meeting the expectations of those it serves." BCBER's summary report of the 2023 survey is included as Attachment K to this Annual Monitoring Report.

Quality Improvement Strategy

As required by federal law and the state's demonstration agreement with CMS, the Division of TennCare during DY 3 updated its strategy for evaluating and improving the quality and accessibility of care offered to enrollees through the managed care network. TennCare held a public notice and comment period on the strategy from November 2 through December 1, 2023, and then submitted the document—titled *2023 Quality Assessment and Performance Improvement Strategy Update*—to CMS on December 21, 2023.

In addition to identifying the state's baseline performance for each quality measure, the strategy pinpoints the performance level the state is attempting to achieve for each measure by 2025. Furthermore, the document describes the manner in which the state monitors the performance of its MCCs in areas like network adequacy, use of evidence-based clinical practice guidelines, and compliance with LTSS-specific requirements. Other topics addressed by the strategy include External Quality Review activities, the use of directed payments to advance the state's quality goals, and performance improvement projects conducted by the MCCs. The state's 2023 update to the strategy is included as Attachment L of this report.

Progress on Shared Savings Metric Set

Attachment M of this report details the state's progress on the metrics that comprise the Shared Savings Metric Set for Demonstration Years 1 and 2.

III. Budget Neutrality and Financial Reporting Requirements

Budget neutrality was successfully maintained by the state throughout DY 3. The state's budget neutrality workbook for the October-December 2023 quarter will be submitted to CMS under separate cover.

IV. Evaluation Activities and Interim Findings

STC 89 requires the state to submit to CMS a draft Evaluation Design for the approval period of the TennCare III demonstration (January 8, 2021 – December 31, 2030). A draft Evaluation Design was submitted to CMS on July 7, 2021, and CMS provided written feedback on the document on July 13, 2022. In compliance with the requirements of STC 90, the state submitted a revised draft Evaluation Design to CMS on September 9, 2022.

The state's proposed Evaluation Design was developed in accordance with the STCs and relevant CMS guidance on evaluation of 1115 demonstration projects. The state's proposed Evaluation Design identifies five primary goals to be achieved by the TennCare III demonstration:

1. Provide high-quality care to enrollees that will improve health outcomes.
2. Ensure enrollee access to health care, including safety net providers.
3. Ensure enrollees' satisfaction with services.
4. Provide enrollees with appropriate and cost-effective HCBS within acceptable budgetary parameters.
5. Manage expenditures at a stable and predictable level, and at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.

For each of these goals, the Evaluation Design outlines a set of corresponding hypotheses, research questions, and data sources to guide the state's evaluation of whether the goals of TennCare III are being achieved.

Following CMS' approval of the revised Evaluation Design, the state will begin testing its hypotheses and answering its research questions. Summaries of these evaluation activities will be included in future Quarterly and Annual Monitoring Reports.

V. State Contact

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Date Submitted to CMS: June 30, 2024

Attachment A:
Special Terms and Conditions Report

STC Activity Report – Demonstration Year 3

The state maintained compliance with all Special Terms and Conditions during Demonstration Year 3. Specific actions and deliverables are detailed below.

STCs #6 and #7: The state submitted one demonstration amendment to CMS during DY 3. The state also made preparations to add allowable benefits/coverage not requiring submission of a demonstration amendment. Details of these proposed program changes are as follows:

- On October 27, 2023, the state provided formal notification to CMS that the income threshold for pregnant women to qualify for TennCare coverage would be raised from 195 percent of the federal poverty level to 250 percent of the federal poverty level.
- On November 13, 2023, the state submitted Amendment 5 to CMS. Amendment 5 would expand access to care for low-income parents and caretaker relatives of dependent children; cover a supply of diapers for children under age 2; and enhance HCBS available under the demonstration, with particular emphasis on supporting employment.

STC #12: Public notice concerning Demonstration Amendment 5 was provided to Tennessee newspapers and posted on TennCare's website on September 13, 2023.

STC #33.d.ii: On April 28, 2023, the state submitted to CMS an enrollment target range for CHOICES Group 2 for the program year beginning July 1, 2023. The range was 9,256 – 11,500. The state also submitted an enrollment target of 1,750 for new enrollment in the CHOICES At Risk Demonstration Group.

STC #33.d.iv.(A): Each Quarterly Monitoring Report submitted during DY 3 provided data on enrollment in all three CHOICES groups, enrollment targets for CHOICES 2 and 3, and the number of reserve capacity slots being held for CHOICES Group 2. The operational procedures for determining individuals for whom CHOICES Group 2 reserve capacity slots are to be held are included as Attachment E to this Annual Monitoring Report. The state originally submitted these procedures to CMS on February 2, 2010, and has subsequently included the procedures as an attachment to each Annual Report. In addition, an updated version of these procedures was submitted to CMS on April 28, 2023.

STC #34.d.ii: On April 28, 2023, the state submitted to CMS enrollment target ranges for all five ECF CHOICES benefit groups for the program year beginning July 1, 2023, as follows:

- Essential Family Supports (ECF CHOICES Group 4): 1,771 – 1,859
- Essential Supports for Employment and Independent Living (ECF CHOICES Group 5): 2,468 – 2,592
- Comprehensive Supports for Employment and Community Living (ECF CHOICES Group 6): 1,637 – 1,749
- Intensive Behavioral Family Supports (ECF CHOICES Group 7): 16 – 50
- Comprehensive Behavioral Supports for Employment and Community Living (ECF CHOICES Group 8): 24 – 50

STC #34.d.iv.(A): Each Quarterly Monitoring Report submitted during DY 3 provided enrollment totals, enrollment targets, and the number of reserve capacity slots being held for all five ECF CHOICES groups. The operational procedures for determining individuals for whom ECF CHOICES reserve capacity slots are to be held are included as Attachment F. The state originally submitted these procedures to CMS on October 28, 2016, and has subsequently included the procedures as an attachment to each Annual Report. In addition, an updated version of these procedures was submitted to CMS on April 28, 2023.

STC #49: Each Quarterly Monitoring Report has summarized actions taken by the state to comply with the HCBS Settings Rule. A comprehensive description of the steps taken to ensure compliance with the regulations governing HCBS settings is included as Attachment H to this Annual Monitoring Report.

STC #51: The state submitted the document entitled *2023 Quality Assessment and Performance Improvement Strategy Update* to CMS on December 21, 2023.

STC #52.d: The state addressed data and trends of the designated CHOICES and ECF CHOICES data elements in each of the Quarterly Monitoring Reports and in this Annual Monitoring Report. Electronic copies of the CHOICES and ECF CHOICES point-in-time data and annual aggregate data were submitted to CMS on June 30, 2023. (The first submission of data for the Katie Beckett and Medicaid Diversion data elements is expected to occur in DY 4 and will be addressed in the corresponding Quarterly and Annual Monitoring Reports.)

STC #54: On May 24, 2023, the state submitted to CMS a revised Monitoring Protocol that incorporated feedback received from CMS.

STC #55: The state submitted Quarterly Monitoring Reports to CMS on June 6, 2023; September 5, 2023; and December 21, 2023. The state submitted the Annual Monitoring Report for DY 2 to CMS on April 7, 2023.

STC #59: The state participated in monthly monitoring calls with CMS on January 26, 2023; February 23, 2023; March 23, 2023; April 27, 2023; June 22, 2023; July 27, 2023; and September 28, 2023. All other monitoring calls were cancelled by joint agreement of CMS and the state.

STC #60: On May 22, 2023, the state notified the public of its intent to host a public forum in which comments on the progress of the TennCare Demonstration would be accepted. The state held the forum on June 23, 2023, and included a summary of comments received at the forum not only in the Quarterly Monitoring Report submitted to CMS on September 5, 2023, but also in this Annual Monitoring Report.

STC #62.e: Member months were reported to CMS by Eligibility Group in each Quarterly Monitoring Report and in this Annual Monitoring Report.

STC #67: On January 20, 2023, and December 21, 2023, the state notified CMS of proposed changes to the reconciliation methodology for funds from the two uncompensated care pools described in STC 66.

STC #72: A quarterly budget neutrality status update for each quarter of DY 3 was submitted to CMS concurrently with the Monitoring Report for that quarter.

Attachment B:
Data on Grievances Received and Resolved by TennCare MCCs During DY 3

[D1] Plan-Level, Set Indicators

#	Indicator	WellPoint	BlueCare	UnitedHealthcare C	TennCare Select	DentaQuest	Optum
IV. Appeals, State Fair Hearings and Grievances							
Subtopic: Grievances							
D1.IV.10	Grievances resolved	2433	950	115	53	169	30
D1.IV.11	Active grievances	0	74	7	3	189	
D1.IV.12	Grievances filed on behalf of LTSS users	149	64	21	N/A		
D1.IV.13	Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance	0	N/A	0	N/A		
D1.IV.14	Number of grievances for which timely resolution was provided	2432	950	114	53		30
Number of grievances resolved by plan during the reporting period related to the following services: (A single grievance may be related to multiple service types and may therefore be c							
D1.IV.15a	Resolved grievances related to general inpatient services	72	N/A	1	N/A		
D1.IV.15b	Resolved grievances related to general outpatient services	1301	N/A	43	N/A		
D1.IV.15c	Resolved grievances related to inpatient behavioral health services	18	N/A	0	N/A		
D1.IV.15d	Resolved grievances related to outpatient behavioral health services	23	N/A	10	N/A		
D1.IV.15e	Resolved grievances related to coverage of outpatient prescription drugs	32	N/A	0	N/A		9
D1.IV.15f	Resolved grievances related to skilled nursing facility (SNF) services	0	N/A	1	N/A		
D1.IV.15g	Resolved grievances related to long-term services and supports (LTSS)	27	53	21	N/A		
D1.IV.15h	Resolved grievances related to dental services	169	N/A	0	N/A	169	
D1.IV.15i	Resolved grievances related to non-emergency medical transportation (NEMT)	624	406	60	22		
D1.IV.15j	Resolved grievances related to other service types	161	N/A	0	N/A		
Number of grievances resolved by plan during the reporting period related to the following reasons: (A single grievance may be related to multiple reasons and may therefore be counte							

D1.IV.16a	Resolved grievances related to plan or provider customer service	994	369	15	19	3	2
D1.IV.16b	Resolved grievances related to plan or provider care management/case management	61	12	0	0		
D1.IV.16c	Resolved grievances related to access to care/services from plan or provider	625	356	45	23	19	9
D1.IV.16d	Resolved grievances related to quality of care	318	205	3	8	79	
D1.IV.16e	Resolved grievances related to plan communications	157	N/A	0	N/A		
D1.IV.16f	Resolved grievances related to payment or billing issues	645	20	0	3	68	
D1.IV.16g	Resolved grievances related to suspected fraud	9	N/A	1	N/A		1
D1.IV.16h	Resolved grievances related to abuse, neglect or exploitation	0	N/A	0	N/A		
D1.IV.16i	Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)	62	N/A	0	N/A		
D1.IV.16j	Resolved grievances related to plan denial of expedited appeal	0	N/A	0	N/A		1
D1.IV.16k	Resolved grievances filed for other reasons	51	N/A	72	N/A	0	8

Attachment C:
Reporting Year 2023 Tennessee Medicaid Payment Error Rate Measurement (PERM) Cycle 2 Summary Report

This document will accompany the state's submission of the Annual Monitoring Report.

Attachment D:
State of Tennessee Single Audit for the Year Ended June 30, 2023, by Tennessee Comptroller of the Treasury

This document will accompany the state's submission of the Annual Monitoring Report.

Attachment E:
Operational Procedures Regarding Reserve Slots in CHOICES Groups 2 and 3

Operational Procedures for
CHOICES Group 2 and Group 3 Reserve Capacity
March 31, 2023

Pursuant to STC #33.d.iv. A, ("**Reserve Capacity**") of the Special Terms and Conditions set forth in the current TennCare Section 1115 demonstration waiver, the state will reserve a specified number of slots in CHOICES Group 2 for:

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

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

- The Area Agency on Aging and Disability (AAAD) or the Managed Care Organization (MCO), as applicable, must complete and submit a Reserve Capacity Enrollment Justification form to the TennCare Division of Long-Term Services and Supports (LTSS), along with supporting documentation.

- The Reserve Capacity Enrollment Justification form will require confirmation of the NF or hospital, as applicable, from which the person is being discharged, and in the case of a hospital discharge, a written explanation of the applicant's circumstances that warrant the immediate provision of NF services unless HCBS are immediately available. This explanation will include such factors as:
    - The reason for the acute care stay
    - The current medical status of the individual
    - Specific types of assistance needed by the individual upon discharge (medical as well as functional)
    - A description of the applicant's natural support system as it relates to discharge needs

- The TennCare Division of LTSS will review the form and supporting documentation in order to determine whether the person meets specified criteria for enrollment into a Reserve Capacity slot.

- If documentation is sufficient to demonstrate that the individual meets specified criteria for a Reserve Capacity slot, TennCare will notify the submitting entity and proceed with the enrollment process, including determination of categorical/financial eligibility (for new Medicaid applicants) and application of federal post-eligibility

provisions.

- If documentation is not sufficient to demonstrate that the individual meets specified criteria for a Reserve Capacity slot, TennCare will notify the submitting entity and place the person on a waiting list for Group 2 until other (i.e., unreserved) capacity is available. TennCare will provide notice of the determination to the applicant, which will include the right to request a fair hearing regarding any valid factual dispute pertaining to the state's decision.

Since June 30, 2015, as a budget reduction item, eligibility for CHOICES Group 3 was limited to those SSI recipients who did not meet Nursing Facility level of care but who were determined to be at risk of institutionalization. Effective October 1, 2022, the state re-opened enrollment to the CHOICES At Risk Demonstration Group up to an enrollment target of 1,750 new enrollees. All 1,750 slots are Reserve Capacity slots in CHOICES Group 3 for individuals who do not meet institutional level of care and who do not receive SSI, but who meet at risk level of care and Institutional Medicaid (IM) standards.

Once all CHOICES Group 3 Reserve Capacity slots have been filled, individuals who qualify for enrollment into CHOICES Group 3 Reserve Capacity will be placed on the waiting list for CHOICES Group 3 until there is a Reserve Capacity slot available.

Attachment F:
Operational Procedures Regarding Reserve Slots in ECF CHOICES

Operational Procedures for
Employment and Community First CHOICES
Reserve Capacity
March 31, 2023

Pursuant to STC #34.d.iv.A ("**Reserve Capacity**") of the Special Terms and Conditions set forth in the TennCare III Section 1115 demonstration waiver, the state reserves a specified number of slots in Employment and Community First (ECF) CHOICES for:

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

These groups were identified in partnership with stakeholders including:

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

For DY 2016 of the TennCare II demonstration, the state reserved 350 slots within the ECF CHOICES Groups 4, 5, 6 Enrollment Targets. Due to limited availability of new state appropriations for DY 2017, DY 2018, and DY 2019 of the TennCare II demonstration, and to further develop the capacity of community providers to deliver home- and community-based services and supports, all increases in the Enrollment Targets for ECF CHOICES Groups 4, 5, and 6 during DY 17, DY 18, and DY 19 were Reserve Capacity slots (a total of 1,250 Reserve Capacity slots across the three approved ECF CHOICES Groups). In addition, all slots in ECF Groups 7 and 8 are considered to be Reserve Capacity slots (including the 50 slots added during DY 19—a total of up to 1,300 Reserve Capacity slots across all ECF CHOICES groups).

An additional 300 Reserve Capacity slots were added effective July 1, 2021, for a total of up to 1,600 Reserve Capacity slots across all ECF CHOICES groups. An additional 2,000 Reserve Capacity slots were added effective September 22, 2021, to ECF CHOICES Groups 4, 5, and 6. The distribution of these slots reflects 400 additional slots in Group 4, 1,275 additional in Group 5, and 325 additional slots in Group 6. Effective July 1, 2022, an additional 300 Reserve Capacity slots were added to ECF CHOICES Groups 4, 5, 6, 7, and 8. The distribution of these slots reflects 15 additional slots in Group 4, 60 additional slots in Group 5, 200 additional slots in Group 6, 10 additional slots in Group 7, and 15 additional slots in Group 8. Of the 15 slots allocated for Group 8, a total of 5 were assigned to Group 7, and 10 were reallocated to Group 6 at the 1:1.5 ratio, assigning an additional 15 slots to Group 6. The total number of Reserve Capacity slots in ECF CHOICES as of 7/1/22 is 3,897.5.

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

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

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

Individuals in emergent circumstances as defined in TennCare rule

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

Emergent criteria shall be as follows:

- The person's primary caregiver is recently deceased and there is no other caregiver available to provide needed long-term supports.
- The person's primary caregiver is permanently incapacitated and there is no other caregiver available to provide needed long-term supports.
- Services/supports in ECF CHOICES are urgently needed because of the recent loss of the person'sliving arrangement, including (as applicable) caregiver supports provided in that living arrangement that will not be available to the person going forward.
- There is clear evidence of serious abuse, neglect, or exploitation in the current living arrangement; the person must move from the living arrangement to prevent further abuse, neglect, or exploitation; and there is no alternative living arrangement available.
- Enrollment into ECF CHOICES is necessary in order to facilitate transition out of a long-term care institution, i.e., a NF or a private or public ICF/IID into a more integrated community-based setting.
- The person is being discharged from an acute care setting and is at imminent risk of being placed in a NF setting absent the provision of HCBS or has applied for admission to a NF and been determined via the Pre-Admission Screening and Resident Review (PASRR) process to be inappropriate for NF placement. TennCare may require confirmation of the NF or hospital discharge and, in the case of hospital discharge, written explanation of the applicant's circumstances that warrant the immediate provision of NF services unless HCBS are immediately available.
- An adult's transition upon aging out of state custody, discharge from an inpatient psychiatric hospital (including regional mental health institute), or release from incarceration is *contingent* on the availability of services and supports in ECF because other appropriate services/supports are not available, and the services available in ECF (including covered physical and behavioral health services) will be sufficient to safely meet the person's needs in the community.
- The person is an adult age 21 or older enrolled in ECF CHOICES Group 4 (Essential Family Supports), ECF CHOICES Group 5 (Essential Supports for Employment and Independent Living),

or the Section 1915(c) Self-Determination Waiver and has recently experienced a significant change in needs or circumstances. TennCare has determined via a Safety Determination that the person can no longer be safely served within the array of benefits available in ECF CHOICES Group 4 (Essential Family Supports) or 5 (Essential Supports for Employment and Independent Living) or the Self-Determination Waiver, as applicable, and the person meets NF level of care, and must be transitioned to ECF CHOICES Group 6 in order to sustain community living in the most integrated setting.

- The health, safety, or welfare of the person or others is in immediate and ongoing risk of serious harm or danger; other interventions including Behavioral Health Crisis Prevention, Intervention and Stabilization services, where applicable, have been tried but were not successful in minimizing the risk of serious harm to the person or others without additional services available in ECF CHOICES; and the situation cannot be resolved absent the provision of such services available in ECF CHOICES.

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

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

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

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

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

Reserve capacity groups related to ECF CHOICES Groups 7 and 8

All slots in Groups 7 and 8 are reserve capacity slots. Enrollment into these slots proceeds in accordance with eligibility and enrollment criteria set forth in STC 34 *(Operations of Employment and Community First (ECF) CHOICES)* of the approved 1115 demonstration or in state rule.

Reserve capacity slots may be held in the appropriate ECF CHOICES Group (4, 5, or 6) for individuals ready for transition from Group 7 or 8, as applicable.

Reserve capacity slots funded through Tennessee's Initial HCBS Spending Plan and Narrative pursuant to Section 9817 of the *ARP*

The 2,000 slots funded through the ARP FMAP funds were targeted to serve those individuals who were actively seeking services, were waiting to receive services the longest, and who did not meet employment-related prioritization criteria—based on information gathered during the referral or any subsequent intake or review process. All 2,000 slots were subsequently filled. As they are vacated, these slots will be repurposed as reserve capacity slots.

Operational Procedures:

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

Reserve capacity slots may be set aside for certain groups as defined herein, e.g., individuals with an intellectual or developmental disability who have an aging caregiver, as defined and required under state law, children aging out of state custody, individuals transitioning out of Group 7 or 8, etc.

Except for individuals with an intellectual or developmental disability who have an aging caregiver, as defined in state law, individuals transitioning into Groups 4, 5, or 6 from Groups 7 or 8, and those individuals who meet the criteria defined for enrollment into slots funded by the ARP Enhanced HCBS FMAP, review and selection of persons who meet criteria for reserve capacity slots in any ECF CHOICES Group will be determined by an interagency review committee, including both TennCare and DIDD. Except as provided above, a potential applicant for ECF CHOICES may apply for enrollment into a reserve capacity slot only if determined through the interagency committee review process that applicable reserve capacity criteria are met, and that enrollment into ECF CHOICES is the most appropriate way to provide needed supports. Such review shall include consideration of other options, including the relative costs of such options.

TennCare will require confirmation that an Applicant meets applicable reserve capacity criteria. Except for individuals with an intellectual or developmental disability who have an aging caregiver, as defined in state law, individuals transitioning into Groups 4, 5, or 6 from Groups 7 or 8, and those individuals who meet the criteria defined for enrollment into slots funded by the ARP Enhanced HCBS FMAP, documentation shall be provided via a form developed by TennCare, along with medical evidence that is submitted by the MCO or DIDD, as applicable, to the interagency review committee.

Except as provided above, only Applicants determined by the interagency review committee to meet specified reserve capacity criteria (including new Applicants seeking to establish eligibility in the ECF CHOICES 217-Like Group or the Interim ECF CHOICES At-Risk Group as well as current SSI-eligible

individuals seeking enrollment into ECF CHOICES) may be enrolled into reserve capacity slots.

Once all reserve capacity slots set aside for a particular purpose have been filled, persons who meet such criteria shall not proceed with the enrollment process except as provided in STC 34.d.iv.B or C, but shall remain on the Referral List for ECF CHOICES, unless they qualify to enroll in an open priority group.

Except as provided in STC 34.d.iv.B or C, if a Potential Applicant does not meet criteria for a reserve capacity slot, the Potential Applicant shall not proceed with the enrollment process, but shall remain on the referral list for ECF CHOICES.

For purposes of transparency, reserve capacity criteria, including the operational procedures pertaining thereto, are set forth in TennCare Rule 1200-13-01 through the rulemaking process, recognizing that the rulemaking processes may lag the initial availability of these slots to enroll additional individuals as appropriate.

Attachment G:
Operational Procedures Regarding Reserve Slots in Katie Beckett and Medicaid Diversion Groups

Operational Procedures for
Katie Beckett and Medicaid Diversion Groups'
Reserve Capacity
March 31, 2023

Pursuant to STC #35.c.ii.A. ("**Reserve Capacity**") of the Special Terms and Conditions set forth in the current TennCare III Section III5 demonstration waiver, the state may reserve slots in Katie Beckett (Part A) and Medicaid Diversion (Part B) groups for:

- Children with the highest level of need;
- Children awaiting discharge from an institution; and,
- Children who are at imminent risk of being placed in an institutional setting absent the provision of home- and community-based services.

Pursuant to state law, Katie Beckett Part A targets and prioritizes enrollment of children with the most significant disabilities or complex medical needs who meet institutional level of care (LOC). There are 2 institutional LOC tiers for Part A, Tier 1 and Tier 2.

- Tier 1 is for children with the most complex needs and disabilities. There are 2 types of Tier 1 institutional LOC.
    - Tier 1 – Medical Institutional LOC
    - Tier 1 – Behavioral Institutional LOC
- Tier 2 is for children who also meet institutional level of care, but their needs are not as significant as children who meet Tier 1 criteria. There are 3 standards for Tier 2 Institutional LOC, and the child must meet only one of these standards to meet Tier 2:
    - Medical
    - Behavioral
    - Functional

Currently, all available slots in Katie Beckett (Part A) are reserve capacity. Children are enrolled into available Katie Beckett Part A program slots in accordance with prioritization criteria set forth in state rule. Once all Katie Beckett (Part A) slots have been filled, children who qualify for enrollment into Katie Beckett (Part A) shall not proceed with the enrollment process into Part A, but shall remain on the waiting list for Katie Beckett (Part A) until there is a Part A slot available.[1]

The first 50 reserve capacity slots are set aside specifically for children who meet the Tier 1 LOC prioritization criteria. The purpose is to ensure that children with the most significant medical needs and disabilities can be enrolled into Katie Beckett (Part A). If a child determined to meet medical eligibility for Katie Beckett (Part A) does not meet the criteria for one of these 50 reserve capacity slots and no other Part A reserve capacity slots are available, the child may not proceed with the enrollment process, but shall remain on the waiting list for Katie Beckett (Part A) unless there is a slot available for which the child meets reserve capacity criteria.

[1] The child may qualify to enroll in Part B until a Part A slot is available. If the child meets criteria for the Continued Eligibility Group, the child may be enrolled in the Continued Eligibility group until a Part A slot is available.

Enrollment into Medicaid Diversion (Part B) shall proceed on a first come, first serve basis. There are no reserve capacity slots in Medicaid Diversion (Part B).

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

Attachment H:
Compliance Measures for Specified HCBS Requirements

COMPLIANCE WITH HCBS REGULATIONS – March 31, 2023

Regulation	Topic	Actions
42 CFR 440.180(a)	Description and requirements for HCBS	1. Attachments E, H, and L of the approved TennCare demonstration and the state Rules for TennCare Long-Term Care Programs (1200-13-01) define the HCBS benefits that are available through the CHOICES, Employment and Community First CHOICES, and Katie Beckett programs and delineate when services may be provided to a CHOICES, Employment and Community First CHOICES, or Katie Beckett member. Where appropriate, service definitions identify "services not included" as specified in 42 CFR 440.180(c)(3). TennCare Rules are available for review at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-01.20230313.pdf 2. The Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization delineates HCBS available to CHOICES, Employment and Community First CHOICES, and Katie Beckett[1] enrollees, the scope of such services, and contractor requirements for the authorization and initiation of such services. The Contractor Risk Agreement also sets forth reporting requirements by which TennCare monitors the Managed Care Organizations' compliance and penalties as needed to remediate non-compliance. A sample contract is available for review at https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf. 3. Provider Agreements between the Managed Care Organizations and network providers delineate the type and scope of services that each provider may deliver and requirements for qualified staff.

[1] Kate Beckett (Part A) enrollees are assigned to only one of the three MCOs: BlueCare. While all three MCOs may serve children in the Continued Eligibility Group, an HCBS wraparound benefit is not provided.

Regulation	Topic	Actions
42 CFR 441.301(c); (1) (2) (3) (4) (5) (6)	Contents of request for a waiver: (1) Person-centered planning process (2) Person-centered service plan (3) Review of the person-centered service plan (4) Home and community-based settings (5) Settings that are not home and community-based (6) Home and community-based settings: compliance and transition	1. The Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization delineates requirements for the person-centered planning process. A sample contract is available for review at the link provided above. 2. The Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization delineates requirements for the person-centered support plan. MCOs use a person-centered support plan template prescribed by TennCare. The Contractor Risk Agreement also sets forth reporting requirements by which TennCare monitors the Managed Care Organizations' compliance and penalties as needed to remediate non-compliance. 3. The Division of TennCare conducts routine audits of enrollee records to ensure compliance with the person-centered planning requirements. Penalties as needed to remediate non-compliance are delineated in the Contractor Risk Agreement. Additional quality monitoring and improvement strategies for person-centered planning are set forth in the integrated Quality Improvement Strategy, a copy of which is Attachment L to this report. 4. [Applicable to (4)-(6) of the Regulation] Tennessee's required Statewide Transition Plan (STP) received final approval from CMS on April 13, 2016. The STP delineates the state's process for assuring compliance with the HCBS settings rule, including the method for assuring Medicaid-reimbursed HCBS are provided in compliant settings; the process for determining settings that are not home and community-based in nature; and the transition process, which encompasses transition to compliance, as well as transition of individuals from a non-compliant setting to a compliant setting of their choice, when applicable. The plan was updated as of July

Regulation	Topic	Actions
		31, 2018, to reflect completion of the heightened scrutiny review process, including public comments regarding the posting of settings for which evidence has been submitted to CMS. By the original March 17, 2019, compliance date, all outstanding site-specific transition plans were fully implemented, bringing ALL of the sites identified in Tennessee's heightened scrutiny evidence package into compliance. The state's progress in implementing the STP and achieving full compliance is detailed in the document entitled *Statewide Transition Plan Quarterly Status Report*, April 2019, and which was previously submitted to CMS. All documents mentioned are available here: https://www.tn.gov/tenncare/long-term-services-supports/transition-plan-documents-for-new-federal-home-and-community-based-services-rules.html In addition to achieving initial compliance with the HCBS settings rule, TennCare and contracted entities ensure that all provider settings maintain compliance with the HCBS Settings Rule on an ongoing basis. As outlined in the Statewide Transition Plan, TennCare amended its Contractor Risk Agreement (CRA) with the MCOs to include HCBS Settings Rule language effective January 1, 2015. Additional amendments became effective July 1, 2015, including the process for ensuring compliance with the HCBS Settings Rule prior to credentialing and re-credentialing providers. Prior to executing a provider agreement with any HCBS provider seeking Medicaid reimbursement, the MCOs are required under the CRA to verify that the provider is compliant with the HCBS Settings Rule using checklists approved by TennCare. The CRA has been amended to extend this credentialing and re-credentialing compliance review requirement to Employment and

Regulation	Topic	Actions
		Community First CHOICES providers as well as Katie Beckett providers. On July 1, 2022, the Department of Intellectual and Development Disabilities (DIDD) assumed responsibility for the credentialing and re-credentialing of Employment and Community First CHOICES providers as outlined in the most recent Interagency Agreement between DIDD and the Division of TennCare. Prior to credentialing or re-credentialing an Employment and Community First CHOICES provider, DIDD is required to verify that all HCBS settings where Medicaid-reimbursed services are provided are compliant with the HCBS Settings Rule. In response to CMS's request for additional information regarding the state's STP on May 24, 2022, TennCare submitted a summary of the following on November 3, 2022: (1) a description of how the state's oversight systems have been modified to embed the regulatory criteria into ongoing operations; (2) a description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance; and (3) a description of a beneficiary's recourse to notify the state of provider non-compliance and how the state addresses beneficiary feedback. On July 1, 2016, the CRA was amended to require the MCOs to create settings compliance committees to conduct reviews of person-centered support plans and behavior support plans, as applicable, that include restrictive interventions, as well as all proposed or emergency right restrictions and restraints not contained in a person-centered support plan or behavior support plan. The committees must review any information from the provider's human rights committee, as applicable, identify and address potential

Regulation	Topic	Actions
		compliance concerns, make recommendations regarding less restrictive interventions or referrals for appropriate services, and ensure informed consent for any restrictions. Settings compliance committees must also periodically review data regarding the use of interventions to determine ongoing effectiveness and whether such restrictions should be discontinued, review and make recommendations to the prescribing professional regarding potential instances of inappropriate utilization of psychotropic medications, review and make recommendations regarding complaints received pertaining to restrictive interventions or settings compliance concerns, and ensure that any proposed restriction, including restrictions in provider-owned or controlled residential settings, is the least restrictive viable alternative and is not excessive. TennCare also requires the MCOs to provide quarterly updates to TennCare on committee recommendations and actions. To monitor compliance at the individual level, a Care or Support Coordinator, as applicable to the particular program, conducts an Individual Experience Assessment (IEA) Survey, a tool developed by TennCare using the HCBS Settings Rule Exploratory Questions from CMS. The survey is intended to measure each individual's level of awareness of and access to rights provided in the HCBS Settings Rule, freedom to make informed decisions, community integration, privacy requirements, and other member experience expectations. IEAs are completed upon initial service initiation, as part of the member's annual Person-Centered Support Plan (PCSP) review, within 30 days of a change in the mental or physical status of a member that impacts modifications/restrictions in place and

Regulation	Topic	Actions
		anytime a change in residence or provider occurs for a person receiving residential services. This data is entered into an electronic system that TennCare uses to aggregate and analyze data by MCO and by provider. Currently, the MCOs are required to review IEA survey responses for all Medicaid recipients receiving HCBS and investigate each "No" response that indicates a potential rights restriction and ensure timely remediation of any potential compliance concern. This data is reported in the CHOICES Quarterly IEA Remediation Report and an ECF CHOICES IEA Remediation Report from each MCO on a quarterly basis. DIDD provides an IEA Remediation Report for the 1915(c) waiver members. The report requires the MCOs and DIDD to investigate these responses to determine if the restriction indicated has gone through the HCBS Settings Rule modifications procedure, and the restriction is appropriately included in the member's Person-Centered Support Plan. If the restriction has not gone through the modification process and is not supported in the person-centered support plan, the MCOs remediate the individual concerns by working with the provider and the person supported and his or her representative, if applicable. In addition, as part of ongoing monitoring of compliance with the HCBS Settings Rule, the MCOs are required to identify trends relating to member concerns with particular providers or provider settings and report those issues to TennCare along with steps for remediation to address those concerns. TennCare's review and analysis of this data informs targeted technical assistance as well as overall ongoing systems transformation efforts.
42 CFR 441.302; (a) (c)	State assurances: (a) Health and Welfare (c) Evaluation of need	1. The state Rules for TennCare Long-Term Care Programs (1200-13-01) define the standards for HCBS providers. These Rules are available for review at

Regulation	Topic	Actions
(d) (g) (j)	(d) Alternatives (g) Institutionalization absent waiver (j) Day treatment or partial hospitalization	https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-01.20230313.pdf 2. The Contractor Risk Agreement between the Division of TennCare and each Managed Care Organization includes: a. Reportable Event Reporting and Monitoring requirements; b. Mandatory elements for all provider agreements; c. Credentialing requirements to ensure a network of qualified providers for CHOICES and Katie Beckett; d. Requirements pertaining to initial and annual Level of Care assessments; e. Mandatory elements of a CHOICES, Employment and Community First CHOICES, or Katie Beckett assessment and person-centered support plan, including risk assessment/planning, as applicable; and f. Maximum timelines for the assessment, development of the person-centered support plan, and service initiation for potential and new CHOICES, Employment and Community First CHOICES, or Katie Beckett members. 3. The Interagency Agreement between the Division of TennCare and DIDD includes credentialing requirements to ensure a network of qualified Employment and Community First CHOICES providers. 4. Provider Agreements between the Managed Care Organizations and network providers include critical incident reporting requirements. 5. Provider Agreements between DIDD and Katie Beckett Part B providers include critical incident reporting requirements. 6. Cost neutrality calculations ensure that an individual's needs can be met safely and effectively at a cost that is less than or equal to care provided in a NF. If the individual's

Regulation	Topic	Actions
		needs cannot safely and effectively be met with HCBS at a cost that is less than or equal to the same Level of Care in a NF, the individual is eligible for—and may elect to receive services in—a NF. 7. Level of Care is confirmed for each CHOICES, Employment and Community First CHOICES, and Katie Beckett member through standard PAE (PreAdmission Evaluation or Level of Care application) processes, requirements for supporting medical documentation, and annual recertification to verify Level of Care requirements continue to be met. 8. Freedom of Choice education appears in materials used by the single point of entry, and in the Freedom of Choice election form (applicable for CHOICES), member handbook, and TennCare website. 9. Please refer to the integrated Quality Improvement Strategy in Attachment L of this report for a list of measures used to verify the state Assurances.
42 CFR 441.303; (a) (c) (d) (e)	Supporting documentation required: (a) Description of safeguards (c) Description of agency plan for evaluation (d) Description of plan to inform enrollees (e) Description of post-eligibility treatment of income	1. Level of Care eligibility for CHOICES, Employment and Community First CHOICES, and Katie Beckett (Part A) is determined through the completion and review of a PAE (Level of Care application). On an annual basis, each member's PAE must be reviewed by the Managed Care Organization or DIDD, as applicable, to verify that the individual continues to meet Level of Care. 2. Please refer to the integrated Quality Improvement Strategy in Attachment L of this report for a list of measures used to verify the State Assurances. These data are reported to CMS annually. 3. The state Rules for the Department of Health, Division of Healthcare Facilities delineate specific licensure requirements for nursing facilities, assisted care living facilities, and Adult Care Homes-Level 2. https://publications.tnsosfiles.com/rules/1200/1200-08/1200-08.htm The state Rules for

Regulation	Topic	Actions
		the Department of Intellectual and Developmental disabilities delineate specific licensure requirements for Community Living Supports, as defined in the three-page document following this table. 4. Post-eligibility treatment of income is delineated in State Rules for TennCare Technical and Financial Eligibility (1200-13-20). These Rules are available for review at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-20.20220811.pdf
42 CFR 441.310	Limits on Federal financial participation	1. The Contractor Risk Agreement between the Division of TennCare and the Managed Care Organizations allows the Managed Care Organizations to contract only with licensed facilities that are eligible to participate in Medicaid. 2. Managed Care Organizations may not provide reimbursement for Room and Board, as is delineated in state Rules for TennCare Long-Term Care Programs (1200-13-01-.02). 3. CHOICES and Katie Beckett services do not include prevocational, educational, or supported employment services. Where appropriate, Employment and Community First CHOICES service definitions specify that services may not be provided under the Employment and Community First CHOICES program if such benefits would be available either under special education and related services as defined in section 602 of the Education of the Handicapped Act (20 U.S.C. 1401) or under vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

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

Providers of Community Living Supports (CLS) and Community Living Supports-Family Model (CLS-FM) in CHOICES and Employment and Community First CHOICES are licensed by the Department of Intellectual and Developmental Disabilities (DIDD) pursuant to statutory requirements set forth in Tennessee Code Annotated, Title 33, and in Chapter 0465-02 of the Rules of the Department of Intellectual and Developmental Disabilities, including:

> **0465-02-11** MINIMUM PROGRAM REQUIREMENTS FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES RESIDENTIAL HABILITATION FACILITIES/SERVICES
>
> **0465-02-13** MINIMUM PROGRAM REQUIREMENTS FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES PLACEMENT SERVICES
>
> **0465-02-15** MINIMUM PROGRAM REQUIREMENTS FOR INTELLECTUAL DISABILITIES SEMI-INDEPENDENT LIVING SERVICES and **0465-02-16** MINIMUM PROGRAM REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES SEMI-INDEPENDENT LIVING SERVICES
>
> **0465-02-18** MINIMUM PROGRAM REQUIREMENTS FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SUPPORTED LIVING SERVICES

The specific type of licensure depends on the level of support need/reimbursement for individuals living in the home, as well as certain factors that are explicit in the statutory and regulatory requirements. For example:

- *The CLS1 and CLS2 provider is licensed by the Department of Intellectual and Developmental Disabilities (DIDD) for Intellectual Disabilities or Developmental Disabilities Semi-Independent Living Services in accordance with licensure regulations.*

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

- *The CLS3 provider is licensed for Intellectual and Developmental Disabilities Supported Living Services or Residential Habilitation Facilities/Services by the Department of Intellectual and Developmental Disabilities (DIDD) in accordance with licensure requirements.*

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

The levels of support for Community Living Supports-Family Model are the same, but all are delivered in an adult foster home setting where the person lives in the home of a family who is the paid caregiver.

- *The CLS-FM provider is licensed by the Department of Intellectual and Developmental Disabilities (DIDD) as Intellectual and Developmental Disabilities Placement Services.*

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

Licensure standards establish the minimum standards that facilities must meet in order to be licensed. These include background checks for all staff.

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

In addition to annual licensure surveys, TennCare contracts with the Department of Intellectual and Developmental Disabilities (DIDD), the operating agency for the state's three Section 1915(c) waivers for individuals with intellectual disabilities, to conduct quality monitoring surveys of providers of CLS and CLS-FM services. TennCare has built on a well-developed quality strategy to establish performance measures and processes for discovery, remediation, and ongoing data analysis and quality improvement regarding CLS services. In addition to providing data specific to the quality of these services offered in the CHOICES and Employment and Community First CHOICES programs, this ensures that TennCare has a comprehensive perspective of quality performance and strategies for quality improvement across the LTSS system as a whole.

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

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

Finally, TennCare participates in *National Core Indicators – Aging and Disability™ (NCI-AD)* survey to assess quality of life, community integration, and person-centered services for the members in the CHOICES program. TennCare also participates in the *National Core Indicators™* In-Person

Survey (NCI-IPS) to assess quality of life, community integration, and person-centered services for Employment and Community First CHOICES members. Both survey processes use a standardized assessment tool to monitor quality of services and quality outcomes for seniors and adults with physical disabilities and individuals with I/DD receiving HCBS, including those in CLS and CLS-FM settings.

Attachment I:
Health and Welfare of HCBS Participants

Waiver operations are in compliance. The state system assures HCBS participants' health and welfare in multiple ways. Through an annual member record review, TennCare reviews and ensures that each member has annual education on abuse, neglect, and exploitation. Additionally, TennCare receives monthly reports on all reportable events that were investigated, and a quarterly analysis report from the Tennessee Department of Intellectual and Developmental Disabilities (DIDD) and the Managed Care Organizations (MCOs), which tracks and trends all the reportable events.

Reportable Events and data are tracked and trended by DIDD, the MCOs, and providers in the One Aligned Reportable Event Management System for all LTSS programs, including CHOICES (Groups 2 & 3), Employment and Community First CHOICES, and Katie Beckett. The MCOs and DIDD, in collaboration with TennCare and providers, evaluate the trended data to address and prevent future instances of abuse, neglect, exploitation, and unexplained death.

The state continues all efforts to ensure the health and welfare of persons served across all LTSS programs. CHOICES and ECF CHOICES providers report Reportable Events to DIDD using an aligned Reportable Event Form accessible through Formstack. These providers are required to be trained on completing Tier 2 Reportable Event Investigations. Since January 1, 2022, Reportable Event Management is fully aligned under the subject matter expertise of DIDD and TennCare jointly.

Systems:

- Data describing investigations is entered on an ongoing basis into the DIDD Incident and Investigation (I&I) Database. Monthly reports are generated by DIDD and submitted to TennCare. They include data describing substantiated investigations concluded during the month and investigations for which an extension beyond thirty (30) days was granted, including the type of allegation, the reason for the extension, and the date the investigation was completed.
- MCOs continue to be required to maintain LTSS Distinction as part of their NCQA Accreditation process. One of the core areas is case management, which requires the implementation and ongoing maintenance of a critical incident management system to promptly report, track, and follow up on incidents such as abuse, neglect, and exploitation.

Reports:

- HCBS Settings Committee Reports are completed quarterly for the 1115 waiver programs by the MCOs. These reports include the total number of proposed or emergency rights restrictions or restraints reviewed during the quarter that are not part of a plan of care or PCSP or BSP; the total number of periodic data reviews regarding interventions; the total number of reviews of psychotropic medications conducted during the quarter; the total number of complaints regarding restrictive interventions or settings compliance concerns received and reviewed during the quarter; and a summary of the outcomes of such reviews, including actions pertaining to individual members or providers or to broader systemic improvements.

- Quarterly IEA Remediation Reports are submitted for the 1115 waiver program by each MCO. These reports capture how each instance of provider non-compliance with the Final Settings Rule is remediated.
- Reportable Event Management Monthly Reports track all reportable event incidents by event type, setting, the provider/staff accused of being responsible, whether the event was substantiated, and the remediation type.
- Reportable Event Quarterly Analysis report includes a narrative describing the MCO's analysis of reportable events for the reporting period, including trends and patterns; opportunities for improvement; and strategies implemented by the MCO to reduce the occurrence of incidents and improve quality.
- Emergency Department (ED) Utilization Quarterly Report of 1115 members evaluates members who have ED visits. The report allows TennCare to follow up with the MCOs to investigate members who have frequent ED visits.

Audits:

- 1115 Existing Member Record Reviews are conducted annually. These record reviews include performance measures related to education of members on the identification and reporting of suspected abuse.
- Using the monthly reports, the Quality Assurance team reviews all Reportable Event Management data and generates a report that reviews compliance for investigation and reporting timeframes.

Attachment J:
Measurement Year 2022 HEDIS/CAHPS Report – Comparative Analysis of Audited Results from TennCare Managed Care Organizations

April 2024

2023 Annual

HEDIS/CAHPS Report

Comparative Analysis of Audited Results from TennCare MCOs for Measurement Year (MY) 2022

Following the MY2022 National Benchmark Release (FNB)

Final, *updated*

TN Division of TennCare

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Acknowledgements, Acronyms, and Initialisms[1]

AAB..... Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
AAP.... Adults' Access to Preventive/Ambulatory Health Services
ABX.....Antibiotic Utilization
ACIP.....Advisory Committee on Immunization Practices
ADD.....Follow-Up Care for Children Prescribed ADHD Medication
ADD-E .....Follow-Up Care for Children Prescribed ADHD Medication - ECDS
ADHD .....Attention-Deficit/Hyperactivity Disorder
AG.....Amerigroup Community Care, Inc., referred to as Amerigroup
AGE/AGM/AGW.....AG referenced by operational region: East (E), Middle (M), or West (W)
AHRQ..... Agency for Healthcare Research and Quality
AIS-E.....Adult Immunization Status—ECDS
AMB ..... Ambulatory Care
AMI.....acute myocardial infarction
AMM..... Antidepressant Medication Management
AMR.....Asthma Medication Ratio
AOD ..... Alcohol or Other Drug
APM ..... Metabolic Monitoring for Children and Adolescents on Antipsychotics
APP..... Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
ASCVD .....Atherosclerotic Cardiovascular Disease
ASF-E.....Unhealthy Alcohol Use Screening and Follow-Up—ECDS
AWC.....Adolescent Well-Care Visits
BC.....BlueCare Tennessee® and BlueCare®, independent licensees of the BlueCross BlueShield Association
BCE/BCM/BCW..... BlueCare referenced by operational region: East, Middle, or West
BCS..... Breast Cancer Screening
BCS-E..... Breast Cancer Screening-ECDS
BMI.....Body Mass Index
BP.....Blood Pressure
BPD..... Blood Pressure Control for Patients With Diabetes
BR.....Biased Rate
CAHPS®.....Refers to the Consumer Assessment of Healthcare Providers and Systems, a registered trademark of AHRQ
CBP..... Controlling High Blood Pressure
CCC .....Children with Chronic Conditions
CCS..... Cervical Cancer Screening
CDC .....Comprehensive Diabetes Care
CHL.....Chlamydia Screening in Women
CIS.....Childhood Immunization Status
C&M..... Continuation and Maintenance
CRE.....Cardiac Rehabilitation
COPD .....Chronic Obstructive Pulmonary Disease
COU ..... Risk of Continued Opioid Use
CPA.....CAHPS Health Plan Survey 5.1H Adult Version
CPC..... CAHPS Health Plan Survey 5.1H Child Version
CT.....Computerized Tomography
CVD.....Cardiovascular Disease
CWP.....Appropriate Testing for Pharyngitis
DMS-E.....Utilization of the PHQ-9 to Monitor Depression

[1] *Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.*

Symptoms for Adolescents and Adults—ECDS
DRR-E ..... Depression Remission or Response for Adolescents and Adults—ECDS
DSF-E ..... Depression Screening and Follow-Up for Adolescents and Adults—ECDS
DTaP .... Diphtheria, Tetanus, and Acellular Pertussis Vaccination
ECDS ..... Electronic Clinical Data Systems
ED ..... Emergency Department
EED ..... Eye Exam for Patients With Diabetes
eGFR ..... Estimated glomerular filtration rate
ENP/ENPA ..... Enrollment by Product Line/ENP Total
Flu ..... Influenza
FNB ..... Following National Benchmark
FSP ..... Frequency of Selected Procedure
FUA ..... Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence
FUH ..... Follow-Up After Hospitalization for Mental Illness
FUI ..... Follow-Up After High-Intensity Care for Substance Use Disorder
FUM ..... Follow-Up After ED Visit for Mental Illness
FVA ..... Flu Vaccinations for Adults Ages 18 to 64
HbA1c ..... Hemoglobin A1c
HBD ..... Hemoglobin A1c Control for Patients With Diabetes
HDO ..... Use of Opioids at High Dosage
HEDIS® ..... A registered trademark of NCQA that refers to the Healthcare Effectiveness Data and Information Set
HepA ..... Hepatitis A Vaccine
HepB ..... Hepatitis B Vaccine
HiB ..... Haemophilus influenzae Type B Vaccine
HPV ..... Human Papillomavirus Vaccine
HrHPV ..... High-Risk Human Papillomavirus
IHS ..... Index Hospital Stays
IET ..... Initiation and Engagement of SUD Treatment
IMA ..... Immunizations for Adolescents
IP; IPU ..... Inpatient; IP Utilization – General Hospital/Acute Care
IPV ..... Inactivated Polio Vaccine
KED ..... Kidney Health Evaluation for Patients with Diabetes
LBP ..... Use of Imaging Studies for Low Back Pain
LDL-C ..... Low-Density Lipoprotein Cholesterol
LOS ..... Length of Stay
LSC ..... Lead Screening in Children
LTSS ..... Long-Term Services and Supports
LTSS-CAU ..... Comprehensive Assessment and Update
LTSS-CPU ..... Comprehensive Care Plan and Update
LTSS-RAC ..... Reassessment/Care Plan Update after Inpatient Discharge
LTSS-SCP ..... Shared Care Plan with Primary Care Practitioner
MCO ..... Managed Care Organization
mg ..... Milligrams
mm HG ..... Millimeters of mercury, unit of measurement for blood pressure
MME ..... Morphine Milligram Equivalent Dose
MMR ..... Measles, Mumps, and Rubella Vaccine
MRI ..... Magnetic Resonance Imaging
MSC ..... Medical Assistance with Smoking and Tobacco Use Cessation
MY ..... Measurement Year
NA ..... Not Applicable
NB ..... No Benefit
NCQA ..... National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™ ..... Trademark of NCQA
NCS ..... Non-Recommended Cervical Cancer Screening in Adolescent Females
NR ..... Not Reported

NQ ..... Not Required
OB-GYN..... Obstetrician-Gynecologist
OUD ..... Opioid Use Disorder
PBH.....Persistence of Beta-Blocker Treatment After a Heart Attack
PCE.....Pharmacotherapy Management of COPD Exacerbation
PCP..... Primary Care Practitioner
PCR..... Plan All-Cause Readmissions
PCV.....Pneumococcal Conjugate Vaccination
PDS-E..... Postpartum Depression Screening and Follow-Up—ECDS
PHQ-9..... Patient Health Questionnaire-9
PND-E .....Prenatal Depression Screening and Follow-Up—ECDS
POD ..... Pharmacotherapy for Opioid Use Disorder
PPC..... Prenatal and Postpartum Care
PRS-E.....Prenatal Immunization Status—ECDS
Qsource®..... A registered trademark
Quality Compass®.....A registered trademark of NCQA, the comprehensive national database of health plans' HEDIS and CAHPS results
R.....Reportable
RV.....Rotavirus Vaccination
SAA.....Adherence to Antipsychotic Medications for Individuals with Schizophrenia
SMC..... Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
SMD ..... Diabetes Monitoring for People with Diabetes and Schizophrenia
SPC.....Statin Therapy for Patients with Cardiovascular Disease
SPD..... Statin Therapy for Patients with Diabetes
SPR.....Use of Spirometry Testing in the Assessment and Diagnosis of COPD
SSD.....Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications
SUD.....Substance Use Disorder
TCS ..... TennCareSelect, operating statewide and administered by BlueCare Tennessee
Td; TdapTetanus and Diphtheria Toxoids Vaccine; Td and Acellular Pertussis Vaccine
TennCare ..... Tennessee Division of TennCare
uACR..... Urine Albumin-Creatinine Ratio
UHC ..... UnitedHealthcare Community Plan, Inc., abbreviated as UnitedHealthcare
UHCE/UHCM/UHCW .....UHC referenced by operational region: East, Middle, or West
UN.....Unaudited
UOP ..... Use of Opioids from Multiple Providers
URI... Upper Respiratory Infection, and the Measure: Appropriate Treatment for URI
VZV .....Chicken Pox/Varicella Zoster Vaccination
W30..... Well-Child Visits in the First 30 Months of Life
W34..... Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
WCC.....Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
WCV.....Child and Adolescent Well-Care Visits

Executive Summary

Medicaid managed care organizations (MCOs) are required to report a full Healthcare Effectiveness Data and Information Set (HEDIS) as a part of the accreditation mandates in Tennessee. The HEDIS requirement is an integral part of the accreditation process of the National Committee for Quality Assurance (NCQA). In 2006, Tennessee became the first state in the nation requiring all MCOs to become accredited by NCQA, an independent, not-for-profit organization that assesses and scores MCO performance on important dimensions of care and service in a broad range of health issues.

More than 90% of health plans in America use the HEDIS tool because its standardized measures of MCO performance allow comparisons to national averages and benchmarks as well as between a state's MCOs, and over time. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) set of standardized surveys is included in HEDIS to measure members' satisfaction with their care. This *MY2022 Annual HEDIS/CAHPS Report—Following the MY2022 National Benchmark Release (FNB)* summarizes the results for the MCOs contracting with the Division of TennCare (TennCare), the Medicaid program in Tennessee, and includes data that are for TennCare's internal use only. The report was produced by Qsource, in coordination with Certified HEDIS Auditor and Health Informatics Consultant, Michael E. Campbell.

For an overview of the performance of TennCare's MCOs, the Statewide Performance section provides a calculated weighted average of the scores of all those reporting. MCO-specific measures are presented in the Individual Plan Performance section. Weighted average performances of Tennessee's MCOs since 2017 on certain measures are presented in the HEDIS Trending section.

Appendix A contains a comprehensive table of plan-specific results for HEDIS MY2022 Utilization Measures. The tables in Appendix B reveal populations reported by MCOs in member months by age and sex for HEDIS MY2022. Appendix C includes plan-specific results for Measures Collected Using Electronic Clinical Data Systems (ECDS) and Long-Term Services and Supports (LTSS) measures.

Background

HEDIS Measures—Domains of Care

HEDIS is an important tool designed to ensure the public has the information needed to reliably compare the performance of managed healthcare plans. Standardized methodologies incorporating statistically valid samples of members ensure the integrity of measure reporting and help purchasers make more reliable, relevant comparisons between health plans. HEDIS measures are subject to an NCQA HEDIS Compliance Audit that must be conducted by an NCQA-certified HEDIS Compliance Auditor under the auspices of an NCQA-licensed organization. This ensures the integrity of the HEDIS collection and calculation process at each MCO through an overall information systems capabilities assessment, followed by an evaluation of the ability to comply with HEDIS specifications.

HEDIS MY2022 assesses care across health systems, access to and satisfaction with healthcare services, and specific utilization through more than 90 measures (Commercial, Medicare and Medicaid) across six domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Utilization and Risk-Adjusted Utilization
- Experience of Care (CAHPS Survey Results)
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems (ECDS)

The following brief descriptions of selected HEDIS measures were extracted from NCQA's *HEDIS Measurement Year 2022 Volume 2: Technical Specifications*, which includes additional information related to each measure. The measures presented in this report reflect data submitted from the following domains of care: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Risk-Adjusted Utilization, Health Plan Descriptive Information, and ECDS. Additional LTSS measures are also included. The following measures and stratifications were retired and will no longer be collected or used by NCQA for MY2022:

- Antibiotic Utilization (ABX)
- The Comprehensive Diabetes Care (CDC) composite measure, including the following rates:
    1. Medical Attention for Nephropathy
    2. Hemoglobin A1c (HbA1c) blood test

The remaining measure rates from CDC were separated into the following standalone measures:

- Hemoglobin A1c Control for Patients With Diabetes (HBD), with separate rates reported for HbA1c control (<8.0%) and poor control (>9.0%).
- Blood Pressure Control for Patients With Diabetes (BPD)
- Eye Exam for Patients With Diabetes (EED)

Effectiveness of Care Measures

The measures in the Effectiveness of Care domain assess the quality of clinical care delivered within an MCO. They address

how well the MCO delivers widely accepted preventive services and recommended screening for common diseases.

The domain also includes some measures for overuse and patient safety and addresses four major aspects of clinical care:

1. How well the MCO delivers preventive services and keeps members healthy.
2. Whether members are offered the most up-to-date treatments for acute episodes of illness and get better.
3. How well the MCO delivers care and assistance with coping to members with chronic diseases.
4. Whether members can get appropriate tests.

Effectiveness of Care measures are grouped into more specific clinical categories, which may change slightly year to year:

- Prevention and Screening
- Respiratory Conditions
- Cardiovascular Conditions
- Diabetes
- Behavioral Health
- Overuse/Appropriateness

Note: Only clinical categories with Medicaid measures are noted here.

Only certain measures from these categories are presented in this report, which does not include the additional category in this domain specific to Medicare. For some measures, eligible members cannot have more than one gap in continuous enrollment of up to 45 days during the measurement year (MY) and members in hospice (General Guideline 17) are excluded.

Prevention and Screening

Immunization measures follow guidelines for immunizations from the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices (ACIP). HEDIS implements changes (e.g., new recommendations) after three years, to account for the measures' look-back period and to allow the industry time to adapt to new guidelines.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

WCC measures the percentage of members 3 to 17 years of age who had an outpatient visit with a primary care practitioner (PCP) or obstetrician-gynecologist (OB-GYN) and who had evidence of three indicators: BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the MY.

Note: Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

For WCC, a total rate and two age stratifications are reported for each indicator:

- 3–11 years
- 12–17 years

Childhood Immunization Status (CIS)

CIS assesses the percentage of children who became two years of age during the MY who had four diphtheria, tetanus, and acellular pertussis vaccines (DTaP); three inactivated polio vaccines (IPV); one measles, mumps, and rubella vaccine (MMR); three haemophilus influenza type B vaccines (HiB); three hepatitis B (HepB) vaccines; one chicken pox/varicella zoster vaccine (VZV);

four pneumococcal conjugate vaccines (PCV); one hepatitis A (HepA) vaccine; two or three rotavirus vaccines (RV); and two influenza vaccines (Flu) by their second birthday.

The measure calculates a rate for each vaccine and three combination rates.

Table 1. Combination Vaccinations for Childhood Immunization Status (CIS)

#	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Flu
3	✓	✓	✓	✓	✓	✓	✓			
7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Note: CIS follows the Centers for Disease Control and Prevention and ACIP guidelines for immunizations.

Immunizations for Adolescents (IMA)

IMA measures the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one dose of tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates: meningococcal and Tdap/Td; and meningococcal, Tdap/Td and HPV.

Lead Screening in Children (LSC)

LSC assesses the percentage of children two years of age during the MY who had one or more capillary or venous lead blood tests for lead poisoning on or before the second birthday. Both the date the test was performed, and the result/finding must be documented in the medical record.

Breast Cancer Screening (BCS)

BCS measures the percentage of women 50 to 74 years of age during the MY who had a mammogram to screen for breast cancer on or between October 1 two years prior to the MY, and through December 31 of the MY.

Cervical Cancer Screening (CCS)

CCS measures the percentage of women 21 to 64 years of age during the MY who were screened for cervical cancer using either of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within the last three years
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years
- Women 30–64 years of age who had cervical cytology/hrHPV co-testing performed within the last five years

Chlamydia Screening in Women (CHL)

CHL assesses the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the MY. This measure calculates a total rate as well as two age stratifications:

- Women ages 16–20
- Women ages 21–24

Respiratory Conditions

Appropriate Testing for Pharyngitis (CWP)

CWP measures the percentage of episodes for members three years of age and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A

streptococcus test for the episode that occurred during the intake period between July 1 of the year prior to the MY and June 30 of the MY. A higher rate represents better performance (i.e., appropriate testing). This measure calculates a total rate in addition to three age stratifications:

- 3–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

SPR reports the percentage of members 40 years of age and older with a new diagnosis during the intake period or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing to confirm the diagnosis. The first COPD diagnosis must have occurred during the intake period between July 1 of the year prior to the MY and June 30 of the MY.

Pharmacotherapy Management of COPD Exacerbation (PCE)

PCE assesses the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient (IP) discharge or emergency department (ED) visit on or between January 1 and November 30 of the MY and who were dispensed appropriate medications. Two rates are reported:

- Dispensed a systemic corticosteroid (or evidence of an active prescription) within 14 days of the event
- Dispensed a bronchodilator (or evidence of an active prescription) within 30 days of the event

Note: The eligible population for this measure is based on acute IP discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.

Asthma Medication Ratio (AMR)

AMR assesses the percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the MY. This measure calculates a total rate as well as four age stratifications:

- 5–11 years
- 12–18 years
- 19–50 years
- 51–64 years

Cardiovascular Conditions

Controlling High Blood Pressure (CBP)

CBP reports the percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the MY.

Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)

PBH measures the percentage of members 18 years of age and older during the MY who were hospitalized and discharged from July 1 of the year prior to the MY to June 30 of the MY with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months (at least 135 days of treatment within a 180-day interval) after discharge.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

SPC reports the percentage of members identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who met the following criteria:

- *Received Statin Therapy*—Members who were dispensed at least one high- or moderate-intensity statin medication during the MY.
- *Statin Adherence 80%*—Members who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period.

For SPC, a total rate and two stratifications of gender and age (as of December 31 of the MY) are reported:

- Males 21–75 years
- Females 40–75 years

Cardiac Rehabilitation (CRE)

CRE measures the percentage of members 18 years and older who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement. Four rates are reported:

- *Initiation*—The percentage of members who attended two or more sessions of cardiac rehabilitation within 30 days after a qualifying event.
- *Engagement 1*—The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event.
- *Engagement 2*—The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.
- *Achievement*—The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.

The measure is reported as a total rate as well as two age stratifications:

- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Diabetes

Hemoglobin A1c Control for Patients With Diabetes (HBD)

HBD measures the percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c control (<8.0%).
- HbA1c poor control (>9.0%).

Note: Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.

Blood Pressure Control for Patients With Diabetes (BPD)

BPD measures the percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mmHg) during the measurement year.

Eye Exam for Patients With Diabetes (EED)

EED measures the percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

Kidney Health Evaluation for Patients with Diabetes (KED)

KED reports the percentage of members 18–85 years of age with diabetes (type I and type II) who received a kidney health

evaluation, defined by an estimated glomerular filtration rate (eGFR) *and* a urine albumin-creatinine ratio (uACR), during the measurement year. The measure is reported as a total rate as well as three age stratifications:

- 18–64 years
- 65–74 years
- 75–85 years

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Statin Therapy for Patients with Diabetes (SPD)

SPD reports the percentage of members 40 to 75 years of age with diabetes during the MY who do not have ASCVD and met the following criteria reported as two rates:

- *Received Statin Therapy*—Members who were dispensed at least one statin medication of any intensity during the MY.
- *Statin Adherence 80%*—Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Behavioral Health

Antidepressant Medication Management (AMM)

AMM measures the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:

- *Effective Acute Phase Treatment*—The percentage who remained on an antidepressant medication for at least 84 days (12 weeks).
- *Effective Continuation Phase Treatment*—The percentage who remained on an antidepressant medication for at least 180 days (6 months).

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

ADD assesses the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed, at which time the member must have been 6 to 12 years of age. Two rates are reported:

- *Initiation Phase*—The percentage who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
- *Continuation and Maintenance Phase*—The percentage who remained on the medication for at least 210 days and who, in addition to the Initiation Phase follow-up, had at least two follow-up visits with a practitioner within 270 days (nine months) of the end of the Initiation Phase.

Follow-Up after Hospitalization for Mental Illness (FUH)

FUH examines the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates report the percentage of discharges for which the member received follow-up within the following:

- 7 days after discharge
- 30 days after discharge

A total rate and three age stratifications are reported:

- 6–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

FUM evaluates the percentage of ED visits for members six years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported as the percentage of ED visits for which the member received follow-up within the following:

- 7 days of ED visit
- 30 days of ED visit

This measure is reported as a total rate as well as three age stratifications:

- 6–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Follow-Up after High-Intensity Care for Substance Use Disorder (FUI)

FUI measures the percentage of acute IP hospitalizations, residential treatment, or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported as the percentage of high-intensity care visits or discharges in which the member received follow-up within the following:

- 7 days after visit or discharge
- 30 days after visit or discharge

This measure is reported as a total rate as well as three age stratifications:

- 13–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Follow-Up after Emergency Department Visit for Substance Use (FUA)

FUA reports on the percentage of ED visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported as the percentage of ED visits for which the member received follow-up within the following:

- 7 days of ED visit
- 30 days of ED visit

For FUA, a total rate and two age stratifications are reported:

- 13–17 years
- 18 years and older

Pharmacotherapy for Opioid Use Disorder (POD)

POD measures the percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days for members ages 16 years and older with a diagnosis of OUD. The measure is reported as a total rate as well as two age stratifications:

- 16–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

SSD measures the percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the MY.

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

SMD is the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both a low-density lipoprotein cholesterol (LDL-C) test and an HbA1c test during the MY.

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

SMC reports the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease (CVD) who had an LDL-C test during the MY.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

SAA assesses the percentage of members 18 years and older during the MY with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

APM measures the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported as the percentage of children and adolescents on antipsychotics who received the following:

- Blood glucose testing
- Cholesterol testing
- Blood glucose *and* cholesterol testing

The measure calculates a total rate as well as two age stratifications:

- 1–11 years
- 12–17 years

Overuse/Appropriateness

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)

NCS records the percentage of adolescent females 16 to 20 years of age who were screened unnecessarily for cervical cancer.

Note: A lower rate indicates better performance.

Appropriate Treatment for Upper Respiratory Infection (URI)

URI measures the percentage of episodes for members three months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event. This measure is reported as an inverted rate [1 - (numerator/eligible population)], with a higher rate indicating appropriate treatment with URI (i.e., the proportion of episodes that did *not* result in an antibiotic dispensing event).

The measure calculates a total rate as well as three age stratifications:

- 3 months–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

AAB reports the percentage of episodes for members ages three months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event. This measure is reported as an inverted rate [1 - (numerator/eligible population)], with a higher rate indicating appropriate treatment of acute bronchitis/bronchiolitis (i.e., the proportion of episodes that did *not* result in an antibiotic dispensing event).

The measure calculates a total rate as well as three age stratifications:

- 3 months–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Use of Imaging Studies for Low Back Pain (LBP)

LBP assesses the percentage of members 18-75 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. This measure is reported as an inverted rate [1 - (numerator/eligible population)], with a higher rate indicating an appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Use of Opioids at High Dosage (HDO)

HDO assesses the proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90 mg) for ≥15 days during the MY.

Note: A lower rate indicates better performance.

Use of Opioids from Multiple Providers (UOP)

UOP measures the proportion of members 18 years and older receiving prescription opioids from four or more different prescribers and/or pharmacies for ≥ 15 days during the MY. Three rates are reported:

- Multiple Prescribers
- Multiple Pharmacies
- Multiple Prescribers and Multiple Pharmacies

Note: A lower rate indicates better performance for all three rates.

Risk of Continued Opioid Use (COU)

COU reports the percentage of members 18 years of age and older who had a new episode of opioid use that puts them at risk of continued opioid use. Two rates are reported by length of opioid use:

- ≥ 15 days/30-day period
- ≥ 31 days/62-day period

Note: For this measure, a lower rate indicates better performance.

Access/Availability of Care Measures

The measures in the Access/Availability of Care domain evaluate how members access important and basic services of their MCO. Included are measures of overall access, how many

members are actually using basic MCO services, and the use and availability of specific services.

Adults' Access to Preventive/Ambulatory Health Services (AAP)

AAP measures the percentage of members 20 years and older who had an ambulatory or preventive care visit during the MY to assess whether adult members have access to/receive such services. MCOs report a total rate and three age stratifications:

- 20–44 years
- 45–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Prenatal and Postpartum Care (PPC)

PPC measures the percentage deliveries of live births on or between October 8 of the year prior to the MY and October 7 of the MY. The measure assesses the following facets of prenatal and postpartum care:

- *Timeliness of Prenatal Care*—A prenatal care visit in the first trimester on or before the MCO enrollment start date *or* within 42 days of enrollment.
- *Postpartum Care*—A postpartum visit on or between 7 and 84 days after delivery.

Initiation and Engagement of Substance Use Disorder Treatment (IET)

IET assesses the percentage of new SUD episodes that result in treatment initiation and engagement. Two rates are reported:

- *Initiation of SUD Treatment*—The percentage of new SUD episodes that result in treatment initiation through an IP SUD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
- *Engagement of SUD Treatment*—The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

MCOs report a total rate and three age stratifications for each:

- 13–17 years
- 18–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

APP measures the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. A total rate and two age stratifications are reported:

- 1–11 years
- 12–17 years

Utilization and Risk-Adjusted Utilization

This domain consists of utilization measures designed to capture the frequency of certain services provided for MCOs' internal evaluation only; NCQA does not view higher or lower service counts as indicating better or worse performance.

Utilization includes two kinds of measures:

- Measures that express rates of service in per 1,000 member years/months (defined/reported in Appendix A).

- Measures as percentages of members receiving specified services (similar to Effectiveness of Care Domain, defined in this section with data in the Results tables).

Well-Child Visits in the First 30 Months of Life (W30)

W30 reports the percentage of members who had a particular number of well-child visits with a PCP during the last 15 months. This measure uses the same structure and calculation guidelines as those in the Effectiveness of Care domain. Two rates are reported:

- *First 15 Months*—Children who turned 15 months old during the measurement year: six or more well-child visits.
- *Age 15 Months–30 Months*—Children who turned 30 months old during the measurement year: two or more well-child visits.

Child and Adolescent Well-Care Visits (WCV)

WCV reports the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. This measure uses the same structure and calculation guidelines as those in the Effectiveness of Care domain. A total rate as well as three age stratifications are reported:

- 3–11 years
- 12–17 years
- 18–21 years

Plan All-Cause Readmissions (PCR)

For members 18 years of age and older, PCR reports the number of acute inpatient and observation stays during the MY that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays (IHS) (denominator)
- Count of Observed 30-Day Readmissions (numerator)
- Count of Expected 30-Day Readmissions.

Experience of Care

For a plan's results in this domain to be considered reliable, the Medicaid MCO must follow one of the standard CAHPS protocols or an enhanced protocol approved by NCQA. Details regarding this calculation methodology and the questions used in each composite are included in *HEDIS Measurement Year 2022 Volume 3: Specifications for Survey Measures*.

Measures Collected Through CAHPS Health Plan Survey

Flu Vaccinations for Adults Ages 18 to 64 (FVA)

FVA reports the percentage of members 18 to 64 years of age who received a flu vaccination between July 1 of the MY and the date when the CAHPS Health Plan Survey 5.1H Adult Version (CPA) was completed.

Medical Assistance with Smoking and Tobacco Use Cessation (MSC)

This measure's collection methodology calculates a rolling average that represents the percentage of members 18 years of age and older who were current smokers or tobacco users seen during the MY. MSC assesses the following facets of providing medical assistance with smoking and tobacco use cessation:

- *Advising Smokers and Tobacco Users to Quit*—Those who received advice to quit.

- *Discussing Cessation Medications*—Those for whom cessation medications were recommended or discussed.
- *Discussing Cessation Strategies*—Those for whom cessation methods or strategies were provided or discussed.

Percentage of Current Smokers and Tobacco Users is not a HEDIS performance measure but provides additional information to support analysis of other MSC data. The MCOs started reporting these data in 2015 in CAHPS results; subsequently, the rates have been added to this report.

CAHPS Health Plan Survey 5.1H Adult Version (CPA) and 5.1H Child Version (CPC)

The CPA and CPC are tools for measuring consumer healthcare satisfaction with the quality of care and customer service provided by their MCOs. These survey tools include four composites asked of members (CPA) or parents of child members (CPC):

- Getting Needed Care
- Getting Care Quickly
- Customer Service
- How Well Doctors Communicate

Each composite category represents an overall aspect of plan quality and how well the MCO meets members' expectations.

There are four global rating questions that use a 0–10 scale to assess overall experience:

- Rating of All Healthcare
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Rating of Health Plan

A single question reflects experience of care in the Coordination of Care area.

For these scaled responses, a 0 represents the 'worst possible' and 10 represents the 'best possible' healthcare received in the last six months. Summary rates represent the percentage of members who responded with a 9 or 10. Additional questions use the same calculations. For any given CPA and CPC question used in a composite, the percentage of respondents answering in a certain way is calculated for each MCO. Summary rates represent the percentage of members who responded in the most positive way, as defined by NCQA. The following descriptions provide a brief explanation of the four composite categories.

Getting Needed Care

The Getting Needed Care Composite measures the ease with which members were able to access care, tests, or treatments needed in the last six months. The summary rate represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

Getting Care Quickly

The Getting Care Quickly Composite measures the ease with which members were able to access care quickly, including getting appointments as soon as needed, in the last six months. The summary rate represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

How Well Doctors Communicate

The How Well Doctors Communicate Composite evaluates provider-patient communications for the last six months by asking members how often their personal doctor listens carefully, explains things in a way to easily understand, shows respect for what they have to say and spends enough time with them. The summary rate represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

Customer Service

The Customer Service Composite measures how often members were able to get information and help from an MCO and how well they were treated by the MCO's customer service in the last six months. The summary rate represents the percentage of members who responded 'Always' or 'Usually' to specified questions.

Children With Chronic Conditions (CCC)

The CAHPS CCC Health Plan Survey is designed for children with a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that generally required by children. Three composites summarize parents' satisfaction with basic components of care essential for successful treatment, management, and support of children with chronic conditions:

- Access to Specialized Services
- Family Centered Care: Personal Doctor Who Knows Child
- Coordination of Care for CCC

Summary rates are reported for each composite and are reported individually for two concepts:

- Access to Prescription Medicines
- Family Centered Care: Getting Needed Information

Health Plan Descriptive Information Measures

These measures help describe an MCO's structure, staffing and enrollment—factors that contribute to its ability to provide effective healthcare to Medicaid members.

Enrollment by Product Line (ENP)

ENP reports the total number of members enrolled in the product line, stratified by age (for the MCOs, reported as ENPA [ENP Total] Medicaid). These results are included in Appendix B as population in member months by MCO and Tennessee Grand Region served.

Measures Reported Using Electronic Clinical Data Systems (ECDS)

This domain requires automated and accessible data by the healthcare team at the point of care, data shared between clinicians and health plans to promote quality improvement across the care continuum. To qualify for HEDIS ECDS reporting, the data must use standard layouts, meet the measure specification requirements, and the information must be accessible by the care team responsible for the member's healthcare needs.

Breast Cancer Screening (BCS-E)

BCS-E measures the percentage of women 50–74 years of age who had a mammogram to screen for breast cancer during the MY.

Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)

ADD-E measures the percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

- *Initiation Phase*— The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.
- *Continuation and Maintenance (C&M) Phase*— The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

DSF-E measures the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. Two rates are reported:

- *Depression Screening*—The percentage of members who were screened for clinical depression using a standardized instrument.
- *Follow-Up on Positive Screen*—The percentage of members who received follow-up care within 30 days of a positive depression screen finding.

The age stratifications for each rate are:

- 12–17 years
- 18–64 years

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

DMS-E measures the percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a Patient Health Questionnaire-9 (PHQ-9) score present in their record in the same assessment period as the encounter. This measure has four age stratifications:

- 12–17 years
- 18–44 years
- 45–64 years
- 65 years and older

Note: Rates for adults ≥65 years are Medicare provisions excluded in this report along with the total rate, which includes this age group.

The measurement period is divided into three assessment periods with specific dates of service:

- *Assessment Period 1*—January 1–April 30
- Assessment Period 2—May 1–August 31
- *Assessment Period 3*—September 1–December 31

Depression Remission or Response for Adolescents and Adults (DRR-E)

DRR-E measures the percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score. Three rates are reported:

- *Follow-Up PHQ-9*—The percentage of members who have a follow-up PHQ-9 score documented within four to eight months after the initial elevated PHQ-9 score.
- *Depression Remission*—The percentage of members who achieved remission within four to eight months after the initial elevated PHQ-9 score.
- *Depression Response*—The percentage of members who showed response within four to eight months after the initial elevated PHQ-9 score.

The four age stratifications for each rate are:

- 12–17 years
- 18–44 years
- 45–64 years
- 65 years and older

Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)

ASF-E measures the percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care. Two rates are reported:

- *Unhealthy Alcohol Use Screening*—The percentage of members who had a systematic screening for unhealthy alcohol use.
- *Alcohol Counseling or Other Follow-Up Care*—The percentage of members receiving brief counseling or other follow-up care within two months of screening positive for unhealthy alcohol use.

There are three age stratifications for each rate:

- 18–44 years
- 45–64 years
- 65 years and older

Adult Immunization Status (AIS-E)

AIS-E measures the percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster, and pneumococcal. MCOs reported four rates:

- Influenza
- Td or Tdap
- Zoster
- Pneumococcal

Prenatal Immunization Status (PRS-E)

PRS-E reports the percentage of deliveries in the MY in which members had received influenza and Tdap vaccinations. Three rates are reported:

- Influenza
- Tdap
- Combination—influenza *and* Tdap

Prenatal Depression Screening and Follow-Up (PND-E)

PND-E assesses the percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Two rates are reported:

- *Depression Screening*—The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.
- *Follow-Up on Positive Screen*—The percentage of deliveries in which members received follow-up care within 30 days of screening positive for depression.

Postpartum Depression Screening and Follow-Up (PDS-E)

PDS-E measures the percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. Two rates are reported:

- *Depression Screening*—The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.
- *Follow-Up on Positive Screen*—The percentage of deliveries in which members received follow-up care within 30 days of screening positive for depression.

Long-Term Services and Supports (LTSS) Measures

Starting in 2020, TennCare required MCOs to submit statewide LTSS measure results, which are presented in this report in Appendix C. HEDIS LTSS measures are currently not required by NCQA to be audited.

Comprehensive Assessment and Update (LTSS-CAU)

LTSS-CAU measures the percentage of LTSS organization members 18 years of age and older who have documentation of a comprehensive LTSS assessment in a specified timeframe that includes documentation of core elements. Two rates are reported:

- *Assessment of Core Elements*—Members who had a comprehensive LTSS assessment with nine core elements documented within 90 days of enrollment (for new members) or during the MY (for established members).
- *Assessment of Supplemental Elements*—Members who had a comprehensive LTSS assessment with nine core elements and at least 12 supplemental elements documented within 90 days of enrollment (for new members) or during the MY (for established members).

Comprehensive Care Plan and Update (LTSS-CPU)

LTSS-CPU measures the percentage of LTSS organization members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified timeframe that includes core elements. Two rates are reported:

- *Care Plan With Core Elements Documented*—Members who had a comprehensive LTSS care plan with nine core elements documented within 120 days of enrollment (for new members) or during the MY (for established members).
- *Care Plan With Supplemental Elements Documented*—Members who had a comprehensive LTSS care plan with nine core elements and at least four supplemental elements documented within 120 days of enrollment (for new members) or during the MY (for established members).

Reassessment/Care Plan Update after Inpatient Discharge (LTSS-RAC)

LTSS-RAC measures the percentage of discharges from inpatient facilities for LTSS organization members 18 years of age and older for whom a reassessment and care plan update occurred within 30 days of discharge. Two rates are reported:

- *Reassessment After Inpatient Discharge*—The percentage of discharges from inpatient facilities resulting in an LTSS reassessment within 30 days of discharge.
- *Reassessment and Care Plan Update After Inpatient Discharge*—The percentage of discharges from inpatient facilities resulting in a LTSS reassessment and care plan update within 30 days of discharge.

Shared Care Plan With Primary Care Practitioner (LTSS-SCP)

LTSS-SCP measures the percentage of LTSS organization members ages 18 years and older with a care plan that was transmitted to their primary care practitioner (PCP), or other

documented medical care practitioner identified by the member within 30 days of its development.

Medicaid Results

Statewide Performance

In conjunction with NCQA accreditation, TennCare MCOs are required to submit a full set of audited HEDIS measures to NCQA and TennCare each year. For HEDIS MY2022, this included the statewide MCO TennCare*Select* (**TCS**), and three statewide MCOs operating in each respective Grand Region (East, Middle and West): Amerigroup Community Care, Inc., as Amerigroup (**AG**—**AGE**, **AGM**, and **AGW**); BlueCare Tennessee (**BC**—**BCE**, **BCM**, and **BCW**); and UnitedHealthcare Community Plan, Inc., abbreviated as UnitedHealthcare (**UHC**—**UHCE**, **UHCM**, and **UHCW**).

Tables 2a, 2b, 3, and 4 summarize the weighted average TennCare score for each of the HEDIS MY2021 and HEDIS MY2022 measures. Weighted state rates are determined by applying the size of the eligible population within each plan to overall results. Using this methodology, plan-specific findings contribute to the TennCare statewide estimate, proportionate to eligible population size.

In Tables 2a, 2b, 3, and 4 the column titled "Change from HEDIS MY2021 to HEDIS MY2022" indicates whether there was an improvement (⬆), a decline (⬇), or no change (⬌) in statewide performance from HEDIS MY2021 to HEDIS MY2022 when measure data are available for both years. Cells are shaded gray for those measures that were not calculated, for measures which data were not reported, or where NCQA indicated a break in trending between MY2022 and the previous years.

Each year, some measures' technical specifications change. Based on whether the changes are significant or minor, the measures may need to be trended with caution or may not be able to be trended. This version of the *HEDIS/CAHPS MY2022 Report* was prepared following the NCQA national benchmark release, although certain protected data were not included so that the report may be shared publicly.

Table 2a. HEDIS MY2022 Weighted State Rates: Effectiveness of Care Measures			
Measure	Weighted State Rate		Change from HEDIS MY2021 to HEDIS MY2022
	HEDIS MY2021	HEDIS MY2022	
Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile:			
3–11 Years	78.97%	83.71%	↑
12–17 Years	77.59%	82.24%	↑
Total	**78.48%**	**83.23%**	↑
Counseling for Nutrition:			
3–11 Years	69.82%	77.54%	↑
12–17 Years	64.22%	68.34%	↑
Total	**67.76%**	**74.29%**	↑
Counseling for Physical Activity:			
3–11 Years	65.71%	70.45%	↑
12–17 Years	64.28%	67.25%	↑
Total	**65.19%**	**69.35%**	↑
Childhood Immunization Status (CIS)			
DTaP/DT	69.49%	69.00%	↓
IPV	86.51%	86.12%	↓
MMR	82.86%	83.73%	↑
HiB	83.00%	81.84%	↓
HepB	88.60%	88.80%	↑
VZV	82.72%	83.27%	↑
PCV	71.09%	71.38%	↑
HepA	82.90%	82.63%	↓
RV	69.85%	70.08%	↑
Influenza	44.31%	36.47%	↓
Combination 3	64.98%	64.36%	↓
Combination 7	57.19%	56.72%	↓
Combination 10	34.35%	28.55%	↓

Table 2a. HEDIS MY2022 Weighted State Rates: Effectiveness of Care Measures			
Measure	**Weighted State Rate**		**Change from HEDIS MY2021 to HEDIS MY2022**
	HEDIS MY2021	**HEDIS MY2022**	
Immunizations for Adolescents (IMA)			
Meningococcal	74.53%	73.52%	↓
Tdap/Td	84.31%	81.73%	↓
HPV	31.97%	31.47%	↓
Combination 1	74.53%	73.19%	↓
Combination 2	31.29%	30.70%	↓
Lead Screening in Children (LSC)	70.47%	64.99%	↓
Breast Cancer Screening (BCS)	48.90%	48.48%	↓
Cervical Cancer Screening (CCS)	58.30%	55.06%	↓
Chlamydia Screening in Women (CHL)			
16–20 Years	47.60%	48.06%	↑
21–24 Years	56.29%	56.18%	↓
Total	**51.21%**	**51.59%**	↑
Respiratory Conditions			
Appropriate Testing for Pharyngitis (CWP)[1]			
3–17 Years	84.86%	84.11%	↓
18–64 Years	71.79%	71.38%	↓
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	25.04%	23.77%	↓
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	72.18%	71.71%	↓
Bronchodilator	81.65%	81.36%	↓
Asthma Medical Ratio (AMR)			
5–11 Years	77.30%	76.64%	↓
12–18 Years	70.52%	70.95%	↑
19–50 Years	54.60%	57.06%	↑
51–64 Years	52.57%	54.41%	↑
Total	**65.75%**	**66.49%**	↑
Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	64.40%	65.91%	↑

Table 2a. HEDIS MY2022 Weighted State Rates: Effectiveness of Care Measures			
Measure	**Weighted State Rate**		**Change from HEDIS MY2021 to HEDIS MY2022**
	HEDIS MY2021	**HEDIS MY2022**	
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	85.76%	83.60%	↓
Statin Therapy for Patients with Cardiovascular Disease (SPC)			
Received Statin Therapy:			
Males 21–75 Years	81.23%	82.11%	↑
Females 40–75 Years	78.88%	79.27%	↑
Total	**80.07%**	**80.70%**	↑
Statin Adherence 80%:			
Males 21–75 Years	70.84%	73.99%	↑
Females 40–75 Years	68.01%	70.78%	↑
Total	**69.47%**	**72.42%**	↑
Cardiac Rehabilitation (CRE): 18–64 Years			
Initiation	2.77%	2.93%	↑
Engagement 1	2.01%	3.08%	↑
Engagement 2	1.55%	2.19%	↑
Achievement	0.79%	0.79%	↔
Diabetes			
Hemoglobin A1c Control for Patients With Diabetes (HBD)			
HbA1c Control (<8.0%)	51.69%	56.33%	↑
Eye Exam for Patients With Diabetes (EED)	47.79%	54.62%	↑
Blood Pressure Control (<140/90 mm Hg) (BPD)	61.34%	63.72%	↑
Kidney Health Evaluation for Patients With Diabetes (KED): 18–64 Years	27.66%	28.68%	↑
Statin Therapy for Patients with Diabetes (SPD)			
Received Statin Therapy	64.73%	64.60%	↓
Statin Adherence 80%	66.14%	68.09%	↑
Behavioral Health			
Antidepressant Medication Management (AMM)			
Effective Acute Phase Treatment	58.53%	59.25%	↑
Effective Continuation Phase Treatment	40.25%	41.35%	↑

Table 2a. HEDIS MY2022 Weighted State Rates: Effectiveness of Care Measures			
Measure	**Weighted State Rate**		**Change from HEDIS MY2021 to HEDIS MY2022**
	HEDIS MY2021	**HEDIS MY2022**	
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	40.77%	46.27%	↑
Continuation and Maintenance Phase	54.32%	57.54%	↑
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up:			
6–17 Years	51.72%	49.51%	↓
18–64 Years	36.68%	34.66%	↓
30-Day Follow-Up:			
6–17 Years	75.45%	75.17%	↓
18–64 Years	56.52%	55.78%	↓
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
7-Day Follow-Up:			
6–17 Years	49.83%	49.42%	↓
18–64 Years	33.73%	29.54%	↓
30-Day Follow-Up:			
6–17 Years	69.40%	67.98%	↓
18–64 Years	47.54%	45.15%	↓
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
7-Day Follow-Up:			
13–17 Years	10.15%	4.88%	↓
18–64 Years	51.58%	57.21%	↑
30-Day Follow-Up:			
13–17 Years	21.32%	20.12%	↓
18–64 Years	75.88%	81.95%	↑
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)[2]			
7-Day Follow-Up:			
13–17 Years		20.05%	
18 Years and Older		16.50%	
Total		**16.74%**	

Table 2a. HEDIS MY2022 Weighted State Rates: Effectiveness of Care Measures			
Measure	Weighted State Rate		Change from HEDIS MY2021 to HEDIS MY2022
	HEDIS MY2021	HEDIS MY2022	
30-Day Follow-Up:			
13–17 Years		33.42%	
18 Years and Older		27.63%	
Total		**28.02%**	
Pharmacotherapy for Opioid Use Disorder (POD): 16–64 Years	28.40%	28.41%	↑
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	81.67%	82.23%	↑
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	72.97%	73.96%	↑
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	78.45%	81.82%	↑
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	60.91%	61.87%	↑
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Blood Glucose Testing:			
1–11 Years	40.64%	41.08%	↑
12–17 Years	60.72%	62.80%	↑
Total	**54.30%**	**55.92%**	↑
Cholesterol Testing:			
1–11 Years	33.41%	33.04%	↓
12–17 Years	45.05%	46.69%	↑
Total	**41.33%**	**42.36%**	↑
Blood Glucose and Cholesterol Testing:			
1–11 Years	28.99%	29.11%	↑
12–17 Years	42.33%	44.49%	↑
Total	**38.06%**	**39.61%**	↑
Overuse/Appropriateness			
Appropriate Treatment for Upper Respiratory Infection (URI)			
3 Months–17 Years	89.28%	89.26%	↓
18–64 Years	70.78%	71.39%	↑
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)			
3 Months–17 Years	64.51%	70.50%	↑

Table 2a. HEDIS MY2022 Weighted State Rates: Effectiveness of Care Measures			
Measure	Weighted State Rate		Change from HEDIS MY2021 to HEDIS MY2022
	HEDIS MY2021	HEDIS MY2022	
18–64 Years	35.34%	36.28%	⬆
Use of Imaging Studies for Low Back Pain (LBP)[2]		67.60%	

[1] *NCQA indicated trending with caution due to changes in measure specifications for MY2022.*
[2] *NCQA indicated a break in trending to prior years due to significant changes in measure specifications for MY2022.*

For the Effectiveness of Care Measures presented in **Table 2b**, a lower rate is an indication of better performance. A decrease in rates from the prior year also indicates improvement (⬇).

Table 2b. HEDIS MY2022 Weighted State Rates: Measures Where Lower Rates Indicate Better Performance			
Measure	Weighted State Rate		Change from HEDIS MY2021 to HEDIS MY2022
	HEDIS MY2021	HEDIS MY2022	
Diabetes			
Comprehensive Diabetes Care (CDC)			
HbA1c Poor Control (>9.0%)	38.76%	32.62%	⬇
Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	0.79%	0.77%	⬇
Use of Opioids at High Dosage (HDO)	7.28%	6.98%	⬇
Use of Opioids From Multiple Providers (UOP)			
Multiple Prescribers	18.56%	19.58%	⬆
Multiple Pharmacies	0.87%	0.89%	⬆
Multiple Prescribers and Pharmacies	0.45%	0.42%	⬇
Risk of Continued Opioid Use (COU)			
18–64 Years: ≥15 days/30-day period	1.49%	1.68%	⬆
≥ 31 days/62-day period	1.11%	1.28%	⬆

Table 3 summarizes results for the Access/Availability Domain of Care.

Table 3. HEDIS MY2022 Weighted State Rates: Access/Availability of Care Measures

Measure	Weighted State Rate		Change from HEDIS MY2021 to HEDIS MY2022
	HEDIS MY2021	HEDIS MY2022	
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
20–44 Years	75.03%	72.19%	↓
45–64 Years	85.31%	83.85%	↓
Prenatal and Postpartum Care (PPC)[1]			
Timeliness of Prenatal Care	84.07%	81.44%	↓
Postpartum Care	73.62%	76.57%	↑
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)—Initiation of AOD Treatment[2]			
13–17 Years: Alcohol		41.97%	
Opioid		48.57%	
Other drug		41.56%	
Total		**41.79%**	
18+ Years: Alcohol		45.13%	
Opioid		61.98%	
Other drug		47.06%	
Total		**50.78%**	
Initiation Total: Alcohol		45.19%	
Opioid		60.35%	
Other drug		46.26%	
Total		**49.75%**	
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)—Engagement of AOD Treatment[2]			
13–17 Years: Alcohol		20.56%	
Opioid		24.28%	
Other drug		20.31%	
Total		**20.45%**	
18+ Years: Alcohol		13.07%	
Opioid		39.14%	
Other drug		13.19%	

Table 3. HEDIS MY2022 Weighted State Rates: Access/Availability of Care Measures			
Measure	Weighted State Rate		Change from HEDIS MY2021 to HEDIS MY2022
	HEDIS MY2021	HEDIS MY2022	
Total		**20.45%**	
Engagement Total: Alcohol		13.02%	
Opioid		37.49%	
Other drug		14.03%	
Total		**20.02%**	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
1–11 Years	57.16%	54.37%	↓
12–17 Years	59.60%	59.71%	↑
Total	**58.79%**	**57.88%**	↓

[1] *NCQA indicated trending with caution due to changes in measure specifications for MY2022.*
[2] *NCQA indicated a break in trending to prior years due to significant changes in measure specifications for MY2022.*

Table 4 summarizes results for the Utilization measures included in the Utilization and Risk-Adjusted Utilization Domain of Care.

Table 4. HEDIS MY2022 Weighted State Rates: Utilization Measures			
Measure	Weighted State Rate		Change from HEDIS MY2021 to HEDIS MY2022
	HEDIS MY2021	HEDIS MY2022	
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	60.65%	63.08%	↑
15 Months–30 Months	65.01%	67.56%	↑
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	59.28%	60.38%	↑
12–17 Years	50.60%	51.14%	↑
18–21 Years	24.45%	24.56%	↑
Total	**50.99%**	**51.52%**	↑

Individual Plan Performance—HEDIS Measures

This section is intended to provide an overview of individual plan performance using appropriate and available comparison data. Tables 6a, 6b, 7, and 8 display the plan-specific performance rates for each measure selected from the Effectiveness of Care, Access/Availability of Care, and Utilization and Risk-Adjusted Utilization domains.

Table 5 provides additional related comments. While Medical Assistance with Smoking and Tobacco Use Cessation is an Effectiveness of Care measure, results are reported through the CPA, as noted in Tables 2a and 6a.

Table 5. HEDIS MY2022 Measure Designations

Color Designation	National Percentile Achieved	Additional Comments
	Greater than 75th percentile	No additional comments
	25th to 75th	No additional comments
	Less than 25th	No additional comments
	No Rating Available	Benchmarking data not available

Measure Designation	Definition
R	Reportable: a reportable rate was submitted for the measure.
NA	Not Applicable: the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate; thus, results are not presented.
NB	No Benefit: the MCO did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	Not Reported: the MCO chose not to report the measure.
NQ	Not Required: the MCO was not required to report the measure.
BR	Biased Rate: the calculated rate was materially biased.
UN	Un-Audited: the MCO chose to report a measure that is not required to be audited. This result applies to only a limited set of measures.

Table 6a. HEDIS MY2022 Plan-Specific Rates: Effectiveness of Care Measures

Measure	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Prevention and Screening										
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)										
BMI Percentile: 3–11 Years	79.60%	79.85%	75.81%	86.33%	82.01%	87.55%	82.87%	86.08%	76.56%	79.06%
12–17 Years	77.02%	75.68%	76.07%	85.94%	73.48%	79.14%	78.26%	74.14%	72.46%	88.06%
Total	**78.59%**	**78.35%**	**75.91%**	**86.20%**	**78.98%**	**84.47%**	**80.41%**	**81.02%**	**75.18%**	**82.00%**

Table 6a. HEDIS MY2022 Plan-Specific Rates: Effectiveness of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Counseling for Nutrition: 3–11 Years	70.00%	77.19%	66.13%	75.39%	73.22%	73.44%	74.03%	77.22%	70.70%	69.31%
12–17 Years	63.35%	68.92%	71.78%	70.31%	61.36%	59.71%	67.15%	62.07%	63.77%	77.61%
Total	**67.40%**	**74.21%**	**68.37%**	**73.70%**	**69.00%**	**68.42%**	**70.36%**	**70.80%**	**68.37%**	**72.02%**
Counseling for Physical Activity: 3–11 Years	65.20%	74.14%	63.31%	67.97%	66.95%	68.46%	69.06%	72.57%	65.57%	65.70%
12–17 Years	65.22%	72.97%	74.23%	67.97%	66.67%	58.99%	64.73%	62.64%	64.49%	76.87%
Total	**65.21%**	**73.72%**	**67.64%**	**67.97%**	**66.85%**	**65.00%**	**66.75%**	**68.37%**	**65.21%**	**69.34%**
Childhood Immunization Status (CIS)										
DTaP/DT	69.83%	72.26%	60.83%	75.18%	71.29%	71.53%	71.53%	72.51%	71.53%	65.69%
IPV	86.37%	87.83%	82.24%	87.10%	89.54%	87.59%	90.27%	87.10%	87.59%	85.16%
MMR	82.48%	85.16%	80.05%	87.35%	86.37%	85.40%	85.64%	86.37%	82.48%	82.97%
HiB	81.75%	84.67%	77.62%	84.18%	86.62%	83.45%	84.67%	82.73%	83.70%	80.78%
HepB	90.27%	88.56%	86.13%	89.78%	90.51%	91.48%	91.00%	88.81%	87.83%	87.83%
VZV	81.75%	84.18%	79.56%	87.59%	84.91%	85.16%	86.37%	84.43%	81.75%	83.70%
PCV	70.80%	75.43%	63.75%	76.16%	75.43%	71.05%	68.37%	73.97%	72.99%	63.50%
HepA	81.51%	85.89%	78.83%	85.40%	85.40%	85.16%	86.37%	84.67%	82.73%	82.97%
RV	66.42%	75.43%	57.42%	75.18%	74.70%	63.50%	61.07%	71.29%	70.07%	60.58%
Flu	37.23%	46.47%	21.17%	30.90%	42.82%	24.33%	48.18%	44.04%	41.85%	27.49%
Combination 3	65.45%	69.10%	56.69%	69.83%	67.15%	66.67%	64.96%	68.37%	67.15%	60.10%
Combination 7	56.69%	63.50%	44.77%	62.04%	60.58%	54.99%	51.58%	60.58%	58.88%	49.39%
Combination 10	27.98%	37.96%	15.57%	24.09%	35.04%	19.95%	32.12%	34.55%	35.04%	21.17%
Immunization for Adolescents (IMA)										
Meningococcal	72.26%	77.86%	74.45%	79.08%	74.70%	69.83%	61.80%	77.13%	72.51%	72.99%
Tdap/Td	81.02%	86.37%	81.51%	85.16%	84.91%	79.81%	69.59%	83.21%	82.97%	80.54%
HPV	27.49%	34.31%	30.17%	34.31%	34.06%	29.20%	28.71%	31.39%	32.12%	34.31%
Combination 1	72.02%	77.62%	74.21%	79.08%	73.72%	69.83%	61.56%	76.16%	72.26%	72.51%
Combination 2	27.25%	34.06%	29.93%	34.06%	32.36%	27.98%	27.49%	30.90%	31.87%	33.58%
Lead Screening in Children (LSC)	67.88%	64.48%	55.47%	69.83%	61.31%	56.93%	67.88%	68.61%	69.59%	59.12%
Breast Cancer Screening (BCS)	37.98%	44.70%	44.45%	51.64%	48.85%	54.13%	23.20%	50.48%	49.40%	51.56%
Cervical Cancer Screening (CCS)	50.85%	51.82%	56.20%	56.12%	59.44%	62.53%	26.52%	53.28%	52.07%	50.36%
Chlamydia Screening in Women (CHL)										
16–20 Years	49.15%	47.26%	55.97%	45.05%	44.14%	52.83%	48.06%	46.75%	41.88%	53.23%
21–24 Years	56.69%	55.25%	66.22%	51.48%	50.29%	62.77%	48.52%	54.33%	49.53%	64.47%
Total	**52.08%**	**51.03%**	**60.24%**	**48.05%**	**46.68%**	**57.78%**	**48.10%**	**49.89%**	**45.26%**	**58.20%**

Table 6a. HEDIS MY2022 Plan-Specific Rates: Effectiveness of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Respiratory Conditions										
Appropriate Testing for Pharyngitis (CWP)[1]										
3–17 Years	71.47%	79.00%	74.77%	85.79%	88.24%	86.01%	87.36%	86.24%	90.79%	87.54%
18–64 Years	61.55%	60.34%	60.96%	74.99%	74.39%	73.79%	74.18%	76.69%	79.25%	72.12%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	21.63%	21.60%	22.82%	26.38%	21.12%	25.45%	0.00%	24.79%	23.05%	25.41%
Pharmacotherapy Management of COPD Exacerbation (PCE)										
Systemic Corticosteroid	68.53%	66.61%	64.64%	73.49%	72.65%	70.16%	75.00%	76.29%	73.30%	72.73%
Bronchodilator	74.30%	79.67%	77.97%	81.16%	76.91%	84.44%	75.00%	85.46%	82.80%	85.45%
Asthma Medical Ratio (AMR)										
5–11 Years	77.37%	77.61%	67.04%	80.00%	81.93%	76.47%	75.00%	74.96%	77.29%	72.02%
12–18 Years	68.69%	66.01%	67.05%	71.39%	71.20%	73.00%	79.31%	71.55%	70.35%	71.57%
19–50 Years	55.15%	54.00%	52.84%	59.44%	52.78%	54.72%	79.45%	58.73%	59.77%	59.39%
51–64 Years	56.25%	50.00%	51.19%	56.69%	46.46%	51.43%	100.00%	52.84%	59.67%	59.84%
Total	**65.64%**	**63.61%**	**60.53%**	**69.03%**	**66.68%**	**65.68%**	**77.99%**	**65.70%**	**67.41%**	**66.56%**
Cardiovascular Conditions										
Controlling High Blood Pressure (CBP)	65.69%	59.37%	62.04%	63.66%	63.56%	61.77%	71.52%	67.64%	62.53%	64.23%
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	73.77%	78.46%	82.35%	89.53%	84.21%	82.00%	100.00%	89.29%	85.88%	77.36%
Statin Therapy for Patients with Cardiovascular Disease (SPC)										
Received Statin Therapy: Males 21–75 Years	82.68%	80.63%	80.80%	81.66%	82.27%	80.36%	50.00%	82.22%	86.19%	80.88%
Females 40–75 Years	74.93%	76.55%	77.34%	78.93%	80.05%	78.36%	40.00%	83.24%	78.91%	81.16%
Total	**79.59%**	**78.73%**	**79.18%**	**80.20%**	**81.14%**	**79.22%**	**44.44%**	**82.72%**	**82.56%**	**81.02%**
Statin Adherence 80%: Males 21-75 Years	71.06%	74.13%	64.20%	75.09%	68.97%	68.81%	50.00%	78.92%	81.58%	72.66%
Females 40–75 Years	63.31%	74.93%	65.57%	69.23%	64.47%	63.18%	50.00%	78.17%	77.33%	70.34%
Total	**68.15%**	**74.49%**	**64.82%**	**72.00%**	**66.71%**	**65.64%**	**50.00%**	**78.55%**	**79.56%**	**71.46%**
Cardiac Rehabilitation (CRE): 18–64 Years										
Initiation	2.21%	3.33%	0.54%	4.69%	3.24%	1.72%	0.00%	4.35%	3.47%	1.02%
Engagement 1	2.65%	2.86%	1.08%	3.97%	3.78%	2.87%	0.00%	4.68%	2.70%	2.04%
Engagement 2	1.33%	1.90%	1.08%	1.81%	3.24%	2.87%	0.00%	3.01%	3.09%	1.02%
Achievement	0.88%	0.00%	1.08%	0.36%	1.08%	1.15%	0.00%	2.01%	0.39%	0.00%

Table 6a. HEDIS MY2022 Plan-Specific Rates: Effectiveness of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Diabetes										
Hemoglobin A1c Control for Patients With Diabetes (HBD)										
HbA1c Control (<8.0%)*	46.72%	53.77%	54.01%	60.24%	52.07%	56.69%	54.42%	66.42%	63.02%	59.85%
Eye Exam for Patients with Diabetes (EED)	39.66%	43.55%	47.93%	59.76%	55.47%	63.02%	65.37%	54.01%	57.18%	56.69%
Blood Pressure Control (<140/90 mm Hg)	60.34%	62.77%	56.69%	68.54%	64.72%	71.05%	71.73%	74.70%	71.53%	67.88%
Kidney Health Evaluation for Patients With Diabetes (KED): 18–64 Years	27.39%	25.86%	31.52%	28.89%	26.80%	32.38%	23.97%	28.43%	28.08%	30.11%
Statin Therapy for Patients with Diabetes (SPD)										
Received Statin Therapy	61.28%	61.94%	64.15%	62.94%	63.53%	63.90%	66.67%	67.40%	65.57%	68.84%
Statin Adherence 80%	63.42%	62.82%	58.89%	68.30%	64.75%	58.69%	79.31%	76.91%	75.90%	71.26%
Behavioral Health										
Antidepressant Medication Management (AMM)										
Effective Acute Phase Treatment	56.33%	54.14%	48.23%	60.70%	55.64%	53.20%	48.24%	70.75%	66.59%	59.43%
Effective Continuation Phase Treatment	38.03%	37.10%	30.42%	41.45%	36.64%	34.03%	32.66%	53.51%	49.78%	44.11%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)										
Initiation Phase	48.31%	45.20%	42.21%	51.45%	43.61%	44.93%	46.97%	46.94%	44.21%	43.22%
Continuation and Maintenance Phase	58.04%	59.33%	54.37%	60.16%	50.36%	66.88%	60.49%	57.14%	53.31%	54.61%
Follow-Up After Hospitalization for Mental Illness (FUH)										
7-Day Follow-Up: 6–17 Years	52.42%	58.61%	39.52%	59.96%	54.59%	43.13%	36.33%	53.25%	52.82%	39.07%
18–64 Years	31.67%	38.17%	25.24%	37.65%	42.07%	30.99%	37.04%	33.49%	38.09%	30.54%
30-Day Follow-Up: 6–17 Years	78.76%	81.78%	65.29%	84.02%	77.51%	75.57%	58.67%	81.82%	80.14%	69.87%
18–64 Years	52.99%	57.05%	44.69%	60.06%	62.05%	52.31%	62.96%	59.04%	57.97%	51.06%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)										
7-Day Follow-Up: 6–17 Years	45.71%	52.32%	45.16%	53.22%	55.09%	40.98%	50.49%	46.51%	45.95%	44.74%
18–64 Years	25.94%	31.53%	37.16%	29.40%	24.63%	38.29%	36.59%	27.09%	25.93%	32.40%
30-Day Follow-Up: 6–17 Years	66.29%	68.21%	54.84%	74.68%	73.05%	55.74%	70.59%	68.99%	61.49%	60.53%
18–64 Years	40.96%	46.82%	49.18%	47.77%	40.67%	54.29%	56.10%	41.79%	40.74%	48.04%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)										
7-Day Follow-Up: 13–17 Years	3.45%	0.00%	11.76%	4.55%	15.38%	0.00%	0.00%	0.00%	9.52%	0.00%
18–64 Years	60.67%	52.01%	50.98%	61.02%	51.56%	56.77%	44.83%	62.65%	56.81%	51.73%
30-Day Follow-Up: 13–17 Years	13.79%	5.56%	41.18%	36.36%	30.77%	7.69%	27.27%	6.25%	19.05%	0.00%

Table 6a. HEDIS MY2022 Plan-Specific Rates: Effectiveness of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
18–64 Years	84.82%	79.16%	74.02%	84.77%	79.66%	80.27%	65.52%	86.27%	79.95%	75.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)[2]										
7-Day Follow-Up: 13–17 Years	20.00%	19.23%	5.56%	32.61%	24.49%	5.26%	24.44%	15.15%	14.29%	25.00%
18 Years and Older	15.86%	17.01%	17.54%	18.29%	15.46%	16.62%	11.11%	17.67%	15.12%	15.72%
Total	**16.11%**	**17.15%**	**17.03%**	**19.25%**	**16.05%**	**16.06%**	**18.52%**	**17.53%**	**15.05%**	**16.20%**
30-Day Follow-Up: 13–17 Years	40.00%	25.00%	5.56%	52.17%	38.78%	10.53%	46.67%	27.27%	25.40%	37.50%
18 Years and Older	29.08%	28.64%	24.56%	30.70%	26.52%	25.07%	19.44%	29.15%	25.94%	27.33%
Total	**29.72%**	**28.42%**	**23.74%**	**32.13%**	**27.32%**	**24.35%**	**34.57%**	**29.05%**	**25.89%**	**27.86%**
Pharmacotherapy for Opioid Use Disorder (POD)*: 16–64 Years	22.90%	23.41%	31.59%	27.70%	28.28%	40.00%	24.00%	30.14%	32.05%	37.99%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	82.58%	83.88%	77.89%	81.82%	82.28%	79.00%	83.53%	85.62%	86.55%	76.92%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	67.69%	77.50%	61.96%	76.99%	72.58%	71.64%	78.95%	79.89%	75.26%	75.31%
Cardiovascular Monitoring for People With CVD and Schizophrenia (SMC)	78.57%	78.38%	73.08%	80.33%	70.59%	80.39%	66.67%	87.76%	84.31%	90.38%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	49.66%	61.52%	42.03%	65.87%	65.98%	54.16%	85.79%	72.48%	73.62%	60.89%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)										
Blood Glucose Testing: 1–11 Years	38.98%	40.54%	31.45%	39.39%	43.08%	40.97%	46.07%	45.04%	45.45%	30.65%
12–17 Years	65.39%	59.83%	51.26%	64.16%	63.92%	59.18%	66.67%	63.01%	65.70%	52.32%
Total	56.16%	53.53%	44.65%	55.28%	56.78%	52.99%	61.53%	57.24%	59.26%	45.23%
Cholesterol Testing: 1–11 Years	34.24%	36.04%	20.75%	30.74%	34.39%	34.36%	35.70%	35.54%	35.12%	27.14%
12–17 Years	48.82%	42.14%	34.59%	49.27%	47.42%	36.96%	55.39%	43.84%	44.51%	35.45%
Total	43.72%	40.15%	29.98%	42.62%	42.95%	36.08%	50.48%	41.17%	41.52%	32.73%
Blood Glucose and Cholesterol Testing: 1–11 Years	27.80%	31.98%	18.24%	24.89%	33.20%	29.07%	32.25%	31.40%	33.88%	24.12%
12–17 Years	46.45%	40.61%	32.39%	46.61%	45.15%	35.15%	52.90%	42.66%	42.58%	32.76%
Total	**39.93%**	**37.79%**	**27.67%**	**38.82%**	**41.06%**	**33.08%**	**47.75%**	**39.04%**	**39.82%**	**29.93%**
Overuse/Appropriateness										
Appropriate Treatment for Upper Respiratory Infection (URI)										
3 Months–17 Years	87.76%	93.85%	90.23%	84.84%	91.99%	86.16%	86.15%	84.39%	93.33%	88.53%

Table 6a. HEDIS MY2022 Plan-Specific Rates: Effectiveness of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
18–64 Years	72.02%	79.01%	72.42%	64.97%	74.59%	68.60%	77.03%	64.57%	77.16%	67.60%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)										
3 Months–17 Years	65.16%	72.66%	84.42%	62.86%	70.41%	77.39%	66.41%	59.03%	68.37%	81.62%
18–64 Years	38.22%	42.40%	42.40%	30.27%	36.57%	37.16%	40.79%	29.12%	37.41%	41.61%
Use of Imaging Studies for Low Back Pain (LBP)	67.65%	66.86%	68.66%	68.09%	68.98%	68.13%	70.09%	67.94%	66.00%	65.91%
Measures Collected Through CAHPS Health Plan Survey										
Flu vaccinations for adults ages 18 to 64 (FVA)	32.72%	33.16%	31.48%	38.78%	35.80%	38.41%	NA	30.86%	34.69%	29.23%
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)										
Advising Smokers and Tobacco Users to Quit	71.71%	74.40%	76.47%	76.05%	77.60%	73.39%	NA	75.63%	69.61%	NA
Discussing Cessation Medications	54.36%	41.60%	48.89%	53.61%	44.53%	50.00%	NA	50.00%	NA	NA
Discussing Cessation Strategies	44.97%	34.40%	45.59%	47.93%	41.27%	45.05%	NA	40.00%	NA	NA
Supplemental Data - % Current Smokers†	37.65%	30.26%	33.73%	37.55%	30.89%	29.07%	16.44%	48.19%	32.26%	37.76%

[1] *NCQA indicated trending with caution due to changes in measure specifications for MY2022.*
[2] *NCQA indicated a break in trending to prior years due to significant changes in measure specifications for MY2022.*
† *For this measure, the rate is not intended to indicate good or poor performance, but for informative purposes to monitor the population of current smokers.*

For the Effectiveness of Care Measures presented in **Table 6b**, a lower rate indicates better performance.

Table 6b. HEDIS MY2022 Plan-Specific Rates: Effectiveness of Care Measures Where Lower Rates Indicate Better Performance										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Diabetes										
Comprehensive Diabetes Care (CDC)										
HbA1c Poor Control (>9.0%)	41.12%	37.71%	37.96%	31.46%	40.15%	31.87%	38.52%	25.55%	25.55%	31.14%
Overuse/Appropriateness										
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	0.17%	0.14%	0.77%	0.75%	0.33%	1.50%	0.66%	1.44%	0.66%	1.95%
Use of Opioids at High Dosage (HDO)	14.61%	16.08%	6.52%	6.32%	3.68%	2.69%	0.00%	7.68%	4.94%	2.00%
Use of Opioids From Multiple Providers (UOP)										
Multiple Prescribers	18.46%	22.01%	15.71%	18.33%	21.75%	17.20%	25.00%	19.21%	22.20%	16.82%
Multiple Pharmacies	0.52%	1.13%	2.12%	0.62%	1.21%	1.01%	0.00%	0.47%	0.85%	1.21%

Table 6b. HEDIS MY2022 Plan-Specific Rates: Effectiveness of Care Measures Where Lower Rates Indicate Better Performance										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Multiple Prescribers and Pharmacies	0.35%	0.41%	0.53%	0.39%	0.46%	0.53%	0.00%	0.26%	0.45%	0.63%
Risk of Continued Opioid Use (COU)										
18–64 Years: ≥15 days/30-day period	1.57%	1.57%	1.67%	0.79%	0.96%	0.96%	0.25%	3.18%	2.66%	2.23%
≥ 31 days/62-day period	1.12%	1.32%	1.19%	0.53%	0.69%	0.67%	0.25%	2.54%	2.09%	1.78%

Table 7 presents rates for Access/Availability of Care Measures.

Table 7. HEDIS MY2022 Plan-Specific Rates: Access/Availability of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Adults' Access to Preventive/Ambulatory Health Services (AAP)										
20–44 Years	69.86%	70.01%	67.01%	77.62%	73.95%	75.50%	39.96%	74.82%	73.57%	68.25%
45–64 Years	78.41%	81.64%	79.89%	86.89%	84.37%	87.05%	34.66%	86.17%	86.83%	84.10%
Prenatal and Postpartum Care (PPC)[1]										
Timeliness of Prenatal Care	85.64%	82.00%	80.78%	87.84%	81.10%	85.06%	74.57%	85.16%	78.83%	71.78%
Postpartum Care	79.81%	76.40%	72.02%	75.68%	77.44%	80.18%	68.21%	80.29%	76.40%	68.86%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)—Initiation of AOD Treatment[2]										
13–17 Years: Alcohol	51.02%	39.47%	24.00%	47.27%	51.06%	18.18%	59.38%	41.46%	28.95%	21.05%
Opioid	57.14%	33.33%	NA	57.14%	20.00%	100.00%	42.11%	33.33%	40.00%	75.00%
Other drug	44.07%	42.86%	41.03%	38.98%	46.44%	34.03%	42.91%	48.97%	42.17%	27.33%
Total	**45.65%**	**42.26%**	**38.67%**	**40.53%**	**46.67%**	**34.47%**	**44.55%**	**47.30%**	**40.29%**	**27.75%**
18+ Years: Alcohol	44.33%	46.28%	53.65%	42.78%	41.42%	43.90%	37.84%	44.10%	42.73%	49.72%
Opioid	63.26%	58.78%	65.44%	63.88%	59.01%	60.39%	60.61%	63.93%	60.38%	66.40%
Other drug	46.37%	50.20%	51.62%	43.63%	47.53%	45.75%	38.64%	45.14%	48.07%	48.54%
Total	**51.10%**	**51.80%**	**54.23%**	**50.36%**	**49.95%**	**48.16%**	**42.08%**	**50.68%**	**50.39%**	**51.76%**
Initiation Total: Alcohol	44.79%	45.60%	52.96%	42.92%	41.99%	43.52%	47.83%	44.02%	42.74%	49.88%
Opioid	62.75%	57.96%	64.29%	63.47%	58.48%	59.14%	53.85%	59.11%	57.44%	63.77%
Other drug	45.95%	49.32%	50.46%	43.07%	47.46%	44.19%	41.48%	44.96%	47.54%	46.13%
Total	**50.51%**	**50.87%**	**53.07%**	**49.60%**	**49.64%**	**46.85%**	**43.58%**	**49.09%**	**49.28%**	**49.98%**

Table 7. HEDIS MY2022 Plan-Specific Rates: Access/Availability of Care Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)—Engagement of AOD Treatment[2]										
13–17 Years: Alcohol	32.65%	15.79%	4.00%	20.00%	23.40%	18.18%	43.75%	24.39%	5.26%	0.00%
Opioid	42.86%	0.00%	NA	42.86%	0.00%	0.00%	31.58%	16.67%	20.00%	0.00%
Other drug	23.33%	21.43%	15.38%	19.81%	23.84%	16.75%	23.37%	24.23%	17.39%	10.00%
Total	**25.53%**	**20.32%**	**13.81%**	**20.27%**	**23.47%**	**16.50%**	**25.96%**	**24.07%**	**15.75%**	**8.67%**
18+ Years: Alcohol	13.52%	14.37%	13.51%	13.51%	12.81%	14.35%	8.11%	12.03%	11.37%	12.29%
Opioid	41.22%	34.38%	37.68%	41.92%	37.84%	38.82%	36.36%	43.94%	35.90%	34.96%
Other drug	13.02%	16.27%	14.25%	11.21%	14.49%	11.97%	3.03%	11.93%	14.08%	13.09%
Total	**21.81%**	**21.22%**	**17.41%**	**22.12%**	**21.87%**	**17.97%**	**9.41%**	**21.78%**	**19.83%**	**16.34%**
Engagement Total: Alcohol	14.20%	14.00%	12.72%	13.64%	13.14%	13.92%	24.64%	12.28%	10.83%	11.41%
Opioid	40.87%	33.14%	36.54%	41.16%	37.07%	37.13%	34.62%	39.61%	33.01%	33.25%
Other drug	14.31%	16.83%	14.18%	12.14%	15.92%	12.52%	16.54%	12.82%	14.34%	12.73%
Total	**21.89%**	**20.76%**	**16.75%**	**21.76%**	**21.79%**	**17.55%**	**19.46%**	**20.91%**	**18.93%**	**15.44%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)										
1–11 Years	57.50%	50.62%	54.84%	63.70%	53.26%	53.41%	58.20%	48.51%	53.66%	44.34%
12–17 Years	56.73%	64.74%	58.06%	64.12%	67.53%	72.16%	50.72%	55.19%	62.00%	53.55%
Total	**57.01%**	**60.24%**	**56.85%**	**63.97%**	**62.20%**	**65.91%**	**52.68%**	**52.82%**	**59.05%**	**49.81%**

[1] *NCQA indicated trending with caution due to changes in measure specifications for MY2022.*
[2] *NCQA indicated a break in trending to prior years due to significant changes in measure specifications for MY2022.*

Table 8 results are for utilization measures that are included in the Utilization and Risk-Adjusted Utilization Domain of Care.

Table 8. HEDIS MY2022 Plan-Specific Rates: Use of Services Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Well-Child Visits in the First 30 Months of Life (W30)										
First 15 Months	68.08%	67.48%	47.58%	73.28%	68.05%	52.46%	58.65%	67.67%	66.22%	44.77%
15 Months–30 Months	68.09%	71.28%	52.15%	74.09%	72.61%	59.40%	69.98%	70.39%	73.55%	55.35%
Child and Adolescent Well-Care Visits (WCV)										
3–11 Years	57.50%	61.52%	51.37%	66.92%	63.70%	59.47%	54.00%	61.25%	62.42%	55.12%
12–17 Years	47.70%	50.63%	45.65%	56.33%	53.34%	51.69%	52.85%	51.38%	51.73%	48.59%

Table 8. HEDIS MY2022 Plan-Specific Rates: Use of Services Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
18–21 Years	23.07%	23.29%	20.54%	28.17%	27.17%	27.01%	26.87%	24.33%	23.26%	21.53%
Total	**47.72%**	**51.99%**	**44.19%**	**57.56%**	**54.31%**	**51.97%**	**48.80%**	**51.44%**	**53.26%**	**47.87%**

Individual Plan Performance—CAHPS

Table 9 details the rating scale and any additional comments used in Table 10, Table 11, and Table 12 to indicate the rating achieved. These tables display the plan-specific performance rates for the CAHPS survey results.

Table 9. MY2022 CAHPS Rating Measure Designations		
Color Designation	**National Percentile Achieved**	**Additional Comments**
	Greater than 75th percentile	No additional comments
	25th to 75th	No additional comments
	Less than 25th	No additional comments
	No Rating Available	Benchmarking data were not available
Measure Designation	**Definition**	
NA	Not Applicable. Health plans must achieve a denominator of at least 100 responses to obtain a reportable result. If the denominator for a particular survey result calculation is less than 100, NCQA assigns a measure result of NA.	

Table 10. MY2022 CAHPS 5.1H Adult Medicaid Survey Results										
AGE	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**Statewide Average**
1. Getting Needed Care (Always + Usually)										
81.50%	82.67%	83.75%	86.79%	88.85%	89.28%	NA	NA	NA	NA	85.47%
2. Getting Care Quickly (Always + Usually)										
76.95%	NA	81.09%	85.87%	NA	NA	NA	NA	NA	NA	81.30%

Table 10. MY2022 CAHPS 5.1H Adult Medicaid Survey Results										
AGE	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**Statewide Average**
3. How Well Doctors Communicate (Always + Usually)										
91.31%	93.07%	92.04%	95.65%	94.06%	96.75%	NA	95.45%	NA	95.54%	94.23%
4. Customer Service (Always + Usually)										
NA	NA	87.98%	NA	NA	NA	NA	NA	NA	NA	87.98%
5. Rating of All Health Care (9+10)										
53.38%	52.11%	55.88%	58.67%	59.23%	67.48%	NA	57.66%	53.92%	50.48%	56.53%
6. Rating of Personal Doctor (9+10)										
65.08%	64.44%	68.48%	69.47%	66.44%	79.61%	NA	73.64%	63.87%	68.07%	68.79%
7. Rating of Specialist Seen Most Often (9+10)										
NA	NA	NA	73.58%	NA	NA	NA	NA	NA	NA	73.58%
8. Rating of Health Plan (9+10)										
57.32%	60.54%	61.11%	66.38%	65.45%	82.76%	NA	61.25%	66.45%	64.79%	65.12%
9. Coordination of Care (Always + Usually)										
NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table 11. MY2022 CAHPS 5.1H Child Medicaid Survey Results (General Population)										
AGE	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**Statewide Average**
1. Getting Needed Care (Always + Usually)										
88.04%	85.35%	84.41%	92.50%	92.84%	86.08%	90.13%	89.43%	NA	NA	88.60%
2. Getting Care Quickly (Always + Usually)										
89.05%	88.76%	84.26%	94.23%	96.39%	86.98%	92.27%	90.69%	NA	NA	90.33%
3. How Well Doctors Communicate (Always + Usually)										
94.80%	94.29%	92.62%	96.73%	90.47%	93.88%	94.46%	94.80%	91.53%	NA	93.73%
4. Customer Service (Always + Usually)										
NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table 11. MY2022 CAHPS 5.1H Child Medicaid Survey Results (General Population)										
AGE	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**Statewide Average**
5. Rating of All Health Care (9+10)										
70.08%	74.33%	67.07%	75.27%	76.72%	79.42%	70.42%	78.44%	69.47%	63.73%	72.50%
6. Rating of Personal Doctor (9+10)										
74.20%	77.61%	74.25%	79.08%	81.42%	78.45%	78.85%	77.45%	77.06%	69.34%	76.77%
7. Rating of Specialist Seen Most Often (9+10)										
NA	NA	NA	79.67%	NA	NA	82.32%	NA	NA	NA	81.00%
8. Rating of Health Plan (9+10)										
64.51%	76.56%	69.05%	78.81%	80.45%	78.89%	76.25%	76.72%	78.13%	72.63%	75.20%
9. Coordination of Care (Always + Usually)										
80.95%	NA	NA	85.96%	86.24%	NA	81.98%	NA	NA	NA	83.78%

Table 12. MY2022 CAHPS 5.1H Child Medicaid Survey Results (Children with Chronic Conditions)										
AGE	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**	**Statewide Average**
1. Access to Specialized Services (Always + Usually)										
NA	NA	NA	NA	NA	NA	76.45%	NA	NA	NA	76.45%
2. Family-Centered Care: Personal Doctor Who Knows Child (Yes)										
91.73%	90.29%	90.65%	92.29%	93.67%	90.04%	91.67%	89.98%	87.95%	NA	90.92%
3. Coordination of Care for Children With Chronic Conditions (Yes)										
NA	NA	NA	78.37%	NA	NA	79.22%	NA	NA	NA	78.80%
4. Family-Centered Care: Getting Needed Information (Always + Usually)										
91.95%	95.36%	88.44%	94.63%	93.60%	90.80%	91.69%	97.37%	89.43%	88.71%	
5. Access to Prescription Medicines (Always + Usually)										
94.00%	93.27%	86.83%	95.75%	91.94%	90.86%	92.31%	90.23%	91.41%	93.60%	92.02%

Medicaid HEDIS Trending—Statewide Weighted Rates

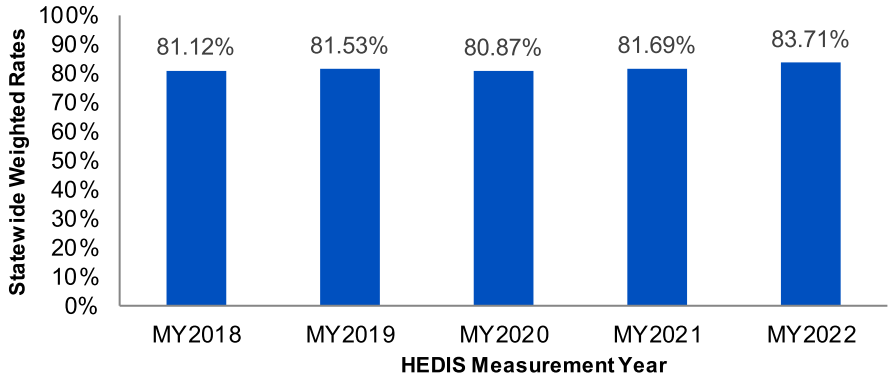
Each year of HEDIS reporting, Qsource has calculated the Medicaid statewide weighted averages for each measure by applying the size of the eligible population for each measure within a health plan to its reported rate. Using this methodology, plan-specific findings can be estimated from an overall TennCare statewide level, with each reporting health plan contributing to the statewide estimate proportionate to its eligible population size. Weighted statewide rates were calculated using MCO statewide files.

Generally, and as stated in footnotes, factors should be considered while trending data, such as instances where measures were not reported (and thereby not plotted) for a particular year.

Trending for first-time measures is not possible and, therefore, is not presented in this section. Likewise, graphs are not presented for measures that had a break in trending for the current measurement year. Remaining measures are plotted to reflect the statewide performance of TennCare MCOs for five years. Trending for prior years is available in previous HEDIS reports.

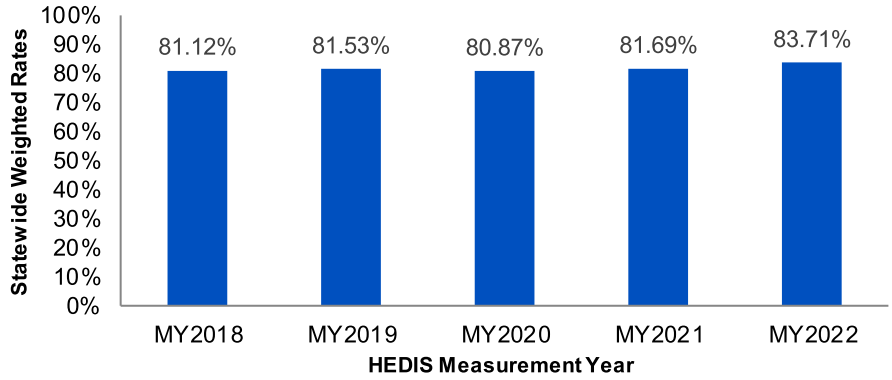
Effectiveness of Care Measures: Prevention and Screening

Fig. 1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile: 3–11 Years



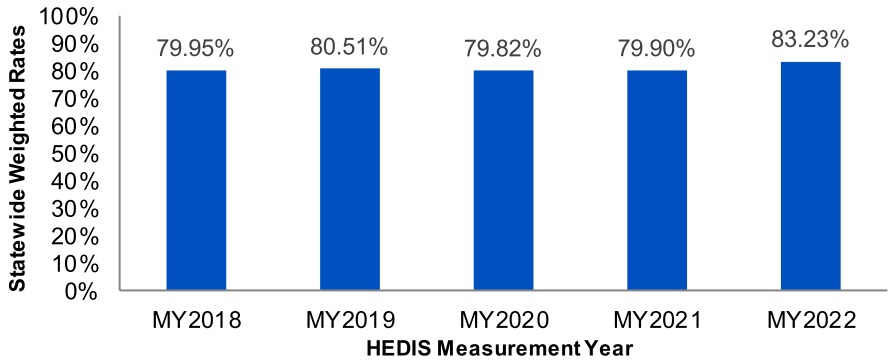
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2018 with previous years should be considered with caution.

Fig. 2. WCC—BMI Percentile: 12–17 Years



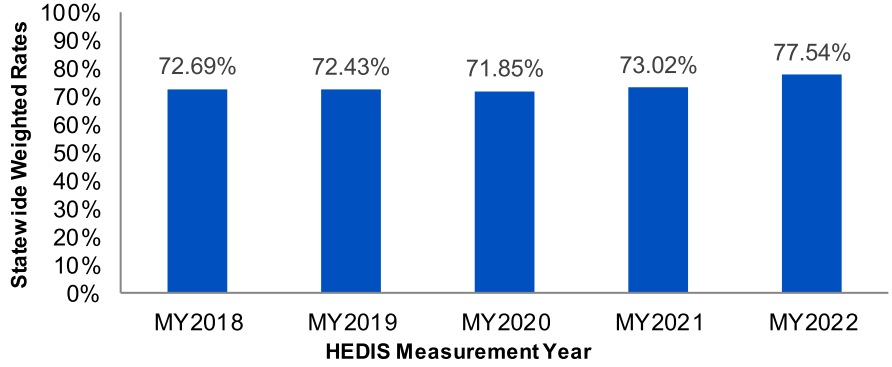
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2018 with previous years should be considered with caution.

Fig. 3. WCC—BMI Percentile: Total



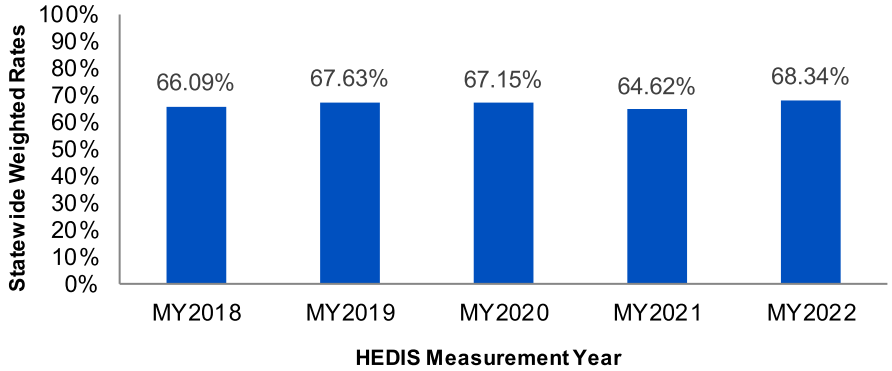
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2018 with previous years should be considered with caution.

Fig. 4. WCC—Counseling for Nutrition: 3–11 Years



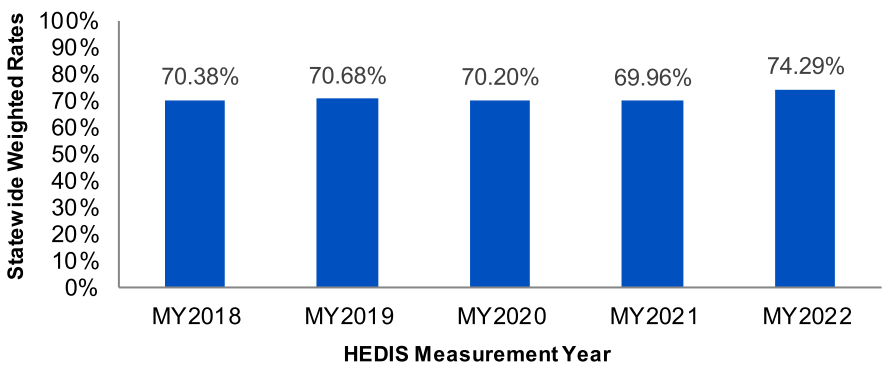
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 5. WCC—Counseling for Nutrition: 12–17 Years



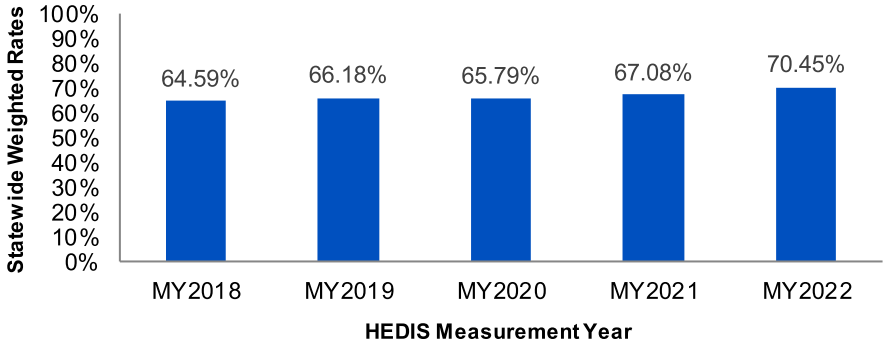
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 6. WCC—Counseling for Nutrition: Total



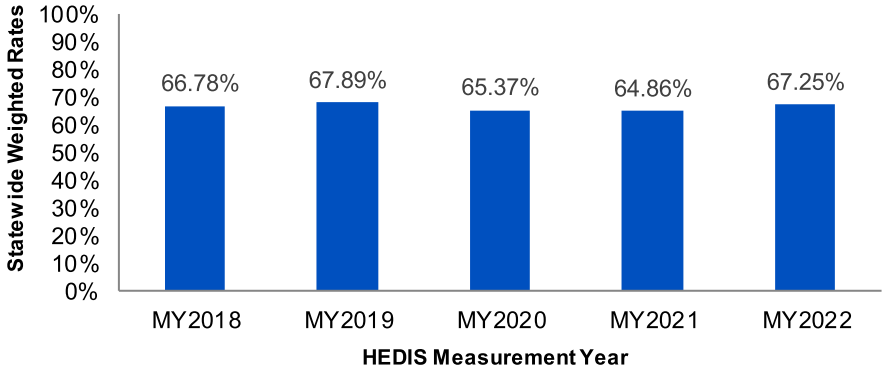
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 7. WCC—Counseling for Physical Activity: 3–11 Years



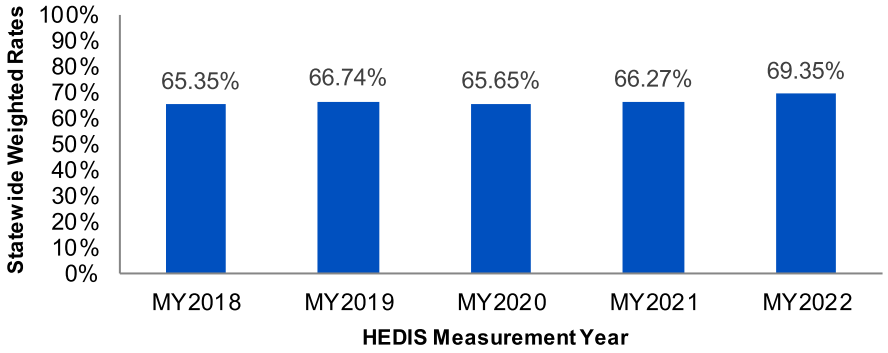
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 8. WCC—Counseling for Physical Activity: 12–17 Years



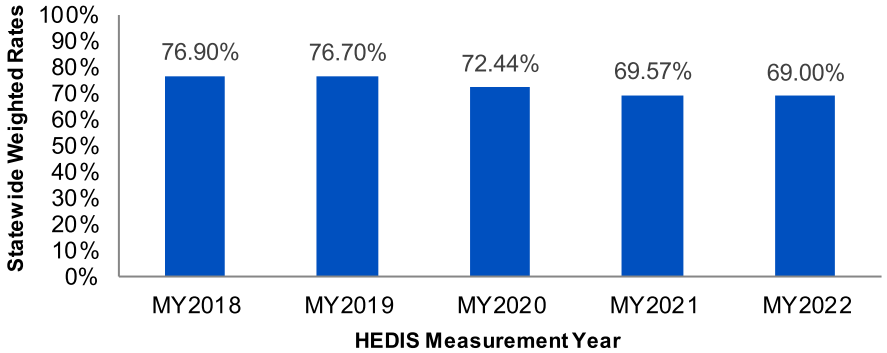
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 9. WCC—Counseling for Physical Activity: Total



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 10. Childhood Immunization Status (CIS): DTaP/DT



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

Fig. 11. CIS: IPV

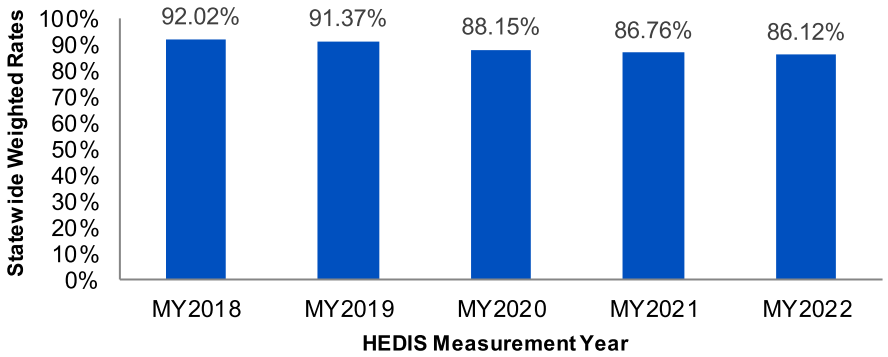
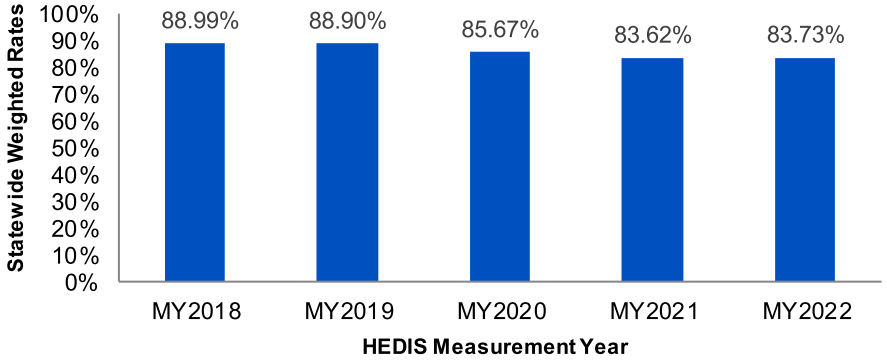


Fig. 12. CIS: MMR



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

Fig. 13. CIS: HiB

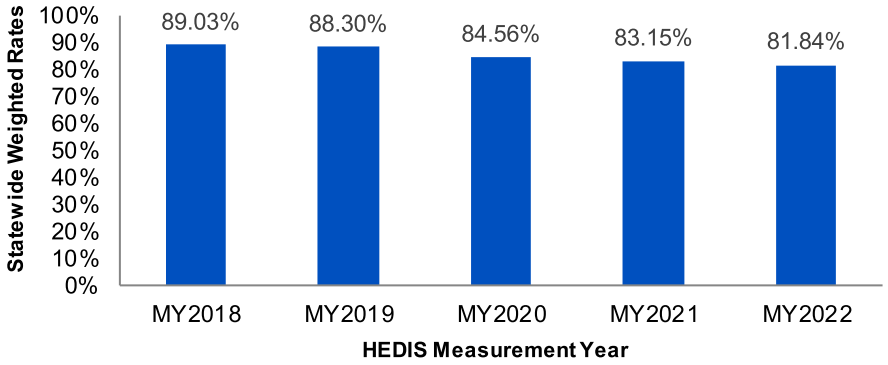


Fig. 14. CIS: HepB

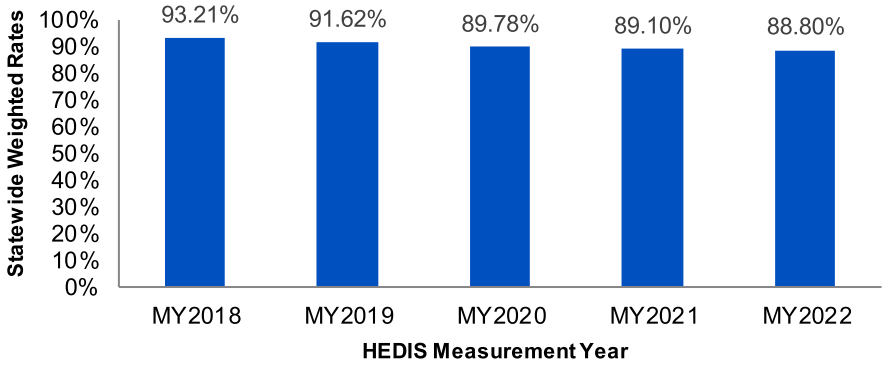


Fig. 15. CIS: VZV

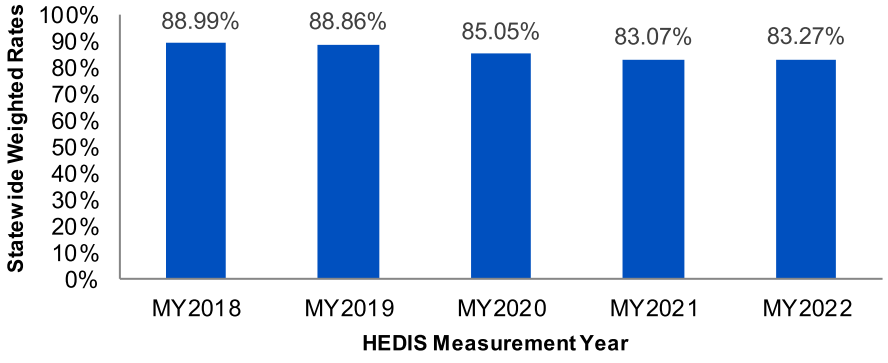


Fig. 16. CIS: PCV

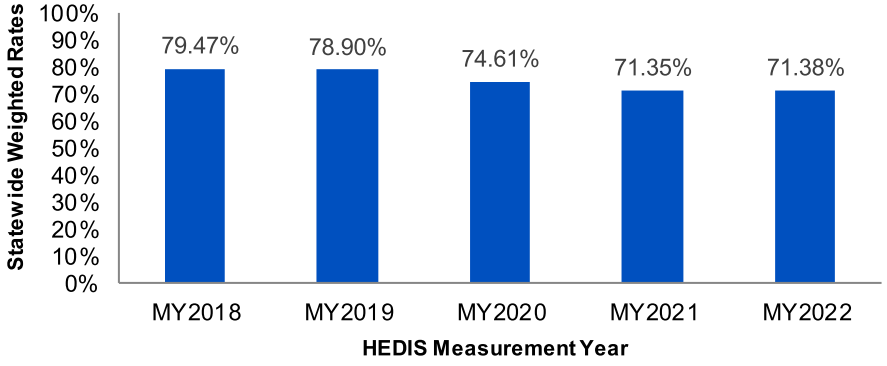
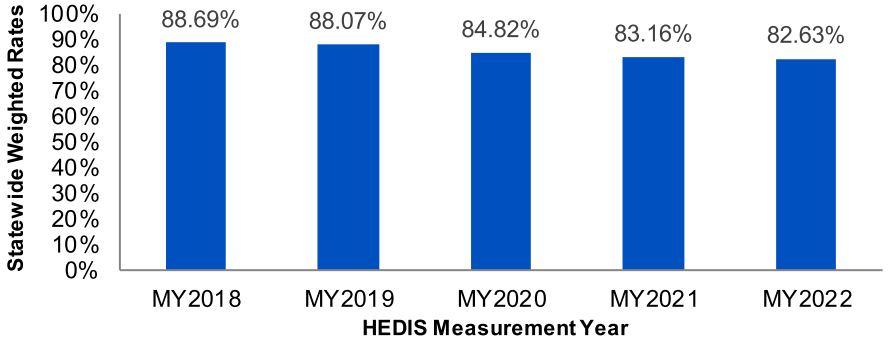


Fig. 17. CIS: HepA



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

Fig. 18. CIS: RV

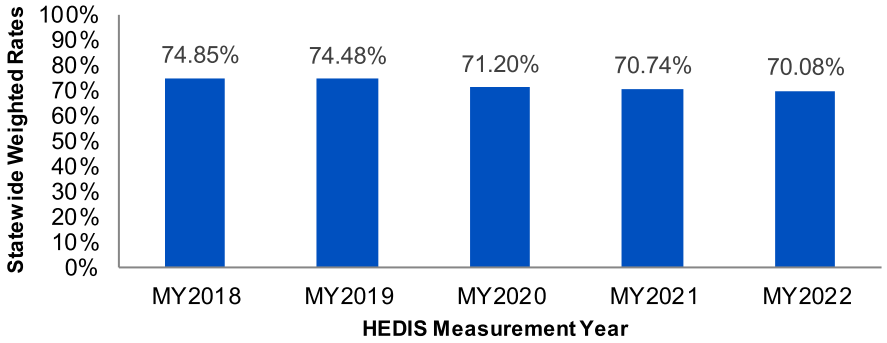


Fig. 19. CIS: Flu

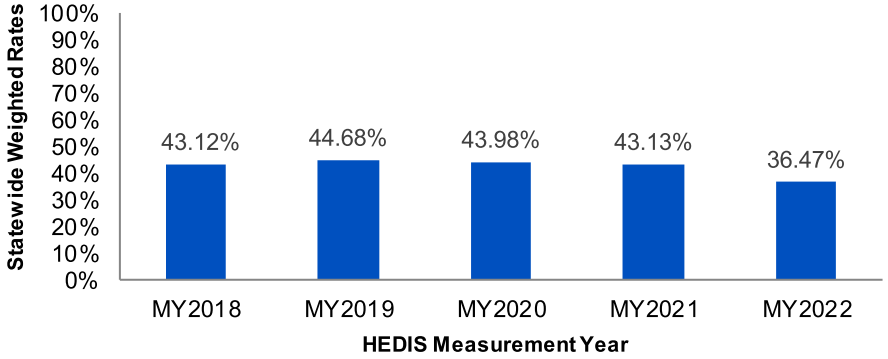
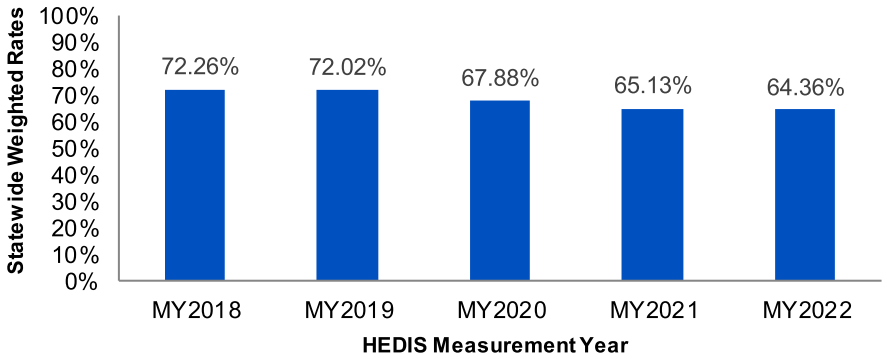
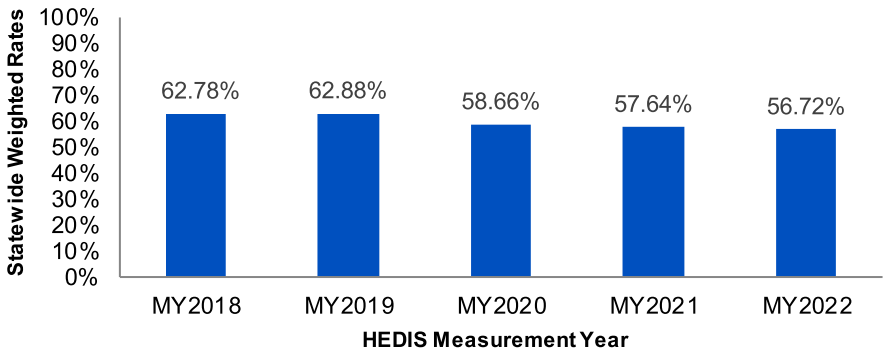


Fig. 20. CIS: Combination 3



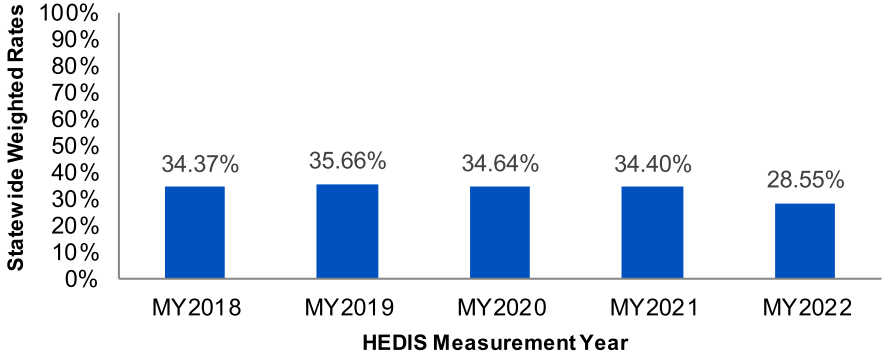
Footnote: Due to changes in measure specification, NCQA indicated trending between 2019 and previous years should be considered with caution.

Fig. 21. CIS Combination 7



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

Fig. 22. CIS: Combination 10



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

Fig. 23. Immunizations for Adolescents (IMA): Meningococcal

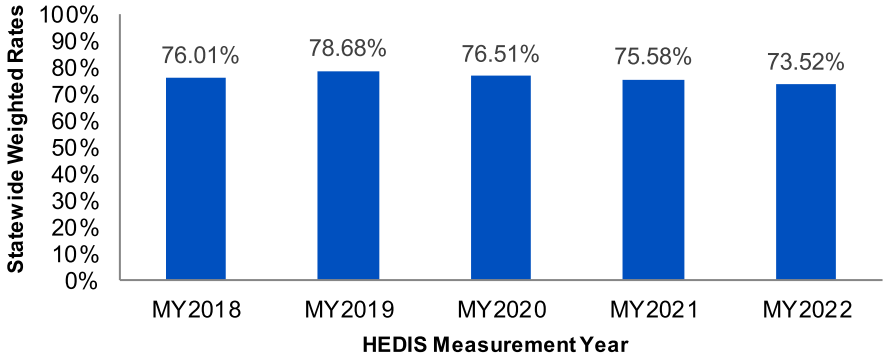


Fig. 24. IMA: Tdap/Td

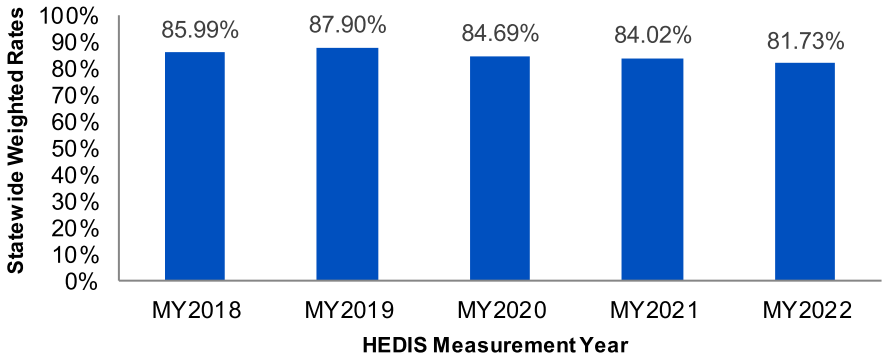


Fig. 25. IMA: HPV

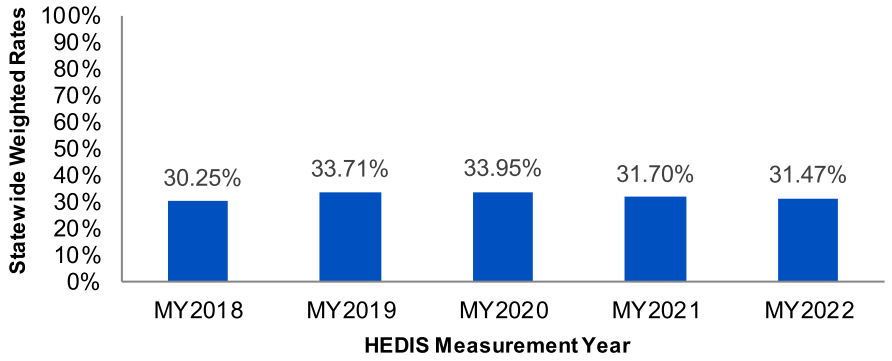


Fig. 26. IMA: Combination 1

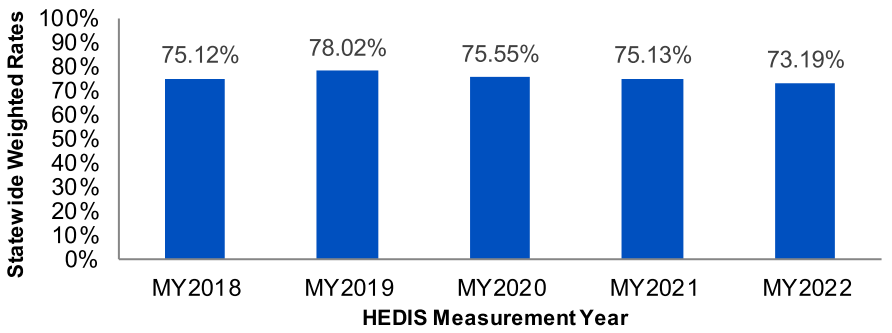


Fig. 27. IMA: Combination 2

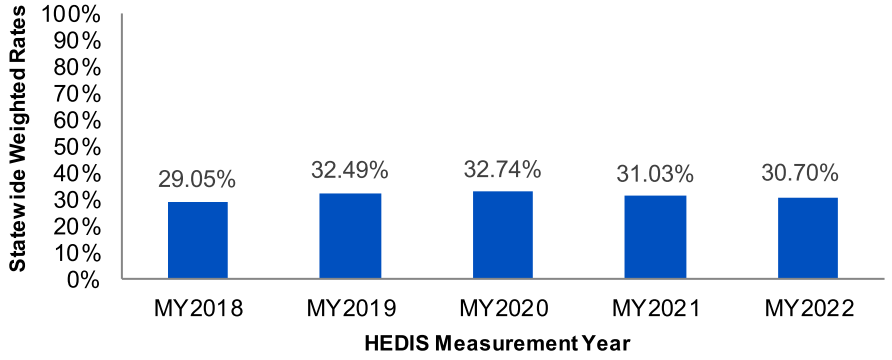


Fig. 28. Lead Screening in Children (LSC)

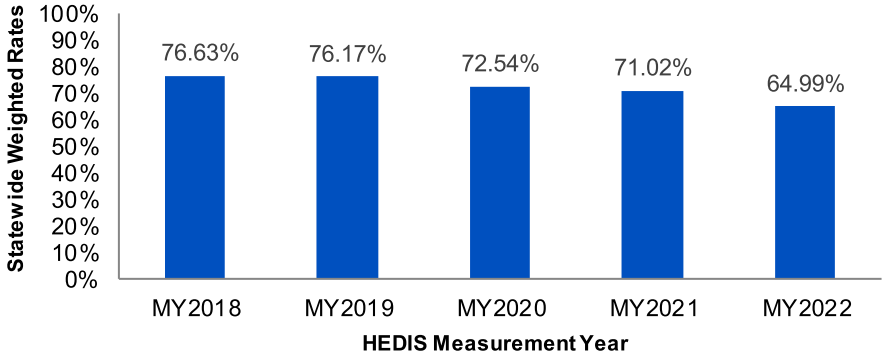
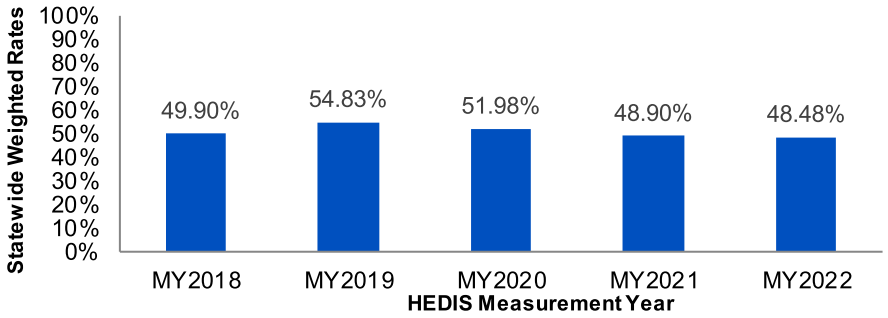
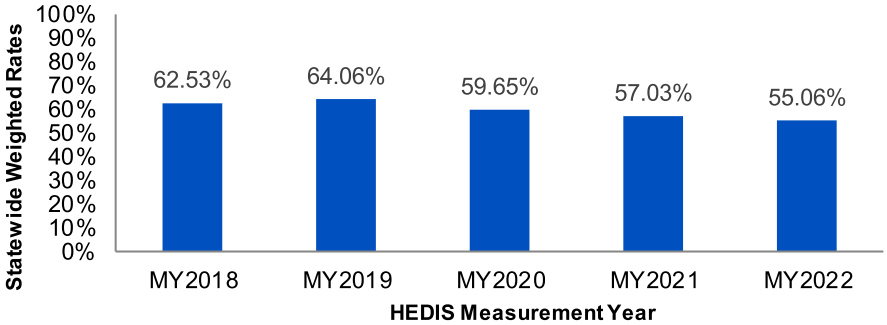


Fig. 29. Breast Cancer Screening (BCS)



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2018 with previous years should be considered with caution.

Fig. 30. Cervical Cancer Screening (CCS)



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2019 with previous years should be considered with caution.

Fig. 31. Chlamydia Screening in Women (CHL): 16–20 Years

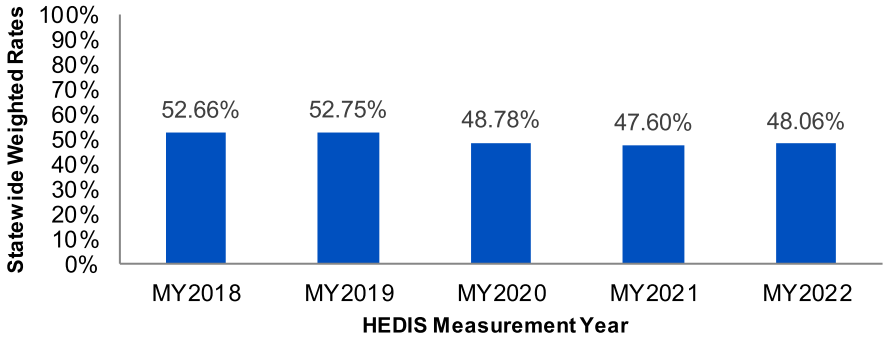


Fig. 32. CHL: 21–24 Years

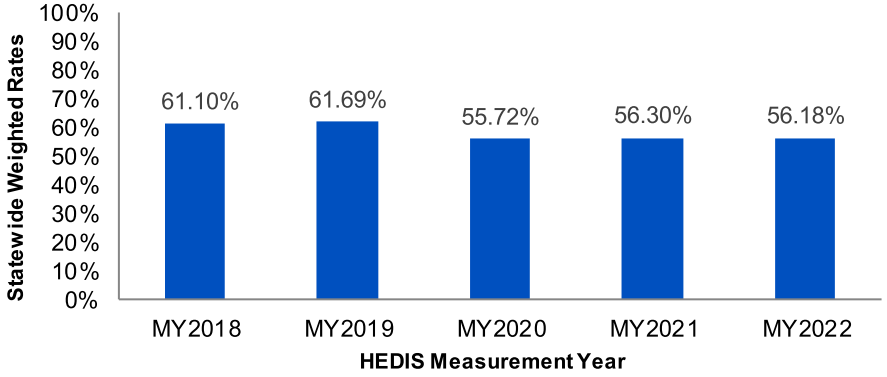
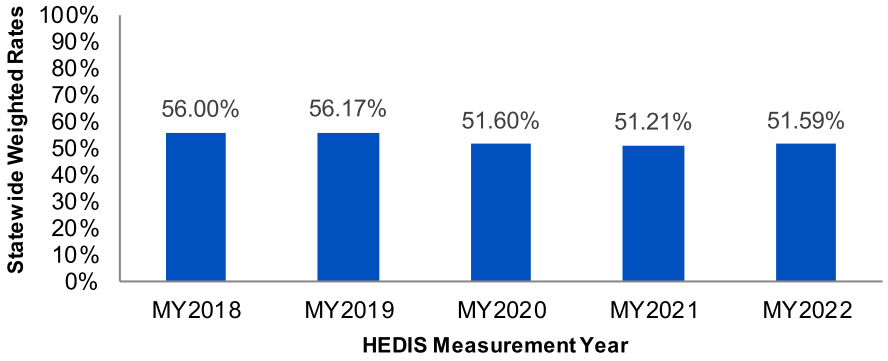
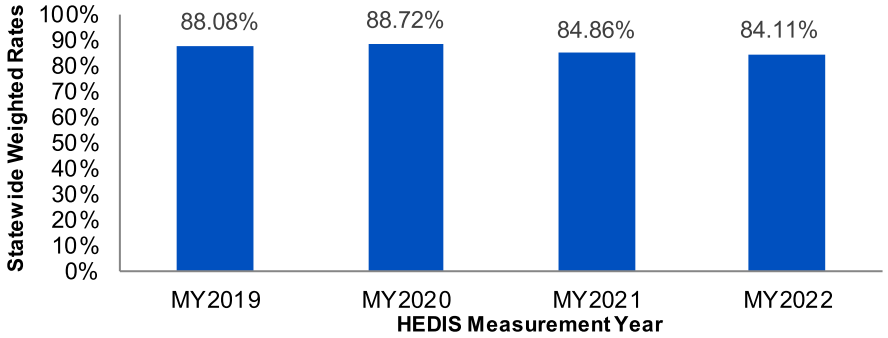


Fig. 33. CHL: Total



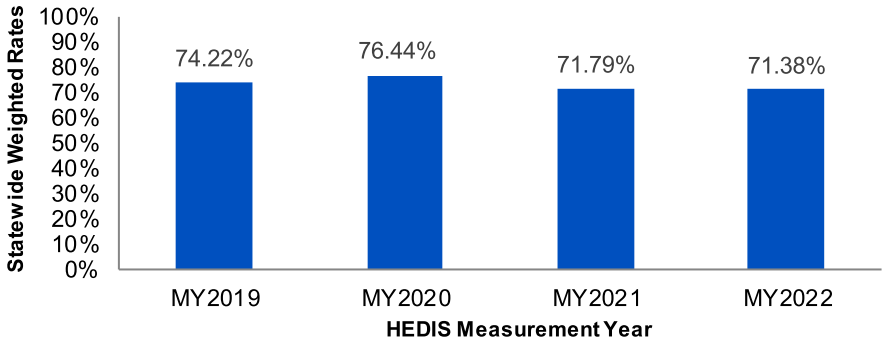
Effectiveness of Care Measures: Respiratory Conditions

Fig. 34. Appropriate Testing for Pharyngitis (CWP): 3–17 Years



Footnote: Due to significant changes in measure specification in MY2019, NCQA indicated a break in trending to prior years. Due to changes in measure specification, NCQA indicated that trending MY2020–MY2022 with previous years should be considered with caution.

Fig. 35. CWP: 18-64 Years



Footnote: Due to significant changes in measure specification in MY2019, NCQA indicated a break in trending to prior years. Due to changes in measure specification, NCQA indicated that trending MY2020–MY2022 with previous years should be considered with caution.

Fig. 36. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

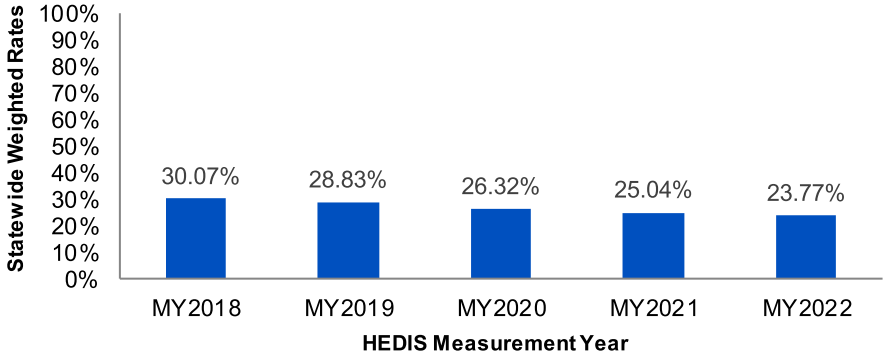


Fig. 37. Pharmacotherapy Management of COPD Exacerbation (PCE): Systemic Corticosteroid

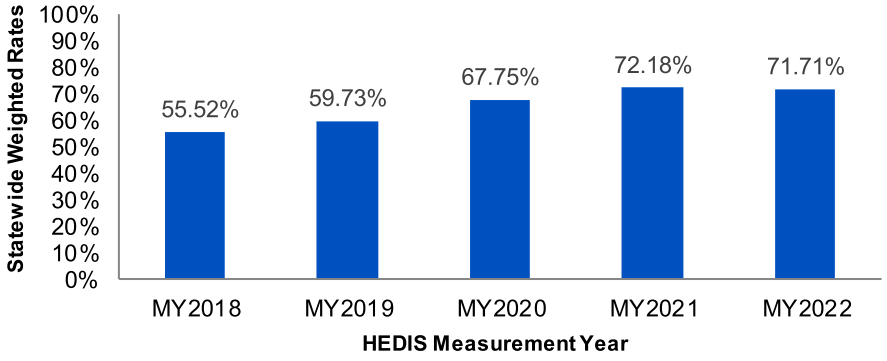


Fig. 38. PCE: Bronchodilator

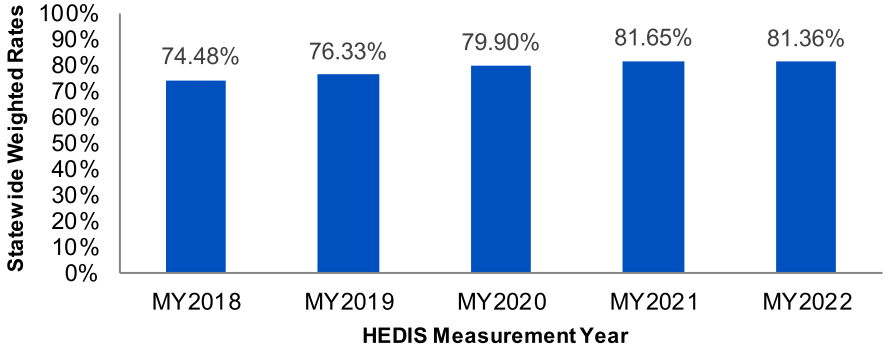
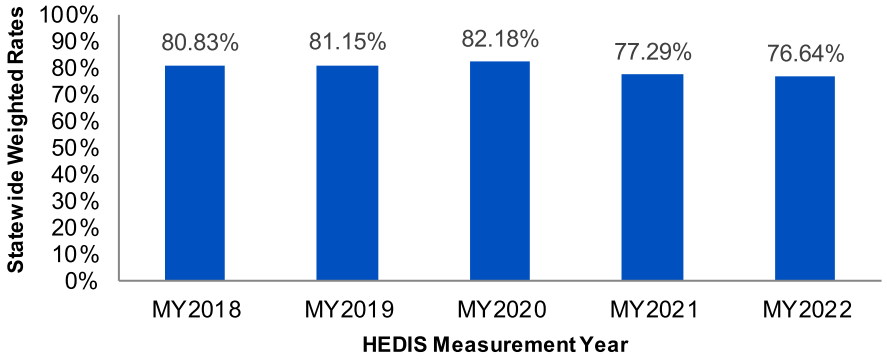
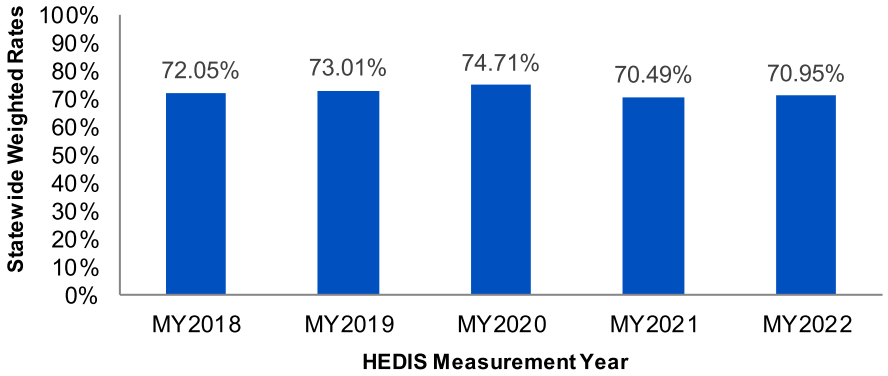


Fig. 39. Asthma Medication Ratio (AMR): 5–11 Years



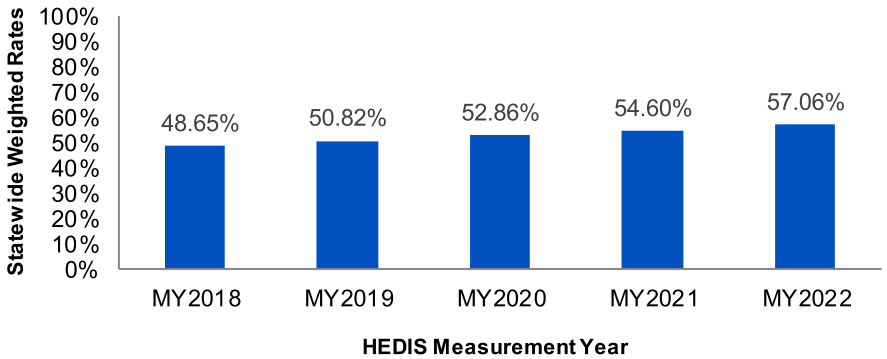
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

Fig. 40. AMR: 12–18 Years



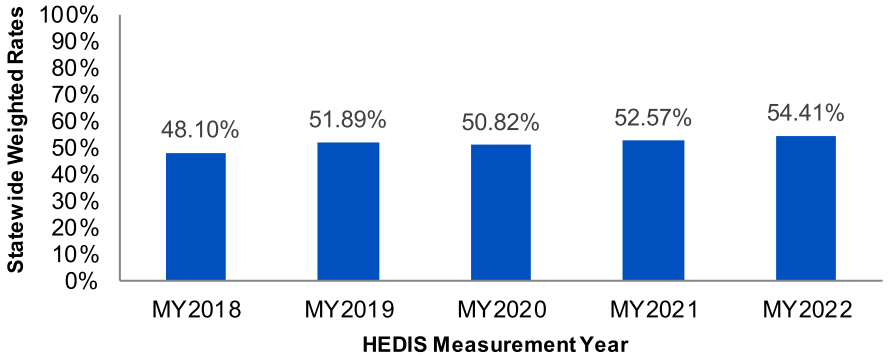
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

Fig. 41. AMR: 19–50 Years



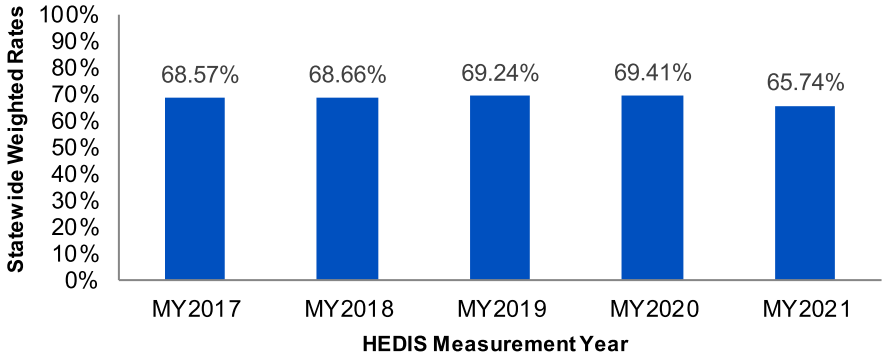
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

Fig. 42. AMR: 51–64 Years



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

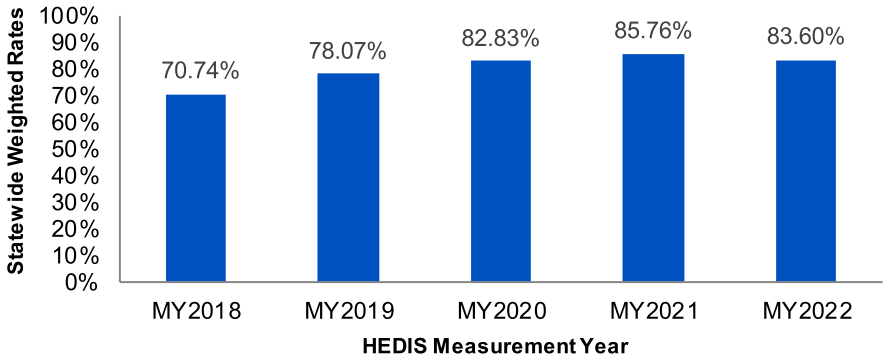
Fig. 43. AMR: Total



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2019 with previous years should be considered with caution.

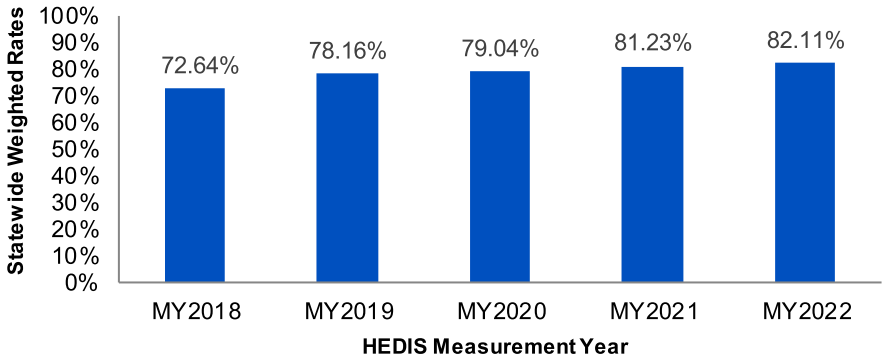
Effectiveness of Care Measures: Cardiovascular Conditions

Fig. 44. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)



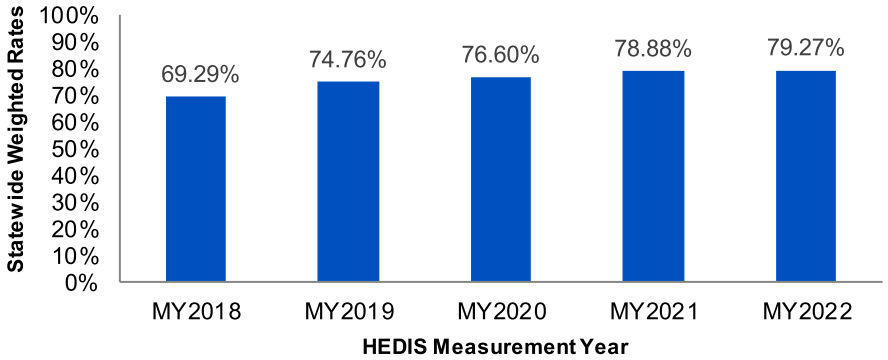
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

Fig. 45. Statin Therapy for Patients with Cardiovascular Disease (SPC)—Received Statin Therapy: Males 21–75 Years



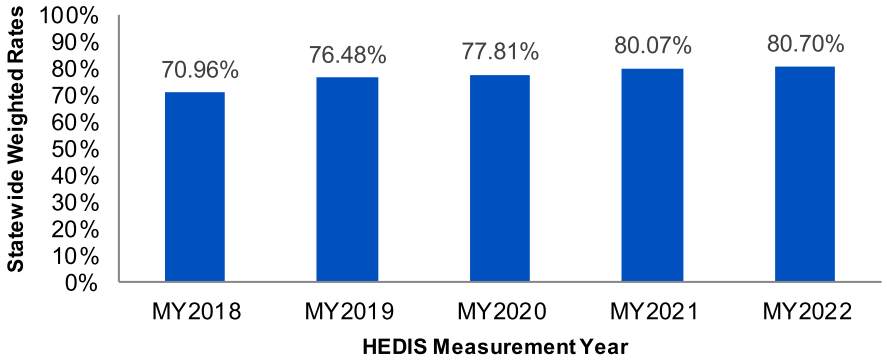
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2018 with previous years should be considered with caution.

Fig. 46. SPC—Received Statin Therapy: Females 40–75 Years



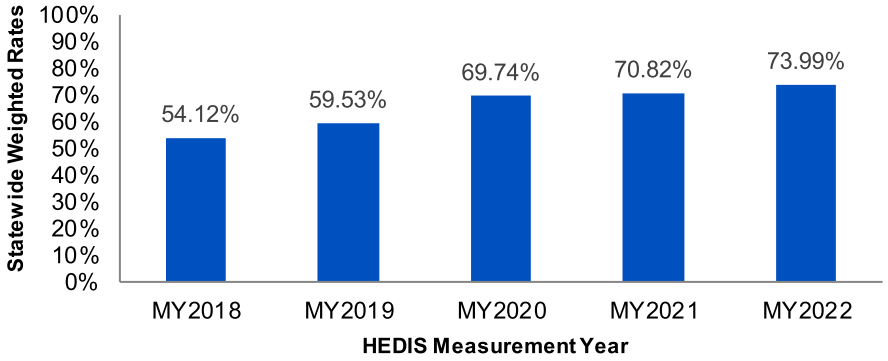
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2018 with previous years should be considered with caution.

Fig. 47. SPC—Received Statin Therapy: Total



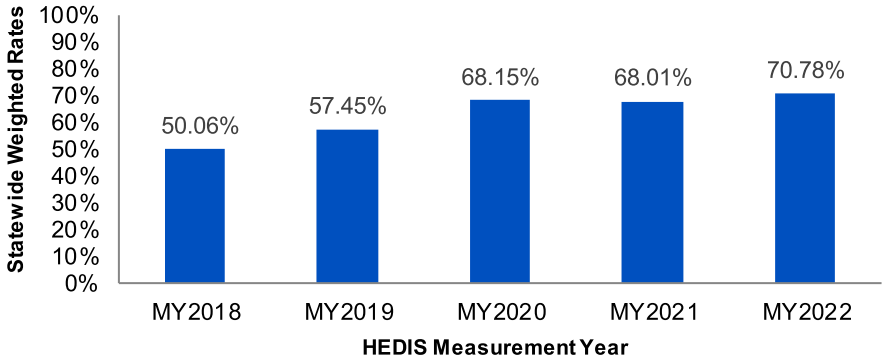
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2018 with previous years should be considered with caution.

Fig. 48. SPC—Statin Adherence 80%: Males 21–75 Years



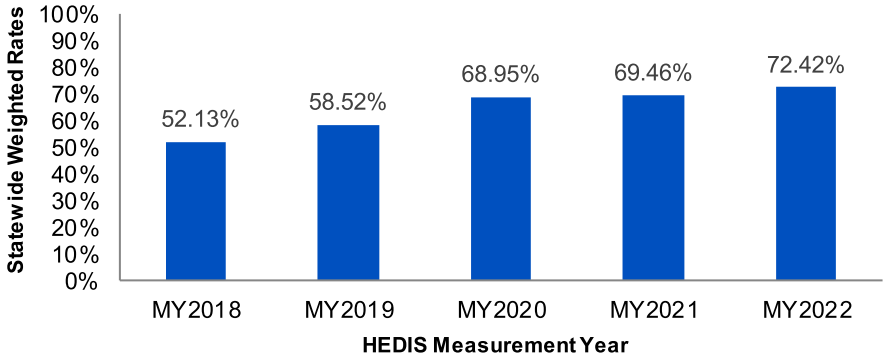
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020-MY2018 with previous years should be considered with caution.

Fig. 49. SPC—Statin Adherence 80%: Females 40–75 Years



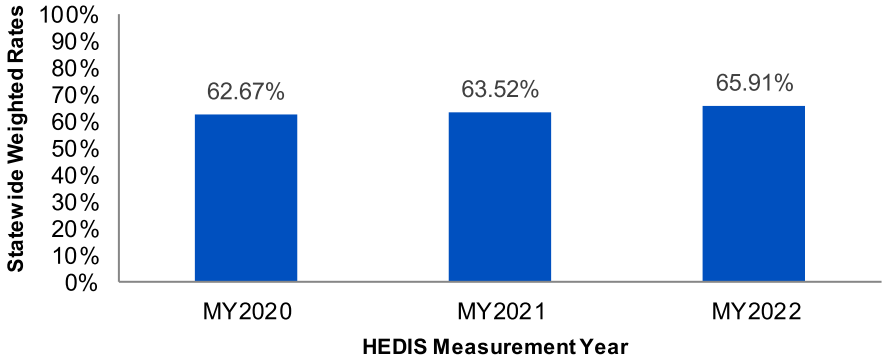
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020-MY2018, and previous years should be considered with caution.

Fig. 50. SPC—Statin Adherence 80%: Total



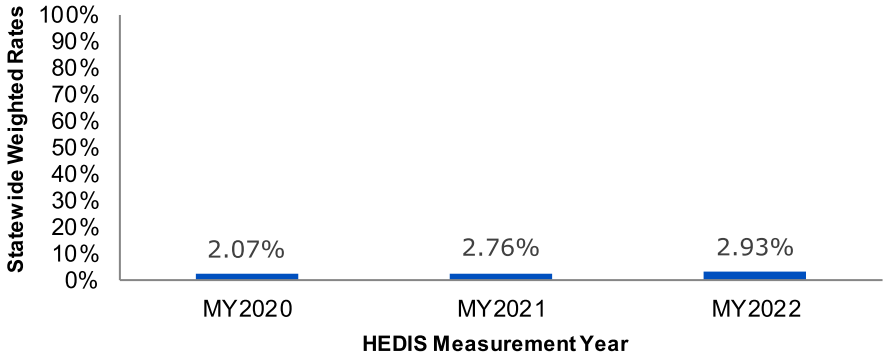
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

Fig. 51. Controlling High Blood Pressure (CBP)



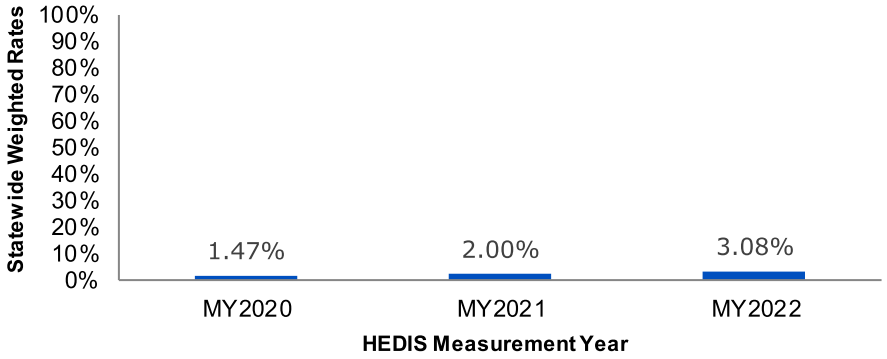
Footnote: Due to significant changes in measure specification in MY2020, NCQA indicated a break in trending to prior years.

Fig. 52. CRE—Initiation



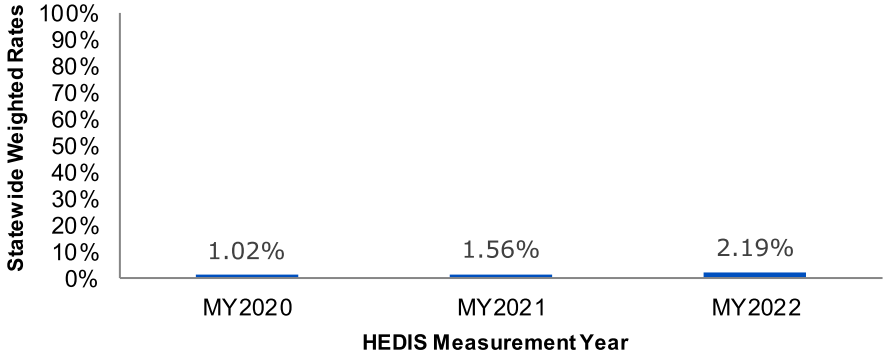
Footnote: First-year measure in MY2020.

Fig. 53. CRE—Engagement 1



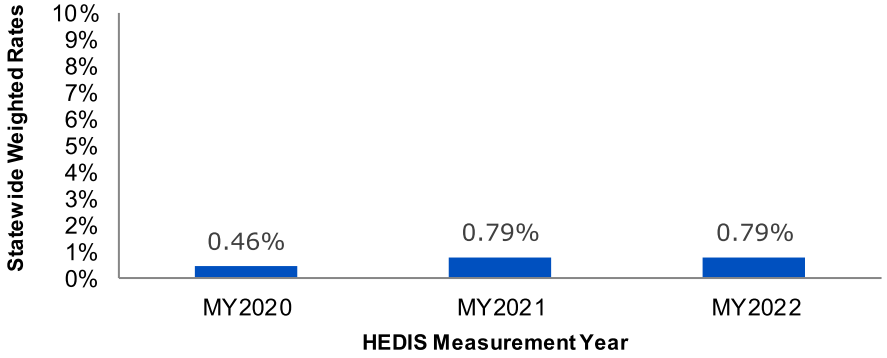
Footnote: First-year measure in MY2020.

Fig. 54. CRE—Engagement 2



Footnote: First-year measure in MY2020.

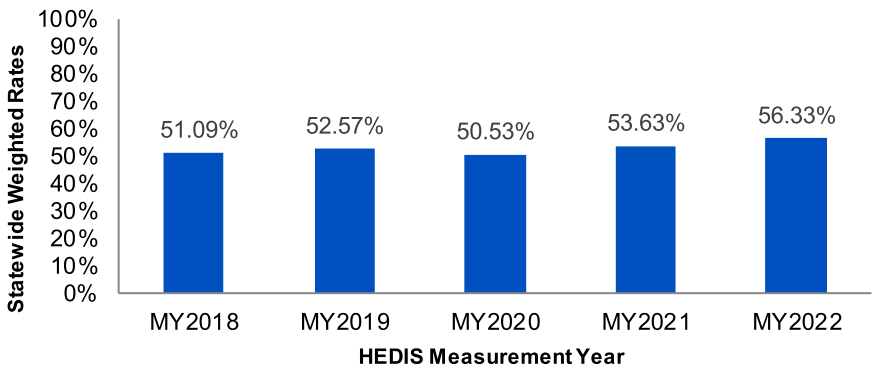
Fig. 55. CRE—Achievement



Footnote: First-year measure in MY2020.

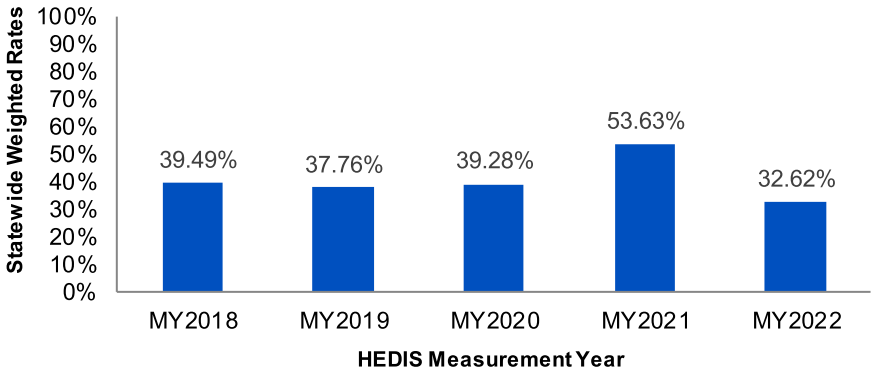
Effectiveness of Care Measures: Diabetes

Fig. 56. HBD: HbA1c Control (<8.0%) for Patients With Diabetes



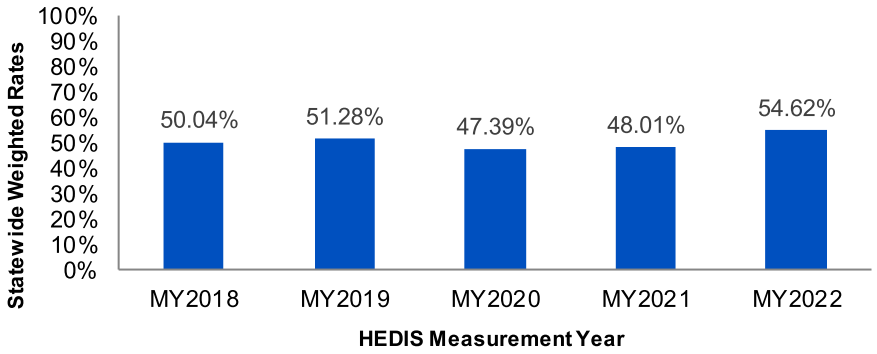
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2018 with previous years should be considered with caution.

Fig. 57. HBD: HbA1c Poor Control (>9.0%) for Patients With Diabetes*



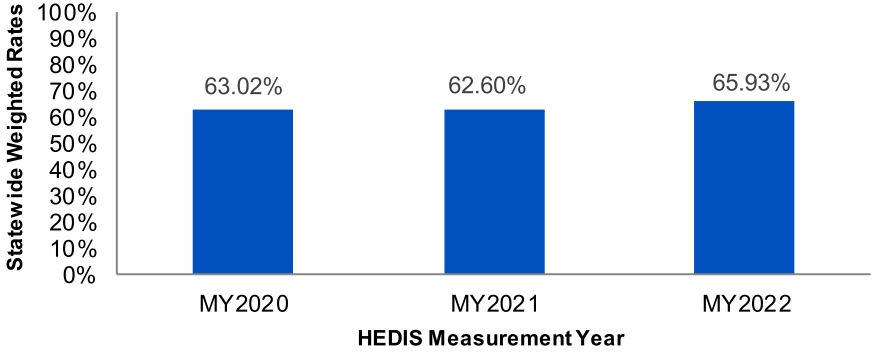
**Lower rates for this measure indicate better performance.*
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2018 with previous years should be considered with caution.

Fig. 58. EED: Eye Exam for Patients With Diabetes



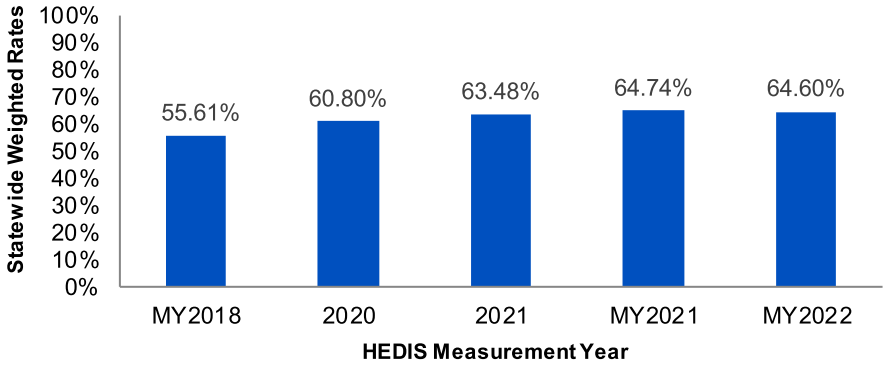
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2018 with previous years should be considered with caution.

Fig. 59. BPD: Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)



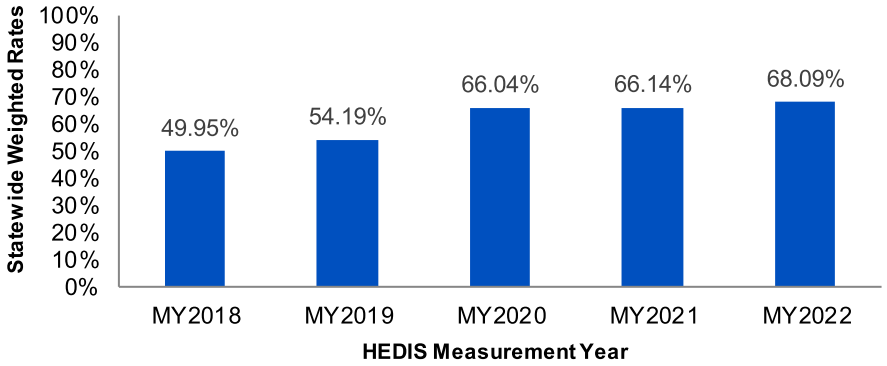
Footnote: Due to significant changes in measure specification in MY2020, NCQA indicated a break in trending to prior years.

Fig. 60. Statin Therapy for Patients with Diabetes (SPD): Received Statin Therapy: 40-75 years



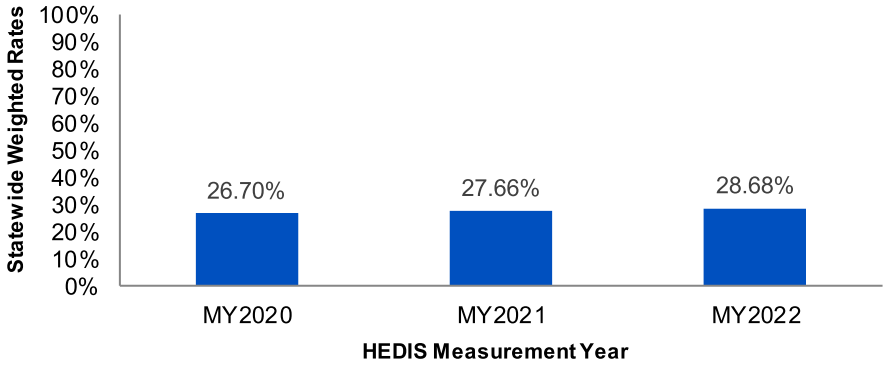
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2018 with previous years should be considered with caution.

Fig. 61. SPD: Statin Adherence 80%: 40-75 years



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020-MY2018 with previous years should be considered with caution.

Fig. 62. Kidney Health Evaluation for Patients with Diabetes (KED): 18-64 years



Footnote: First-year measure in MY2020.

Effectiveness of Care Measures: Behavioral Health

Fig. 63. Antidepressant Medication Management (AMM): Effective Acute Phase Treatment

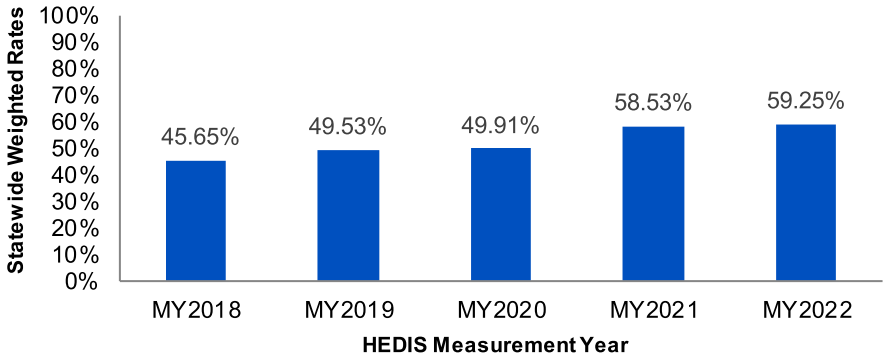


Fig. 64. AMM: Effective Continuation Phase Treatment

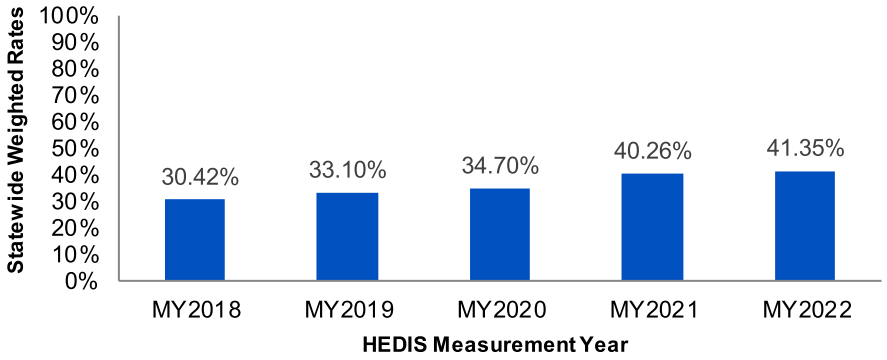
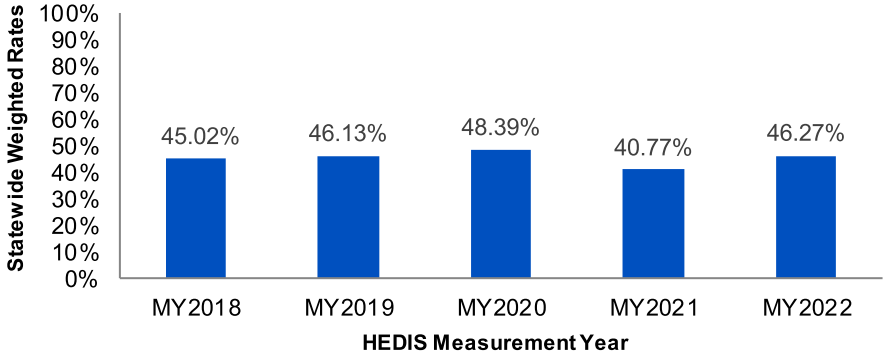
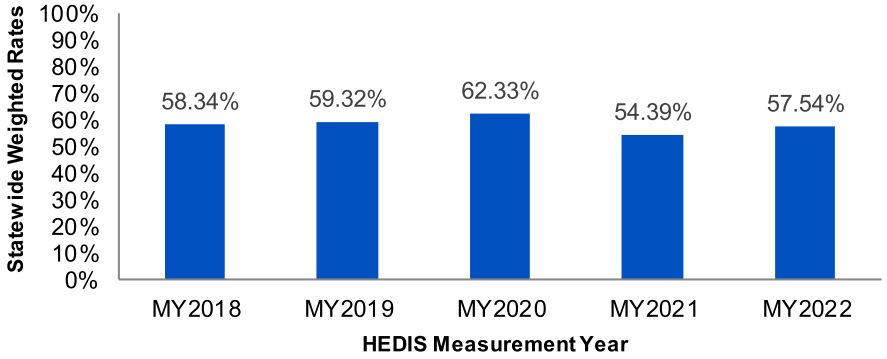


Fig. 65. Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase



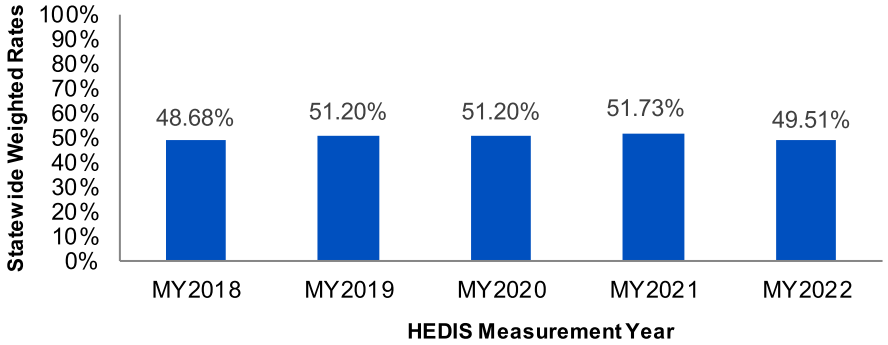
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 66. ADD: Continuation and Maintenance Phase



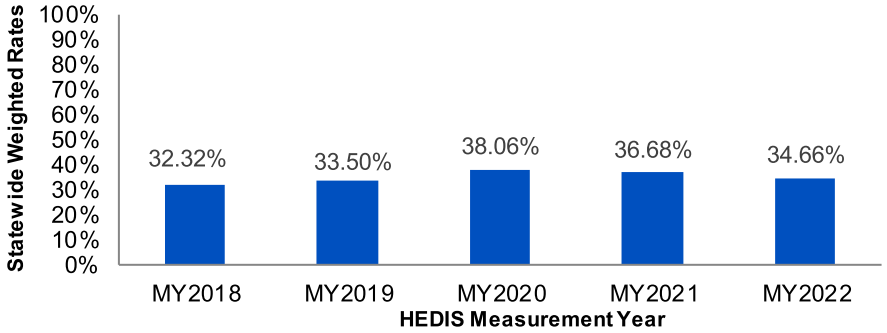
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 67. Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up: 6–17 Years



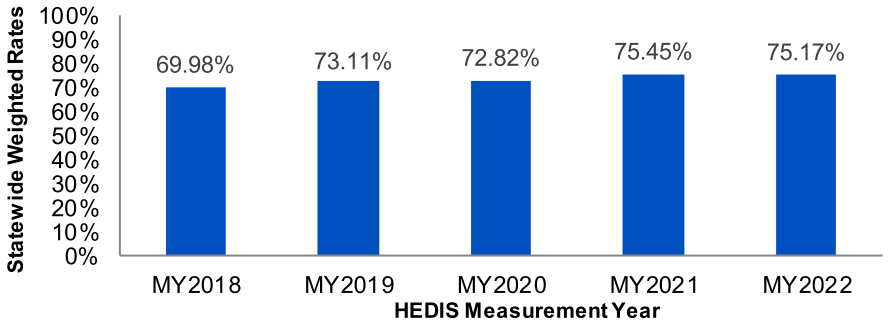
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 68. FUH—7-Day Follow-Up: 18–64 Years



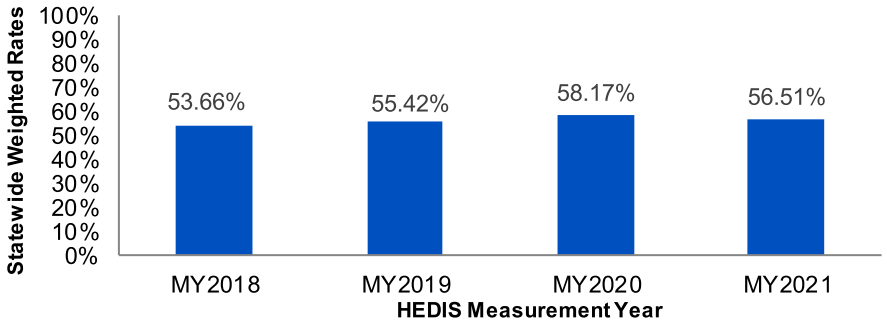
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 69. FUH—30-Day Follow-Up: 6–17 Years



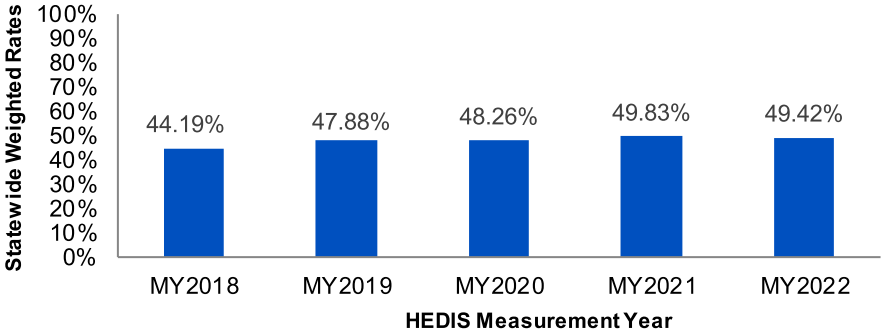
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 70. FUH—30-Day Follow-Up: 18–64 Years



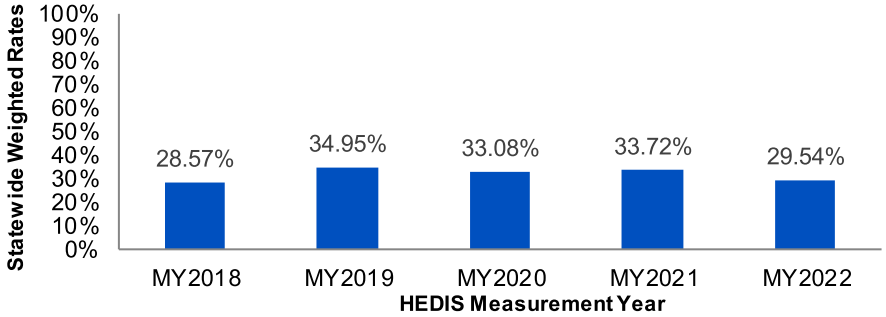
Footnote: Due to changes in measure specification, NCQA indicated trending between MY2020 and previous years should be considered with caution.

Fig. 71. Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up: 6–17 Years



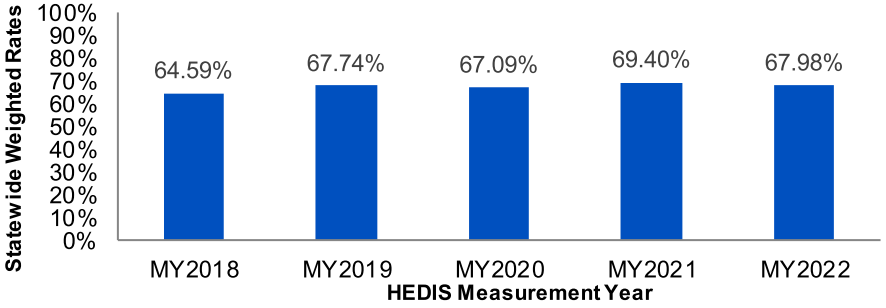
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 72. FUM—7-Day Follow-Up: 18–64 Years



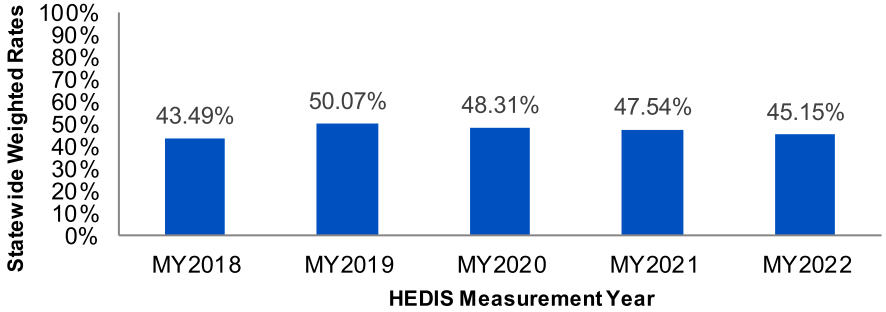
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 73. FUM—30-Day Follow-Up: 6–17 Years



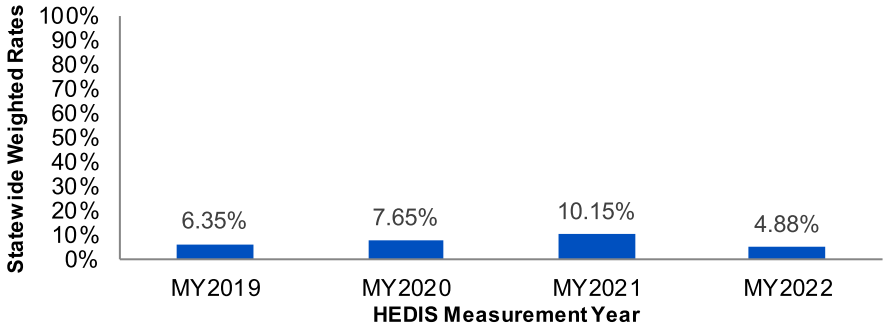
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 74. FUM—30-Day Follow-Up: 18–64 Years



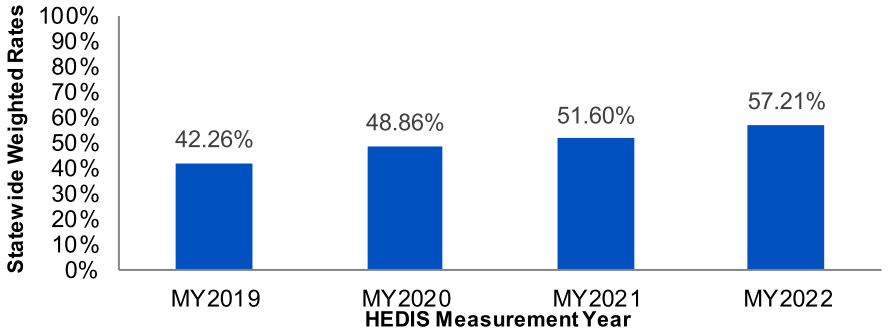
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 75. Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)—7-Day Follow-Up: 13–17 Years



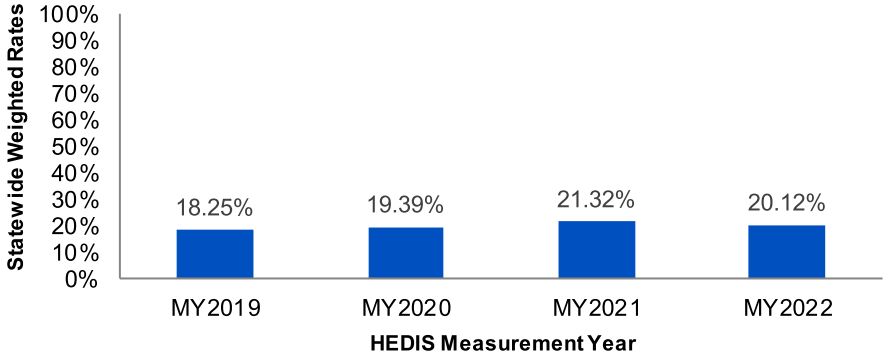
Footnote: First-year measure in MY2019. Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 76. FUI—7-Day Follow-Up: 18–64 Years



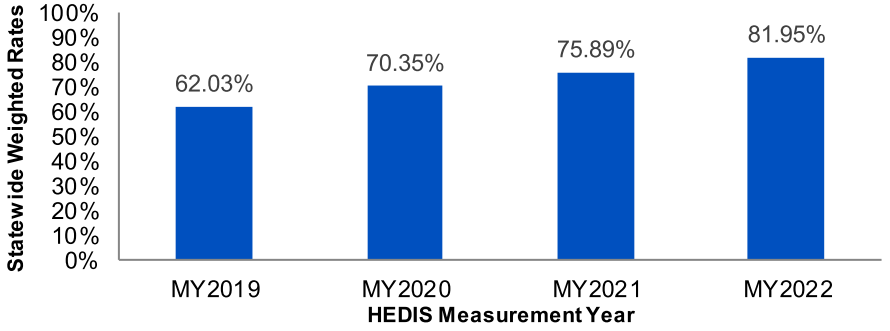
Footnote: First-year measure in MY2019. Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 77. FUI—30-Day Follow-Up: 13–17 Years



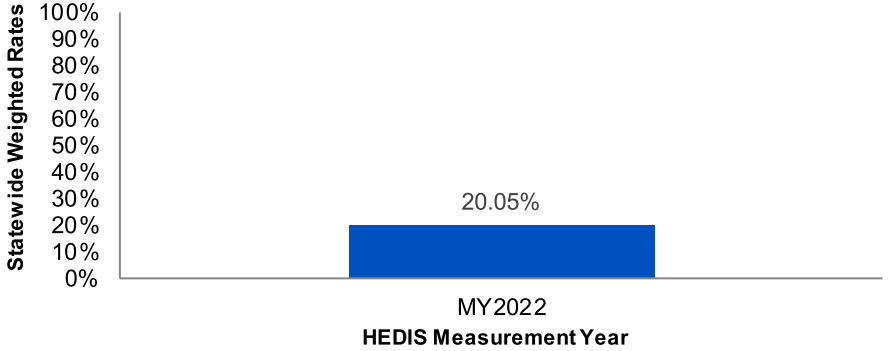
Footnote: First-year measure in MY2019. Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 78. FUI—30-Day Follow-Up: 18–64 Years



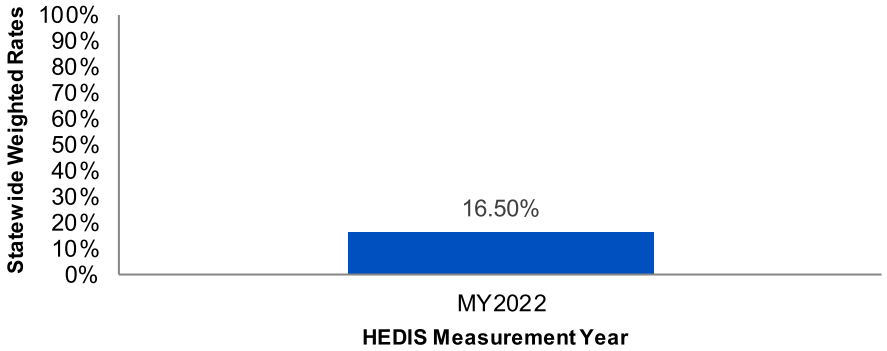
Footnote: First-year measure in MY2019. Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 79. Follow-Up After ED Visit for Substance Use (FUA)—7-Day Follow-Up: 13–17 Years



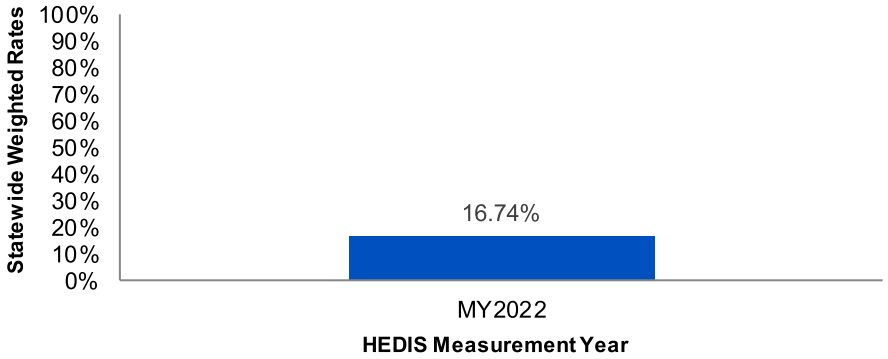
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 80. FUA—7-Day Follow-Up: ≥18 Years



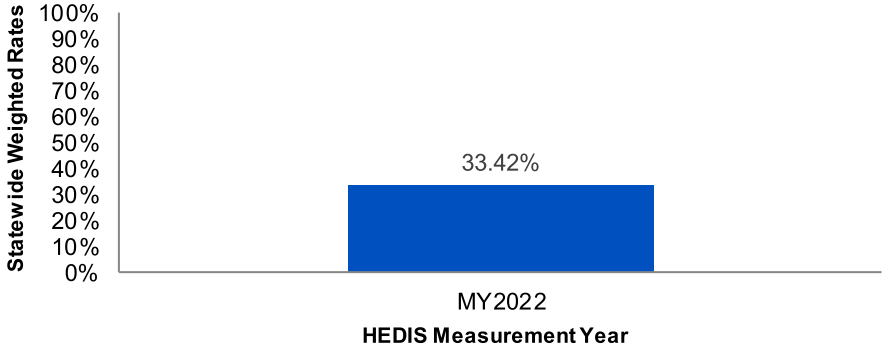
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 81. FUA—7-Day Follow-Up: Total



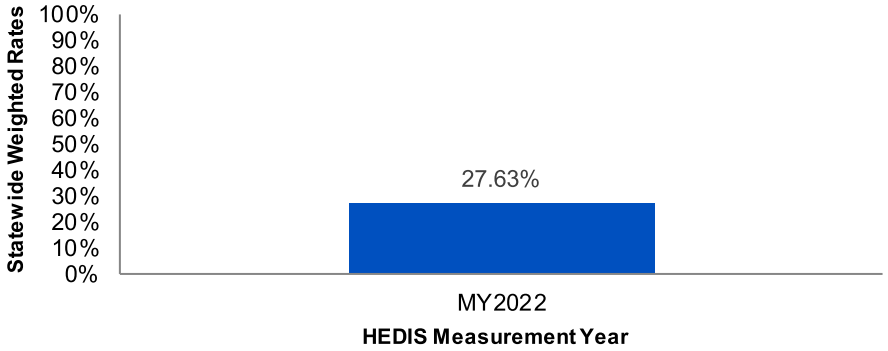
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 82. FUA—30-Day Follow-Up: 13–17 Years



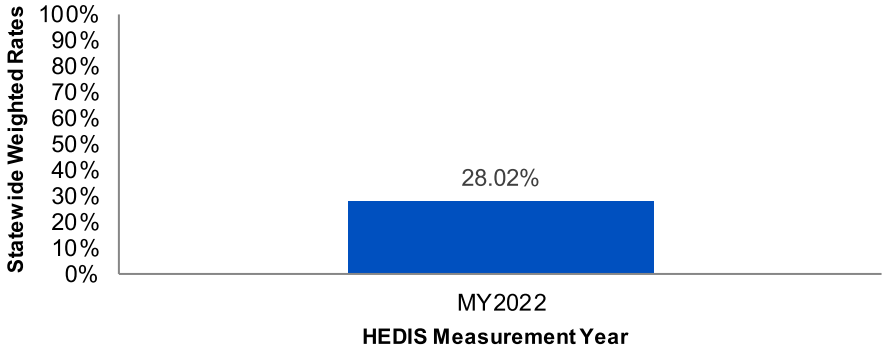
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 83. FUA—30-Day Follow-Up: ≥18 Years



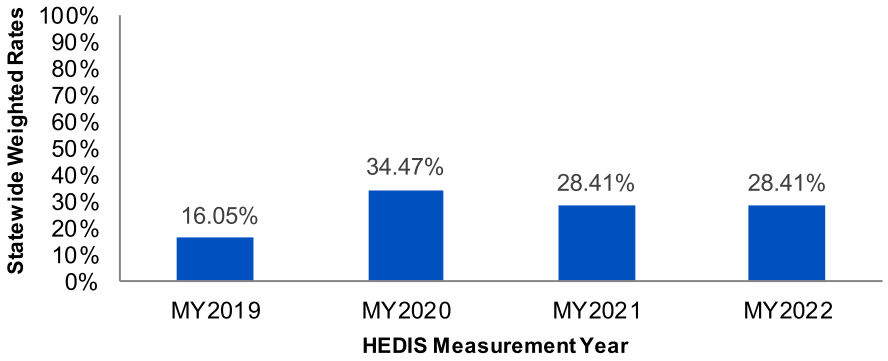
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 84. FUA—30-Day Follow-Up: Total



Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 85. Pharmacotherapy for Opioid Use Disorder (POD)



Footnote: First-year measure in MY2019. Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 86. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)

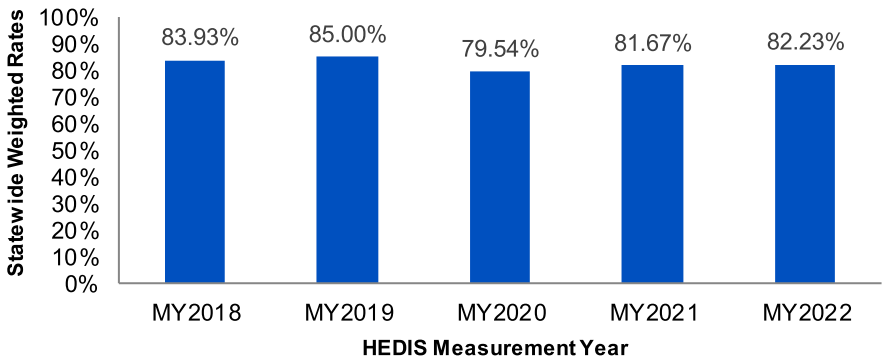


Fig. 87. Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

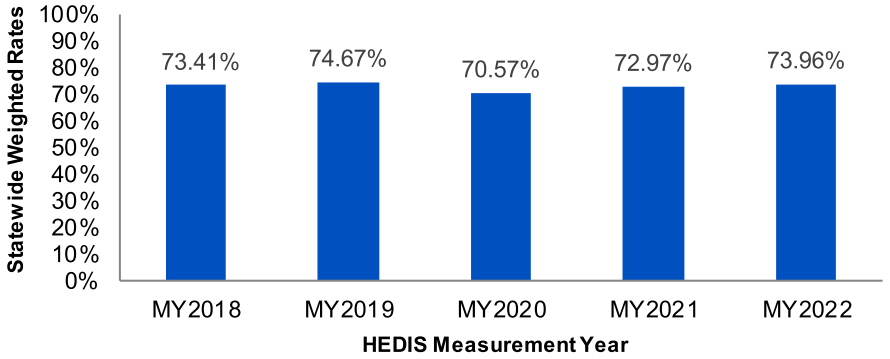


Fig. 88. Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

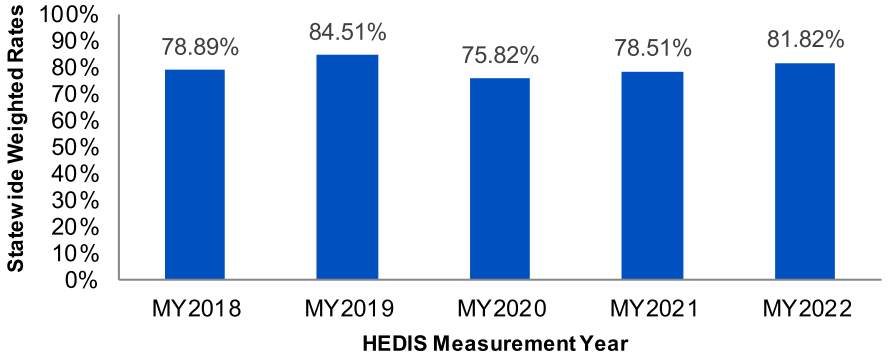


Fig. 89. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)

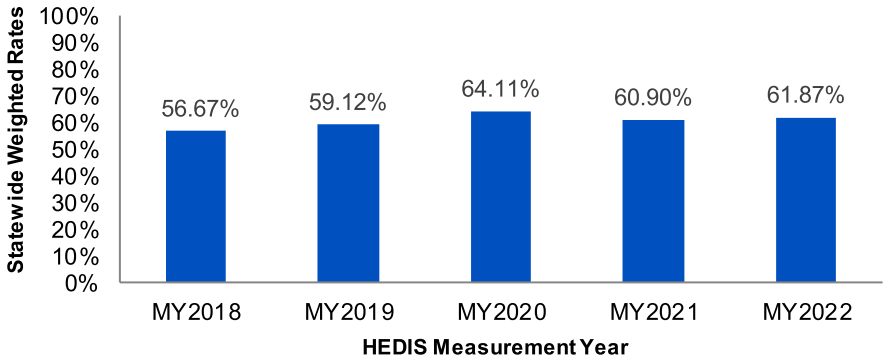
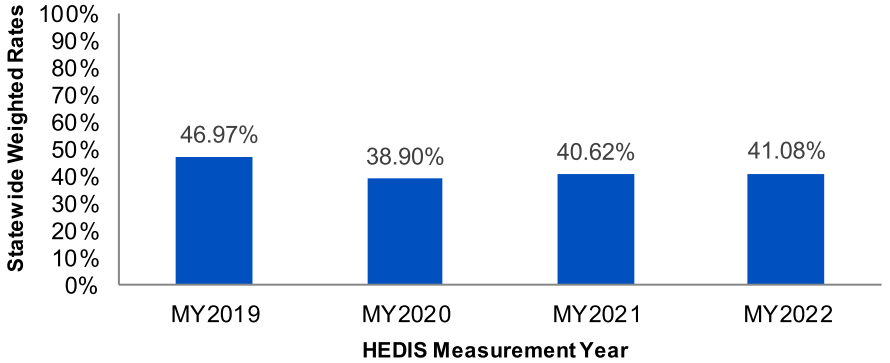
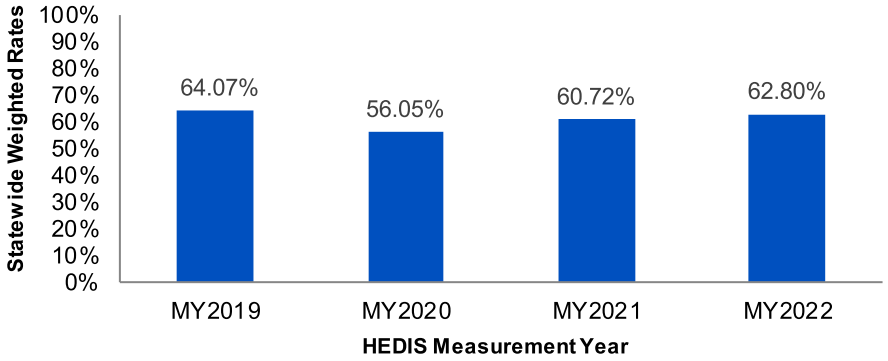


Fig. 90. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Blood Glucose Testing: 1–11 Years



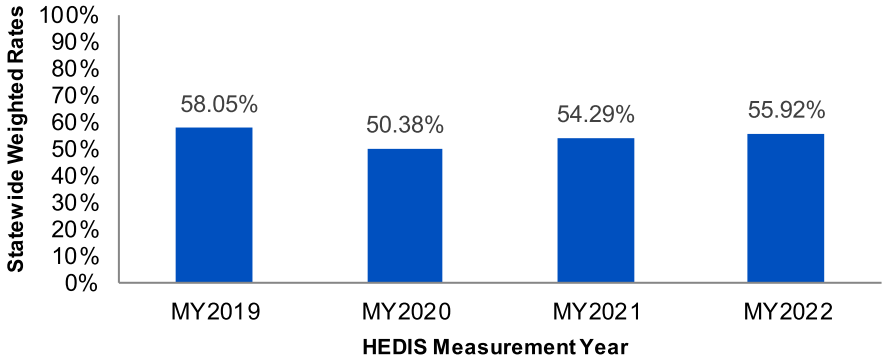
Footnote: Since age stratifications/measure indicators were changed for this measure in MY2019, trending with prior years is not possible.

Fig. 91. APM—Blood Glucose Testing: 12–17 Years



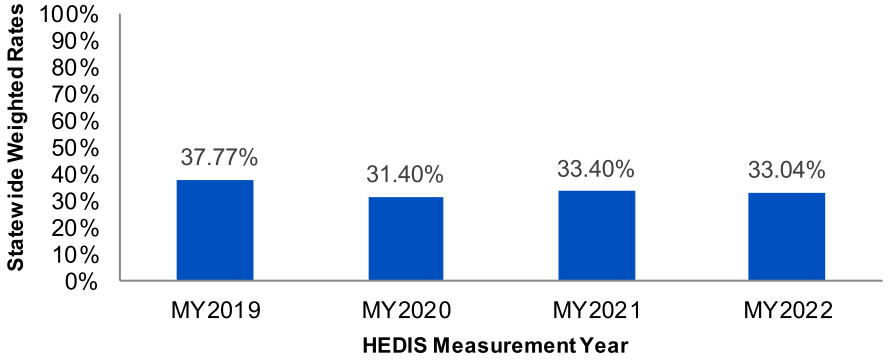
Footnote: Since age stratifications/measure indicators were changed for this measure in MY2019, trending with prior years is not possible.

Fig. 92. APM—Blood Glucose Testing: Total



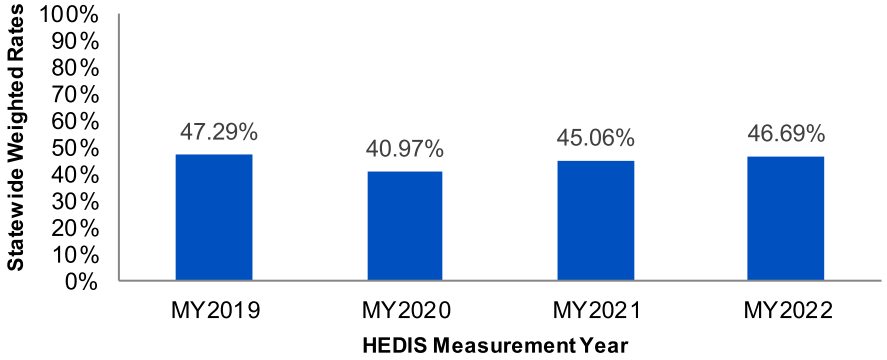
Footnote: Since age stratifications/measure indicators were changed for this measure in MY2019, trending with prior years is not possible.

Fig. 93. APM—Cholesterol Testing: 1-11 Years



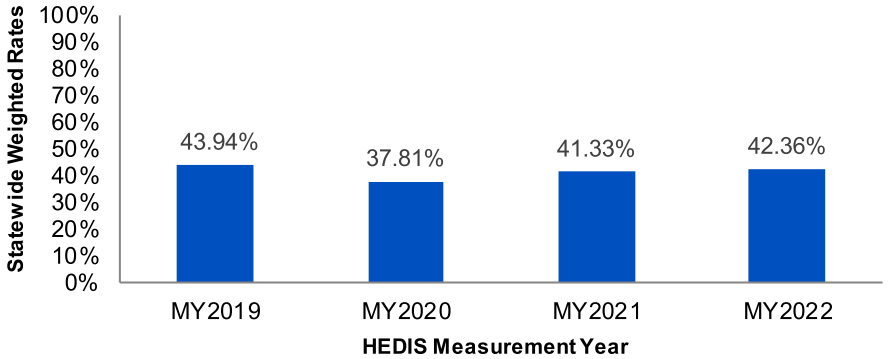
Footnote: Since age stratifications/measure indicators were changed for this measure in MY2019, trending with prior years is not possible.

Fig. 94. APM—Cholesterol Testing: 12-17 Years



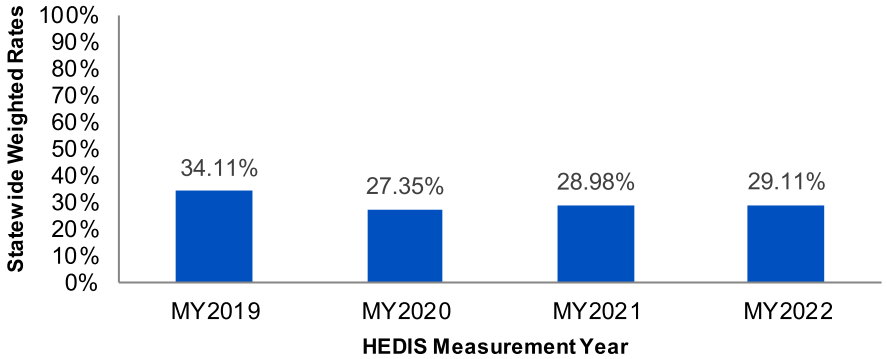
Footnote: Since age stratifications/measure indicators were changed for this measure in MY2019, trending with prior years is not possible.

Fig. 95. APM—Cholesterol Testing: Total



Footnote: Since age stratifications/measure indicators were changed for this measure in MY2019, trending with prior years is not possible.

Fig. 96. APM—Blood Glucose and Cholesterol Testing: 1-11 Years



Footnote: Since age stratifications/measure indicators were changed for this measure in MY2019, trending with prior years is not possible.

Fig. 97. APM—Blood Glucose and Cholesterol Testing: 12-17 Years

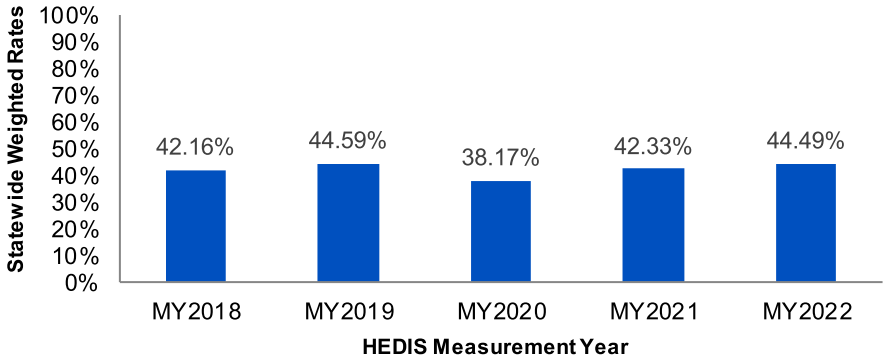
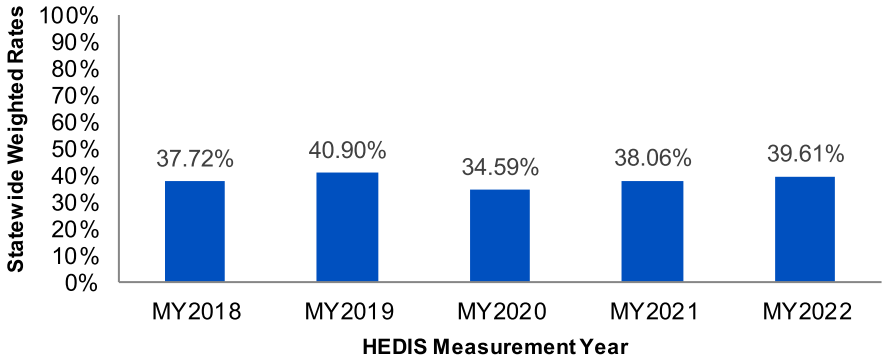
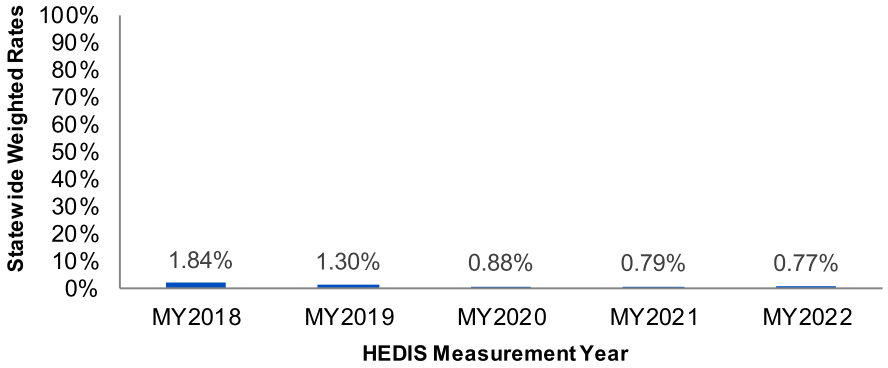


Fig. 98. APM: Blood Glucose and Cholesterol Testing: Total



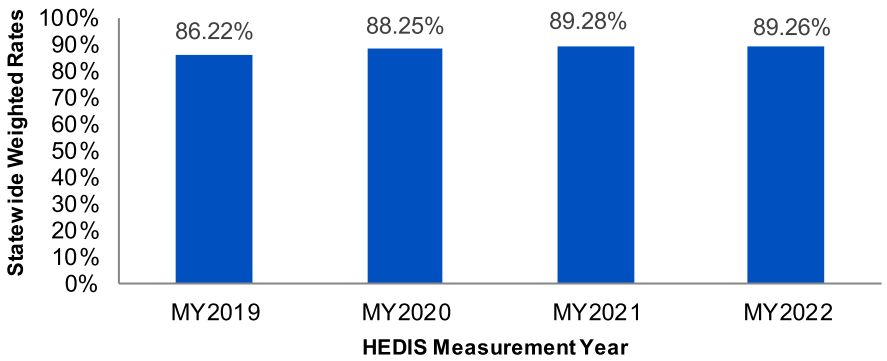
Effectiveness of Care Measures: Overuse/Appropriateness

Fig. 99. Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*



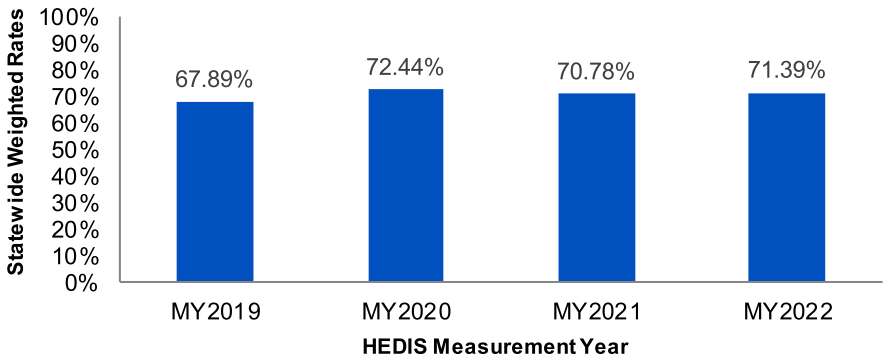
**Lower rates for this measure indicate better performance.*

Fig. 100. Appropriate Treatment for Upper Respiratory Infection (URI): 3 Months–17 Years



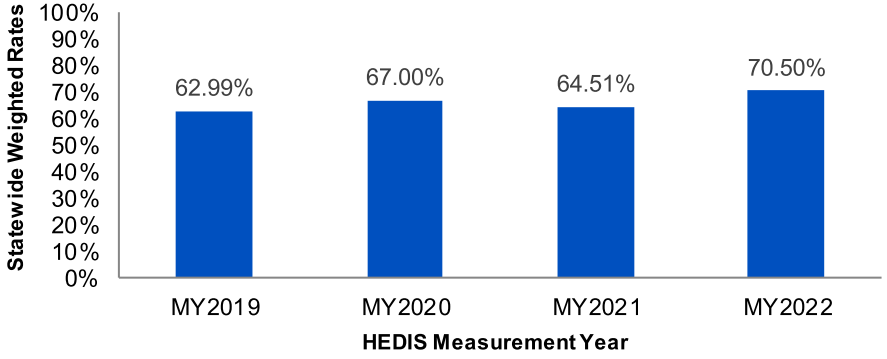
Footnote: Due to significant changes in measure specification in MY2019, NCQA indicated a break in trending to prior years.

Fig. 101. URI: 18–64 Years



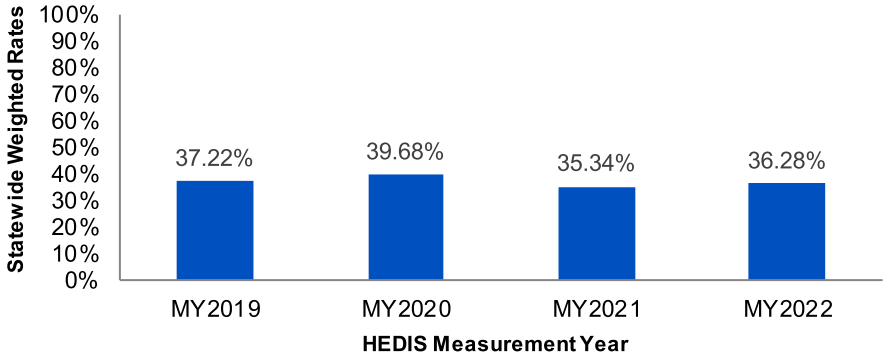
Footnote: Due to significant changes in measure specification in MY2019, NCQA indicated a break in trending to prior years.

Fig. 102. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB): 3 Months–17 Years



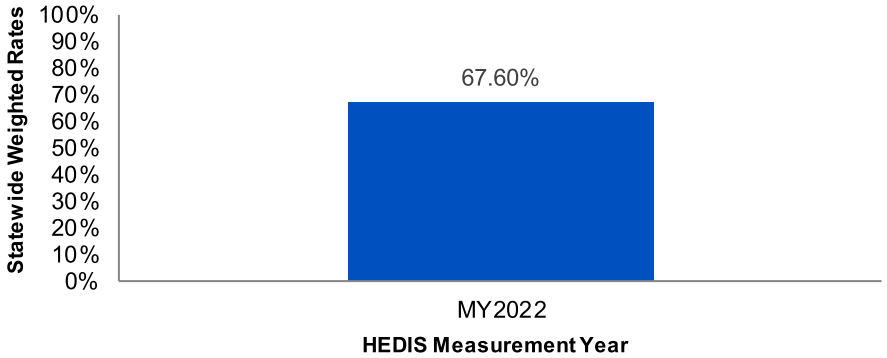
Footnote: Due to significant changes in measure specification in MY2019, NCQA indicated a break in trending to prior years.

Fig. 103. AAB: 18–64 Years



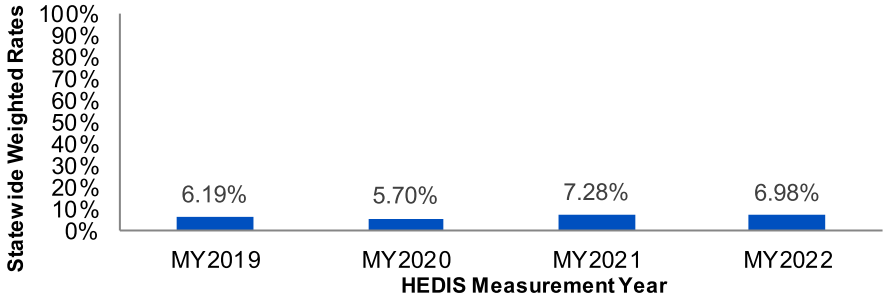
Footnote: Due to significant changes in measure specification in MY2019, NCQA indicated a break in trending to prior years.

Fig. 104. Use of Imaging Studies for Low Back Pain (LBP)



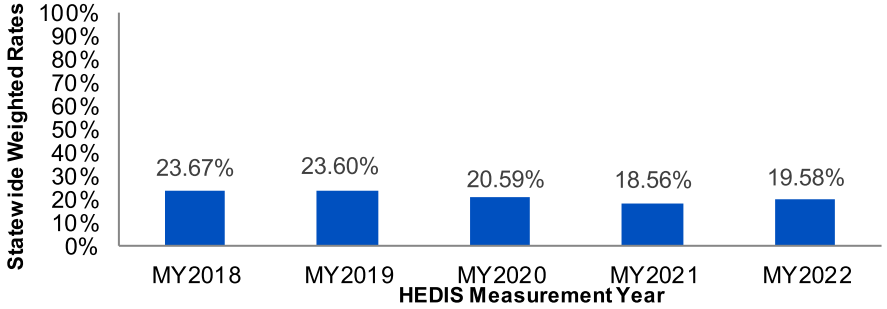
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 105. Use of Opioids at High Dosage (HDO): Total*



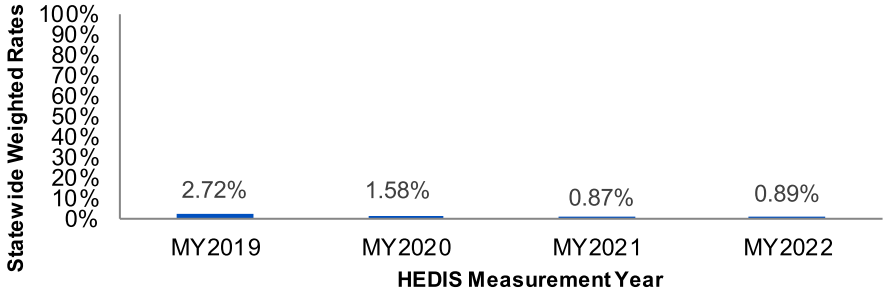
**Lower rates for this measure indicate better performance.*
Footnote: Due to significant changes in measure specification in MY2019, NCQA indicated a break in trending to prior years. NCQA also indicated that trending MY2020 with previous years should be considered with caution.

Fig. 106. Use of Opioids from Multiple Providers (UOP): Multiple Prescribers*



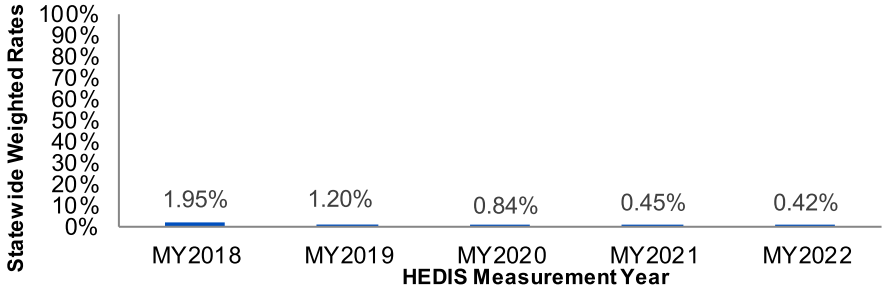
**Lower rates for this measure indicate better performance.*
Footnote: NCQA indicated a break in trending in MY2018 due to measure results being displayed as percentage. Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 107. UOP: Multiple Pharmacies*



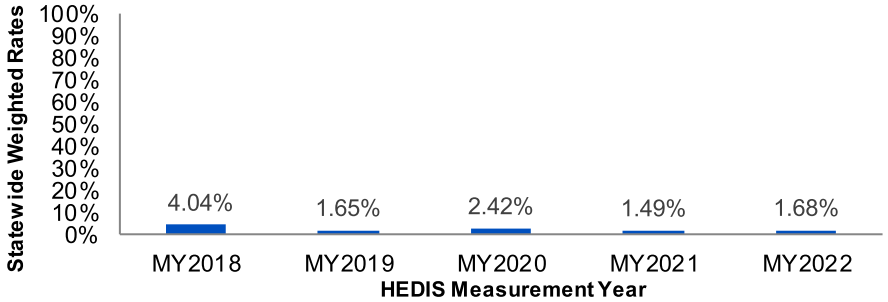
**Lower rates for this measure indicate better performance.*
Footnote: NCQA indicated a break in trending in MY2018 due to measure results being displayed as percentage. Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 108. UOP: Multiple Prescribers and Pharmacies*



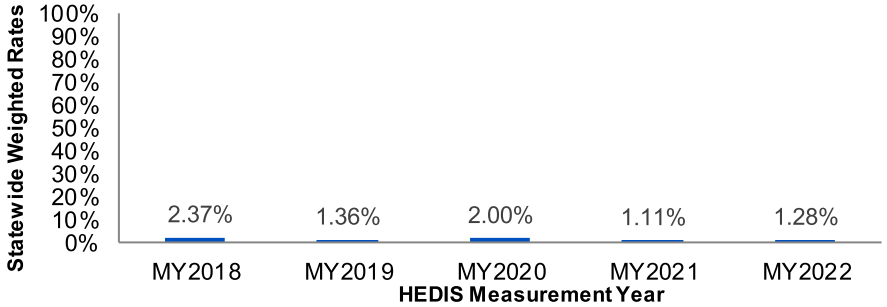
**Lower rates for this measure indicate better performance.*
Footnote: NCQA indicated a break in trending in MY2018 due to measure results being displayed as percentage. Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

Fig. 109. Risk of Continued Opioid Use (COU): ≥15 days/30-day period*



**Lower rates for this measure indicate better performance.*
Footnote: First-year measure in MY2018. Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

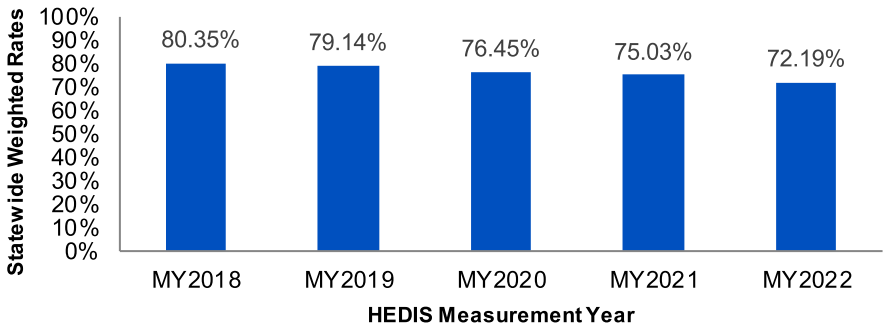
Fig. 110. COU: ≥ 31 days/62-day period*



**Lower rates for this measure indicate better performance.*
Footnote: First-year measure in MY2018. Due to changes in measure specification, NCQA indicated that trending MY2020 with previous years should be considered with caution.

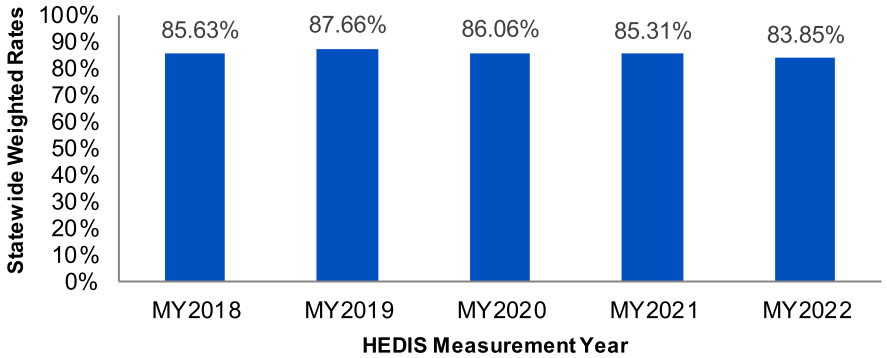
Access/Availability of Care Measures

Fig. 111. Adults' Access to Preventive/Ambulatory Health Services (AAP): 20–44 Years



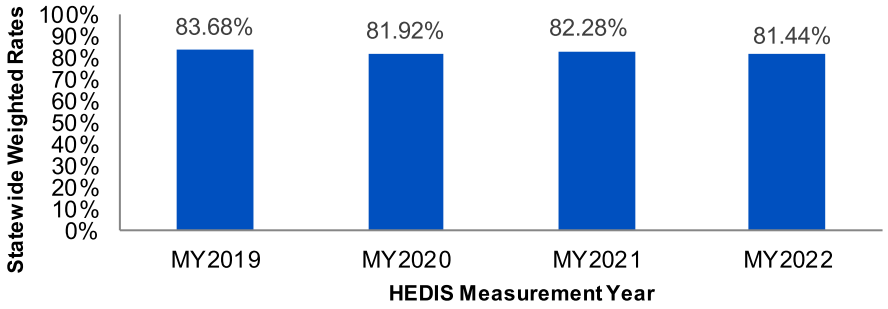
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2019 and MY2018 with previous years should be considered with caution.

Fig. 112. AAP: 45–64 Years



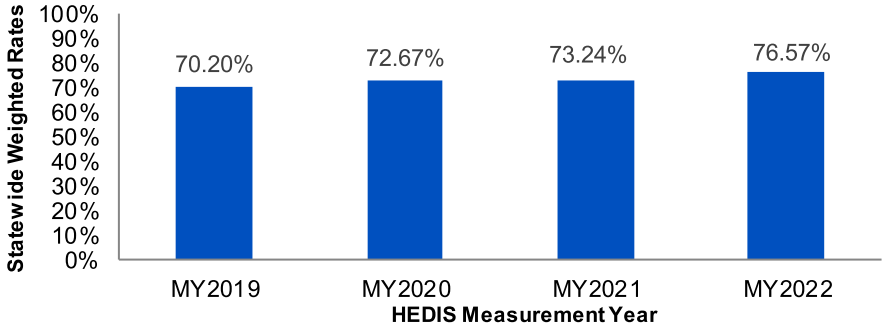
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2019 and MY2018 with previous years should be considered with caution.

Fig. 113. Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care



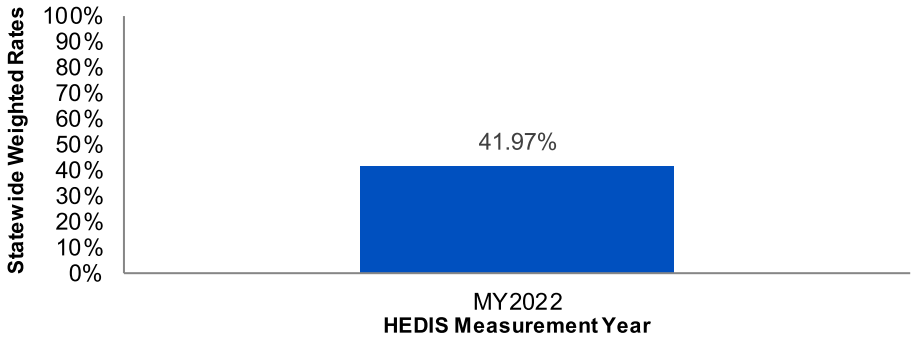
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2022 with previous years should be considered with caution.

Fig. 114. PPC: Postpartum Care



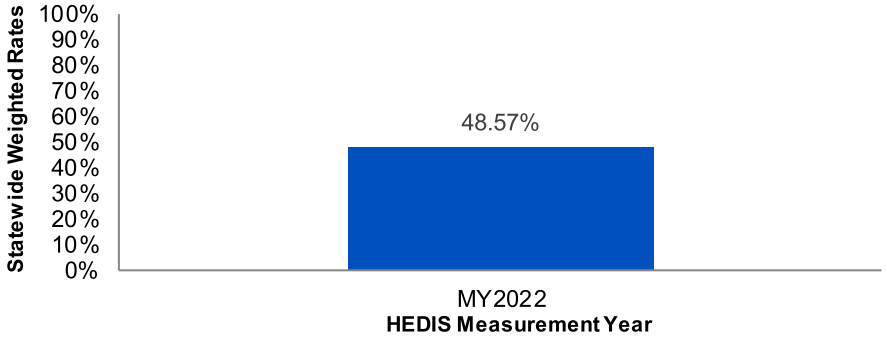
Footnote: Due to changes in measure specification, NCQA indicated that trending MY2020 and MY2022 with previous years should be considered with caution.

Fig. 115. IET—Initiation: 13-17 Years: Alcohol



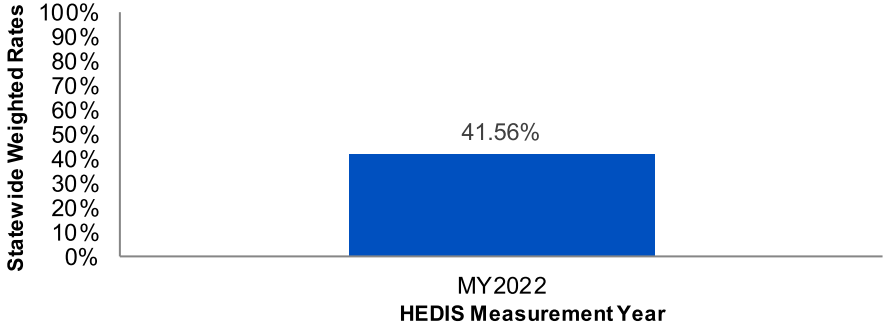
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 116. IET—Initiation: 13-17 Years: Opioid



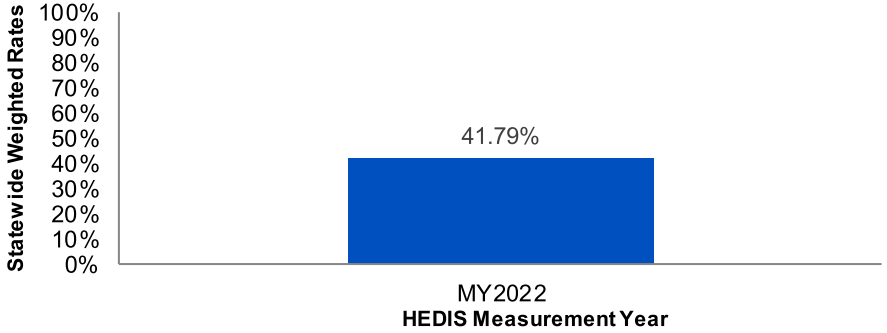
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 117. IET—Initiation: 13–17 Years: Other Drug



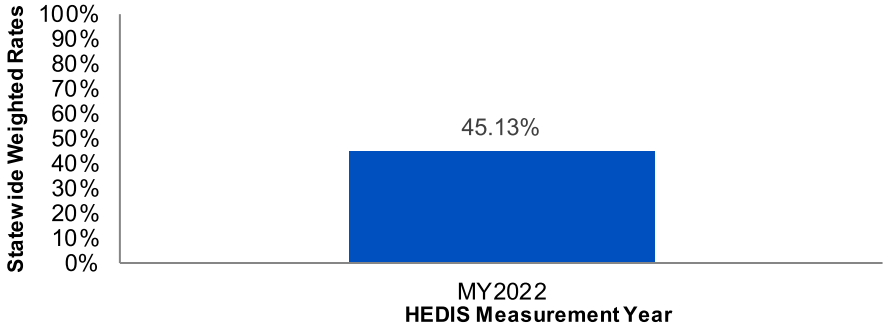
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 118. IET—Initiation: 13–17 Years: Total



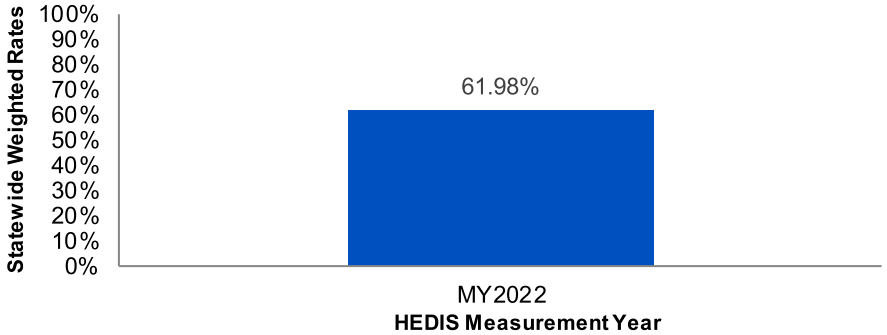
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 119. IET—Initiation: ≥18 Years: Alcohol



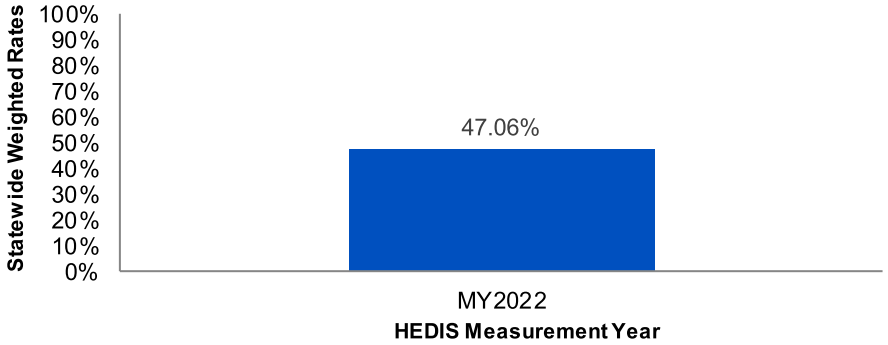
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 120. IET—Initiation: ≥18 Years: Opioid



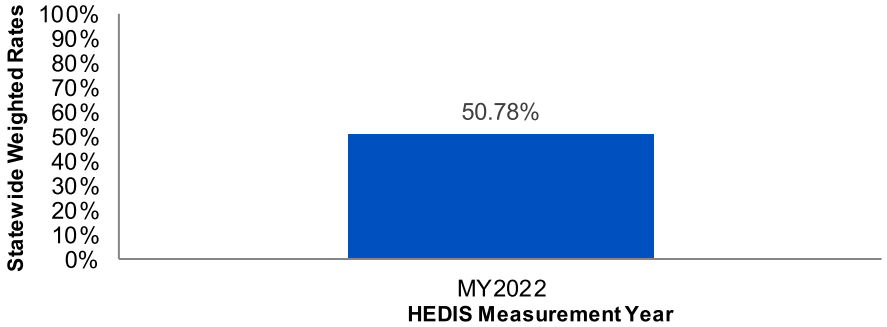
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 121. IET—Initiation: ≥18 Years: Other Drug



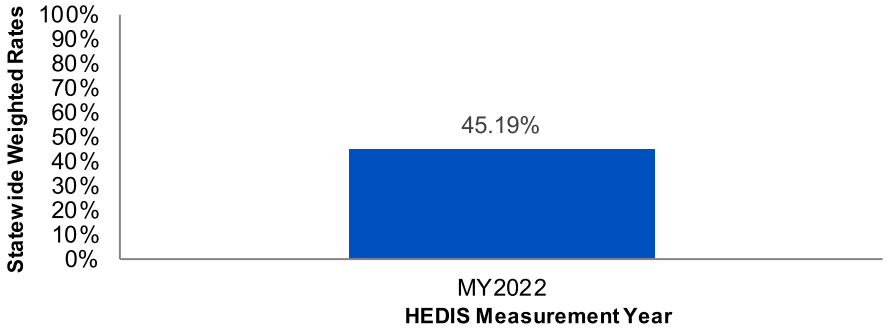
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 122. IET—Initiation: ≥18 Years Total



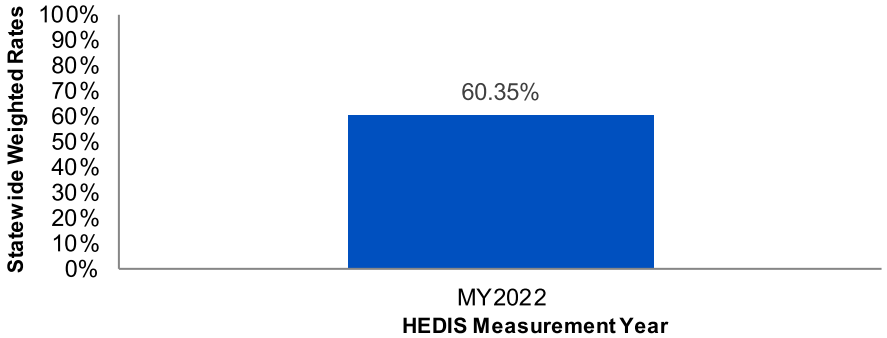
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 123. IET—Initiation: Total: Alcohol



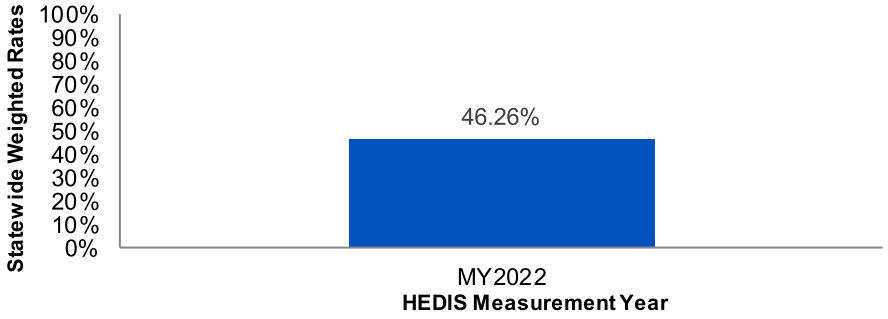
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 124. IET—Initiation: Total: Opioid



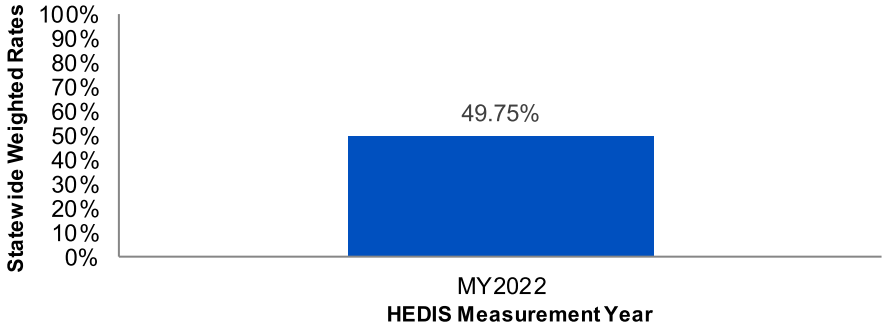
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 125. IET—Initiation: Total: Other Drug



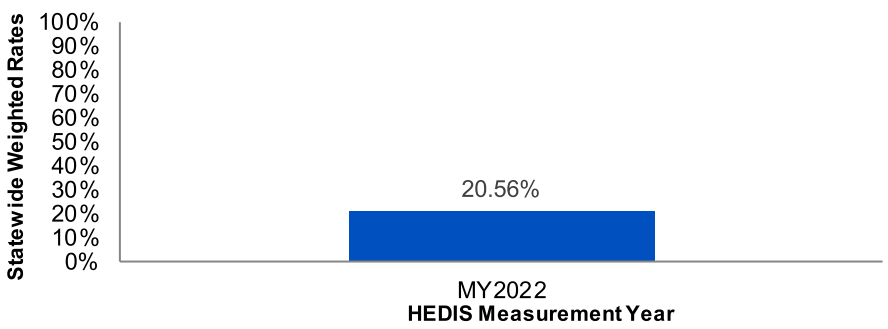
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 126. IET—Initiation: Total



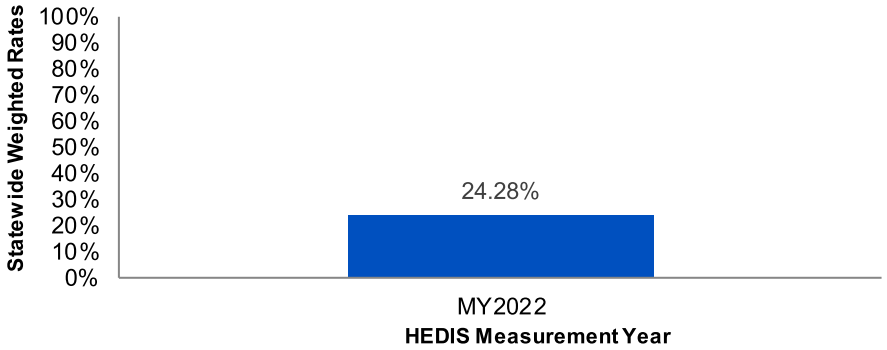
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 127. IET—Engagement: 13–17 Years: Alcohol



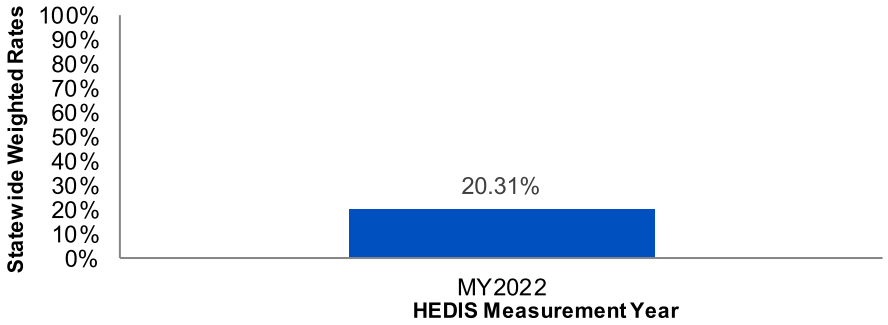
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 128. IET—Engagement: 13–17 Years: Opioid



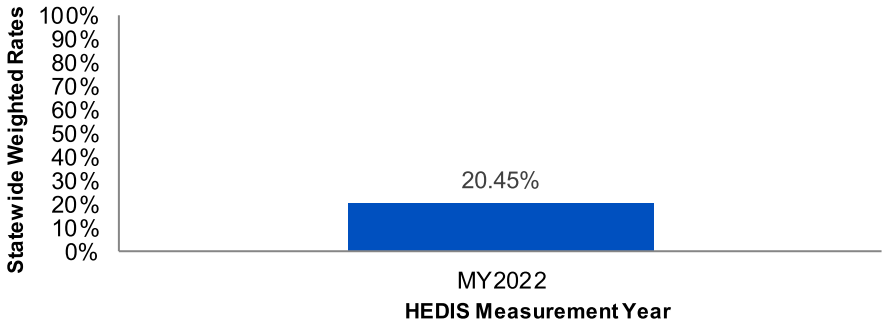
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 129. IET—Engagement: 13–17 Years: Other Drug



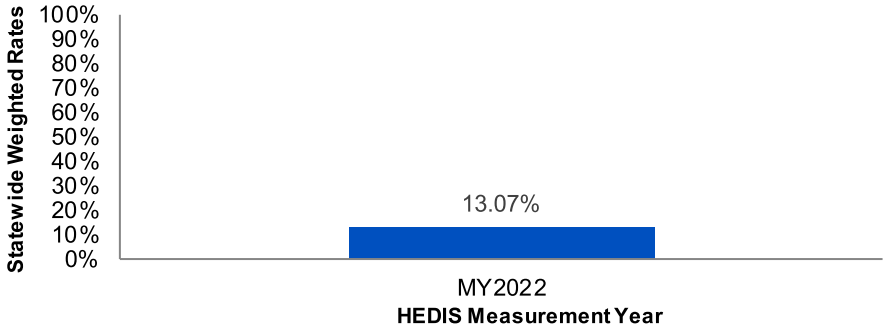
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 130. IET—Engagement: 13–17 Years: Total



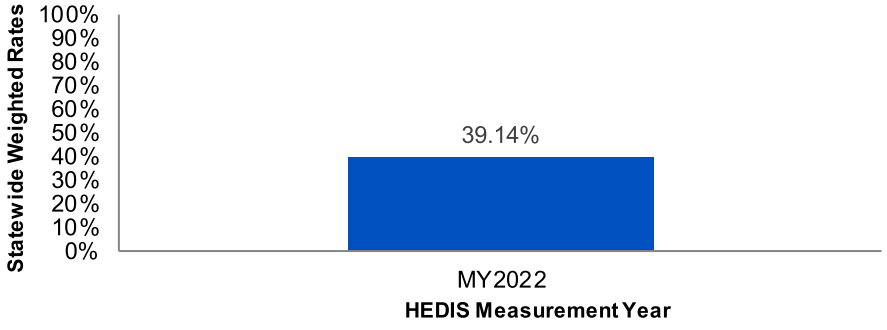
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 131. IET—Engagement: ≥18 Years: Alcohol



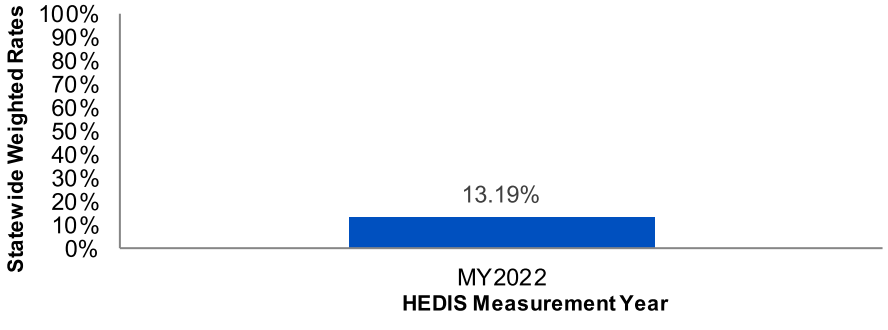
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 132. IET—Engagement: ≥18 Years: Opioid



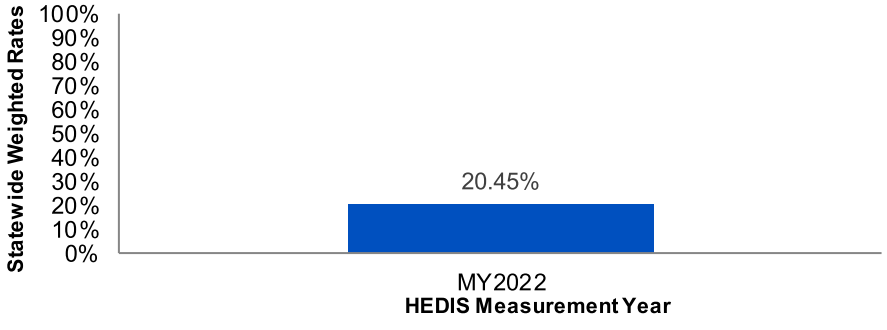
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 133. IET—Engagement: ≥18 Years: Other Drug



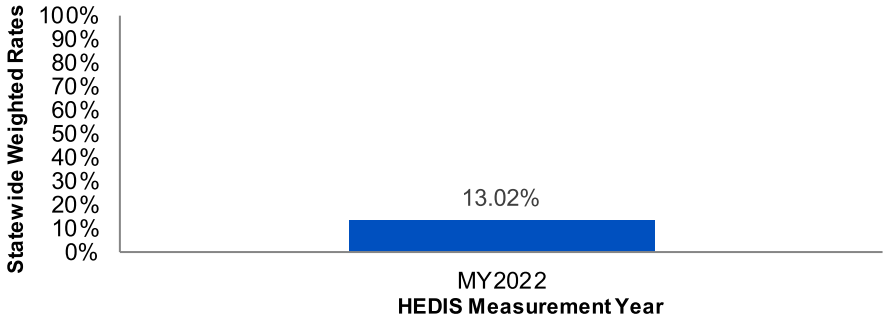
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 134. IET—Engagement: ≥18 Years: Total



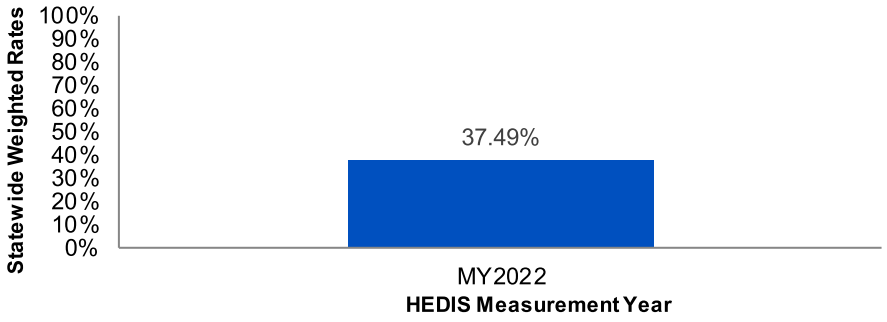
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 135. IET—Engagement: Total: Alcohol



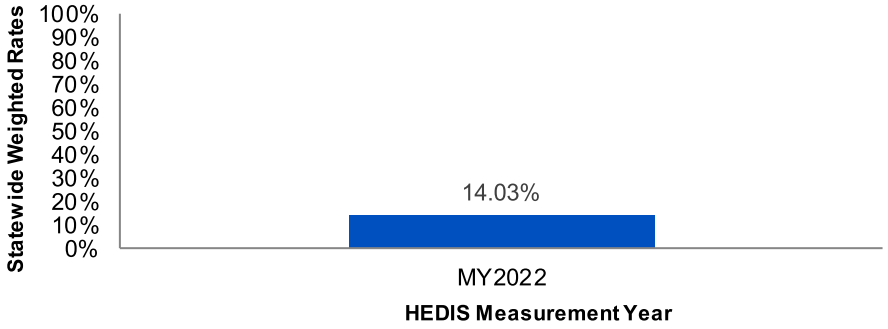
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 136. IET—Engagement: Total: Opioid



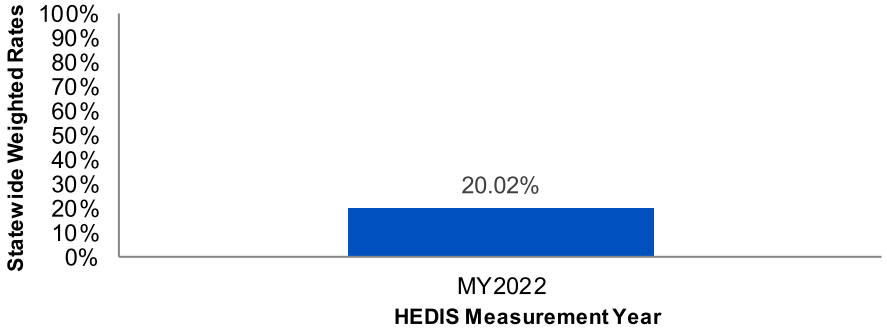
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 137. IET—Engagement: Total: Other Drug



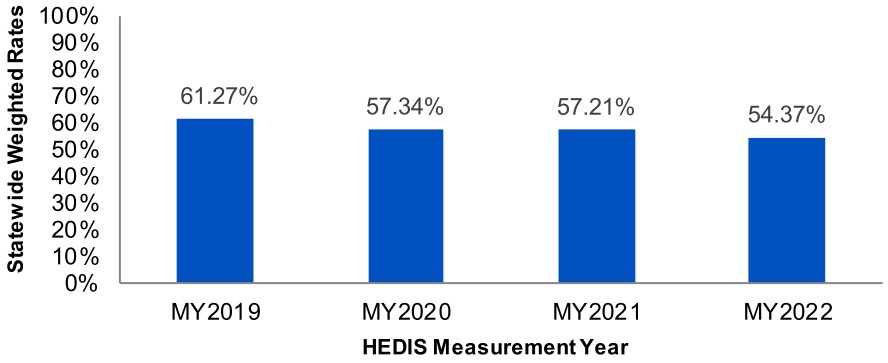
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 138. IET—Engagement: Total



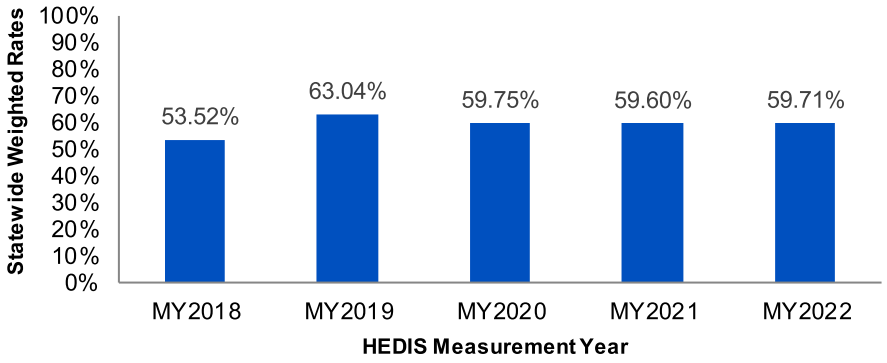
Footnote: Due to significant changes in measure specification in MY2022, NCQA indicated a break in trending to prior years.

Fig. 139. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP): 1–11 Years



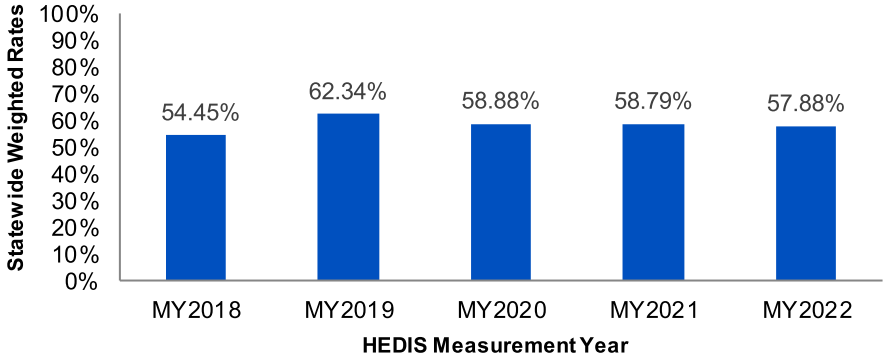
Footnote: Due to changes in the age stratification, trending between MY2019 and previous years is not possible.

Fig. 140. APP: 12–17 Years



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2019 with previous years should be considered with caution.

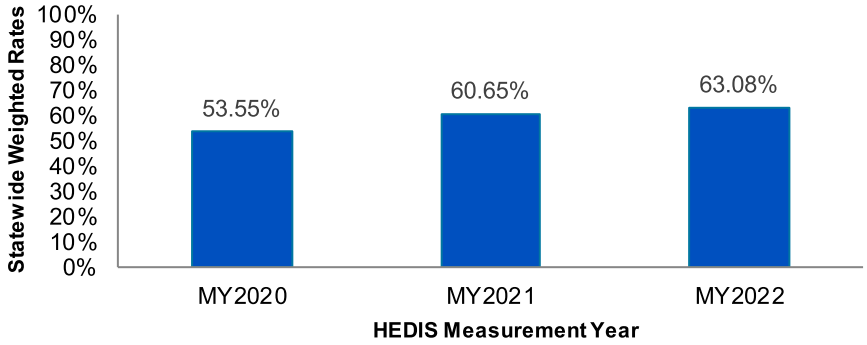
Fig. 141. APP: Total



Footnote: Due to changes in measure specification, NCQA indicated that trending MY2019 with previous years should be considered with caution.

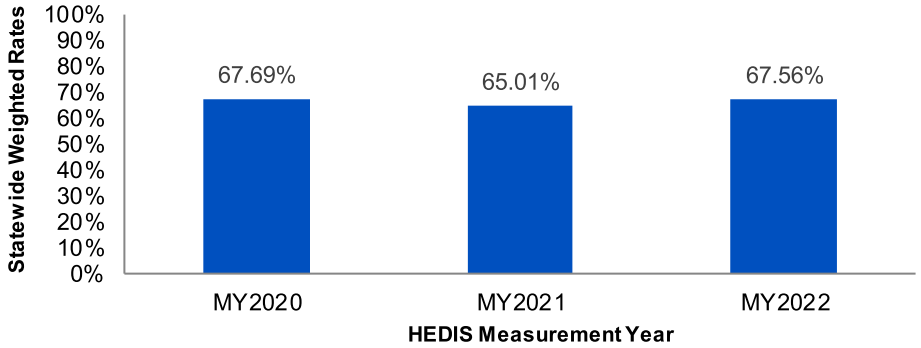
Utilization and Risk-Adjusted Utilization

Fig. 142. Well-Child Visits in the First 30 Months of Life (W30): First 15 Months



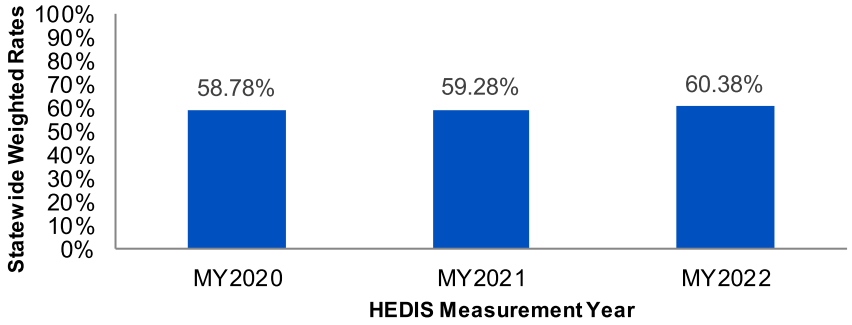
Footnote: NCQA indicated that W34 and AWC measures were combined as WCV measure. Due to significant changes in measure specification in MY2020, NCQA indicated a break in trending to prior years.

Fig. 143. Well-Child Visits in the First 30 Months of Life (W30): 15-30 Months



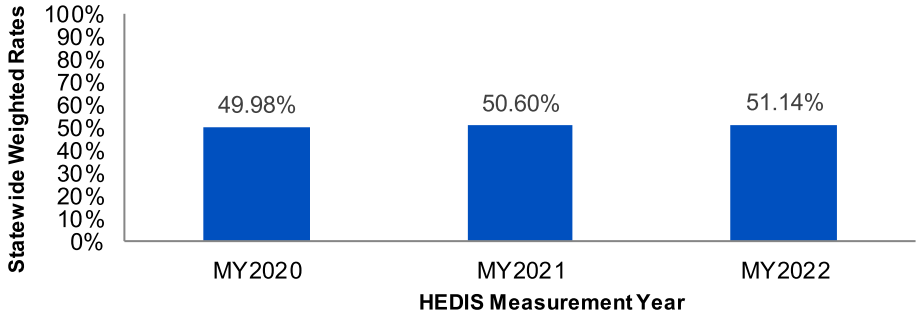
Footnote: NCQA added a new indicator for MY2020.

Fig. 144. Child and Adolescent Well-Care Visits (WCV): 3-11 years



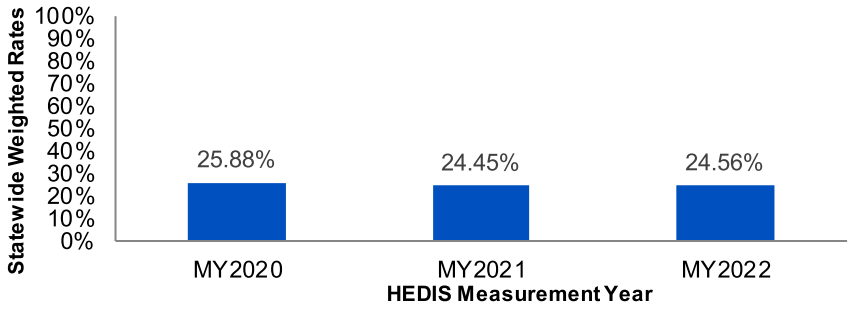
Footnote: NCQA indicated that W34 and AWC measures were combined as WCV measure. Due to significant changes in measure specification in MY2020, NCQA indicated a break in trending to prior years.

Fig. 145. Child and Adolescent Well-Care Visits (WCV): 12-17 years



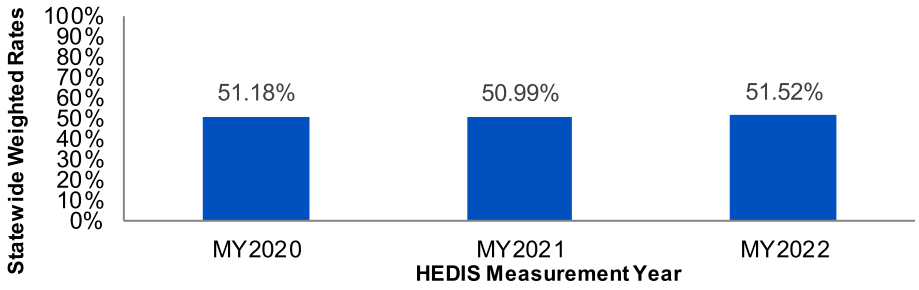
Footnote: NCQA indicated that W34 and AWC measures were combined as WCV measure. Due to significant changes in measure specification in MY2020, NCQA indicated a break in trending to prior years.

Fig. 146. Child and Adolescent Well-Care Visits (WCV): 18-21 Years



Footnote: NCQA indicated that W34 and AWC measures were combined as WCV measure. Due to significant changes in measure specification in MY2020, NCQA indicated a break in trending to prior years.

Fig. 147. Child and Adolescent Well-Care Visits (WCV): Total



Footnote: NCQA indicated that W34 and AWC measures were combined as WCV measure. Due to significant changes in measure specification in MY2020, NCQA indicated a break in trending to prior years.

APPENDIX A | Medicaid Utilization Results

Additional Utilization Measure Descriptions

Frequency of Selected Procedure (FSP)

FSP summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.

Ambulatory Care (AMB)

AMB summarizes utilization of ambulatory care in the following categories:

- ED Visits
- Outpatient Visits including telehealth

Inpatient Utilization – General Hospital/Acute Care (IPU)

IPU summarizes utilization of acute IP care and services in the following categories:

- Total IP
- Medicine
- Surgery
- Maternity

Utilization Measures: Medicaid Plan-Specific Rates

In **Table A1**, cells are shaded gray for those measures that were not calculated or for which data were not reported.

Table A1. HEDIS MY2022 Medicaid Plan-Specific Rates: Utilization Measures

Measure by Age	Sex	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Frequency of Selected Procedures (FSP)[1]											
Bariatric Weight Loss Surgery: Procedures/1,000 Member Years											
0–19	M	0.02	0.00	0.00	0.03	0.00	0.02	0.05	0.00	0.00	0.00
20–44		0.40	0.42	0.00	0.71	0.46	0.45	0.00	0.84	0.41	0.24
45–64		0.43	0.15	0.00	0.58	0.61	0.00	0.00	0.38	1.31	0.39
0–19	F	0.02	0.02	0.05	0.03	0.00	0.05	0.00	0.00	0.00	0.00
20–44		2.85	2.58	2.30	3.76	2.32	2.52	0.32	3.26	2.62	2.63
45–64		2.16	2.34	1.73	2.34	2.50	3.21	0.00	2.47	3.26	2.84
Tonsillectomy: Procedures/1,000 Member Years											
0–9	M&F	11.78	8.90	4.30	12.65	9.39	5.68	10.91	11.54	8.47	4.55
10–19		4.69	2.60	2.02	5.15	2.93	2.25	2.11	5.19	2.87	2.15
Hysterectomy—Abdominal (A) and Vaginal (V): Procedures/1,000 Member Years											
15–44 (A)	F	0.42	0.75	0.98	0.75	0.72	1.39	0.00	0.81	0.51	0.75
45–64 (A)		1.02	0.96	1.30	0.97	1.75	2.84	0.00	0.68	1.05	1.81
15–44 (V)	F	1.48	0.69	0.98	1.80	0.97	1.67	0.00	2.02	0.95	0.54
45–64 (V)		1.70	0.75	0.43	2.02	1.00	2.47	0.00	1.11	1.53	0.90
Cholecystectomy—Open (O) and Closed (C)/Laparoscopic: Procedures/1,000 Member Years											
30–64 (O)	M	0.07	0.07	0.34	0.45	0.20	0.28	0.00	0.22	0.38	0.44
15–44 (O)	F	0.07	0.00	0.05	0.05	0.06	0.07	0.14	0.05	0.02	0.09
45–64 (O)		0.57	0.21	0.58	0.32	0.37	0.12	0.00	0.77	0.10	0.00
30–64 (C)	M	4.07	3.12	1.93	4.60	3.03	2.48	2.20	4.34	3.43	1.99

Table A1. HEDIS MY2022 Medicaid Plan-Specific Rates: Utilization Measures											
15–44 (C)	F	8.14	6.48	4.56	9.96	7.70	5.45	3.83	9.37	7.46	4.40
45–64 (C)		6.81	5.75	4.48	7.59	6.62	4.20	4.27	6.65	8.15	5.69
Back Surgery: Procedures/1,000 Member Years											
20–44	M	1.11	1.82	1.44	2.42	3.23	1.69	0.00	2.51	2.86	1.07
	F	1.71	2.06	0.81	1.96	2.37	0.97	0.32	2.27	2.26	1.14
45–64	M	4.12	10.71	7.26	6.21	9.78	3.50	3.03	6.54	12.83	3.66
	F	5.33	8.30	2.75	7.59	12.62	5.81	0.00	10.83	12.94	4.27
Mastectomy: Procedures/1,000 Member Years											
15–44	F	0.16	0.31	0.41	0.34	0.23	0.42	0.00	0.18	0.38	0.24
45–64		1.93	1.92	1.16	4.20	2.87	3.95	4.27	1.88	3.64	1.68
Lumpectomy: Procedures/1,000 Member Years											
15–44	F	0.63	0.89	0.73	0.94	0.99	1.16	0.71	0.79	0.74	0.84
45–64		2.50	1.70	1.88	5.09	3.87	4.69	0.00	2.81	3.07	1.94
Measure		**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
Ambulatory Care: Total (AMB)[1]											
Total: Visits/1,000 Member Months											
Outpatient		3810.48	3993.02	3185.34	4932.37	4007.22	4002.54	3479.17	4915.31	4604.55	3808.12
ED		598.25	574.03	556.85	631.96	622.95	658.18	461.90	628.73	633.73	639.07
Dual Total: Visits/1,000 Member Months											
Outpatient		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
ED		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Disabled Total: Visits/1,000 Member Months											
Outpatient		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
ED		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table A1. HEDIS MY2022 Medicaid Plan-Specific Rates: Utilization Measures

Inpatient Utilization—General Hospital/Acute Care: Total (IPU)[1]										
Total Inpatient										
Per 1,000 Member Months										
Discharges	61.94	65.87	64.13	74.78	71.41	76.75	54.44	79.96	74.29	71.71
Days	295.26	309.22	352.12	329.71	309.72	348.77	373.90	421.65	355.48	428.31
Length of Stay (LoS): Average # of Days										
Average LoS	4.77	4.69	5.49	4.41	4.34	4.54	6.87	5.27	4.79	5.97
Medicine										
Per 1,000 Member Months										
Discharges	25.31	25.38	23.19	31.23	26.44	27.31	34.98	39.98	33.24	32.73
Days	133.51	132.75	117.92	144.98	122.71	128.15	198.39	226.44	183.87	201.15
LoS: Average # of Days										
Average LoS	5.27	5.23	5.09	4.64	4.64	4.69	5.67	5.66	5.53	6.15
Surgery										
Per 1,000 Member Months										
Discharges	12.67	11.49	14.98	13.70	12.16	14.51	14.40	16.84	12.88	15.75
Days	104.03	96.81	168.59	116.71	102.58	137.30	160.62	141.11	99.41	169.09
LoS: Average # of Days										
Average LoS	8.21	8.42	11.26	8.52	8.44	9.46	11.15	8.38	7.72	10.74
Maternity										
Per 1,000 Member Months										
Discharges	34.29	43.81	38.08	45.91	50.84	54.21	7.60	33.62	43.56	35.29
Days	82.61	120.35	96.23	104.62	130.82	129.29	22.39	78.59	111.63	88.20
LoS: Average # of Days										
Average LoS	2.41	2.75	2.53	2.28	2.57	2.39	2.94	2.34	2.56	2.50

[1] *NCQA indicated a break in trending to prior years due to significant changes in measure specifications for MY2022.*

As a Risk-Adjusted Utilization measure, PCR rates in **Table A2** represent percentages of members who were readmitted for any diagnosis within 30 days of discharge from a hospital, broken into age stratifications.

Table A2. HEDIS MY2022 Plan All-Cause Readmissions (PCR)

Measure by Age	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Plan Population: Observed Readmission Rate										
18-44	9.55%	9.63%	10.50%	7.79%	8.63%	7.99%	10.26%	8.91%	8.64%	10.89%
45-54	13.28%	14.14%	13.82%	9.88%	10.44%	9.27%	15%	12.61%	11.04%	13.33%
55-64	12.30%	14.71%	14.69%	10.79%	10.85%	11.23%	17.39%	13.08%	12.77%	12.61%
Total	**10.98%**	**11.62%**	**12.18%**	**8.91%**	**9.44%**	**8.93%**	**11.11%**	**10.80%**	**10.09%**	**11.82%**

APPENDIX B | Medicaid MCO Population

Table B1. HEDIS MY2022 Medicaid MCO Population Reported in Member Months and Years by Age

Age Group	Months/Years	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
<1	Years	3,770	5,840	3,555	7,290	6,016	5,390	641	3,773	5,841	3,521
	Months	45,240	70,081	42,662	87,483	72,191	64,674	7,693	45,272	70,093	42,253
1–4	Years	16,349	25,323	15,363	30,084	24,931	22,200	4,591	15,692	24,005	15,136
	Months	196,187	303,876	184,357	361,013	299,171	266,394	55,086	188,307	288,058	181,629
5–9	Years	23,165	30,669	21,115	31,306	26,968	21,695	7,882	20,142	28,265	19,561
	Months	277,982	368,033	253,374	375,669	323,615	260,335	94,586	241,701	339,179	234,733
10–14	Years	21,793	28,955	21,140	27,792	25,240	20,127	9,602	20,674	25,716	18,327
	Months	261,513	347,455	253,674	333,501	302,876	241,524	115,220	248,089	308,592	219,924
15–17	Years	13,677	15,273	11,140	15,364	15,066	11,023	6,914	11,532	13,680	9,739
	Months	164,127	183,272	133,681	184,373	180,796	132,279	82,968	138,383	164,154	116,871
18–19	Years	8,450	8,910	6,873	9,057	8,519	6,208	3,373	6,877	7,609	5,406
	Months	101,404	106,923	82,470	108,686	102,223	74,500	40,480	82,529	91,306	64,866
20–24	Years	11,887	15,716	10,137	16,537	12,571	12,450	2,738	11,388	12,709	9,214
	Months	142,645	188,595	121,642	198,448	150,854	149,400	32,853	136,657	152,508	110,569
25–29	Years	8,148	10,270	7,497	12,152	9,234	8,601	715	6,870	8,625	6,319
	Months	97,775	123,237	89,968	145,824	110,808	103,213	8,585	82,437	103,505	75,829
30–34	Years	9,562	11,836	9,155	12,342	9,944	8,210	777	8,422	10,052	7,328
	Months	114,738	142,037	109,861	148,103	119,332	98,515	9,318	101,063	120,624	87,935
35–39	Years	8,133	10,420	6,931	10,726	8,284	7,420	654	7,520	9,364	5,682
	Months	97,596	125,044	83,168	128,717	99,408	89,035	7,851	90,242	112,371	68,188
40–44	Years	6,557	8,676	4,897	8,834	6,230	6,351	486	6,903	8,133	5,386
	Months	78,682	104,106	58,767	106,004	74,760	76,211	5,835	82,839	97,601	64,627
45–49	Years	4,626	5,422	3,375	6,111	4,028	3,854	276	5,301	5,164	3,657
	Months	55,506	65,066	40,502	73,328	48,331	46,243	3,317	63,611	61,968	43,886

Table B1. HEDIS MY2022 Medicaid MCO Population Reported in Member Months and Years by Age											
50–54	Years	4,009	3,936	2,869	4,993	3,399	2,878	203	4,976	4,316	2,987
	Months	48,109	47,227	34,429	59,914	40,791	34,541	2,437	59,706	51,792	35,849
55–59	Years	4,004	3,566	2,950	4,453	2,973	2,628	177	4,931	4,152	3,213
	Months	48,044	42,788	35,396	53,434	35,678	31,541	2,129	59,169	49,822	38,560
60–64	Years	3,332	3,088	2,735	3,926	2,593	2,488	146	4,448	3,754	3,122
	Months	39,982	37,056	32,824	47,111	31,116	29,859	1750	53,372	45,048	37,459
65–69	Years	881	1,171	1,002	1,255	799	851	11	2,350	1,698	1,580
	Months	10,576	14,054	12,029	15,063	9,589	10,207	132	28,194	20,374	18,954
70–74	Years	380	621	471	574	263	336	2	1,467	929	857
	Months	4,555	7,450	5,647	6,893	3,157	4,028	19	17,608	11,143	10,278
75–79	Years	173	381	185	322	164	196	2	927	574	523
	Months	2081	4,568	2215	3,868	1,967	2,349	24	11,127	6,893	6,271
80–84	Years	99	198	77	195	133	97	2	492	292	297
	Months	1192	2,376	926	2,340	1598	1163	25	5,898	3,506	3,566
85–89	Years	54	118	47	93	66	82	0	259	171	140
	Months	652	1415	563	1110	796	981	1	3,110	2,052	1,678
≥90	Years	20	43	29	52	56	39	0	124	99	90
	Months	236	514	345	627	666	471	0	1,486	1184	1079
Total	**Years**	**149,069**	**190,431**	**131,542**	**203,459**	**167,477**	**143,122**	**39,192**	**145,067**	**175,148**	**122,084**
	Months	**1,788,822**	**2,285,173**	**1,578,500**	**2,441,509**	**2,009,723**	**1,717,463**	**470,309**	**1,740,800**	**2,101,773**	**1,465,004**

APPENDIX C | ECDS and LTSS Measure Results

Table C1 presents MCO results for HEDIS MY2022 ECDS measures.

Table C1. HEDIS MY2022 Medicaid Plan-Specific Rates: ECDS Measures

Measure	AGE	AGM	AGW	BCE	BCM	BCW	TCS	UHCE	UHCM	UHCW
Breast Cancer Screening (BCS-E)	37.78%	44.53%	44.35%	51.34%	48.61%	53.82%	23.20%	50.32%	49.13%	51.41%
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E):										
Initiation Phase	48.31%	45.20%	42.21%	51.45%	43.61%	44.93%	46.97%	46.94%	44.21%	43.22%
Continuation and Maintenance Phase	58.04%	59.33%	54.37%	60.16%	50.36%	66.88%	60.49%	57.14%	53.31%	54.61%
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)										
Depression Screening										
12–17 years	0.00%	0.00%	0.00%	1.43%	1.72%	1.25%	0.42%	0.62%	0.37%	0.22%
18–64 years	0.00%	0.00%	0.00%	2.34%	2.56%	2.24%	0.48%	0.62%	1.03%	0.67%
Follow-Up on Positive Screen										
12–17 years	NA	NA	NA	47.62%	27.78%	33.33%	33.33%	72.73%	84.62%	50.00%
18–64 years	NA	NA	NA	33.33%	17.83%	24.32%	0.00%	78.38%	72.06%	50.00%
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)										
Assessment Period 1										
12–17 years	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
18–44 years	0.00%	0.00%	0.00%	0.02%	0.00%	0.40%	0.00%	0.07%	0.04%	0.08%
45–64 years	0.00%	0.00%	0.00%	0.00%	0.00%	0.52%	0.00%	0.04%	0.00%	0.00%
65 years and older	0.00%	0.00%	0.00%	0.00%	0.00%	1.30%	NA	0.00%	0.00%	0.00%
Assessment Period 2										
12–17 years	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
18–44 years	0.00%	0.00%	0.00%	0.00%	0.00%	0.55%	0.78%	0.00%	0.11%	0.00%
45–64 years	0.00%	0.00%	0.00%	0.00%	0.00%	1.03%	0.00%	0.04%	0.06%	0.00%
65 years and older	0.00%	0.00%	0.00%	0.00%	0.00%	2.04%	NA	0.27%	0.28%	0.00%
Assessment Period 3										

Table C1. HEDIS MY2022 Medicaid Plan-Specific Rates: ECDS Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
12–17 years	0.00%	0.00%	0.00%	0.00%	0.00%	0.17%	0.00%	2.50%	1.02%	0.67%
18–44 years	0.00%	0.00%	0.00%	0.00%	0.00%	0.16%	0.00%	2.74%	3.52%	0.50%
45–64 years	0.00%	0.00%	0.00%	0.05%	0.00%	0.42%	0.00%	2.20%	2.85%	1.23%
65 years and older	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.72%	1.91%	1.30%
Depression Remission or Response for Adolescents and Adults (DRR-E)										
Follow-Up:										
12–17 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
18–44 years	NA	NA	NA	NA	NA	NA	NA	NA	0%	NA
45–64 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
65 years and older	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Depression Remission:										
12–17 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
18–44 years	NA	NA	NA	NA	NA	NA	NA	NA	0%	NA
45–64 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
65 years and older	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Depression Response										
12–17 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
18–44 years	NA	NA	NA	NA	NA	NA	NA	NA	0%	NA
45–64 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
65 years and older	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)										
Alcohol Use Screening										
3–17 years	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
18–64 years	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
65 years and older	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Counseling or Other Follow-up Positive Screen										
3–17 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table C1. HEDIS MY2022 Medicaid Plan-Specific Rates: ECDS Measures										
Measure	**AGE**	**AGM**	**AGW**	**BCE**	**BCM**	**BCW**	**TCS**	**UHCE**	**UHCM**	**UHCW**
18–64 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
65 years and older	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Adult Immunization Status (AIS-E)										
Influenza	5.87%	6.44%	4.55%	8.41%	8.24%	7.13%	5.13%	13.36%	12.23%	9.24%
Td or Tdap	28.47%	30.42%	27.34%	44.60%	39.69%	40.22%	30.73%	34.45%	32.95%	28.50%
Zoster	0.77%	0.77%	0.52%	1.58%	1.49%	0.96%	0.49%	5.10%	4.65%	2.92%
Pneumococcal	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Prenatal Immunization Status (PRS-E)										
Influenza	17.40%	18.08%	9.50%	23.40%	21.55%	13.67%	16.34%	20.46%	19.83%	13.00%
Tdap	47.96%	48.48%	35.13%	54.63%	51.15%	41.37%	43.14%	54.51%	51.60%	35.42%
Combination	14.35%	15.28%	7.35%	19.41%	17.65%	10.38%	13.73%	16.92%	16.61%	10.11%
Prenatal Depression Screening and Follow-Up (PND-E)										
Depression Screening	0.00%	0.00%	0.00%	13.14%	14.90%	12.94%	5.88%	0.00%	0.12%	0.43%
Follow-Up on Positive Screen	NA	NA	NA	15.87%	17.02%	5.45%	NA	NA	50.00%	NA
Postpartum Depression Screening and Follow-Up (PDS-E)										
Depression Screening	0.00%	0.00%	0.00%	6.27%	5.65%	5.76%	1.02%	0.03%	0.06%	0.00%
Follow-Up on Positive Screen	NA	NA	NA	52.46%	22.22%	36.67%	100.00%	NA	NA	NA

Note: NA indicates no calculable data reported for a measure.

Table C2 presents statewide MCO results for HEDIS MY2022 LTSS measures. *Note: TCS does not have members who receive LTSS.*

Table C2. HEDIS MY2022 Medicaid Plan-Specific Rates: LTSS Measures			
Measure	**AG**	**BC**	**UHC**
Comprehensive Assessment and Update (LTSS-CAU)			
Assessment of Core Elements	100.00%	98.96%	89.58%
Assessment of Supplemental Elements	100.00%	98.96%	89.58%
Comprehensive Care Plan and Update (LTSS-CPU)			
Care Plan with Core Elements Documented	98.96%	96.88%	85.42%

Table C2. HEDIS MY2022 Medicaid Plan-Specific Rates: LTSS Measures			
Measure	**AG**	**BC**	**UHC**
Care Plan with Supplemental Elements Documented	98.96%	96.88%	85.42%
Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)			
Reassessment After Inpatient Discharge	84.38%	60.42%	18.75%
Reassessment and Care Plan Update After Inpatient Discharge	76.04%	60.42%	8.33%
Shared Care Plan With Primary Care Practitioner (LTSS-SCP)	100.00%	76.04%	68.75%

Attachment K:
The Impact of TennCare: A Survey of Recipients, 2023

THE IMPACT OF TENNCARE

A Survey of Recipients, 2023

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The Impact of TennCare: A Survey of Recipients, 2023

Method

The Boyd Center for Business and Economic Research at the University of Tennessee, under contract with the Department of Finance and Administration of the State of Tennessee, conducted a survey of Tennessee residents to ascertain their insurance status and use of medical facilities and their level of satisfaction with the TennCare program. A sample size of 5,000 households allows us to obtain accurate estimates for subpopulations. The Boyd Center prepared the survey instrument in cooperation with personnel from the Division of TennCare.

The University of Tennessee Social Work Office of Research and Public Service (SWORPS) and Wilkins Research Services conducted the survey by randomly selecting potential respondents from a land line and cell phone set of numbers and contacting those families between May and July 2023. TennCare provided SWORPS with 10,000 (de-identified) phone numbers to help reach TennCare households. We also enhanced the telephone lists by using a larger web panel compared to the web panel used in previous years.[1]

Up to five calls were made to each residence, at staggered times, to minimize non-response bias. The design chosen was a "Household Sample," and the interview was conducted with the head of the household. When Spanish-speaking households without an available English speaker were reached, a person fluent in Spanish would call the household at a later time to conduct the survey. Approximately 21.8 percent of those who answered their land line phone or cell phone were willing to participate in the survey.[2] The large sample size allowed for the weighting of responses by income and age to provide unbiased estimates for the entire population. For all statewide estimates, a correction factor was used to adjust for the degree to which the sample over- or under-represented Tennesseans grouped by household income and head of household age.[3] (Table 1).

This is a follow-up to previous surveys of around 5,000 Tennessee households conducted annually since 1993, the last year of Medicaid before Tennessee adopted TennCare. Throughout this report, we make comparisons to findings from earlier surveys.

[1] Beginning in 2017, SWORPS supplemented random dialing with a web panel of respondents. Prior to the survey, these web respondents provided some basic information such as age and income and were contacted to balance the distribution of responses across age and income combinations.

[2] In the land line phone sample, there were 2,783 completed surveys, 7,588 refusals, and 487 who did not qualify. In the cell phone sample, there were 723 completed surveys, 2,521 refusals, and 222 who did not qualify. There were 1,506 surveys completed by web panel participants. Our final sample included 5,012 responses. An individual will not qualify to participate if he/she is not a head of household, not a Tennessee resident or is under the age of 18.

[3] Starting with the 2016 report, the 5-year American Community Survey (ACS) conducted by the U.S. Census Bureau is used to adjust the sample by household income and head of household age. The ACS is a nationwide survey designed to provide reliable and timely estimates of the demographic, social, economic and housing characteristics of the U.S. population and for parts of the U.S., such as states.

TABLE 1: Head of Household Age and Household Income

Age-Head of Household	Proportion in 2023 Survey (Percent)	Proportion in ACS* (Percent)	Deviation (Percent)
Under 25	8.5	3.9	-4.6
25-44	37.4	32.1	-5.3
45-64	36.0	37.5	1.5
65+	18.1	26.5	8.4
Household Income Level	**Proportion in 2023 Survey (Percent)**	**Proportion in ACS* (Percent)**	**Deviation (Percent)**
Less than $10,000	5.8	6.2	0.4
$10,000 to $14,999	9.9	4.7	-5.2
$15,000 to $19,999	6.8	4.6	-2.2
$20,000 to $29,999	10.0	9.3	-0.7
$30,000 to $39,999	11.0	9.5	-1.5
$40,000 to $49,999	9.8	8.8	-1.0
$50,000 to $59,999	8.8	8.0	-0.8
$60,000 to $99,999	15.9	23.0	7.1
$100,000 to $149,999	13.1	14.3	1.2
$150,000 and over	8.9	11.6	2.7

*Census Bureau, 2018-2021 American Community Survey 5-year Estimates for Tennessee.

Estimates for Insurance Status

Estimates for the number of Tennesseans who are uninsured are presented below. These statewide estimates are extrapolated from the weighted sample. The estimated population of uninsured persons represents approximately 7.7 percent of the 7,051,339 Tennessee residents, a slight increase from the 2022 estimate of 7.5 percent. (Table 2 and Figure 1).[4] The percent of uninsured adults increased from 9.0 percent in 2022 to 9.1 percent in 2023. The uninsured rate for children in 2023 is 2.5 percent (up from 2.3 percent in 2022), and the estimated number of uninsured children is 39,001 (Table 2a).

TABLE 2: Statewide Estimates of Uninsured Populations (2003–2023)

	2003	2004	2005	2006	2007	2008	2009
State Total	371,724	387,975	482,353	649,479	608,234	566,633	616,967
Percent	6.4	6.6	8.1	10.7	10.0	9.3	10.0

	2010	2011	2012	2013	2014	2015	2016
State Total	618,445	604,222	577,813	611,368	472,008	426,301	364,732
Percent	9.9	9.5	9.2	9.6	7.2	6.6	5.5

	2017	2018	2019	2020	2021	2022	2023
State Total	400691	486,661	468,096	566,523	564,452	522,097	541,900
Percent	6.0	6.7	6.9	8.3	8.3	7.5	7.7

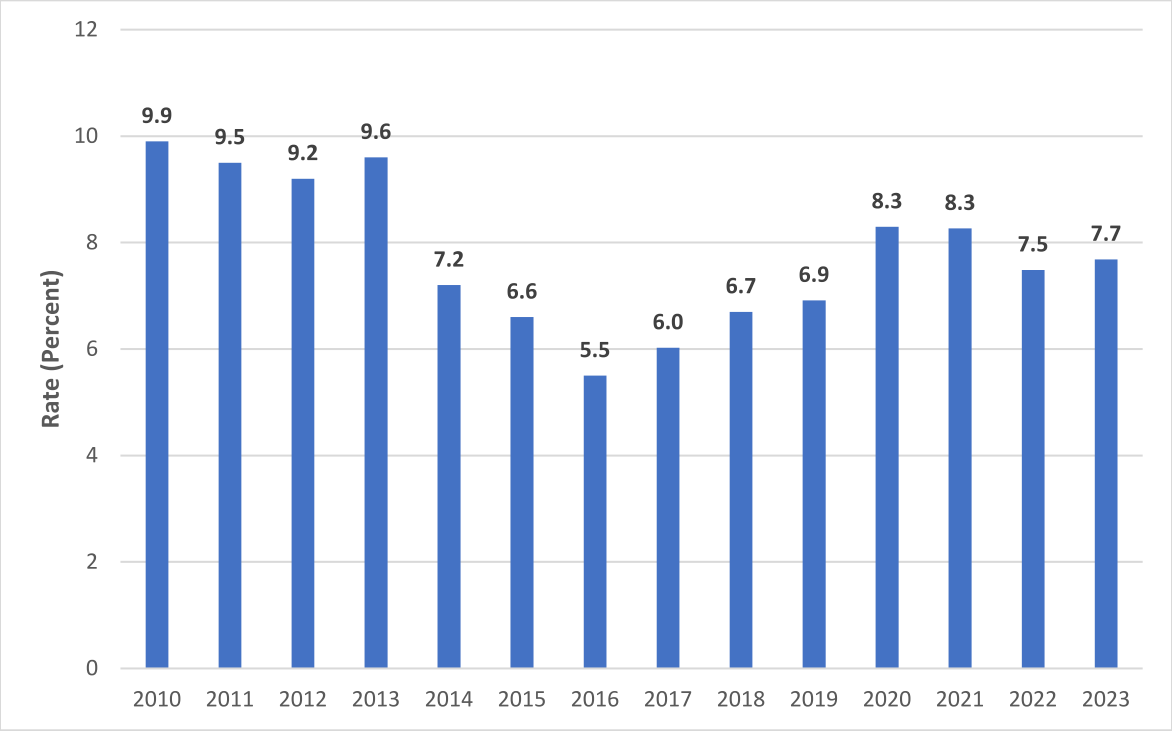
TABLE 2a: Uninsured Tennesseans by Age (2010–2023)

	2010	2011	2012	2013	2014	2015	2016
Under 18 Total	57,912	35,743	40,700	55,319	36,104	21,959	27,226
Under 18 Percent	3.9	2.4	2.7	3.7	2.4	1.5	1.8
18+ Total	560,532	568,479	537,113	556,049	435,904	404,342	337,506
18+ Percent	12.0	12.0	11.2	11.4	8.7	8.2	6.6

	2017	2018	2019	2020	2021	2022	2023
Under 18 Total	22,009	34,458	42,749	42,090	37,354	35,436	39,001
Under 18 Percent	1.5	2.3	2.8	2.8	2.5	2.3	2.5
18+ Total	378,682	417,170	425,347	524,433	527,098	486,661	502,899
18+ Percent	7.4	8.0	8.1	9.9	9.9	9.0	9.1

[4] Population estimates are found using U.S. Census Bureau Population Estimates. In prior years (1993 to 2008), population figures were gathered from the "Interim State Population Projections," also prepared by the U.S. Census Bureau.

FIGURE 1: Statewide Rate of Uninsured Populations (2010-2023)



Reasons for Failure to Obtain Medical Insurance

Affordability remains the top-cited reason for failing to obtain health insurance. Seventy-eight percent of uninsured respondents cited “cannot afford” as a major reason and 7 percent cited affordability as a minor reason (Table 3). We report the distribution of responses who cited affordability as a major reason by income bracket in Table 4. The share of households with income of $40,000 or more had the largest change, increasing from 66 percent in 2022 to 71 percent in 2023.

TABLE 3: Reasons for Not Having Insurance (2003–2023) (Percent)

Reason	Cannot Afford			Did Not Get to It			Do Not Need		
Year	Major Reason	Minor Reason	Not a Reason	Major Reason	Minor Reason	Not a Reason	Major Reason	Minor Reason	Not a Reason
2003	82	8	10	10	20	70	8	15	77
2004	82	7	11	8	19	73	8	16	76
2005	82	7	10	9	16	75	8	15	77
2006	87	4	9	12	14	74	12	14	74
2007	89	6	4	9	11	79	5	13	82
2008	93	4	4	7	11	82	5	8	87
2009	92	3	4	3	15	81	5	10	85
2010	91	5	4	5	13	82	6	15	80
2011	88	5	7	11	12	77	8	12	79
2012	88	5	7	9	13	78	7	13	80
2013	83	6	11	9	17	74	5	16	79
2014	86	6	8	11	15	75	12	14	74
2015	83	7	10	9	13	77	9	10	80
2016	80	5	16	16	10	73	17	13	70
2017	78	9	13	11	15	74	13	13	74
2018	82	8	11	8	14	78	10	12	78
2019	81	8	11	11	15	74	13	12	75
2020	81	10	9	9	22	68	10	23	67
2021	80	6	14	12	22	66	11	18	71
2022	82	6	12	15	20	65	14	17	70
2023	78	7	15	14	22	64	15	21	64

TABLE 4: "Cannot Afford" Major Reason for No Insurance: By Income (2017–2023) (Percent) [5]

Household Income	2017	2018	2019	2020	2021	2022	2023
Less than $20,000	80	81	80	76	78	77	75
$20,000 - $39,999	75	80	81	84	79	80	76
$40,000 and above	42	77	68	79	78	66	71

[5] Results in Table 4 omit respondents who did not report household income.

Evaluations of Medical Care and Insurance Coverage

Tennessee residents' perceptions about the quality of care received have remained consistently high for the last decade. Since 2014, the share of all heads of households who rated quality of care received as "good" or "excellent" has ranged from 77 percent to 80 percent and was 77 percent in 2023. Since 2014, the share of TennCare heads of households who rated their quality of care as "good" or "excellent" has ranged from 70 percent to 77 percent and was 77 percent in 2023 (Table 5).

TABLE 5: Quality of Medical Care Received by Heads of Households (2014–2023) (Percent)

All Heads of Households	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Excellent	31	32	33	33	32	33	33	34	30	30
Good	47	46	45	45	45	47	46	45	46	47
Fair	16	17	17	17	17	15	16	15	18	17
Poor	6	5	5	5	6	5	6	6	6	6
Heads of Households w/ TennCare	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Excellent	25	28	31	27	26	30	30	30	27	32
Good	45	42	43	46	45	46	44	43	46	45
Fair	22	24	23	22	24	19	20	20	22	18
Poor	8	5	3	5	5	5	6	7	5	5

In 2023, all heads of households and heads of households with TennCare children reported similar levels of satisfaction with the quality of healthcare received by covered children. In 2023, 86 percent of all households and households with TennCare children reported quality of care received as "excellent" or "good." Forty-four percent of households with TennCare children reported quality of care as "excellent" versus 39 percent of all households with children. These responses are consistent with long-term trends, indicating respondents remain satisfied with the quality of care received by their children (Table 6).

TABLE 6: Quality of Medical Care Received by Children of Heads of Households (2014–2023) (Percent)

All Heads of Households	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Excellent	41	45	46	43	44	45	45	44	40	39
Good	48	44	42	45	45	44	44	44	45	47
Fair	9	8	10	10	9	8	9	10	13	12
Poor	2	3	2	2	2	3	3	2	2	2
Heads of Households w/ TennCare[6]	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Excellent	38	41	43	39	43	45	41	44	40	44
Good	49	46	44	48	45	42	43	41	43	42
Fair	10	9	12	11	10	11	13	12	15	12
Poor	3	4	1	3	2	3	3	3	2	2

Overall Satisfaction with the TennCare Program

TennCare recipients continue to show high levels of satisfaction with the TennCare program as a whole (Table 7). Specifically, 95 percent of respondents indicated they are “very satisfied” or “somewhat satisfied” with the TennCare program in 2023, and rates have consistently exceeded 90 percent over time.[7] In addition, 98 percent are “very satisfied” or “somewhat satisfied” with the TennCare program for their children (untabulated).

TABLE 7: Percent Indicating Satisfaction with TennCare (2011–2023) (Percent)

2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
95	93	95	93	95	92	95	95	94	94	92	95	95

[6] This subgroup includes all households in which at least one child is enrolled in TennCare, even if the head of the household is not enrolled.

[7] A three-point scale was used, and respondents could indicate “very satisfied,” “somewhat satisfied,” or “not satisfied.” We ask a related question about satisfaction with TennCare coverage, and 93 percent report that they are “satisfied.”

Behavior Relevant to Medical Care

Each respondent was asked a series of questions regarding his or her behavior when initially seeking medical care (Table 8). Reported behavior for 2023 is very consistent with recent surveys. Ninety-two percent of all heads of households first sought care at a doctor's office or clinic, while 90 percent of TennCare heads of households did the same. In 2023, 96 percent of all households with children and 95 percent of TennCare households with children first sought care at a doctor's office or clinic (Table 9). The 2023 results are similar to the amounts reported in 2022.

TABLE 8: Heads of Households: Medical Facilities Used When Medical Care Initially Sought (2014-2023) (Percent)

All Heads of Households	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Doctor's Office	81	81	80	80	79	78	78	77	76	74
Clinic	14	15	16	15	16	17	16	17	17	18
Hospital	3	3	3	3	3	3	4	4	4	5
Other	2	1	2	2	2	2	2	2	3	3
Heads of Households with TennCare	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Doctor's Office	72	76	78	79	76	76	79	76	75	73
Clinic	18	18	18	13	15	17	14	17	17	17
Hospital	8	7	3	7	7	6	6	6	6	7
Other	2	0	2	2	1	1	1	1	2	3

TABLE 9: Children: Medical Facilities Used When Medical Care Initially Sought (2014-2023) (Percent)

All Heads of Households	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Doctor's Office	87	86	85	84	85	78	83	81	81	80
Clinic	12	12	13	13	13	17	14	15	16	16
Hospital	1	1	1	2	2	3	2	3	2	3
Other	<1	<1	<1	<1	<1	2	1	1	1	1
Heads of Households with TennCare[8]	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Doctor's Office	84	83	86	85	85	76	83	82	82	80
Clinic	14	14	12	11	12	17	13	14	14	15
Hospital	1		3	2	4	3	6	3	4	4
Other	1		0	<1	0	<1	1	1	<1	<1

[8] This subgroup includes all households in which at least one child is enrolled in TennCare, even if the head of the household is not enrolled.

TennCare recipients continue to see physicians on a more frequent basis than the average Tennessee household (Table 10). The proportion of all heads of households that reported seeing a doctor at least weekly or monthly was 17 percent in 2023 (14 percent in 2022), versus 29 percent of TennCare heads of households (up from 27 percent in 2022). In 2023, 14 percent of all households reported taking their children to visit a doctor at least monthly versus 19 percent for TennCare children. The rate of frequent visits increased for both children on TennCare and non-TennCare children (Table 11).

TABLE 10: Frequency of Visits to Doctor for Heads of Households (2014–2023) (Percent)

All Heads of Households	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Weekly	2	2	2	2	2	2	2	3	2	3
Monthly	11	11	12	12	11	13	12	12	12	14
Every Few Months	47	46	44	46	47	47	45	45	47	47
Yearly	25	25	26	26	25	23	25	24	23	21
Rarely	15	16	16	15	15	15	16	16	16	15
Heads of Households w/ TennCare	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Weekly	6	3	5	5	5	5	4	6	4	5
Monthly	31	26	31	28	26	28	22	25	23	24
Every Few Months	45	49	42	42	45	43	48	42	45	45
Yearly	11	9	10	14	12	12	15	14	15	14
Rarely	8	13	12	11	12	13	11	13	13	12

TABLE 11: Frequency of Visits to Doctor for Children (2014–2023) (Percent)

All Heads of Households	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Weekly	1	1	1	1	1	1	1	1	1	2
Monthly	9	7	8	7	7	10	8	8	10	12
Every Few Months	47	47	44	48	51	50	48	44	47	49
Yearly	35	36	38	36	35	32	36	40	35	31
Rarely	8	8	9	7	6	7	7	7	7	6
Heads of Households with TennCare[9]	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Weekly	2	1	3	3	2	2	2	4	3	3
Monthly	17	13	12	14	12	19	11	15	13	16
Every Few Months	53	51	53	48	57	52	51	46	52	51
Yearly	25	28	29	31	24	24	30	29	28	26
Rarely	2	5	4	4	5	4	6	6	4	4

[9] This subgroup includes all households in which at least one child is enrolled in TennCare, even if the head of the household is not enrolled.

Ease of Obtaining a Doctor's Appointment for TennCare Families

The reported time required for a family with TennCare to obtain an appointment decreased overall compared to 2022. The share of respondents who obtained an appointment within one day increased from 32 percent to 39 percent. Moreover, 69 percent of TennCare recipients were able to make a doctor's appointment within a week, up from 62 percent in 2022 but still below the 75 percent in 2018. Nineteen percent reported waiting three weeks or longer for an appointment, down from 27 percent in 2022 (Table 12), but still higher than the 15 percent in 2018. TennCare patients reported waiting on average 44 minutes after arriving for their appointments. The average travel time to a physician's office was 21 minutes (Table 13).

TABLE 12: Time between Attempt to Make Appointment and First Availability of Appointment: TennCare Heads of Households (2014–2023) (Percent)

When you last made an appointment to see a primary care physician for an illness in the last 12 months, how soon was the first appointment available?	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Same day	18	24	19	21	23	21	14	15	14	18
Next day	21	18	22	21	24	21	20	20	18	21
1 week	29	26	28	29	28	30	37	31	30	30
2 weeks	8	8	9	9	10	13	11	11	11	12
3 weeks	6	3	4	5	4	4	4	5	6	5
Over 3 weeks	19	21	18	14	11	11	14	18	21	14

TABLE 13: Wait for Appointments: TennCare Heads of Households (2014–2023) (Minutes)

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Number of minutes wait past scheduled appointment time?	53	63	52	42	50	45	42	37	44	44
Number of minutes to travel to physician's office?	22	27	24	22	23	26	23	23	25	21

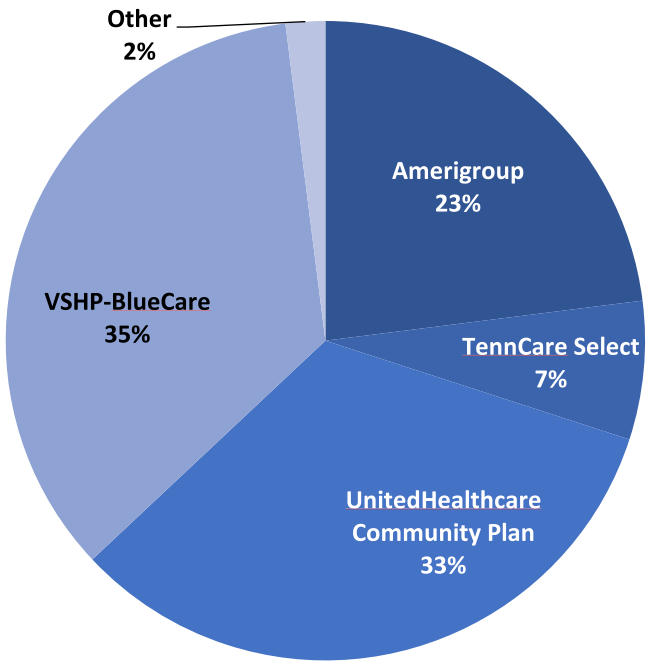
TennCare Plans

TennCare participants are covered by one of four health plans. Table 14 and Figure 2 below report the responses from our 2023 survey. About 91 percent of TennCare household members surveyed reported being signed up with Volunteer State Health Plan (35 percent), UnitedHealthcare (33 percent) or Amerigroup (23 percent). The remaining 9 percent report being enrolled in TennCare Select or gave an incorrect answer.

TABLE 14: Reported TennCare Plan (2018–2023) (Percent)

What company manages your TennCare plan?	2018	2019	2020	2021	2022	2023
Amerigroup	21	21	24	22	24	23
TennCare Select	8	8	7	7	9	7
UnitedHealthcare Community Plan	33	33	32	34	32	33
VSHP -- BlueCare	36	36	34	34	33	35
Other	2	2	3	3	2	2

FIGURE 2: Reported TennCare Plan (2023)



Six percent of respondents indicated that they had changed plans within the preceding 12 months. Of that total, 40 percent requested the change. The most commonly-cited reason for changing plans was "limited choice of doctors and hospitals."

Seventy-six percent of TennCare heads of households reported receiving a list of rights and responsibilities this year. Fifty-nine percent of households reported receiving an enrollment card and 67 percent reported receiving information about filing an appeal. These results are very similar to those reported in 2022 (Table 15).

TABLE 15: Households Receiving TennCare Information from Plans (2014–2023) (Percent)

Please indicate whether or not you or anyone in your household has received each of the following regarding TennCare	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
An enrollment card	63	69	67	71	67	69	59	62	61	59
Information on filing appeals	70	82	76	76	74	70	64	66	66	67
A list of rights and responsibilities	78	85	81	82	79	75	72	74	74	76
Name of MCO to whom assigned	76	84	81	81	75	76	71	72	73	77

Mail has held steady as the most popular mode of communication for TennCare households. Approximately 63 percent reported that mail is still the preferred method for receiving information. Those who prefer getting information via email or website increased slightly to 21 percent in 2023, up from 20 percent in 2022. (Table 16).

TABLE 16: Best Way to Get Information about TennCare (2014–2023) (Percent)

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Mail	75	78	78	72	73	64	64	62	62	63
Doctor	5	4	5	6	3	6	5	7	5	5
Phone	6	8	4	5	4	4	6	6	6	5
Handbook	4	3	2	4	4	4	2	2	3	2
Drug Store	<1	<1	<1	<1	<1	<1	1	1	<1	<1
Friends	<1	<1	<1	<1	<1	<1	2	3	1	1
TV	<1	<1	<1	<1	<1	1	1	<1	1	<1
Paper	<1	0	<1	<1	<1	<1	<1	<1	<1	<1
Email			5	5	7	10	12	13	14	14
Website			4	4	6	7	5	4	6	7
Other	8	6	<1	<1	1	2	2	1	1	1

In the past 12 months, 12 percent of TennCare households used a non-emergency care provider that did not participate in their plan (down from 14 percent in 2022), with 53 percent of that 12 percent stating that they used non-participating providers one to two times (Figure 3). Of the 12 percent of TennCare households using non-participating providers, the most common type of care sought was from a general medical care/family doctor, followed by dental care and eye care (Table 17 and Figure 4).

FIGURE 3: Number of Times Sought Non-Emergency Care at a Non-Participating Provider in Past 12 Months (Percent)

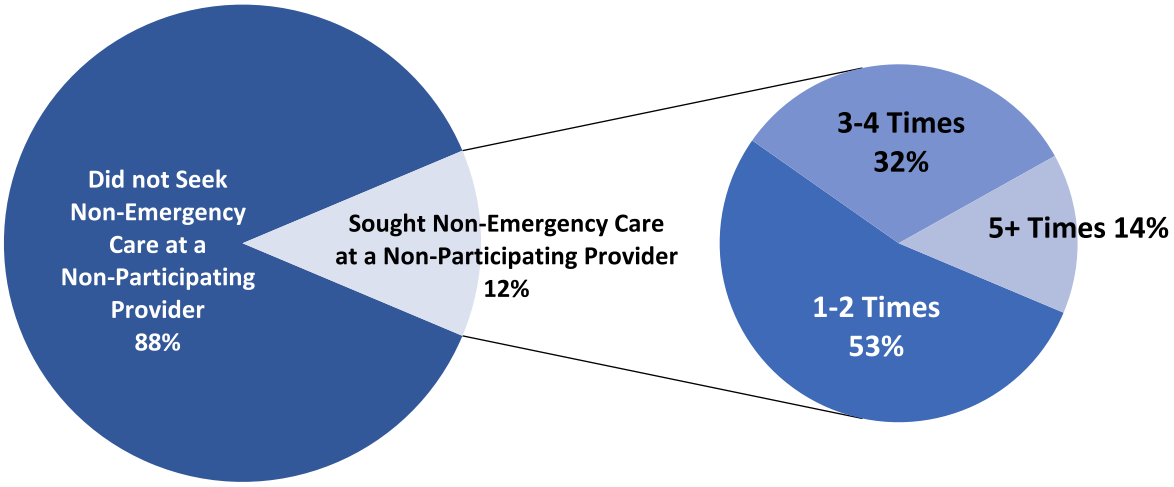
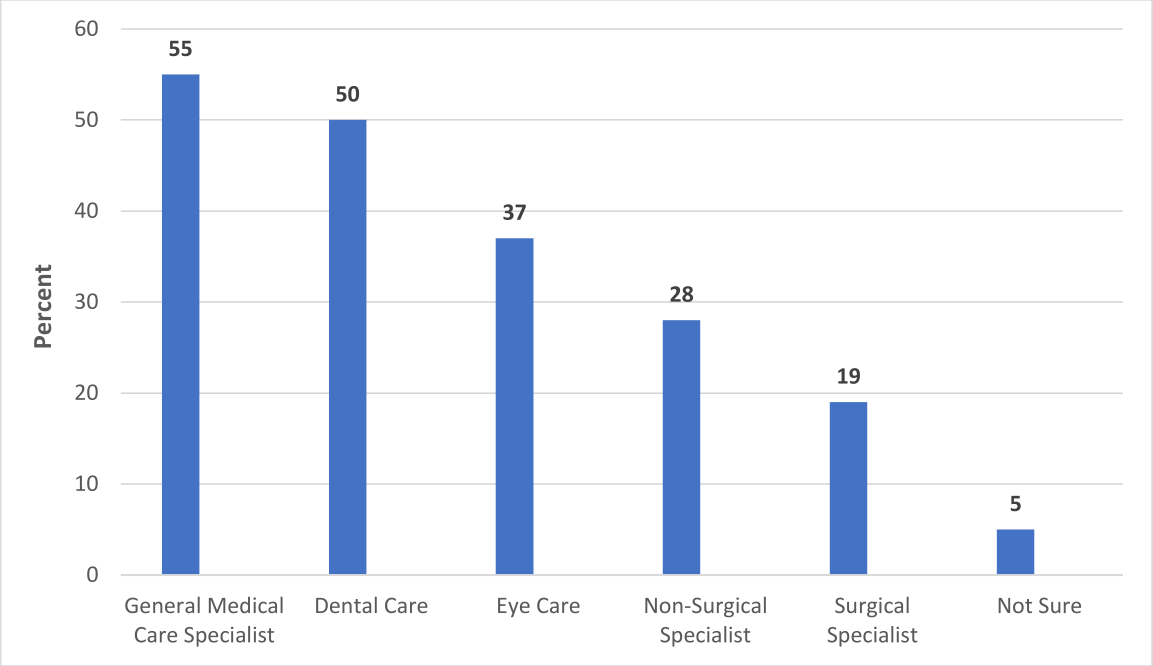


TABLE 17: Type of Non-Emergency Care Sought from a Non-TennCare Provider (2022-2023) (Percent)

	2022	2023
General Medical Care Specialist	39	55
Dental Care	33	50
Eye Care	20	37
Non-Surgical Specialist	21	28
Surgical Specialist	12	19
Not Sure	4	5

Respondents could choose more than one type of non-emergency care.

FIGURE 4: Type of Non-Emergency Care Sought from a Non-TennCare Provider (2023)



Approximately 5 percent of all TennCare households sought care from a non-TennCare provider because the service was not covered under TennCare, 2 percent because there was not a TennCare provider in the area, and 3 percent mistakenly made an appointment with a provider that did not accept TennCare. Only 1 percent sought alternative care because they were dissatisfied with the quality of service from the TennCare provider (Table 18). Almost half of the respondents (45 percent) reported that TennCare helped them find a provider that participated in the TennCare plan.

TABLE 18: Reasons Sought Non-Emergency Care from a Non-TennCare Provider (2023) (Percent of TennCare Recipients)

	2023
Dissatisfaction with quality of service from TennCare provider	1
Service was not covered by TennCare	5
No TennCare provider in the area	2
Could not get timely appointment with TennCare provider	1
When I made the appointment or received care, I mistakenly thought the provider participated in my TennCare health care plan	3

Conclusion

The number of uninsured Tennesseans increased by approximately 19,800 in 2023, with the overall uninsured rate increasing slightly from 7.5 in 2022 to 7.7 percent in 2023. The proportion of uninsured adults was essentially unchanged (9.0 percent in 2022 to 9.1 percent in 2023), while the proportion of uninsured children increased slightly from 2.3 percent in 2022 to 2.5 percent in 2023. Overall, the uninsured population is very similar to the prior year.

Respondents report near record high levels of satisfaction with the TennCare program overall and with the quality of care received by heads of households and their children. For TennCare households, 95 percent report that they are very or somewhat satisfied by the program overall. For quality of care, 77 percent of TennCare heads of households reported that quality of care was excellent or good, and 86 percent of TennCare households reported excellent or good quality of care for their children. For the first time in our survey, reported quality of care for TennCare households and their children meet or exceed reported quality of care for all Tennessee households.

Affordability continues to be the major reason for not having insurance, cited by approximately 78 percent of respondents across all income categories. For those covered by TennCare, 90 percent of heads of households and 95 percent of their children first sought medical care at a doctor's office or clinic versus a hospital. Only 12 percent of TennCare families reported needing to use non-emergency care providers that do not participate with their plan, primarily because the service was not provided by TennCare.

Overall, TennCare continues to receive positive feedback from its recipients, with 95 percent reporting satisfaction with the program. This positive feedback is a strong indication that TennCare is providing satisfactory medical care and meeting the expectations of those it serves.

Attachment L:
2023 Quality Assessment and Performance Improvement Strategy Update

2023 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY UPDATE

Initial Strategy Submitted to CMS for Review and Feedback: December 20, 2022

2023 Strategy Update Available for Public Comment: November 2, 2023 – December 1, 2023

2023 Strategy Update Submitted to CMS for Review and Feedback: December 26, 2023

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Section I: Introduction

Background

On January 1, 1994, Tennessee implemented a new Medicaid reform program under the authority of a Section 1115 demonstration. This new program, known as TennCare, moved almost the entirety of Tennessee's Medicaid program into managed care. The TennCare 1115 demonstration has been renewed continuously by the state and CMS since 1994.

Since 1994, all (100 percent) of Medicaid beneficiaries in Tennessee have enrolled in managed care to receive most or all of their Medicaid benefits. Over time, Tennessee has worked toward more complete integration and more effective coordination of care to improve the member experience, support more cost-effective care delivery, and promote improved health outcomes. In 2009, Tennessee ended the separate carve-out for behavioral health services so that a single entity (the member's managed care organization or MCO) is responsible for administering and coordinating members' medical/surgical and behavioral health care. Long term services and supports (LTSS) for persons who are elderly or who have physical disabilities were carved into the MCO program with the creation of the CHOICES program in 2010, and in 2016, Tennessee integrated certain LTSS for individuals with intellectual and developmental disabilities into the MCO program with the implementation of Employment and Community First CHOICES.

In 2019, a new Katie Beckett Program was established under the demonstration, providing services and supports for children under age 18 with disabilities and/or complex medical needs who are not otherwise eligible for Medicaid because of their parents' income or assets.

In 2020, TennCare and the Department of Intellectual and Developmental Disabilities (DIDD) jointly announced that all Medicaid long-term services and supports (LTSS) programs for people with intellectual and developmental disabilities (I/DD), including the Section 1915(c) HCBS waivers, the Employment and Community First CHOICES Program, and Intermediate Care Facility services for Individuals with Intellectual Disabilities (ICF/IID) will, for the first time, be aligned in the managed care program. The primary goal of this integration will be to finally and fully achieve a single, seamless, person-centered system of service delivery system for people with I/DD that supports them to increase their independence, fully participate in their communities, and achieve their competitive, integrated employment goals. In early 2021, TennCare submitted waiver amendments to the 1115 waiver as well as the three 1915(c) waivers seeking to integrate I/DD services. The 1115 waiver amendment is still pending.[1]

On January 1, 2021, Tennessee transitioned its separate Children's Health Insurance Program (CHIP) program from fee-for-service to managed care, leveraging the state's existing managed care contracts and infrastructure to ensure close coordination and strategic alignment between Medicaid and CHIP. Because Tennessee uses the same managed care contractors to provide care to both its Medicaid and CHIP beneficiaries, this quality strategy addresses the steps taken to improve quality in both programs.

[1] At the request of CMS, the 1915(c) waivers were temporarily withdrawn in order to align approval of IDD integration across Medicaid authorities. Once integrated, the 1915(c) data will affect LTSS metrics related to the I/DD population.

As noted above, Tennessee's managed care program encompasses all of the state's Medicaid and CHIP beneficiaries, and virtually all covered services. The state's managed care system currently consists of six managed care contractors (MCCs). The MCCs that the state contracts with are listed in Table 1. This Quality Assessment and Performance Improvement Strategy applies to all MCCs and the populations served by TennCare.

Table 1. TennCare Managed Care Contractor Information

Plan Name	MCC Type	Managed Care Authority	Populations Served
Amerigroup[2]	MCO	1115; CHIP State Plan	Medicaid adults, children, and CHIP
Volunteer State Health Plan, Inc. dba BlueCare	MCO	1115; CHIP State Plan	Medicaid adults, children, and CHIP
UnitedHealthcare Plan of the River Valley, Inc. dba UnitedHealthcare Community Plan	MCO	1115; CHIP State Plan	Medicaid adults, children, and CHIP
TennCare Select	PIHP	1115	Selected populations as specified in the state's 1115 demonstration
DentaQuest	PAHP	1115	Medicaid adults and children
OptumRx	PAHP	1115	Medicaid adults and children with a pharmacy benefit (i.e., non-duals)

TennCare Quality Strategy Goals and Objectives

TennCare's commitment to quality and continuous improvement in the lives of Tennesseans is reflected in its vision and mission of a healthier Tennessee by improving lives through high-quality cost-effective care. TennCare has three goals that have served as the foundation of the program since its inception, with a fourth added in 2009 upon approval of LTSS integration.

1. Provide high-quality care that improves health outcomes
2. Ensure enrollee access to health care, including safety net providers
3. Ensure enrollees' satisfaction with services
4. Provide enrollees with appropriate and cost-effective Home and Community-Based Services (HCBS)

To provide high-quality care to enrollees that will improve health outcomes, TennCare will focus on improving the health and wellness of mothers and infants, increasing preventive services for the state's Medicaid and CHIP populations and improving chronic health conditions. In addition, TennCare will ensure that enrollees have improved access to care by maintaining robust member access to health services. TennCare will ensure enrollees' satisfaction with services by integrating patient-centered, holistic care into population health coordination for all members. TennCare will also improve the quality of life for members with LTSS needs by ensuring access to high-quality, cost-effective home and community-based services that allow members to meet their individualized goals and live the life of their choosing.

[2] Effective January 1, 2024, the name of the Amerigroup MCO will change to WellPoint.

The progress toward TennCare's goals and associated objectives is measured through key physical health, behavioral health, and long-term services and support performance measures. The objectives are drawn from nationally recognized and validated measure sets, as well as internal custom measures. Table 2 outlines TennCare's Quality Strategy Goals, the baseline performance, and the performance target where applicable.

Table 2. TennCare Quality Strategy Goals and Objectives

Objective	Objective description	Quality measure	Statewide performance baseline (year)	Statewide performance target for objective (year)
Goal 1: Improve the health and wellness of mothers and infants				
1.1	Increase the use of prenatal services	Timeliness of Prenatal Care (PPC-CH)	78.4% (2019)	82.4% (2025)
1.2	Increase the use of postpartum services	Postpartum Care (PPC-AD)	69.4% (2019)	73.4% (2025)
1.3	Increase the use of well-child visits in the first 15 months of life	Well-Child Visits in the 1st 30 Months of Life, 1st 15 Months (W30-CH)	53.7% (2020)	56.6% (2025)
Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions				
2.1	Increase child and adolescent well care visits	Child and Adolescent Well-Care Visits, Total Rate (WCV-CH)	51.1% (2020)	53.1% (2025)
2.2	Increase CMS-416 EPSDT screening rate	CMS-416 EPSDT Screening Rate	69.0% (2020)	80.0% (2025)
2.3	Increase child immunizations	Childhood Immunization Status – Combo10 (CIS-CH)	36.7% (2019)	39.7% (2025)
2.4	Improve high blood pressure control in adults	Controlling High Blood Pressure (CBP-AD)	64.2% (2019)	66.2% (2025)
2.5	Increase cervical cancer screening in adults	Cervical Cancer Screening (CCS-AD)	64.2% (2019)	66.2% (2025)
2.6	Increase dental sealant use in children	Sealant Recipient on Permanent First Molars, at least one sealant (SFM-CH)	60.7% (2020)	62.7% (2025)
2.7	Decrease emergency department utilization for children*	Ambulatory Care (AMB-CH), ED visits, Total Rate ages 0-19	49.0 (2019)	46.0 (2025)
2.8	Reduce rate of hospital readmissions	Plan All Cause Readmissions (PCR-AD)	1.07 (2019)	0.79 (2025)
Goal 3: Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members				
3.1	Maintain high member satisfaction with TennCare	Percent of respondents indicating satisfaction with TennCare (UT survey)	94.0% (2019)	94.0% (2025)
3.2	Increase screening for non-medical risk factors	Percent of members screened by the MCO for non-medical risk factors (Custom)	3.2% (2021)	15.0% (2025)
3.3	Ensure CHOICES members receive person-centered care	Percent of Members whose service plan reflects their preferences and choices (NCI-AD, Q10 PCP)**	80.0% (2021-2022)	82.0% (2025)

3.4	Ensure ECF CHOICES members receive person-centered care	Percent of members who report their service plan includes things that are important to them (NCI-IPS, Q 52)***	N/A ****	N/A
3.5	Ensure Katie Beckett members receive person-centered care	Percent of members/families who report feeling that supports and services have made a positive difference in the life of their child (NCI-CFS, Q 62)	N/A ****	N/A
Goal 4: Improve positive outcomes for members with LTSS needs				
4.1	Maintain or improve quality of life for CHOICES members	Percent of members who report their paid service and supports help them live the life they want (NCI-AD, Q 90)**	88.0% (2018-2019)	90.0% (2025)
4.2	Maintain or improve quality of life for individuals with I/DD	Percent of members who report services and supports are helping to live a good life (NCI-IPS, Q 57)	N/A ****	N/A
4.3	Maintain or improve quality of life for eligible children in the Katie Beckett program	Percent of members who report they are satisfied with the services and supports their child currently receives (NCI-CFS, Q 68)	N/A ****	N/A
4.4	Increase percentage of older adults and adults with physical disabilities receiving LTSS in the community (HCBS) as compared to those receiving LTSS in an institution	CHOICES baseline data	39.3% (2021)	41.3% (2025)
4.5	Increase percentage of individuals with I/DD receiving LTSS in the community (HCBS) as compared to those receiving LTSS in an institution	ECF CHOICES baseline data	70.0% (2021)[3]	72.0% (2025)
Goal 5: Provide additional support and follow-up for patients with behavioral health care needs				
5.1	Improve follow-up after hospitalization for mental illness in adults	Follow-up After Hospitalization for Mental Illness (FUH-AD), 30-Day Follow-up	55.4% (2019)	57.4% (2025)
5.2	Improve follow-up after hospitalization for mental illness in children	Follow-up After Hospitalization for Mental Illness (FUH-CH), 30-Day Follow-up	73.3% (2019)	75.3% (2025)
5.3	Increase the use of medication assisted treatment of opioid dependance and addiction	Use of Pharmacotherapy for OUD, Total Rate (OUD-AD)	32.4% (2019)	34.4% (2025)

[3] This includes only individuals enrolled in the Employment and Community First CHOICES program until CMS approves the pending waiver amendments to integrate the 1915(c) waiver programs into the 1115 Waiver. If 1915(c) waiver programs were included, this would be 91.0%.

Goal 6: Maintain robust member access to health care services				
6.1	Ensure all members can access care according to time and distance standards	TennCare custom measure	100% (2021)	100% (2025)
6.2	Ensure adult members can access care, tests, or treatments timely	"Getting Needed Care" (CAHPS)	85.6% (2020)	87.6% (2025)
6.3	Ensure child members can access care, tests, or treatments timely	"Getting Needed Care" (CAHPS)	89.6% (2020)	90.6% (2025)
6.4	Maintain high compliance scores for access and availability (MCO)	EQRO Annual Technical Report, Annual Network Adequacy, MCO Access/Availability	97.0% (2020)	99.0% (2025)
6.5	Maintain high compliance scores for access and availability (DBM)	EQRO Annual Technical Report, Annual Network Adequacy, DBM Access/Availability	99.0% (2020)	100% (2025)
Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care				
7.1	Maintain the percentage of TennCare members attributed to PCMH organizations	TennCare custom measure	40.7% (2019)	40.0% (2025)
7.2	Increase the percentage of TennCare members eligible for Tennessee Health Link (THL) who are active in THL	TennCare custom measure	49.0% (2019)	51.0% (2025)
7.3	Increase the percentage of nursing facilities showing quality improvement	QuILTSS for NF	45.61% (2020 QuILTSS 13 cycle)	47.61% (2025)
7.4	Increase the average Tier Score for facilities supporting members with ventilators or tracheostomies (Enhanced Respiratory Care)	TennCare custom measure	1.44 (October 2020-March 2021)*****	1.3 (2025)

*Lower rates are better.

**Metric replaced to align with CMS' HCBS Quality Measure Set, updated measure comparable to existing measure.

***Reflects updated numerical order for 2023-2024 NCI-IPS and NCI-AD surveys.

**** Baseline data will be available for the 2024 update.

***** Closer to 1 is better

Selecting measures and determining performance targets

The TennCare Quality Strategy Goals and Objectives are established by the state to measure the health status of all populations served by the state's managed care plans.

To set statewide performance targets, TennCare statewide performance was compared to NCQA HEDIS Quality Compass data, where available. Statewide rates were compared to the national benchmarks (50th, 75th, 90th, etc. percentiles) and targets were set based on the statewide performance. If there was no NCQA HEDIS Quality Compass data, the TennCare statewide performance was compared to CMS Chart Packs data for the Adult and Child Core Sets, where available. CMS Chart Packs data provides national information on all CMS Core Measures where at least 25 states reported quality data. If there was no national data available for a measure, the performance target was set to show two percent improvement.

LTSS quality is measured in many areas using data from the National Core Indicators (NCI) Aging and Disabilities Surveys (NCI-AD), In Person Surveys (NCI-IPS), and Child and Family Surveys (NCI-CFS). Tennessee has participated in the NCI-AD survey for many years, however, due to the COVID-19 pandemic, no data for NCI-AD was collected for the 2019-2020 survey year. For that reason, baseline data for NCI-AD-related measures is 2018-2019. Tennessee implemented the NCI-IPS surveys with our Employment and Community First CHOICES population for the 2019-2020 survey year. However, this data is not recommended for use due to the impact of the COVID-19 pandemic. In addition, Tennessee will be utilizing the NCI-CFS tool starting in 2022 for the Katie Beckett member population and does not yet have baseline data. To support national standardization of quality measures in HCBS some NCI metrics within the Quality Strategy have been updated to capture newly required metrics outlined in state Medicaid Director Letter 22-003. These updates will ensure ongoing consistency in metrics as none of these required measures will be retired or replaced by NCI. For further alignment with the new quality measure set TennCare plans to significantly increase NCI samples to capture health equity. For these reasons, TennCare plans to update the measures reliant upon NCI-IPS and NCI-CFS data with baseline and target data in the annual Quality Strategy update, which will also include further updates and alignment with the state Medicaid Director Letter 22-003.

Updating the Quality Strategy

TennCare values continuous improvement and will update its Quality Strategy annually. The state will include significant changes that have occurred as well as updated evaluation data. Significant changes are defined by the state as changes that: 1) alter the structure of the TennCare Program; 2) change benefits; and/or 3) include changes in MCCs. Updated interventions and activities will also be provided.

Every three years, TennCare will coordinate a comprehensive review and update to the Quality Strategy.[4] The state's EQRO conducted an evaluation of the effectiveness of the quality strategy in 2020. The results of this review are included in Appendix 2 and was also included in the state's 2021 Update to the Quality Assessment and Performance Improvement Strategy, which is published on the state's website at https://www.tn.gov/tenncare/information-statistics/additional-tenncare-reports.html.[5] TennCare will update its quality strategy with recommendations identified in the EQRO's effectiveness evaluation. The Chief Quality Officer and Chief Medical Officer will review the recommendations and indicate which recommendations TennCare will adopt in the following year's Quality Strategy.[6]

Pursuant to 42 CFR § 438.340(c)(1), the state made a draft of this Quality Assessment and Performance Improvement Strategy available for public review and comment. The strategy was published on the TennCare website on October 3, 2022, and comments were accepted from October 3 through November 3, 2022. The state received three sets of comments in response to its public notice. All comments were reviewed and considered by the state prior to the submission of the Strategy to CMS, and no changes were made to the Strategy as a result of the feedback received. Tennessee has no federally recognized Indian tribes, Indian Health Programs, or Urban Indian Organizations that furnish health care services, and therefore did not consult with Tribes.

[4] *42 CFR 438.340(b)(10) and (c)(3)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).*

[5] *42 CFR 438.340(c)(2), 438.340(c)(2)(i), and 438.340(c)(2)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).*

[6] *42 CFR 438.340(c)(2)(iii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.364(a)(4) and 457.1250(a).*

In 2023, TennCare reviewed the 2022 Quality Assessment and Performance Improvement Strategy to provide an annual update. The strategy was available for public review and comment November 2, 2023 through December 1, 2023. The state did not receive comments in response to its public notice.

Section II: Quality and Appropriateness of Care Assessment

State Requirements

Since TennCare's inception, continuous quality improvement has been a priority for TennCare and its partner MCOs. TennCare has instituted several process improvement efforts and requirements to ensure that quality improvement efforts remain in place and are refined over time. TennCare requires accreditation and specific distinctions of each of its MCOs. TennCare requires all MCOs to be National Committee for Quality Assurance (NCQA) health plan accredited, as well as to maintain distinction status in LTSS and Multicultural Health Care. MCOs are required, by contract, to provide TennCare with the entire accreditation survey and associated results. They are also required to submit to TennCare their annual NCQA Accreditation update. Accreditation information is available on the TennCare website: https://www.tn.gov/tenncare/members-applicants/managed-care-organizations.html

Additionally, the state's MCOs are required to report a full set of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data as a part of the accreditation mandates in Tennessee. The HEDIS requirement is an integral part of the accreditation process of the NCQA and includes completion of all LTSS HEDIS Measures. This information is also provided to Qsource, Tennessee's external quality review organization (EQRO), for review and trending. Qsource then prepares an annual report of findings for TennCare. TennCare publishes outcomes on all HEDIS measures to its website annually at the following website: https://www.tn.gov/tenncare/information-statistics/mco-quality-data.html [7]

TennCare also reports CMS Core performance measures for children and adults in Medicaid and CHIP. These measures encompass both the physical and mental health of Medicaid/CHIP measures. Demonstrating a commitment to high quality care, Tennessee measures and submits over 90 percent of the CMS performance measures for children and adults in Medicaid/CHIP each year. TennCare aims to show improvement each year on the CMS core measures, and sets goals based on improvement or maintenance of the NCQA Quality Compass national benchmarks.

The state's DBM is required to have a written Quality Monitoring Program (QMP) that clearly defines its quality improvement structures, processes, and related activities. The DBM uses the results of the QMP activities to improve the quality of dental health with appropriate input from providers and members. The DBM is also incentivized to achieve defined preventive care targets for dental sealants and silver diamine fluoride or SDF.

TennCare involves the PBM to work closely with a Drug Utilization Review (DUR) Board, Pharmacy Advisory Committee, and CoverRx Clinical Advisory Committee which include multi-disciplinary healthcare professionals to monitor and evaluate new drugs and generics for safety and efficacy, provide opportunities for improved medication access, recommend drug interventions based on clinical information, and focus on influencing provider habits and utilization management strategies. The PBM also provides these services to CoverKids, Tennessee's CHIP Program, which utilizes a PBM commercial formulary. The PBM, through maintenance of the CoverKids formulary, oversight by the PBM's Pharmacy & Therapeutics (P&T) Committee, and operation of its

[7] *42 CFR 438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).*

utilization management programs, ensures the safety and efficacy of all medications offered through CoverKids Program thereby improving both medication access and appropriate medication utilization. Additionally, TennCare helps facilitate collaboration between the MCOs and PBM to enact change at the vendor level for the benefit of members.

The state's PBM utilizes an electronic Prospective Drug Utilization Review (ProDUR) monitoring system to screen prescriptions submitted for TennCare members to identify potential problems and concerns based on the members past prescription claim history and medical conditions. Pharmacy claims identified through this ProDUR monitoring system are flagged at the dispensing pharmacy to address pharmacy related medical concerns. The PBM relies on the Pharmacists to use their clinical expertise and judgment for prompt resolution of these medical related concerns through consultation with the member and/or provider prior to dispensing the medication. The PBM further requires pharmacists to submit specific ProDur edit codes or Professional Pharmacy Services (PPS) codes for members with specific needs, such as those with intellectual and/or developmental disabilities in the system to signify to the PBM that ProDUR edits have been resolved for the member. The PBM provides a reporting system to track outcomes of DUR, thus develop educational outreach to providers to further identify patients who require specific medication needs. The TennCare Retrospective DUR Reporting System mainly focuses on improving quality of care. The system allows the PBM to track the impact of DUR initiatives by comparing specified data elements pre and post intervention. DUR metrics and interventions are used to support quality improvements in all population types, and often become the catalyst for change during Committee meetings, or at the program level.

Quality Metrics and Performance Targets

Goal 1: Improve the health and wellness of mothers and infants

TennCare has several initiatives that aim to improve the health and wellness of mothers and infants. Since 2016, increasing access to most effective forms of contraception, such as long-acting reversible contraceptives (LARCs), has been a priority for TennCare. Three initiatives are in place to reduce barriers to LARCs : 1) TennCare supports reimbursement of immediate postpartum long-acting contraception in hospitals, 2) TennCare updated reimbursement policies to support reimbursement of same day LARC insertion as an office visit, and 3) TennCare partnered with a specialty pharmacy to support an inventory management program where LARC units are stocked in provider offices for point of care use. Increasing access to LARC may support patient-centered family planning and optimize interpregnancy intervals.

Providing maternal health care, including mental health, in the first year after delivery has been shown to have an outsized impact on early infant health and childhood development. TennCare continues to invest in women and children. In 2022, TennCare extended postpartum coverage and provided new dental coverage for members who have Medicaid during their pregnancy for the full 12 months. TennCare members who have Medicaid during their pregnancy now have continuous eligibly for 12 months following the end of a pregnancy and in 2023, TennCare

began providing dental coverage for all adult members. Additionally in 2023, TennCare added a new outpatient benefit for mothers and infants to see a lactation provider both before and after delivery.

Table 3. Goal 1 Quality Metrics and Performance Targets

Improve the health and wellness of mothers and infants				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Contraceptive Care – All women (CCW-AD and CCW-CH)*				
Long-acting reversible contraception, Ages 15-20	CMS Child Core Set	5.7% (2019)	N/A	Medicaid, CHIP, TennCare Select
Long-acting reversible contraception, Ages 21-44	CMS Adult Core Set	6.4% (2019)	N/A	Medicaid, CHIP, TennCare Select
Contraceptive Care – Postpartum Women (CCP-CH and CCP-AD)*				
Long-acting reversible contraception 3-day rate, Ages 15-20	CMS Child Core Set	2.2% (2019)	N/A	Medicaid, CHIP, TennCare Select
Long-acting reversible contraception 60-day rate, Ages 15-20	CMS Child Core Set	16.1% (2019)	N/A	Medicaid, CHIP, TennCare Select
Long-acting reversible contraception 3-day rate, Ages 21-44	CMS Adult Core Set	2.2% (2019)	N/A	Medicaid, CHIP, TennCare Select
Long-acting reversible contraception 60-day rate, Ages 21-44	CMS Adult Core Set	12.7% (2019)	N/A	Medicaid, CHIP, TennCare Select
Well Child Visits in the first 30 months of life (W30-CH)				
1st 15 months	CMS Child Core Set	53.7% (2020)	56.7% (2025)	Medicaid, CHIP, TennCare Select
15-30 months	CMS Child Core Set	67.8% (2020)	70.8% (2025)	Medicaid, CHIP, TennCare Select

* TennCare encourages increasing access to LARCs, but it is voluntary and as such, TennCare wants to be sure that it is member driven. Therefore, these quality metrics do not have a specific performance target. Metrics are included for tracking purposes.

Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions

TennCare was one of the first states to require all its managed care organizations to have a comprehensive population health program and required clinical risk stratification of the population so that resources could be efficiently optimized to help provide care coordination in a sustainable way. These population health efforts have resulted in significant targeted care coordination and supports that have made meaningful and measurable impacts in high-risk members healthcare journey. The efforts also have identified and scaled cost-effective approaches to ensuring members access to care.

Most recently, TennCare began integrating social risk factor supports into the population health strategy in 2019. TennCare has invested significant internal resources to improve the coordination around population health and social risk factors by collaborating with its MCO's to redesign the requirements of the population health programs to incorporate new emerging evidence and best practices.

TennCare's MCOs are held accountable for EPSDT screening rates. TennCare holds an annual EPSDT strategy meeting with all three MCOs to identify high-priority target areas and a joint strategy to continually improve the screening rates across the state. The MCOs are then required to develop an annual EPSDT investment plan that identifies areas of low screening rates and focus on investing new resources to closing care gaps. The MCO investment plans have included strategies such as member and provider incentives, scheduling platforms, and partnerships with behavioral health providers. Beginning January 2022, TennCare's MCOs were provided additional funding through the CDC COVID-19 Supplemental Funding Grant to engage in statewide events and outreach to improve well child visits and immunization rates. The funding will be available through FY24.

In 2016, TennCare launched the patient centered dental home (PCDH), which is a dental practice that maintains an ongoing relationship between the dentist and the patient inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible and coordinated way. Modeled after TennCare's Patient Centered Medical Home (PCMH) program, all primary care dentists, which include general and pediatric dentists who participate in TennCare Medicaid and CoverKids are required to be a dental home. The PCDH is critical in achieving improvements in oral health outcomes. The PCDH requires the DBM to use various metrics to rank providers based on quality and to make new member assignments and reassignments to dental homes based on provider performance. TennCare tracks member utilization of dental services, utilization of oral disease prevention measures and minimally invasive dental treatments such as Silver Diamine Fluoride (SDF). In 2023, dental coverage became effective for all adult TennCare members.

Table 4. Goal 2 Quality Metrics and Performance Targets

Increase use of preventive care services for all members to reduce risk of chronic health conditions				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC-CH)				
BMI percentile 3-11 years	CMS Child Core Set	80.2% (2019)	83.2% (2025)	Medicaid, CHIP, TennCare Select
BMI percentile 12-17 years	CMS Child Core Set	76.5% (2019)	79.5% (2025)	Medicaid, CHIP, TennCare Select
BMI percentile total	CMS Child Core Set	79.0% (2019)	82.0% (2025)	Medicaid, CHIP, TennCare Select
Immunizations for Children and Adolescents				
Childhood Immunization Status (CIS-CH) Combination 10	CMS Child Core Set	36.7% (2019)	39.7% (2025)	Medicaid, CHIP, TennCare Select
Immunization for Adolescents (IMA-CH) Combination 2	CMS Child Core Set	33.4% (2019)	36.4% (2025)	Medicaid, CHIP, TennCare Select
Breast Cancer Screening (BCS-AD)				

Breast cancer screening (BCS-AD)	CMS Adult Core Set	54.8% (2019)	57.8% (2025)	Medicaid, CHIP, TennCare Select
Asthma medication ratio (AMR-CH and AMR-AD)				
Overall	HEDIS	51.0% (2019)	54.0% (2025)	Medicaid, CHIP, TennCare Select
Dental measures				
Increase utilization of Silver Diamine Fluoride (SDF)	TennCare custom measure	0.6% (2019)	2.6% (2025)	Medicaid, CHIP
Increase the percentage of members 2-20 years of age who had one or more dental services annually	Partial enrollment adjusted ratio (PEAR), (Custom)	53.9% (2019)	55.9% (2025)	Medicaid, CHIP
Diabetes measures				
HbA1c Control (<8%) (HBD-AD)	CMS Adult Core Set	50.1% (2019)	53.0% (2025)	Medicaid, CHIP, TennCare Select
HbA1c Poor Control (>9%) (HBD-AD) *	CMS Adult Core Set	39.3% (2019)	36.3% (2025)	Medicaid, CHIP, TennCare Select
Blood Pressure Control (BPD)	HEDIS	60.4% (2019)	63.4% (2025)	Medicaid, CHIP, TennCare Select
Eye Exam (EED)	HEDIS	52.0% (2019)	55.0% (2025)	Medicaid, CHIP, TennCare Select
Kidney Health Evaluation (KED)	HEDIS	26.9% (2020)	28.9% (2025)	Medicaid, CHIP, TennCare Select
Child and Adolescent Well-Care Visits (WCV-CH)				
Ages 3-11	CMS Child Core Set	58.6% (2020)	60.6% (2025)	Medicaid, CHIP, TennCare Select
Ages 12-17	CMS Child Core Set	49.9% (2020)	51.9% (2025)	Medicaid, CHIP, TennCare Select
Ages 18-21	CMS Child Core Set	25.9% (2020)	27.9% (2025)	Medicaid, CHIP, TennCare Select

*Lower rates are better.

Goal 3: Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members

TennCare has a strong focus on patient-centered, holistic care that includes non-medical risk factors. The agency has a disparities plan[8] to identify, evaluate, and reduce, to the extent practical, health disparities based on age, race, ethnicity, sex, primary language, and disability status.

Identification of health disparities and disability status

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

[8] *42 CFR 438.340(b)(6), applicable also to CHIP managed care programs per 42 CFR 457.1240(e).*

statuses and instructs the applicant that responses to the race, ethnicity, and language questions are voluntary. An individual is considered disabled if they qualified for Medicaid on the basis of having a disability.

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

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

Evaluation of health disparities

TennCare addresses disparities in healthcare through tracking the rates of illness and chronic conditions in relation to key demographic factors. TennCare contractually requires the MCOs to conduct QM/QI activities to address healthcare disparities identified through data collection and requires them to include the methodology utilized for collecting the data as well as interventions taken to enhance the accuracy of the data collected. Additionally, TennCare is directly working to reduce healthcare disparities through contractually requiring its MCOs to provide essential networks and services required to address disparity issues. These requirements include providing care coordination and direct support services for CHOICES HCBS enrollees and Employment and Community First CHOICES enrollees. Dual Eligible Special Needs Plans (D-SNPs) are also charged with coordinating health-related social supports that may impact dual eligible members' health-related behaviors and outcomes.

Reducing health disparities

Social risk factors of health are conditions in the environment where TennCare members are born, live, learn, work, play, worship, and age that have an outsized impact on individuals' health. In Tennessee, risk factors directly related to an individual's social, economic, and physical environment are estimated to drive at least 40-60% of an individual's health. These risk factors affect a wide range of health, functioning, and quality-of-life outcomes. TennCare, as part of its 4-year strategic plan, has begun integrating whole-person health approaches to better address the social risks of our TennCare members. These efforts, which TennCare refers to broadly as its "Health Starts Initiative," span a series of evidence-based and innovative initiatives that aim to provide clinical supports, resources, and technological enhancements to reduce the impact of social risk factors.

On April 1, 2021, TennCare's MCOs began piloting efforts with key TennCare providers to determine how to consistently screen members for social needs, refer members to community resources to meet identified needs, and ensure that the social needs referral was completed. The provider partnerships are also designed to measure impact on the member and uncover best practices associated with addressing needs at the provider level. TennCare's goal is to take the best practices and new innovative approaches and scale them across multiple provider types to include primary care, hospital- based care, post-acute care, LTSS, and community partners.

In June 2023, TennCare issued and launched a community health worker (CHW) grant program to Tennessee providers to support the implementation of evidence-based best practices. Eight provider organizations across the state were selected to receive technical support and facilitating sustainability efforts as these provider organizations to hire and onboard CHW and CHW supervisors and provide CHW services to TennCare members. Each grant will continue for a minimum of two years. The efforts of these organizations will directly support TennCare's ability to gather learnings and best practices to support the three-year goal of implementing a sustainable financial reimbursement model for community health worker services. Additionally, the Tennessee Community Health Worker Association (TNCHWA) was awarded a grant to build out program standards for CHW organizations and creating the foundation to serve as an accrediting body for CHW organizations across the state.

TennCare is also integrating a statewide, Closed-Loop Referral System (CLRS) to provide enhanced support to providers and MCOs as they address social needs in the TennCare population. The CLRS is a technology-based platform that facilitates systematic social risk referrals and contains up-to-date community resource directories and referral outcomes tracking capabilities. The solution will serve as a repository of community-based resources to be utilized by the MCOs and healthcare providers. Social risk factor questionnaires can be performed in the system and will serve as data to populate community resources for member referrals. The system also supports data analytics to understand the population health needs and other key health outcome metrics which will be used to further improve and refine existing efforts and expand the way TennCare meets social needs and addresses social risk factors.

In addition to programmatic efforts, TennCare MCOs are required to obtain and maintain NCQA's Health Equity Accreditation. The distinction isa representation of TennCare's commitment to offer culturally and linguistically appropriate services and provides an avenue to evaluate how well the MCOs comply with standards for collecting race/ethnicity and language data, provide language assistance, cultural responsiveness, quality improvement of CLAS, and reduction of health care disparities. As of March 2023, all MCOs achieved the Health Equity Accreditation.

Patient-Centered Focus

TennCare is committed to ensuring enrollees' satisfaction with services. TennCare contracts with the University of Tennessee Boyd Center for Business and Economic Research to conduct an annual survey of 5,000 Tennessee households to gather information on insurance status, how individuals and families engage in the health care process and satisfaction with TennCare. The design for the survey is a "household sample," and the interview is conducted with the head of the household. The report, "The Impact of TennCare: A Survey of Recipients", allows comparison between responses from all households and households receiving TennCare. The most recent 2022 survey shows that 95 percent of TennCare recipients expressed satisfaction with the program's quality of care, making 2022 the 14th straight year in which satisfaction with TennCare exceeded 90 percent. TennCare is proud of the growth in member satisfaction that has been achieved over time. This improvement is a reflection of TennCare's commitment to high quality care and performance improvement.

Table 5. Goal 3 Quality Metrics and Performance Targets

Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Non-medical risk factors (Health Starts)				
Increase the number of authorized users using a statewide CLRS	TennCare Custom	0 (2022)	600 (2025)	Medicaid, CHIP, LTSS, TennCare Select
Increase the percentage of referrals created by MCO to meet identified needs	TennCare Custom	52.9% (2021)	54.9% (2025)	Medicaid, CHIP, LTSS, TennCare Select
LTSS Member Satisfaction				
Increase the percentage of CHOICES members who report that people who are paid support staff show up and leave when they are supposed to	(NCI-AD Q 29)*	69.0% (2018/2019)	71.0.0% (2025)	LTSS
Increase the percentage of ECF CHOICES members who report their paid support staff show up and leave when they are supposed to	(NCI-IPS Q 43)*	N/A**	N/A	LTSS
Increase the percentage of Katie Beckett member families satisfied with the services and supports their child currently receives	(NCI-CFS Q 61)	N/A**	N/A	LTSS

* Reflects updated numerical order for 2023-2024 NCI-IPS and NCI-AD surveys.

** Baseline data will be available for the 2024 update.

Goal 4: Improve positive outcomes for members with LTSS needs

Each of the MLTSS programs is specifically designed to support the achievement of specific outcomes.

CHOICES

The CHOICES program provides home and community-based services (HCBS) for elderly and/or physically disabled persons who would otherwise require Nursing Facility (NF) services. TennCare provides these services for individuals at a cost that does not exceed the individual cost neutrality test used in a Section 1915(c) waiver. Through improved coordination of care and use of more cost-effective home and community-based alternatives, TennCare expands access to home and community-based services for persons who do not yet meet a NF level of care, but who are "at risk" of needing NF services, thereby delaying or preventing the need for more expensive institutional care.

Employment and Community First CHOICES

The Employment and Community First CHOICES program is a tiered benefit structure based on the needs of individuals enrolled in the program and allows the state to provide HCBS and other Medicaid services more cost-effectively so that more people who need HCBS can receive them. This includes people with ID who would otherwise be on the waiting list for a section 1915(c) waiver and people with other DD who are not eligible for Tennessee's current section 1915(c) waivers. The development of a benefit structure and the alignment of financial incentives specifically geared toward promoting integrated competitive employment and integrated community living will result in improved employment and quality of life outcomes.

Katie Beckett

The Katie Beckett program was designed for children under the age of 18 with disabilities or complex medical needs. The program supports children with disabilities and complex medical needs to grow and thrive in their homes and communities, including planning and preparing the child for transition to employment and community living with as much independence as possible. The program also supports and empowers families caring for a child with disabilities or complex medical needs at homes and keeps families together and sustains family caregivers. The program provides services in the most cost-effective manner possible in order to serve as many children as possible within approved program funding.

Identification of persons who need LTSS or require special health care needs[9]

The state provides LTSS benefits through managed care. The MCOs are contractually required to make a best effort to conduct an initial screening of each member's needs, within ninety (90) days of the effective date of enrollment for all new members to assess member's health risk utilizing a health risk assessment or a comprehensive health risk assessment. The MCO must make subsequent attempts to conduct an initial screening of each member's needs if the initial attempt to contact the member is unsuccessful. The information collected from these health assessments will be used to align individual members with appropriate intervention approaches and maximize the impact of the services provided.

At time of enrollment and annually thereafter, the MCO must make a reasonable attempt to assess the member's health. The comprehensive health risk assessment required by Level 2 Population Health programs, CHOICES, ECF CHOICES, Katie Beckett, Dual Special Needs Program (D-SNP), Select Community, and Department of Children's Services (DCS) can be used in lieu of the approved health assessment required by the contract. The completed approved health assessment or comprehensive health risk assessment data may be shared among TennCare MCOs and used to meet the annual requirement. The MCO shares with TennCare, or other MCCs serving the member, the results of any identification and assessment of that member's needs to assist in facilitating the administration of health-related services and to prevent duplication of those activities.

The MCO conducts a comprehensive Health Risk Assessment (HRA) for all members enrolled in the Chronic Care Management, Complex Case Management, and High-Risk Maternity Programs. The HRA should include screening

[9] *42 CFR 438.340(b)(8), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.208(c)(1) and 457.1230(c).*

for physical conditions, mental health, and substance abuse for all members. For members considered high risk, the assessment includes documenting the individual health history, determining each member's health literacy status, identifying substance abuse and behavioral issues/problems, identifying needs and gathering information, when appropriate, from other sources (e.g., family members, medical providers, and educators). The MCO also conducts an assessment for the need of a face-to-face visit for members considered to have high health risks that are enrolled in the Chronic Care Management, Complex Case Management, or High-Risk Maternity programs. The MCO will assess the need for a face-to-face visit using the standard assessment criteria provided by TennCare. If needed, such a visit will be conducted following consent of the member.

The PBM also identifies persons with special health care needs by updating its eligibility file on a daily basis. The PBM receives daily MMIS eligibility file updates from TennCare and includes the general TennCare and CoverKids members and those identified by a unique indicator as being in a special needs' program including CHOICES, ECF CHOICES, Department of Children's Services (DCS) Select Community, and dual eligible Medicare/Medicaid members. Katie Beckett members are included in the daily file, but they are not identified by an indicator. Rather a separate monthly file from TennCare is provided to the PBM with the Katie Beckett members identified, which is uploaded to the PBM's system.

Table 6. Goal 4 Quality Metrics and Performance Targets

Improve positive outcomes for members with LTSS needs[10]				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Quality of Life				
Increase percentage of CHOICES members who report they feel like they have more choice and control over their life than 12 months ago.	NCI-AD (Q TN-5)	19.0% (2018-2019)	21.0% (2025)	LTSS
Increase percentage of ECF CHOICES members who report having enough choice in life decisions.	NCI-IPS (Q72-75, 82)*	N/A**	N/A	LTSS
Increase percentage of parents/families who report feeling that services and supports have improved their ability to care for their child	NCI-CFS (Q 64)	N/A**	N/A	LTSS
Community Integration				
Increase percentage of working age adults with I/DD enrolled in HCBS who are employed in an integrated setting earning at or above minimum wage	ECF CHOICES baseline data	28.0% (2021)	30.0% (2025)	LTSS

[10] *42 CFR 438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.330(c)(1)(ii).*

Increase the percentage of older adults and adults with physical disabilities who report being as active in their community they would like.	NCI-AD (Q 53)*	56.0% (2021-2022)	60.0% (2025)	LTSS
Increase the percentage of individuals with I/DD who report satisfaction with the level of participation in community inclusion activities	NCI-IPS (Q 56, 58, 59, 61)*	N/A**	N/A	LTSS
Increase the percentage of children participating in activities in the community	NCI-CFS (Q 40)	N/A**	N/A	LTSS
Rebalancing				
Increase HCBS expenditures for older adults and adults with physical disabilities as a percentage of total LTSS expenditures	CHOICES baseline data	21.1% (2021)	23.1% (2025)	LTSS
Increase HCBS expenditures for individuals with I/DD as a percentage of total LTSS expenditures	ECF CHOICES baseline data	28.8% (SFY 2021)	30.8% (2025)	LTSS
LTSS HEDIS Measures – Comprehensive Assessments and Care Plans				
Comprehensive Assessment and Update (LTSS-CAU)				
Assessment of Core Elements	HEDIS	78.0% (2019)	80.0% (2025)	LTSS
Assessment of Supplemental Elements	HEDIS	74.6% (2019)	76.6% (2025)	LTSS
Comprehensive Care Plan and Update (LTSS-CPU)				
Care Plan with Core Elements Documented	HEDIS	75.6% (2019)	77.6% (2025)	LTSS
Care Plan with Supplemental Elements Documented	HEDIS	75.5% (2019)	77.5% (2025)	LTSS
Reassessment/Care Plan Update after Inpatient Discharge (LTSS-RAC)				
Reassessment after Inpatient Discharge	HEDIS	21.1% (2019)	23.1% (2025)	LTSS
Reassessment and Care Plan Update after Inpatient Discharge	HEDIS	16.6% (2019)	18.6% (2025)	LTSS
Shared Care Plan with Primary Care Practitioner (LTSS-SCP)				
Shared Care Plan with Primary Care Practitioner	HEDIS	53.7% (2019)	55.7% (2025)	LTSS

*Metric replaced to align with CMS' HCBS Quality Measure Set, updated measure comparable to existing measure.
**Baseline data will be available for the 2024 update.

Goal 5: Provide additional support and follow-up for patients with behavioral health care needs

TennCare and its contracted MCOs operate two statewide behavioral health programs where the focus is on improving healthcare quality outcomes and care coordination for members with severe and persistent mental illness (SPMI) and/or substance use disorders (SUD).

Tennessee Health Link (THL) coordinates health care services for TennCare members with the highest behavioral health needs. Through better coordinated behavioral and physical health services, the Health Link program is meant to produce improved member outcomes, greater provider accountability and multidisciplinary care coordination when it comes to the delivery of appropriate care for each individual, and improved cost control for the state. For more information about THL, see goal 7.

Buprenorphine Enhanced Medication Assisted Recovery and Treatment (BESMART) Program was developed in 2019 to be a specialized provider network focused on contracting with high quality medication assisted treatment (MAT) providers to provide comprehensive care to TennCare members with SUD. BESMART providers commit to providing best practice clinical standards of comprehensive medication assisted therapy, care coordination, behavioral health support.

Table 7. Goal 5 Quality Metrics and Performance Targets

Provide additional support and follow-up for patients with behavioral health care needs				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Use of Opioids at High Dosage in Persons without Cancer (OHD-AD)				
Use of Opioids at High Dosage in Persons without Cancer*	CMS Adult Core Set	2.9% (2019)	1.9% (2025)	Medicaid
Concurrent Use of Opioids and Benzodiazepines (COB-AD)				
Concurrent Use of Opioids and Benzodiazepines*	CMS Adult Core Set	9.4% (2019)	8.4% (2025)	Medicaid
Follow-up After Hospitalization for Mental Illness (FUH-AD)				
7-day rate	CMS Adult Core Set	33.5% (2019)	35.5% (2025)	Medicaid, CHIP, TennCare Select
30-day rate	CMS Adult Core Set	55.4% (2019)	57.4% (2025)	Medicaid, CHIP, TennCare Select
Follow-up After Hospitalization for Mental Illness (FUH-CH)				
7-day rate	CMS Child Core Set	51.4% (2019)	53.4% (2025)	Medicaid, CHIP, TennCare Select
30-day rate	CMS Child Core Set	73.3% (2019)	75.3% (2025)	Medicaid, CHIP, TennCare Select
Use of Pharmacotherapy for OUD (OUD-AD)				
Total Rate	CMS Adult Core Set	32.4% (2019)	34.4% (2025)	Pharmacy
Buprenorphine	CMS Adult Core Set	28.0% (2019)	30.0% (2025)	Pharmacy

*Lower rates are better.

Goal 6: Maintain robust member access to health care services

TennCare monitors MCO General Network Access, Specialty Network Access, Behavioral Health Network Access and Long Term Services & Supports. The standards can be accessed at https://www.tn.gov/tenncare/information-statistics/tenncare-contracts.html. All TennCare Network Access Requirements are located in Attachment III (General Access), Attachment IV (Specialty) and Attachment V (Behavioral Health) of the CRA. TennCare has

historically maintained 100% network access with its contracted MCOs for many years. As new standards have been developed over the years, TennCare sets benchmarks over several months that MCOs must meet prior to go live.

The state's MCCs are contractually required to provide available and accessible, adequate numbers of contracted providers for the provision of TennCare covered services. The Division of TennCare uses Quest Analytics software as to monitor enrollee access to care. These software applications and other measures are utilized to identify potential deficiencies in each MCC's provider network. Geo Reports are routinely prepared for each MCC monthly. If a potential network deficiency is identified, the MCC is notified and is requested to address the deficiency.

Transition of Care

TennCare maintains a transition of care policy that addresses transfers between managed care contractors and that ensures continued access to services during any transition between managed care contractors.[11] This transition of care policy specifies that transferring enrollees continue to have access to services consistent with their prior access, including the ability to retain their current provider for a period of time if that provider is not in the new managed care contractor's network. In addition, the transition of care policy ensures that the enrollee is referred to appropriate providers of services that are in the new managed care contractor's network. Under the state's transition of care policy, the enrollee's old managed care contractor must fully and timely comply with appropriate information requests from the enrollee's new managed care contractor, including requests for historical utilization data. In addition, the enrollee's new providers are able to obtain copies of the enrollee's medical records, consistent with federal and state law. The transition of care policy also includes a process for the electronic exchange of specified data classes and elements.

Table 8. Goal 6 Quality Metrics and Performance Targets

Maintain robust member access to health care services				
Metric Name	**Metric specifications**	**Baseline performance (year)**	**Performance target (year)**	**Program**
Adult Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20-44	HEDIS	79.0% (2019)	81.0% (2025)	Medicaid, CHIP, TennCare Select
Ages 45-64	HEDIS	87.7% (2019)	89.7% (2025)	Medicaid, CHIP, TennCare Select
General Network Access Standards				
Maintain high compliance for adult members	General Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP, LTSS
Maintain high compliance for pediatric members	General Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
Specialty Network Access Standards				
Maintain high compliance for adult members	Specialty Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
Maintain high compliance for pediatric members	Specialty Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP

[11] *42 CFR 438.340(b)(5), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.62(b).*

Behavioral Network Access Standards				
Maintain high compliance for adult members	Behavioral Health Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
Maintain high compliance for pediatric members	Behavioral Health Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
General Dental Network Access Standards				
Maintain high compliance for adult members	General Dental Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP, LTSS
Maintain high compliance for pediatric members	General Dental Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
Maintain high compliance for ECF CHOICES members	General Dental Network Access standards	99.9% (2021)	100% (2025)	LTSS
Pharmacy Network Access Standards				
Maintain high compliance for adult members	Pharmacy Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
Maintain high compliance for pediatric members	Pharmacy Network Access standards	100% (2021)	100% (2025)	Medicaid, CHIP
LTSS Network Access Standards				
Maintain high compliance for CHOICES HCBS members	MLTSS Network Adequacy Scores	100% (2021)	100% (2025)	LTSS
Maintain high compliance for ECF CHOICES members	MLTSS Network Adequacy Scores	99.8% (2021)	100% (2025)	LTSS

Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care

Patient-Centered Medical Homes

TennCare's Patient Centered Medical Home (PCMH) program aims to improve the quality of primary care services for members, the capabilities and reach of primary care providers, and the overall quality of health care delivered to the TennCare population. TennCare believes that a strong primary care system is the backbone of a thriving health care delivery system. Primary care transformation focuses on the role of the primary care provider: preventing illness, managing chronic illnesses, coordinating care with other providers, and engaging members in the community. As part of Tennessee's Health Care Innovation Initiative, the state has committed to moving away from paying for volume to paying for value. The mission is to reward health care providers for improving health outcomes by providing high quality and efficient treatment of medical conditions and maintaining people's health over time. This strategy includes PCMH for the general population of adults and children, a Tennessee Health Link (THL) model for TennCare members with high behavioral health needs, and a Care Coordination Tool that offers additional information to primary care providers (e.g., it alerts primary care providers when their patients go to the emergency room or the hospital). The PCMH program launched in January 2017 and serves children and

adults. As of March 2022, approximately 40% percent of TennCare members are attributed to one of over 80 organizations, and 450 sites statewide.

Across program years 2017, 2018, and 2019 TennCare observed improved quality in 11 of the 13 measures. TennCare utilizes the National Committee for Quality Assurance (NCQA) HEDIS® measures for the majority of PMCH Core Quality Measures. The largest improvements were seen in the metrics Comprehensive Diabetes Care: Blood Pressure Control (<140/90) and BMI Percentile Assessment for Children/Adolescents which both improved an average of 12 percentage points across the three years. Well-child visit screening rates increased for ages 7 – 11 by six percentage points, and by two percent points for ages 3 – 6, the first 15 months and ages 12 - 21.

Tennessee Health Link

The primary objective of THL is to coordinate health care services for TennCare members with the highest behavioral health needs. Through better coordinated behavioral and physical health services, the Health Link program is meant to produce improved member outcomes, greater provider accountability and flexibility when it comes to the delivery of appropriate care for each individual, and improved cost control for the state. There are 18 agencies who provide THL services across the state.

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

Episodes of Care

TennCare's Episodes of Care program strives to transform the way specialty and acute healthcare services are delivered in Tennessee by incentivizing high-quality, cost-effective care; encouraging provider coordination; and disincentivizing ineffective and/or inappropriate care. An episode of care includes all the relevant health care services a patient receives during a specified period for the treatment of a physical or behavioral health condition. For each episode of care, a principle accountable provider (or "quarterback") is defined and held accountable for the quality and cost of care delivered during the entire episode. With regards to promoting quality, these "quarterbacks" are given quarterly reports outlining how that provider has performed on the gain-sharing quality metrics (i.e., metrics tied to financial accountability) and informational quality metrics of the episodes they are responsible for. If the "quarterback" meets cost and quality thresholds for a given episode, that provider then becomes eligible for a reward payment, based on shared savings. Tennessee is committed to providing quality data for episodes on an annual basis. Based on the latest full-year set of performance data, 51 percent of quality metrics tied to gain-sharing improved or maintained performance from 2020 to 2021. A full summary of each gain-sharing quality metric and its year-over-year performance in the program can be found under the "Results" section at the following link: https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/results-changes.html. If TennCare identifies a quality metric that has undergone a significant decrease in performance,

the state works alongside its MCO partners to analyze the data, identify potential reasons for the change (e.g., updated practice guidelines, new medical codes, etc.), and update an episode's design if applicable.

Quality Improvement in Long-Term Services and Supports (QuILTSS)

Nursing Facilities

Quality Improvement in Long-Term Services and Supports (QuILTSS) is the name given to TennCare's value-based purchasing and delivery system transformation (VBP/DST) approach for LTSS. QuILTSS encompasses a number of initiatives focused on promoting a person-centered approach to service planning and delivery, improving quality of care and quality of life, and shifting payment to be outcomes driven and other VBP approaches, with a primary emphasis on improving the member's experience of care across services and settings, including nursing facilities (NFs) and home and community- based services (HCBS).

Working in partnership with stakeholders, Tennessee is continuing to implement quality- and acuity-based payment and delivery system reform for Long-Term Services and Supports Nursing Facility services. Successes already realized from this work include a nursing home payment structure that takes into account the acuity of residents and the quality of care provided as well as a 25 percent reduction in payments to nursing homes for complex respiratory care with more people weaned from the ventilator and reductions in adverse outcomes (infections, hospitalizations, deaths).

Home and Community Based Services (HCBS)

HCBS QuILTSS also encompasses a number of different VBP/DST initiatives across TennCare's HCBS programs and authorities. The Systems of Support (SOS) model was implemented in early 2016 as a new model of support for the delivery of behavioral crisis prevention, intervention, and stabilization services for individuals with intellectual and developmental disabilities (I/DD). Delivered under the managed care program, the service focuses on crisis prevention, in-home stabilization, sustained community living, and improved quality of life for individuals with challenging behaviors that place themselves and others at risk. The VBP approach utilizes a monthly case rate aligned to support improvement and increased independence over time as the provider is successful in helping paid or unpaid caregivers increase their capacity to provide needed support in order to prevent and/or manage crises. A second VBP component introduced in 2019 added outcome-based deliverables in order to receive monthly payments. Learnings from this initiative helped to inform the design of new Groups 7 and 8 in Employment and Community First CHOICES (described below), including the VBP/DST approach and data collection process (which was launched before the collection of non-claims-based SOS measurement data).

Employment and Community First CHOICES is a managed LTSS program designed to promote integrated employment and community living as the first and preferred outcome for individuals with I/DD. Employment benefits designed in consultation with experts from the federal Office of Disability Employment Policy create a pathway to employment, even for people with severe disabilities. Reimbursement for employment benefits in this program reflects a variety of value-based approaches including outcome-based reimbursement for up-front services leading to employment, tiered outcome-based reimbursement for Job Development and Self-Employment Start-Up based on the member's "acuity" level and paid in phases to support tenure, and tiered reimbursement for Job Coaching also based on the member's acuity, but taking into account the length of time

the person has held the job and the amount of paid support required as a percentage of hours worked (which helps to incentivize greater independence in the workplace, the development of natural supports, and the fading of paid supports over time).

New Groups 7 and 8 targeted specifically to children and adults, respectively, with I/DD and severe co-occurring psychiatric conditions or challenging behavior support needs, were implemented in September 2019. Building on the lessons learned from the SOS model, the VBP approach for the primary benefit in each group — Intensive Behavioral Family-Centered Treatment, Stabilization and Support and Intensive Behavioral Community Transition and Stabilization Services, respectively — combines outcome-based deliverables with a monthly case rate aligned to support improvement and increased independence over time.

LTSS Workforce Incentives

An essential component of the comprehensive strategy is the alignment of incentives for workers to both enroll and especially to complete the education program. Funding for this program was made available as part of the FY21 budget to launch direct wage incentives to workers delivering Medicaid services in TennCare's CHOICES (including NF and HCBS), Employment and Community First CHOICES, and Section 1915(c) HCBS waivers operated by DIDD.

While the education program was poised to launch in the fall 2020 the onset of the COVID-19 public health emergency (PHE) resulted in loss of funding from the state budget as well as a shift in the focus of Tennessee's Community Colleges and Colleges of Applied Technology to converting all classes to an online format in preparation for the fall semester. In addition, the COVID-19 pandemic resulted in the loss of one of TennCare's longstanding competency-based education partners. However, with the availability of ARPA FMAP funding, Tennessee pivoted to a revised and diversified plan and launched the workforce development education and training program, *TN Direct Support Professional Training,* providing quality incentive payments to Direct Support Professionals (DSPs) and Frontline Supervisors, who complete accredited, competency-based curriculum. Additionally, this amended plan offers providers incentives for promoting and encouraging their DSPs to participate and complete the competency-based trainings.

Performance Improvement Projects (PIP) and PIP interventions[12]

In accordance with the contractor risk agreements (CRAs) with TennCare, MCOs must conduct at least two clinical and at least three non-clinical PIPs. The DBM and PBM must conduct at least one clinical and one non-clinical PIP, respectively. For MCOs, the two required clinical PIPs must include one study on behavioral health relevant to one of the population health programs for bipolar disorder, major depression, or schizophrenia, while the other must focus on child or perinatal health. One of the three required non-clinical PIPs must be conducted in the area of long-term care focusing on one of the HEDIS LTSS measures, or other efforts to drive quality performance and improvement in person-centered planning or person-centered support plans. In addition, MCOs must conduct a study on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening and outreach if their overall CMS-

[12] *42 CFR 438.340(b)(3)(ii), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.330(d) and 457.1240(b).*

416 rates are below 80%. Each of the PIPs tie into the Quality Strategy and advance at least one of the state's goals and objectives. See Appendix 3 for the full listing of PIPs for each MCC.

Section III: Monitoring and Compliance

Network adequacy and availability of services[13]

TennCare's MCCs consistently maintain adequate networks. Remediation efforts (e.g., CAP, ORR, or RFI) are rarely required to address a deficiency. Additionally, TennCare maintains high compliance scores for access and availability for its MCOs and the DBM.

TennCare provides the state's MCO network adequacy and availability of services standards within the Contractor Risk Agreement (CRA), which can be found at https://www.tn.gov/tenncare/information-statistics/tenncare-contracts.html. All TennCare Network Access Requirements are located in Attachment III (General Access), Attachment IV (Specialty) and Attachment V (Behavioral Health) of the CRA. The standards apply for Medicaid, CHIP and LTSS members.

General Network Access (Attachment III of CRA)
TennCare MCOs provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis for all members (adults and children) as outlined in the General Network Access requirements.

Specialty Network Access (Attachment IV of CRA)
TennCare MCOs adhere to Specialty Network Access requirements to ensure access and availability to specialists for all members (adults and children) who are not dually eligible for Medicare and TennCare (non-dual members). For the purpose of assessing specialty provider network adequacy, TennCare evaluates the MCO's provider network with monitoring these 17 specialties: Allergy, Cardiology, Chiropractic, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Nephrology, Neurology, Neurosurgery, Oncology/Hematology, Ophthalmology, Orthopedics, Psychiatry (adult), Psychiatry (child and adolescent), and Urology.

Behavioral Health Network Access (Attachment V of CRA)
TennCare MCOs adhere to the following Behavioral Health Network Access requirements to ensure access and availability to behavioral health services for all members (adults and children). For the purpose of assessing behavioral health provider network adequacy, TennCare evaluates the MCO's provider network relative to the contractual requirements. Providers serving adults are evaluated separately from those serving children.

MLTSS Network Access
In addition to the General Network Access standards above, TennCare has established specific MCO standards regarding network adequacy for MLTSS providers to include time and distance standards for LTSS provider types in which an enrollee must travel to the provider to receive services.[14] Additionally, TennCare has MCO network

[13] *42 CFR 438.340(b)(1), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.68, 438.206, 457.1218, and 457.1230(a).*
[14] Pursuant to 42 CFR 438.68(2), in addition to the requirements in Section A.2.11.1 and Attachment III of the CRA. *See CRA Section A.2.11.7.*

adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services. For services provided in the member's home, MCOs must ensure a choice of providers for every HCBS and a sufficient number of providers to initiate services as specified in the person-centered support plan ensuring continuity of services without gaps in care. MCO standards also apply for special populations, specifically that individuals with I/DD have a network of providers with appropriate experience and expertise in serving people with I/DD and in achieving important program outcomes, such as employment.

In the future, TennCare intends to incorporate quality performance as part of the network adequacy structure for LTSS. At this juncture, TennCare is implementing quality monitoring and quality measurement processes that will allow the state to identify high performing providers and to establish a process for taking quality performance into consideration as part of the review of network adequacy for LTSS providers.

General Dental Services

The DBM makes services, service locations and service sites available and accessible so that transport distance/time to general dental, oral surgery services, orthodontic services, pediatric dental services and dental specialty providers will be the usual and customary, not to exceed the network access standards as outlined in the Dental Benefit Managers contract, found at: https://www.tn.gov/content/dam/tn/tenncare/documents2/DentaQuest59802.pdf.

Pharmacy Benefit Services

The PBM provides available, accessible, and adequate numbers of pharmacies to meet the pharmacy network access standards as outlined in the Pharmacy Benefits Managers contract, found at https://www.tn.gov/content/dam/tn/tenncare/documents2/Optum3186500600.pdf.

Clinical practice guidelines[15]

The state requires MCOs to utilize evidence-based clinical practice guidelines required by 42 CFR 438.236 in its Population Health Programs. Wherever possible, MCOs utilize nationally recognized clinical practice guidelines. For example, all three MCOs use the nationally recognized Guidelines for Perinatal Care (American Academy of Pediatrics & American Congress of Obstetrics and Gynecology) and the Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease (Global Initiative for Chronic Obstructive Lung Disease (GOLD)). On occasion, tools for standardized specifications for care to assist practitioners and patient decisions about appropriate care for specific clinical circumstances are developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus. The guidelines must be reviewed and revised whenever the guidelines change and at least every two years. The MCO is required to maintain an archive of its clinical practice guidelines for a period of five years. Such archive must contain each clinical guideline as originally issued so that the actual guidelines for prior years are retained for program integrity purposes. All MCOs are required to be NCQA accredited. As part of the accreditation survey, files are reviewed to ensure that the NCQA requirements for clinical practice guidelines are met.

[15] *42 CFR 438.340(b)(1), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.236 and 457.1233(c).*

TennCare prioritizes the use of evidenced-based practice and clinical interventions that have demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness.

For additional information on each MCOs clinical practice guidelines, please see the following websites:

Amerigroup
https://provider.amerigroup.com/docs/gpp/TN_CAID_ClinicalPracticeGuidelinesMatrix.pdf?v=202106011539

BlueCare
https://provider.bcbst.com/tools-resources/manuals-policies-guidelines

UnitedHealthcare
https://www.uhcprovider.com/en/health-plans-by-state/tennessee-health-plans/tn-comm-plan-home/tn-cp-policies.html

Intermediate sanctions[16]

Tennessee's managed care contracts include the use of intermediate sanctions against managed care contractors for failure to meet performance standards. Consistent with federal regulations, these sanctions may be imposed upon a reasonable determination by the state that the contractor is deficient in the performance of its obligations, which include (but may not be limited to):

- Fails substantially to provide medically necessary covered services;
- Imposes on members cost sharing responsibilities that are in excess of the cost sharing permitted by TennCare;
- Acts to discriminate among enrollees on the basis of health status or need for health care services;
- Misrepresents or falsifies information that it furnishes to CMS or to the State;
- Misrepresents or falsifies information furnished to a member, potential member, or provider;
- Fails to comply with the requirements for physician incentive plans as listed in 42 CFR 438.6(h);
- Has distributed directly, or indirectly through any agent or independent contractor, marketing or member materials that have not been approved by the state or that contain false or materially misleading information; and
- Has violated any of the other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

Intermediate sanctions imposed by the state against a contractor may include the development and implementation of corrective action plans, liquidated damages, suspension of enrollment, disenrollment of members, limitation of the contractor's service area, civil monetary penalties (as provided for in 42 CFR 438.704), appointment of temporary management (as provided for in 42 CFR 438.706), or suspension of payment for members enrolled after the effective date of the sanction until the state is satisfied that the issue has been resolved. These remedies provide the state with a range of administrative mechanisms to address performance

[16] *42 CFR 438.340(b)(7), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing Part 438 Subpart I*

issues. The disposition of any corrective action depends upon the nature, severity and duration of a deficiency or non-compliance.

Compliance with Federal LTSS Requirements[17]

While populations served through LTSS programs are included in the performance objectives listed above, TennCare has also outlined the compliance measures specific to LTSS populations given the unique needs of those served. These measures specific to CHOICES were established based on section 1915(c) waiver assurances and sub-assurances, including level of care, service plan, qualified providers, health and welfare, administrative authority, and participant rights—largely measures of compliance with federal and/or state requirements.

Upon implementation of Employment and Community First CHOICES and Katie Beckett, these measures were expanded to encompass the new programs. In addition, TennCare incorporated quality components of the Medicaid Managed Care Rule specified in 42 C.F.R. § 438.330. More recently, STC 52 to the TennCare III Demonstration, Quality Improvement Strategy for 1915(c) or 1915(i)-approvable HCBS Services, requires that "the state's Quality Assessment and Performance Improvement Plan must encompass LTSS-specific measures set forth in the federal rule and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302." Appendix 4 outlines compliance measurement goals and objectives for the State's three MLTSS programs – CHOICES, Employment and Community First CHOICES, and Katie Beckett Part A Programs.

[17] TennCare III Demonstration, STC 51: Quality Improvement Systems and Strategy for the CHOICES, ECF CHOICES, and Katie Beckett (Part A) Programs. TennCare III Demonstration, STC 52: Quality Improvement Strategy for 1915(c) or 1915(i) approvable HCBS Service s.

Section IV: External Quality Review Arrangements

EQR arrangements[18]

Tennessee contracts with Qsource to provide all External Quality Review (EQR) activities. The contract is effective beginning on September 1, 2020 and ends on September 30, 2023. The contract may be extended with the state reserving the right to execute two (2) one-year renewal options extending the contract term no longer than September 30, 2025. The services to be provided under this contract include multiple tasks and deliverables that are consistent with applicable federal EQR regulations and protocols for Medicaid Managed Care Organizations and state-specific requirements. The contract allows the state to be compliant with Federal EQR regulations and rules and to measure MCC-specific compliance with the TennCare Section 1115 Waiver.

Qsource conducts independent reviews of the quality outcomes, timeliness of and access to the services covered under each MCC. The Annual Quality Survey reviews the MCOs' compliance with Medicaid and CHIP Managed Care regulations. It includes a review of enrollee rights and protections, quality assessment and performance improvement, structure and operation standards, measurement and improvement standards, and compliance with the appeal process. The survey process includes document review, interviews with key MCC personnel, and an assessment of the adequacy of information management systems. In addition to this survey, QSource conducts Performance Improvement Project validations and Performance Measure Validation in accordance with federal requirements. Qsource also conducts an Annual Network Adequacy survey to determine the extent to which the MCCs' networks are compliant with contractual requirements. The EQRO provides these reviews for all MCOs, DBM, and the PBM. Tennessee contracts with FIDE-SNPs that are fully aligned with the MCOs. These plans and their members are included in the state's EQR activities and in the annual EQR technical report.

EQR non-duplication option[19]

TennCare exercises the non-duplication option in 42 CFR 438.360 for EQR-related activities, specifically the required compliance review also referred to as the TennCare Annual Quality Survey.

Every year, Qsource updates compliance assessment tools based on current Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations, titled Annual Quality Survey (AQS) for TennCare, and based on the most recent contractual obligations between the state and managed care organizations (MCOs). After the AQS tools are updated, Qsource compares the evaluation elements with elements in the applicable NCQA accreditation standards. AQS elements with the same requirements as NCQA elements are deemed to prevent duplication. All Tennessee MCOs are required to have NCQA Health Plan Accreditation. These processes prevent duplication of activities for the MCO TennCare program participants. The full list of deemable items can be found in Appendix 5.

[18] *42 CFR 438.340(b)(4), applicable to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.350, which is applicable to CHIP per 42 CFR 457.1250*

[19] *42 CFR 438.340(b)(9), applicable also to CHIP managed care programs per 42 CFR 457.1240(e), cross-referencing 438.360(c), which is applicable to CHIP per 42 CFR 457.1250(a)*

Section V: Directed Payments

Since the implementation of the Medicaid and CHIP Managed Care Final Rule, TennCare has pursued approval on a variety of directed payments. In accordance with §438.6(c)(2)(i)(C) of the managed care rule, TennCare has designed its directed payment programs so that they advance at least one goal or objective in the quality strategy. Appendix 6 provides additional details and outlines the goals that are being advanced by each directed payment.

Section VI: Appendix

Appendix 1: Acronyms

AAP	American Academy of Pediatrics
AAP	Ambulatory Health Services
ANA	Provider Annual Network Adequacy Benefit Delivery Review
AQS	Annual Quality Survey
ARPA FMAP	American Rescue Plan Act Federal Medical Assistance Percentage
BCBST	BlueCross BlueShield of Tennessee
BESMART	Buprenorphine Enhanced Medication Assisted Recovery and Treatment
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCT	Care Coordination Teams
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CLAS	Culturally and linguistically appropriate services
CLRS	Closed-Loop Referral System
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CRA	Contractor Risk Agreement
DBM	Dental Benefits Manager
DCS	Department of Children's Services
DD	Developmental Disabilities
DSP	Direct Support Professionals
DST	Delivery System Transformation
DIDD	Department of Intellectual and Developmental Disabilities
D-SNPs	Dual Eligible Special Needs Plans
DSW	Direct Support Worker/Workforce
ECF CHOICES	Employment and Community First CHOICES

ED	Emergency Department
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FIDE SNP	Fully Integrated Dual Eligible Special Needs Population
FY	Fiscal Year
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HRA	Health Risk Assessment
I/DD	Intellectual and/or Developmental Disabilities
ICF/IID	Immediate Care Facility for Individuals with Intellectual Disabilities
LARC	Long- Acting Reversible Contraceptives
LOC	Level of Care
LTSS	Long Term Services and Supports
MAT	Medication Assisted Treatment
MCC	Managed Care Contractor
MCO	Managed Care Organization
MDS	Minimum Data Set
MLTSS	Medicaid Managed Long Term Services and Supports
MMIS	Medicaid Management Information System
MRR	Medical Record Review
NCI	National Core Indicators
NCI-AD	National Core Indicators – Aging and Disabilities
NCI-CFS	National Core Indicators – Child and Family Surveys
NCI-IPS	National Core Indicators – In Person Surveys
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
OUD	Opioid Use Disorder
ORR	On Request Report
PAE	Pre-Admission Evaluation
PAHP	Prepaid Ambulatory Health Plan

PBM	Pharmacy Benefits Manager
PCDH	Patient Centered Dental Home
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider or Practitioner
PCSP	Person-Centered Support Plan
PH	Population Health
PHE	Public Health Emergency
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPC	Prenatal and Postpartum Care
QA	Quality Assurance
QI	Quality Improvement
QI/UM	Quality Improvement/Utilization Management
QM/QI	Quality Management/Quality Improvement
QuILTSS	Quality Improvement in Long Term Services and Supports
RFI	Request for Information
REM	Reportable Event Management
SDF	Silver Diamine Fluoride
SDOH	Social Determinants of Health
SIM	State Innovation Model (grant)
SPMI	Severe and Persistent Mental Illness
SOS	System of Support
STC	Special Terms and Conditions
SUD	Substance Use Disorder
TCS	TennCare Select
THL	Tennessee Health Link
UM	Utilization Management
VBP	Value Based Purchasing
VLARC	Voluntary Long Acting Removable Contraceptives
WFD	Workforce Development

Appendix 2: TennCare 2020 Quality Strategy Evaluation Summary

In February 2021, TennCare's EQRO conducted an evaluation of the 2020 Quality Strategy. This report provides an evaluation of the progress TennCare made in 2020 toward achieving the goals set forth in its Quality Strategy, which is required by 42 *Code of Federal Regulations* (CFR) 438.340(c)(2)(i), 438.340(c)(2)(ii), and 457.1240(e) to be reviewed and updated at least every three years.

According to 42 CFR § 438.340, all states with managed care are required to submit to the Centers for Medicaid & Medicare Services (CMS) a written strategy for assessing and improving the quality of managed care services provided to Medicaid members. TennCare's Quality Strategy outlines the State's quality improvement activities, which are consistent with the Three Aims of the National Quality Strategy: better care, healthy people/healthy communities, and affordable care. TennCare's Quality Strategy is shaped by four primary physical and behavioral health goals:

1. Ensure appropriate access to care;
2. Provide high-quality, cost-effective care;
3. Ensure enrollees' satisfaction with services; and
4. Improve healthcare for program enrollees.

In addition, TennCare's 2020 Quality Strategy has established performance measures specific to populations enrolled in TennCare's two long-term services and supports (LTSS) programs, CHOICES and Employment and Community First (ECF) CHOICES. The first CHOICES program provides home- and community-based services (HCBS) for older adults and adults with physical disabilities, while ECF CHOICES provides employment opportunities and HCBS for individuals with intellectual and developmental disabilities. As these programs and the Quality Strategy have evolved, TennCare has continued to focus quality improvement efforts on the core objectives for which both CHOICES programs were established. Due to changes in the goals for the CHOICES programs, this report does not evaluate the LTSS goals for 2020.

Methodology/Data Sources

This report provides a progress update on statewide managed care organization (MCO) performance in meeting the Quality Strategy's four physical and behavioral health goals. A variety of data sources were used to measure the effectiveness of these goals and objectives, including statewide average Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) rates; patient-centered medical home (PCMH) data provided by the National Committee for Quality Assurance (NCQA); and TennCare enrollment and claims data.

Results

Overall, the Quality Strategy represents an effective tool for measuring and improving the quality of TennCare's managed care services. Of the 11 objectives that make up the Quality Strategy's physical and behavioral health goals, six met or exceeded the goals set forth for 2020, one was partially met, and data for one objective were

unavailable due to the COVID-19 pandemic. Several objectives significantly exceeded the targets, and trending with previous years reveals that many measures have steadily improved over time, including the following:

- **Objective 2.1:** The Postpartum Care rate for the Prenatal and Postpartum Care (PPC) HEDIS measure exceeded the goal by 6.61 percentage points at 70.20% (goal: 63.59%).

Objective 3.2: For CAHPS 2020, the percentage of TennCare members who responded "Always" or "Usually" to the Getting Needed Care composite measure was 85.77% for the adult Medicaid population (goal: 82.48%) and 88.84% for the child Medicaid population (goal: 86.82%). These rates exceeded the target, and trending reveals steady increases in the measure since CAHPS 2018.

Objective 4.1: These three Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) rates surpassed the goals by 6.24, 3.36, and 4.35 percentage points, respectively:

- BMI Percentile Documentation: 80.51% (goal: 74.27%)
- Counseling for Nutrition: 70.68% (goal: 67.32%)
- Counseling for Physical Activity: 66.74% (goal: 62.39%)

Three objectives and one partial objective did not fully achieve the 2020 aims. The results for these objectives are listed below:

- **Objective 1.1:** The statewide EPSDT screening rate fell slightly short of the 80% goal at 79% in FFY 2019. Of the 16 counties with screening rates between 60% and 69%, only five improved by 5% or more; however, a total of seven brought their screening rates to 70% or higher.

- **Objective 2.1:** The Timeliness of Prenatal Care rate for the PPC measure fell slightly short of the target at 83.68% (goal: 83.76%). The other PPC rate exceeded the goal. However, while both rates are improvements over previous years, NCQA indicated a break in trending for PPC due to changes in measure specifications for HEDIS 2020.
- **Objective 2.4:** The statewide rates for HEDIS 2020 (measurement year 2019) were as follows: CIS—MMR: 88.90% (goal: 90.1%); IMA—Combination 1: 78.02% (goal: 79.19%); CIS—Influenza: 44.68% (goal: 46.91%). Although these rates fell slightly short of the goals, trending with previous years reveals steady improvements in all three rates.
- **Objective 4.2:** The statewide rates for these population health outcome measures, in which lower rates indicate better performance, were as follows: ED visits per 1000 members—593 (goal: 582); 30-day readmissions per 100 members—13.6 (goal: 10.7); ESRD per 100 members with diabetes—7.8 (goal: 7.0). Although these rates did not meet the goals, trending shows steady improvement in the ED visit rate over the previous three years.

Appendix 3: TennCare PIP Summary

In accordance with the contractor risk agreements (CRAs) with TennCare, MCOs must conduct at least two clinical and at least three non-clinical PIPs. The DBM and PBM must conduct at least one clinical and one non-clinical PIP, respectively. For MCOs, the two required clinical PIPs must include one study on behavioral health relevant to one of the population health programs for bipolar disorder, major depression, or schizophrenia, while the other must focus on child or perinatal health. One of the three required non-clinical PIPs must be conducted in the area of long-term care. In addition, MCOs must conduct a study on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening and outreach if their overall CMS-416 rates are below 80%.

Note: Improvement strategies are not applicable to PIPs that were in their baseline measurement year in 2022. Verbiage quoted from the MCCs' PIP Summary Forms appears in italics and is included to capture MCCs' aims and strategies in their own words. Each PIP is linked to a specific goal in the Quality Strategy (QS) as indicated in the first column. Also included in the table are each PIP's measurement year (Baseline [B]; Remeasurement 1 [R1]; Remeasurement 2 [R2]; Remeasurement 3 [R3]; Remeasurement 4 [R4]) and classification as clinical (C) or non-clinical (NC).

Table 9. TennCare 2022 Performance Improvement Projects

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
Amerigroup					
2	R1	C	*Improve Childhood Immunization Status (CIS) Combination 10 Rates—East, Middle, and West Regions*	*Will targeted interventions, such as member incentives, digital outreach, and innovative community collaborations, increase the percentage of members receiving childhood combination 10 immunizations over each measurement year?*	♦ Healthy Rewards Member Incentive for Rotavirus and Flu Vaccines
5	R2	C	*Improve Diabetic Screening Compliance for Members with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication in West Region*	*Will targeted interventions consisting of education, member gap closures and incentives for gap closures improve over each measurement year diabetic screening compliance in members with Schizophrenia, Schizoaffective disorder or Bipolar disorder that are taking antipsychotic medications?*	♦ Provider Support to Target Members with Gaps in Care (GIC) ♦ Provider Incentives ♦ Glucose and Hemoglobin A1c Testing Capture During Inpatient Behavioral Health (BH) Hospitalization Encounter
3	R2	NC	*Improve East Grand Region Member Satisfaction with the Health Plan*	*Will health plan and provider education along with telehealth and additional transportation options increase over each*	♦ CAHPS Awareness Training—Educate Amerigroup staff (including provider

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
				measurement year the percentage of respondents that answered Question 49 (Rating of Health Plan) on the CAHPS Child Medicaid-General Population survey with a score of 8, 9, or 10?	collaboration staff), Develop a Providers one-page summary 11-16-20 ♦ Telemedicine—Telehealth with member's provider ♦ Enhance Non-emergency medical transportation (NEMT)
2	R1	NC	*Increase Eye Exam Screening Rates for Members with Diabetes Type 1 or Type 2*	*In pursuit of health equity goals, will member and provider incentives focused on minimizing the impact of social determinates of health improve retinal eye exam screenings for members with type 1 or type 2 diabetes within their community during the HEDIS® measurement year?*	♦ Provider monetary incentive to purchase of a retinal eye camera for diabetic eye exams within the practice to close gaps-in-care on members struggling in an environmental health disparity
4	B	NC	*Increase Statewide the % of Members with Documented LTSS Reassessment and Care Plan Update, Including Nine Core Elements, within 30 Days of Inpatient Discharge*	*Will targeted interventions, electronic data capture system enhancements, new monitoring reports, and PCSP re-assessment auditing with inter-rater reliability testing, for established LTSS members 18 years of age and over in Groups 2 through 8, improve the time frame for the completion of re-assessments and care plan updates with the nine core elements to within 30 days of discharge from an inpatient facility over each measurement year?*	
2	B	C	*Increase Well Child Visit (WCV) HEDIS Rate in West TN Region*	*Will targeted member outreach along with member and provider incentives and innovative interventions improve the WCV HEDIS rate in the 3–20-year-old age group over each measurement year in the West Region?*	
BlueCare					
5	R2	NC	*Decrease the Use of Opioids at High Dosage (HDO)*	*Will implementing provider and member targeted interventions decrease the proportion of BlueCare Statewide members 18 years and older who received*	♦ External Vendor Enhancement of monitoring practice pattern analysis of providers.

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
				prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days over each remeasurement year?	♦ Behavioral Health Quality Coaches ♦ BlueCare Statewide Shift to new PH Model/Program that included development of Opioid cohort and Internal Dashboards Statewide. ♦ Integration of Controlled Substance Monitoring Database (CSMD) into the documentation system of record.
5	R2	C	*Improving Antidepressant Medication Management (AMM)*	*Will focused provider interventions increase member compliance with the continuation phase of antidepressant therapy for treatment of major depression for members 18 years of age and older with a diagnosis of major depression over each remeasurement year?*	♦ Initiated text message and telephone calls for new fills and refills of antidepressant medication to MCO plan members statewide and implemented provider education strategy. ♦ Periodic provider education statewide on the AMM-C measure in partnership with the Provider Incentive and Engagement (PIE) team ♦ Implemented telehealth for a variety of measures, and additional medication allowances, and developed targeted provider notification and education strategy to make providers aware of allowances that could specifically impact this measure. ♦ Targeted provider practice collaboration and education strategy to better understand barriers and provide education to providers seeing a large part of the population for this study.
	R2	C	*Improving Childhood and Adolescents Immunization Rates (CIS/IMA)*	*Will targeted provider interventions result in increased influenza vaccination in children 2 years of age and HPV vaccination rates in adolescents 13 years*	Development of a Vaccination Hesitancy Educational Flyer for providers to use during clinical encounters (Statewide)

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
				of age over each remeasurement period in the Statewide BlueCare population (broken out by regions)?	Provider Incentive and Engagement Team began Quarterly reviews statewide with providers addressing child and adolescent immunizations targeting influenza and HPV Targeted provider practice collaboration and education strategy focused on Child and Adolescent Immunizations and Catch-Up Schedules for providers that serve a large part of the population < 21 years of age
	R5	NC	*Improving Early Periodic Screening Diagnosis & Treatment (EPSDT)*	*Do targeted provider engagement activities improve the EPSDT rates over each remeasurement period for BlueCare members under the age of 21 (all regions)?*	Provider Education and Partnerships Implementation of an Integrated Appointment Scheduling Platform Supersizing Provider Program-Incentivize providers to capitalize on sick visits and covert to an EPSDT visit to address preventive care. Partnerships with THL providers in the past have been successful at engaging members.
4	B	NC	*Long-Term Services and Supports Reassessment/Care Plan Update After Inpatient Discharge (RAC)*	*Will targeted data interventions improve the rate of completion of a reassessment/care plan update for CHOICES/ECF CHOICES members 18 years of age and older within 30 days of inpatient discharge, over each remeasurement year?*	
3	R2	NC	*Social Determinants of Health Data Collection Process*	*Will the development of a systematic process to collect SDoH information targeting the social determinants of health assessment in the internal documentation system of record on members with an open care management case in the Statewide BlueCare population, increase the number of SDoH assessments completed, social determinants identified, and referral needs addressed, and*	Implementation of the new modified SDoH Assessment Tool Community Resource Tool – Repository of community resources identified by category needs, county, and zip code. This tool is for all staff to utilize for the member's needs. (Statewide) Identification of process for collecting the SDoH Performance Measures data directly from the internal

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
				improve member outcomes over each measurement year?	documentation system of record based on the assessment tool completed by the case managers. (Statewide) BlueCare Tennessee Statewide Shift to new PH Model/Program-This new model included a focus on identifying social determinants, addressing through referral sources so that our Statewide BlueCare members have improved health outcomes.
TennCare*Select*					
5	R2	NC	*Decreasing Plan All-Cause Readmissions*	*Do targeted member interventions decrease the number of Statewide TennCareSelect acute inpatient and observation stays for members 1864 years of age that are followed by an unplanned acute readmission for any diagnosis within 30 days over each measurement year?*	Member Outreach phone calls to members statewide for appointment scheduling assistance, with financial incentive for members who keep appointment. Transition of Care (TOC) / Discharge Planning Transition UM evaluates members statewide for tele-monitoring referral to an external vendor using specific criteria for each diagnosis. Currently applies to only medical members Contracted with statewide vendor that utilizes providers to complete follow-up visits with members after hospitalization for mental illness that has the potential to impact readmissions. Provider Coaching – BH Provider Quality Coaching to address follow-up care, coordination, and readmissions.
5	R3	C	*Follow-Up After Hospitalization for Mental Illness – 7 Day – TennCareSelect*	*Do targeted member and/or provider interventions improve the rate of timely follow-up care for TennCareSelect members ages 6 and older who were*	Tennessee Health Link (THL) Provider incentivized measure, Quarterly education and support given to providers statewide. FUH – within 7 Days is an incentivized THL quality

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
				hospitalized for treatment of mental illness over each remeasurement period?	measure. Member Outreach phone calls to members statewide for appointment scheduling assistance, with financial incentive for members who keep appointment. Incorporating behavioral health inpatient and outpatient practices statewide into the Integrated Appointment Scheduling Platform. Statewide vendor that utilizes providers to complete the 7-day follow-up visit after hospitalization for mental illness. Provider and Community Partner Education. Educational WebEx presented for providers and Department of Children's Services (DCS) workers (Nurses, Case Managers, etc.) statewide to increase knowledge about Behavioral Health HEDIS® measures, including FUH (compliance and importance of timely follow-up). Provider Coaching. • BH Provider Quality Coaching to address follow-up care, coordination, and readmissions.
2	R2	C	*Improving Childhood and Adolescents Immunization Rates (CIS/IMA)*	*Will targeted provider interventions result in increased influenza vaccination in children 2 years of age and HPV vaccination rates in adolescents 13 years of age over each remeasurement period in the Statewide TennCareSelect population?*	Development of a Vaccination Hesitancy Educational Flyer for providers to use during clinical encounters (Statewide) Provider Incentive and Engagement (PIE) Team began Quarterly reviews statewide with providers addressing child and adolescent immunizations targeting influenza and HPV. Targeted provider practice collaboration and education strategy focused on Child and Adolescent Immunizations and Catch-Up Schedules for providers that serve a large part of

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
					the population < 21 years of age.
2	R2	NC	*Improving Comprehensive Diabetes Care (Blood Pressure Control for SelectCommunity)*	*Does providing member and/or provider focused interventions and approaches improve the Comprehensive Diabetes Care: Blood Pressure Control (CDC BP) HEDIS® rate for the TennCareSelect SelectCommunity population (18-75 years old) over each measurement year?*	Interventions during baseline measurement (1/1/19-12/31/19) were limited. The focus for 2019 for 2019 for SelectCommunity Case Management was on Agent Workspace technology being implemented for the SelectCommunity program during 2019. COVID-19 presented challenges for interventions with this population during 2020. BlueCare suspended all face-to-face visits in conjunction with Department of Intellectual & Developmental Disabilities (DIDD) effective 3/17/2020. In 4th quarter 2020, limited medical appointments began being allowed, while limiting contact with external customers coming into homes, etc. Targeted Provider and Case Manager education/communication strategy regarding COVID related allowances for blood pressure medication. Provider HEDIS letter reporting patient's HEDIS gaps.
2	R5	NC	*Improving Early Periodic Screening Diagnosis & Treatment (EPSDT) – BlueCareTennCareSelect*	*Do targeted provider engagement activities improve the EPSDT rates over each remeasurement period for TennCareSelect members under the age of 21 (all regions)?*	Provider Education and Partnerships Implementation of an Integrated Appointment Scheduling Platform Supersizing Provider Program-Incentivize providers to capitalize on sick visits and covert to an EPSDT visit address preventive care Partnerships with THL providers in the past have been successful at engaging members

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
3	R3	NC	*Social Determinants of Health Data Collection Process.*	*Will the development of a systematic process to collect SDoH information targeting the social determinants of health assessment in the internal documentation system of record on members with an open care management case in the Statewide TCS population, increase the number of SDoH assessments completed, social determinants identified, and referral needs addressed, and improve member outcomes over each measurement year?*	Implementation of the new modified SDoH Assessment Tool – Internal education for all case managers on the use/documentation of the new modified SDoH tool in the documentation system of record so that the data is in the same location for use by case managers for the collection of data. This education will continue for new hires moving forward. (Statewide) Community Resource Tool – Repository of community resources identified by category needs, county, and zip code. This tool is for all staff to utilize for the member's needs. (Statewide) Identification of the process for collecting the SDoH Performance Measures data directly from the internal documentation system of record based on the assessment tool completed by the case managers. (Statewide) BlueCare Tennessee Statewide Shift to new PH Model/Program-This new model included a focus on identifying social determinants, addressing through referral sources so that our Statewide TCS members have improved health outcomes.
UnitedHealthcare					
5	R2	C	*Adherence to Antipsychotic Medications for Individuals w/ Schizophrenia (SAA)*	*Will targeted provider and member interventions increase adherence to antipsychotic medications for individuals diagnosed with schizophrenia over each measurement period?*	Provider Targeted. To improve SAA HEDIS® measure rates, the Quality Analyst developed a provider-specific educational flyer. Provider Targeted. To increase SAA medication adherence, the UHCCP Behavioral Health Quality Analyst provided quarterly outreach and

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
					member-specific pharmacy fill data to THL providers. Member Targeted. To increase SAA medication adherence, the UHCCP Behavioral Health Quality Analyst developed a member-specific educational newsletter article on the importance of medication adherence.
3	R3	NC	*Care Coordination*	*Can targeted provider outreach improve provider and member perception of coordination of care between health care practitioners as indicated by UnitedHealthcare Community Plan Provider Satisfaction Survey and CAHPS® Survey responses over each measurement period?*	Creation of a new Social Determinants of Health (SDOH) role within the health plan to assist network providers with resource access for their patients/our members with these non-medical risk factors as a support for care coordination activities. Care Management staff restructure to organize into geographically aligned community care teams situated under our existing Population Health structure.
2	R3	C	*Impact of Member and Provider Outreach on Immunization Rates for CIS Combo 10*	*Will targeted provider and member interventions increase the immunization rates for members ages birth to two years old over each remeasurement period?*	Maximize the alignment of our education and outreach strategies with the metrics and incentives of value based contracting programs, specifically Patient Centered Medical Home (PCMH) and TennStar. Increase outreach and education efforts for those identified as past due for immunizations.
3	R2	NC	*Increasing the Physical Health Provider Satisfaction Survey Engagement Rate*	*Can enhanced communication efforts to providers regarding the importance of their feedback increase the response rates for*	In an effort to increase our Physical Health Provider Satisfaction Survey response rate, details of

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
				our Physical Health Provider Satisfaction Survey over each measurement period?	improvements made based on responses from the previous year were added to the Survey Cover Letter from our Chief Medical Officer (CMO) emphasizing the impact of the survey.
2	R1	C	*Increasing the Screening Rates of Child & Adolescent Well-Care Visits (WCV)*	*Will the use of targeted member outreach and incentives increase screening rates for children 18-21 years of age over each remeasurement year?*	Maximize the alignment of our education and outreach strategies with the metrics and incentives of value based contracting programs.
4	B	NC	*UnitedHealthcare Long Term Services and Supports (LTSS) HEDIS Process Improvement for Reassessment and Care Plan Updates Within 30 days After Inpatient Discharge for LTSS Eligible Populations*	*Will targeted reporting interventions improve the HEDIS rates for Reassessment within 30 days from Inpatient Discharge and Reassessment and Care Plan within 30 days of Inpatient Discharge for LTSS populations by 3% points from the baseline?*	
DentaQuest					
2	R4	C	*Increasing Provider Use of Silver Diamine Fluoride (SDF) as a Preventive Measure*	*Can the percentage of TennCare member utilizers 0-20 that receive an application of Silver Diamine Fluoride (SDF) be increased through targeted education to our providers over each remeasurement year?*	SDF Provider Toolkit available on DQ Provider page The American Dental Association redefined CDT code D1354 from a full-mouth application to a per-tooth application state-wide. Provider utilization of SDF was added to the quarterly Provider Performance Report scorecard for provider behavior Provider incentive payment was calculated based on number of SDF applications, along with other preventive measures Provider hospital readiness form was updated to clinically deny treatment in

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
					a hospital under general anesthesia unless the provider has tried SDF or explained why SDF is not an appropriate treatment. New Person-Centered Dental Home Program implemented for all TennCare network providers, emphasizing minimum expectation of SDF use and individual education and remediation for offices not using SDF
5	R4	NC	*Decreasing TennCare Enrollees Receiving Opioid Prescriptions*	*Can the percentage of TennCare member utilizers 0-20 that receive an opioid prescription be decreased through targeted education to TennCare dental providers over each remeasurement year?*	Opioid Provider toolkit available on DentaQuest provider page. (disco) DQ Dental Director presented dangers of and alternatives to opioids to dental students at Meharry and University of TN Dental Schools. DentaQuest identified Dental Providers that are outliers amongst their peers, in terms of percentage of TennCare patients receiving an opioid prescription. These providers were targeted with a letter sent via mail and email calling attention to their prescriptive behaviors as well as providing education and alternative strategies for pain management.
OptumRx					
7	B	C	*Schizophrenia Medication Compliance Improvement Plan*	*Will the increased use of long-acting injectable antipsychotics reduce the frequency and costs associated with psychotic breaks (e.g., inpatient facility days and medical cost) in patients with schizophrenia who have been non-compliant with oral antipsychotics over each remeasurement year?*	

2022 Performance Improvement Projects					
QS	**Year**	**C/NC**	**Topic**	**PIP Aim Statement**	**Improvement Strategies**
5	R1	NC	*Usage of Diagnosis Code Override by Providers for Preferred Atypical Antipsychotics*	*Does targeted communication to providers about the diagnosis code override process for preferred atypical antipsychotics increase the use of appropriate diagnosis code overrides for TennCare members with at least one preferred atypical antipsychotic claim over each remeasurement year?*	Distribute TennCare's Diagnosis Code for PA Bypass List to all TennCare prescribers and pharmacies via fax, email, and newsletter throughout the year as education for 2021

Appendix 4: MLTSS Compliance Measurement Goals

Table 10. MLTSS Compliance Measurement Goals

Metric name/Objective	Metric Specifications	Baseline performance (year)	Performance target (year)
1. Maintain the percent of CHOICES Group 2 members who are offered a choice between institutional services and HCBS	Member Record Review	100% (2021)	100% (2025)
2. Ensure CHOICES, Employment and Community First CHOICES, and Katie Beckett Part A[20] members will have a level of care determination indicating the need for institutional services or being "At-Risk" for institutional placement, as applicable, prior to enrollment in CHOICES, Employment and Community First CHOICES, or Katie Beckett, as applicable, and receipt of Medicaid-reimbursed HCBS.	MMIS system standards[21]	100% (2021)	100% (2025)
3. Ensure CHOICES Groups 2 and 3, Employment and Community First CHOICES, and Katie Beckett Part A members have a PCSP that clearly identifies the member's needs, preferences and timed and measurable goals, along with services and supports that are consistent with the member's needs, preferences, and goals.	Member Record Review	99.2% (2021)	100% (2025)
4. Ensure CHOICES Group 2 and 3, Employment and Community First CHOICES, and Katie Beckett Part A members have a PCSP that meets requirements specified by the CRA and/or in TennCare protocol.	Member Record Review	98.0% (2021)	100% (2025)
5. Ensure CHOICES Group 2 and 3, Employment and Community First CHOICES, and Katie Beckett Part A member records document that the member (or their family member/authorized representative, as applicable) received education/information at least annually regarding how to identify and report abuse, neglect and exploitation.	Member Record Review	100% (2021)	100% (2025)
6. Ensure CHOICES Groups 2 and 3, Employment and Community First CHOICES, and Katie Beckett Reportable Event records will indicate the incident/event was reported within timeframes specified in the CRA.	ECF CHOICES Reportable Events Audit[22]	100% (2021)	100% (2025)
7. Ensure CHOICES Group 2 and 3, Employment and Community First CHOICES, and Katie Beckett Part A member records in which HCBS were denied, reduced, suspended, or terminated as evidenced in the PCSP as applicable document that the member was informed of and afforded the right to request a Fair Hearing as determined by the presence of a notice of action. 100% remediation of all individual findings is expected; compliance percentage at or below 85% requires a quality improvement plan.	Member Record Review	100% (2021)	100% (2025)

[20] The Katie Beckett Part A population was not included in the MRR for 2021, however, it will be included in future years.
[21] As a practical matter, TennCare cannot enroll anyone in the MMIS unless there is a LOC determination in PERLSS. This is completed as part of the process 100% of the time.
[22] For 2023, there will be one Reportable Event Audit due to the alignment of Critical Incident reporting across all LTSS programs in 2021.

Appendix 5: EQR Nonduplication

During the Annual Quality Survey (AQS), each MCO will be evaluated for deeming based on the NCQA standards for which it received accreditation. Elements that score 100% on the applicable NCQA elements will be deemed. Elements will not be partially deemed. Example: Availability of Services Element #1, all four NCQA elements (NET 1, MED 3, MED 12, and LTSS 1) should have a score of 100%; e.g., if the MED 3 score was less than 100% or not reviewed by NCQA, then this element cannot be deemed and all required documentation should be provided.

QP Standard: Availability of Services				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Adequate Access for All Members	438.206.b.1	NET 1: Elements A-C MED 3: Element A factor 2, B factors 1-2 MED 12: Element A LTSS 1: Element B factor 10, C	NET 1: Elements A-C MED 3: Elements A factor 2, B factors 1-2 MED 12: Element A LTSS 1: Elements B factor 10, C
2	Women's Health Specialists	438.206.b.2	NET 1: Element A MED 1: Element A	NET 1: Element A MED 1: Element A
3	Second Opinion	438.206.b.3	MED 1: Element C	MED 1: Element C
4	Out-of-Network Services	438.206.b.4	MED 1: Element D	MED 1: Element D
5	Out-of-Network Costs	438.206.b.5	MED 1: Element E	MED 1: Element E
6	Credentialing and Recredentialing Policy	438.206.b.6 438.214.b.2-d.1	Not Deemable	CR 1: Elements A-B CR 2: Element A LTSS 1: Element I factors 1-3 MED 1: Element L
7	Family Planning	438.206.b.7	NET 1: Element B-C	NET 1: Elements B-C
8	Timely Access	438.206.c.1.i	NET 2: Element A-C	NET 2: Elements A-C
9	Hours of Operation and Access	438.206.c.1.ii-.iii	MED 1: Element F-G	MED 1: Elements F-G

QP Standard: Availability of Services				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
10	Compliance	438.206.c.1.iv-.vi	QI 2: Element A CR 5: Element A	QI 2: Element A CR 5: Element A
11	Cultural Competency	438.206.c.2	MED 12: Element A NET 1: Element A ME 2: Element B	MED 12: Element A NET 1: Element A ME 2: Element B MHC 3: Elements A-B MHC 4: Element A
12	Accessibility for Members with Disabilities	438.206.c.3	MED 3: Element A	MED 3: Element A

QP Standard: Assurances of Adequate Capacity and Services				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Appropriate Range of Services and Providers	438.207.b.1-.2	NET 1: Elements B-C MED 1: Element B	NET 1: Elements B-C MED 1: Element B

QP Standard: Coordination and Continuity of Care				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Primary Care	438.208.b.1	MED 5: Element A NET 1: Element B NET 2: Element A PHM 5: Elements A, E LTSS 1: Element A factor 5, B-I	MED 5: Element A NET 1: Element B NET 2: Element A PHM 5: Elements A, E LTSS 1: Element A factor 5, B-I
2	Coordination of Services	438.208.b.2-.2.iv	Not Deemable	MED 5: Element A factors 3-6

QP Standard: Coordination and Continuity of Care				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
				QI 3: Elements A-D LTSS 1: Element A factor 5 LTSS 3: Element A factor 7, B-C
3	Initial Screening	438.208.b.3	MED 6: Element A	MED 6: Element A
4	Prevent Duplication of Services	438.208.b.4	MED 6: Element B	MED 6: Element B
5	Medical Records	438.208.b.5	MED 5: Element B	MED 5: Element B
6	Protected Health Information	438.208.b.6	MED 5: Elements A-C	MED 4: Elements A-C
7	Comprehensive Assessment Mechanisms	438.208.c.2	LTSS 1: Element A factors 2-3, B-D	LTSS 1: Element A factors 2-3, B-D
8	Treatment and Service Plans	438.208.c.3-.3.v	Not Deemable	MED 5: Element C LTSS 1: Elements E, F, G factor 13, and I LTSS 3: Element A factor 8
9	Direct Access to Specialists	438.208.c.4	MED 1: Element A-B	MED 1: Elements A-B

QP Standard: Coverage and Authorization of Services				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
2	Arbitrary Limitations Prohibited	438.210.a.3.ii	MED 9: Element D	MED 9: Element E
3	Service Limitations	438.210.a.4-.4.i	UM 1: Element A factors 5-6 UM 2: Element A	UM 1: Element A factors 5-6 UM 2: Element A
5	Medically Necessary Definition	438.210.a.5-.5.i	UM 1: Element A factors 5-6	UM 1: Element A factors 5-6
8	Processing Authorizations	438.210.b.2-.2.iii	UM 2: Element C UM 7: Element A, D	UM 2: Element C UM 7: Elements A, D

QP Standard: Coverage and Authorization of Services				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
			LTSS 1: Element A factor 2	LTSS 1: Element A factor 2
9	Appropriate Expertise	438.210.b.3	UM 4: Element A-D, F MED 9: Element B	UM 4: Element A-D, F MED 9: Element C
10	Notice of Adverse Benefit Determination	438.210.c	UM 7: Element B, E	UM 7: Element B, E
18	Emergency Service Limitations	438.114.d-.d.1.ii	MED 9: Element C	MED 9: Element D
19	Subsequent Treatment	438.114.d.2	MED 9: Element C	MED 9: Element D
20	Transfer or Discharge	438.114.d.3	MED 9: Element C	MED 9: Element D
24	Language and Format	438.10.d.1-.d.6.iii	MED 12: Elements C-H ME 7: Element A factor 5, B factor 5 ME 2: Element A factor 5, B UM 3: Element A factors 4-5 MED 13: Element B-C NET 6: Element L NET 1: Element A ME 3: Element C	MED 12: Element C-G ME 3: Element C
26	Provider Termination	438.10.f.1	MED 1: Element H NET 5: Element A	MED 1: Element H NET 5: Element A

QP Standard: Provider Selection				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Credentialing and Recredentialing Process	438.214.b.2	CR 1: Element A-B CR 2: Element A LTSS 1: Element I	CR 1: Element A-B CR 2: Element A LTSS 1: Element I factors 1-3

2	Provider Selection P&Ps	438.214.c	CR 1: Element A factor 6	CR 1: Element A factor 6
3	Excluded Providers	438.214.d.1	Not Deemable	MED 1: Element L

QP Standard: Confidentiality				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Written P&Ps	438.224	MED 4: Element A-C	MED 4: Elements A-C MHC 1: Element C factors 1-3

QP Standard: Grievance and Appeal Systems				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	System in Place	438.402.a	MED 10: Element A-B ME 7: Element A-B UM 5: Element D UM 8: Element A factor 10 ME 2: Element A factor 15	MED 10: Elements A-B ME 7: Elements A-B UM 5: Element D UM 8: Element A factor 10 ME 2: Element A factor 15
2	One Level	438.402.b	UM 8: Element A factor 10 ME 2: Element A factor 15	UM 8: Element A factor 10 ME 2: Element A factor 15
3	State Fair Hearing (SFH)	438.402.c-.c.1.i	MED 10: Element A factor 4, B factor 4 UM 8: Element A factor 14 ME 2: Element A factor 15	MED 10: Element A factor 5, B factor 4 UM 8: Element A factor 14 ME 2: Element A factor 15
4	Provider Assistance	438.402.c.1.ii	UM 8: Element A factor 14	UM 8: Element A factor 14
5	Timeframe to Request Appeal	438.402.c.2-.2.ii	MED 10: Element A UM 8: Element A	MED 10: Element A UM 8: Element A

QP Standard: Grievance and Appeal Systems				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
6	Methods	438.402.c.3-.3.ii	MED 10: Element A factor 4	MED 10: Element A factor 5
7	Availability of Notices	438.404.a	UM 5 UM 7 MED 9	UM 5 UM 7 MED 9
8	ABDN Inclusions	438.404.b.1-.6	UM 7: Element B-C MED 9: Element A	UM 7: Element B, C, E, F MED 9: Element B
9	ABDN Mailing	438.404.c.1	Not Deemable	MED 9: Element A
10	Denial of Payment	438.404.c.2	UM 5: Element A factor 5, B UM 8: Element A factor 7 UM 9: Element B factor 1	UM 5: Element A factor 5, B UM 8: Element A factor 7
12	Reasonable Assistance	438.406.a	Not Deemable	UM 3: Element A factors 1-5 MED 10: Element A factors 4 & 10
13	Acknowledge Receipt	438.406.b-.b.1	MED 10: Element A factor 1	MED 10: Element A factor 1
14	Reviewer Requirements	438.406.b, b.2-b.2.iii	UM 8: Element A factors 2-6 UM 9: Element A factors 1-2 MED 10: Element A factor 2	UM 8: Element A factors 2-6 UM 9: Element A factors 1-2 MED 10: Element A factor 3
15	Oral Inquiries	438.406.b.3	MED 10: Element A factor 4 ME 7: Element B factors 1-5 UM 8: Element A factors 4, 9, &12	MED 10: Element A factors 2 & 5 ME 7: Element B factors 1-5 UM 8: Element A factors 4, 9, & 12
16	Opportunity to Make an Argument	438.406.b.4	UM 8: Element A factor 4	UM 8: Element A factor 4
17	Member Information Provided	438.406.b.5	UM 8: Element A factor 4 & 12	UM 8: Element A factors 4 & 12
18	Parties to the Appeal	438.406.b.6-.6.ii	UM 7: Element C factor 2 & F factor 2 UM 8: Element A factor 14	UM 7: Element C factor 2 & F factor 2

QP Standard: Grievance and Appeal Systems				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
				UM 8: Element A factor 14
20	Standard Grievance Resolutions	438.408.b.1	MED 10: Element A factor 4	MED 10: Element A factor 5
21	Standard Appeal Resolutions	438.408.b.2	UM 8: Element A factors 7-8 UM 9: Element B factors 1-2	UM 8: Element A factors 7-8 UM 9: Element B factors 1-2
22	Expedited Appeal Resolutions	438.408.b.3	UM 8: Element A factor 9 UM 9: Element B factor 3	UM 8: Element A factor 9 UM 9: Element B factor 3
23	Timeframe Extensions	438.408.c.1-.1.ii	MED 10: Element A UM 8: Element A UM 9: Element B	MED 10: Element A UM 8: Element A UM 9: Element B
24	Requirements Following Extension	438.408.c.2-.2.ii	MED 10: Element A UM 8: Element A UM 9: Element B	MED 10: Element A UM 8: Element A UM 9: Element B
25	Format of Resolutions	438.408.d.2-.2.ii	MED 10: Element A factor 5 MED 12: Element F factors 1-4 ME 7: Element B factor 3 UM 8: Element A factor 9 UM 9: Element D factors 1-6	MED 10: Element A factor 6 MED 12: Element F factors 1-4 ME 7: Element B factor 3 UM 8: Element A factor 9 UM 9: Element D factors 1-6
26	Results and Date	438.408.e.1	UM 9: Element D factor 1	UM 9: Element D factor 1
27	Additional Resolution Contents	438.408.e.2-.2.iii	UM 8: Element A factor 16 ME 2: Element A factor 15 MED 9: Element A factors 1 & 4	UM 8: Element A factor 16 ME 2: Element A factor 15 MED 9: Element B factors 1 & 4
28	Expedited Review Process	438.410.a	UM 8: Element A factor 9	UM 8: Element A factor 9
29	Punitive Action Prohibited	438.410.b	Not Deemable	MED 10: Element A factor 7
30	Expedited Resolution Denials	438.410.c-.c.2	MED 10: Element A factor 6 UM 8: Element A factors 7-9	MED 10: Element A factor 8 UM 8: Element A factors 7-9

QP Standard: Grievance and Appeal Systems				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
31	Information for Providers and Subcontractors	438.414	MED 10: Element B factors 1-5	MED 10: Element B factors 1-5
32	Ongoing Monitoring	438.416.a	MED 10: Element C factors 1-8 UM 9: Element A factors 1-3	MED 10: Element C factors 1-8 UM 9: Element A factors 1-3
33	Records Requirements	438.416.b-.b.6	MED 10: Element C factors 1-8	MED 10: Element C factors 1-8
35	Continuous Benefits Requirements	438.420.b-.b.5	MED 11: Element B factors 1-5	MED 11: Element B factors 1-5
36	Termination of Benefits	438.420.c-.c.3	MED 11: Element C factors 1-3	MED 11: Element C factors 1-3
37	Cost Recovery	438.420.d	MED 11: Element B-C	MED 11: Elements B-C
38	Services Not Furnished During Pending Appeal	438.424.a	MED 10: Element D factor 1	MED 10: Element D factor 1
39	Services Furnished During Pending Appeal	438.424.b	MED 10: Element D factor 2	MED 10: Element D factor 2

QP Standard: Subcontractual Relationships and Delegation				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Delegated Activities	438.230.a-.c.1.i	CR 8, ME 8, UM 13 QI 5: Element B	CR 8, ME 8, UM 13 QI 5: Element B
2	Remedies for Unsatisfactory Performance	438.230.c-.c.1, .c.1.ii-.iii	CR 8, ME 8, UM 13 QI 5: Elements A-B	CR 8, ME 8, UM 13 QI 5: Elements A-B
QP Standard: Health Information Systems				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**

1	System Requirements	438.242.a	MCO's ability to submit NCQA's IDSS files	MCO's ability to submit NCQA's IDSS files
2	Data Collection	438.242.b, .b.2	MCO's ability to submit NCQA's IDSS files	MCO's ability to submit NCQA's IDSS files
3	Data Accuracy and Completeness	438.242.b, .b.3-.3.iii	HEDIS Compliance Audit encompasses these requirements.	HEDIS Compliance Audit encompasses these requirements.
4	Data Availability	438.242.b, .b.4	MCO's ability to submit NCQA's IDSS files	MCO's ability to submit NCQA's IDSS files

QP Standard: Quality Assessment and Performance Improvement (QAPI) Program				
Element #	**AQS Tool Element Name**	**CFR Reference(s)**	**2020 NCQA Element(s)**	**2021 NCQA Element(s)**
1	Program in Place	438.330.a.1	QI 1: Element A factors 1-6, B factors 1-5	QI 1: Element A factors 1-6, B factors 1-5
3	Under-/Over-Utilization	438.330.b, .b.3-.4	MED 7: Element A factors 1-4	MED 7: Element A factors 1-4
4	LTSS Requirements	438.330.b, .b.5-.5.ii	MED 7: Element A factor 3 LTSS 1: Element H factors 1-5 LTSS 2: Element A factors 1-2, E factors 2 & 4	MED 7: Element A factor 3 LTSS 1: Element H factors 1-5 LTSS 2: Element A factors 1-2, E factors 2 & 4

Appendix 6: Tennessee Directed Payment Programs

Table 11. 438.6(c) Directed Payment Programs Overview

	Directed Payment Description	Payment Type	Quality Strategy Goals	Quality Strategy Objectives
1	Fee Schedules ("Sweeper")	Fee Schedule	Goal 3: Integrate patient-centered, holistic care including non-medical risk factors into population health coordination for all members Goal 4: Improve positive outcomes for members with LTSS needs Goal 6: Maintain robust member access to health care services	Objective(s): 3.3-3.5 Ensure CHOICES, ECF CHOICES, and Katie Beckett members receive holistic care 4.1-4.3 Maintain or improve quality of life for CHOICES, ECF CHOICES and Katie Beckett members 6.1 Ensure all members can access care according to time and distance standards
2	Hospital Uniform Percentage Increase	Fee Schedule	Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions	Objective(s): 2.8 Reduce rate of hospital readmissions
3	Hospital Rate Variation	Fee Schedule	Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions	Objective(s): 2.7 Decrease emergency department utilization for children 2.8 Reduce rate of hospital readmissions
4	Emergency Medical Services (ground ambulance) Uniform Dollar Increase	Fee Schedule	Goal 6: Maintain robust member access to health care services	Objective(s): 6.2 Ensure adult members can access care, tests, or treatments timely 6.3 Ensure child members can access care, tests, or treatments timely
5	Patient Centered Medical Homes (PCMH)	Fee Schedule & Value-Based Purchasing	Goal 1: Improve the health and wellness of new mothers and infants Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions	Objective(s): 1.3 Increase the use of well-child visits in the first 30 months 2.1 Increase child and adolescent well care visits 2.3 Increase child immunizations

			Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care	2.4 Improve high blood pressure control in adults 7.1 Maintain the percentage of TennCare members attributed to PCMH organizations
6	Academic Affiliated Physicians' Upper Payment Limit Initiative for Tennessee (UPLIFT)	Fee Schedule & Value-Based Purchasing	Goal 1: Improve the health and wellness of new mothers and infants Goal 2: Increase use of preventive care services for all members to reduce risk of chronic health conditions	Objective(s) 1.1 Increase the use of prenatal services 1.2 Increase the use of postpartum services 2.3 Increase child immunizations 2.8 Reduce the rate of hospital readmissions
7	Tennessee Health Link (THL)	Value-Based Purchasing	Goal 5: Provide additional support and follow-up for patients with behavioral health care needs Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care	Objective(s): 5.1 Improve follow-up after hospitalization for mental illness in adults 5.2 Improve follow-up after hospitalization for mental illness in children 7.3 Increase the number of TennCare members who are active in the Tennessee Health Link program
8	Emergency Medical Services (ground ambulance) Minimum Fee Schedule	Fee Schedule (State Plan Amendment)	Goal 6: Maintain robust member access to health care services	Objective(s): 6.2 Ensure adult members can access care, tests, or treatments timely 6.3 Ensure child members can access care, tests, or treatments timely
9	Home & Community Based Services (HCBS) Workforce Development Incentives	Value-Based Purchasing	Goal 3: Increase LTSS Member Satisfaction Goal 4: Improve positive outcomes for members with LTSS needs	Objective(s): 3.3-3.5 Ensure CHOICES, ECF CHOICES, and Katie Beckett members receive holistic care 4.1-4.3 Maintain or improve quality of life for CHOICES,

			Goal 7: Maintain financial stewardship through increasing value-based payments and cost-effective care	ECF CHOICES and Katie Beckett members

Attachment M:
Report on Claiming DSIPs for DYs 1 and 2 of the TennCare III Demonstration

Report on DSIP Claiming for DYs 1 and 2 of TennCare III Demonstration

Under the terms of the TennCare III demonstration, Tennessee may claim federal funds for Designated State Investment Programs (DSIPs), as described in STC 32 of the demonstration and subject to the conditions specified in the STCs.[1] This report identifies the DSIP claiming that is applicable for DYs 1 and 2 of the TennCare III demonstration.[2]

Overview

Allowable Expenses for DSIPs

Under STC 32, allowable DSIP expenses include:

- Medicaid services for non-Medicaid eligible people,
- Non-Medicaid services for Medicaid eligible people, and
- Medicaid provider stabilization payments for current Medicaid services for people at-risk for Medicaid if services are not received.

Additionally, Attachment O of the demonstration includes a list of expenditure categories that CMS has approved as eligible for claiming as allowable DSIP expenses. Those categories are listed below. They are also included in an accompanying Excel workbook.

State Agency	Program
Department of Health	Community and Faith-Based Clinics
Department of Mental Health and Substance Abuse Services	Behavioral Health Safety Net
Department of Intellectual and Developmental Disabilities	SafetyNet – ID/DD Services
Department of Education	K-12 Nurses
Department of Education	K-12 Psychologists
Department of Education	K-12 Social Workers
Department of Education	At-Risk Student Services
Division of TennCare	CoverRx Prescription Medication Support

The state confirms that all expenses reported on the DSIP line of CMS-64 for DYs 1 and 2 are in compliance with the requirements listed above.

Non-Allowable Expenses for DSIPs

According to STC 32, non-allowable DSIP expenses include:

- Capital investments,

[1] Note that CMS approved an amended version of the TennCare demonstration on August 4, 2023, that modified certain aspects of the DSIP claiming process. This report describing DSIP claiming for Demonstration Years 1 and 2 reflects the STCs that were in place prior to August 4, 2023 (i.e., the STCs that were in effect during Demonstration Years 1 and 2).

[2] STC 32 specifies that progress on the shared savings metric set will be documented in demonstration monitoring reports, as well as the calculation of shared savings and how shared savings are spent in each demonstration year. This report, which is being submitted at CMS's request, will also be appended to the annual monitoring report for Demonstration Year 3.

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- Expenditures that are not health related, and
- Any other expenditure that is otherwise prohibited by statute or regulation.

Additionally, Tennessee is not allowed to claim federal matching funds for expenditures for which the state is already receiving federal financial participation.

The state confirms that all expenses reported on the DSIP line of the CMS-64 for DYs 1 and 2 are in compliance with the requirements listed above.

Documentation of DSIP Expenditures

Upon reporting DSIP expenditures on the CMS-64, Tennessee will provide to CMS detailed, auditable data justifying all the expenditures claimed on the DSIP line. The majority of this information comes from Edison, which is the state of Tennessee's accounting system and the official system of record for all Tennessee governmental expenditures. This data will be provided to Tennessee's assigned Financial Management Specialist, Joshua Portz. TennCare will also provide this information to any other office within CMS upon request.

Shared Savings Metric Set

The TennCare demonstration includes a set of shared savings metrics consisting of 10 measures specified in the demonstration's Shared Savings Quality Measures Protocol. (See Attachment P of the TennCare demonstration.) The shared savings metric set includes measures applicable to all demonstration populations (including measures from the Medicaid Adult, Child, and Maternity Core Sets), measures relevant to both medical/surgical and behavioral health conditions, and measures related to both preventive and acute care.

Performance on the shared savings metrics set is used to determine the overall amount of DSIP funding Tennessee is eligible to claim as shared savings in Demonstration Years 1 and 2, as described in Attachment P of the demonstration and discussed below.

Demonstration Year 1

Progress on Shared Savings Metric Set and Quality Performance Adjustment

Table 1 illustrates the state's performance on the metrics that comprise the shared savings metric set for Demonstration Year 1.

Table 1. TennCare III Shared Savings Metric Set Performance, Demonstration Year 1

Measure	Baseline Value	Significant Change Threshold	2021 Value	Difference (2021 – Baseline)	Significant Change? (Y/N)
Adult Measures					
Controlling High Blood Pressure (CBP)	64.33%	5%	62.67%	-1.66%	N
Follow-Up After Hospitalization for Mental Illness Ages 18-64, 30-Day (FUH)	55.42%	6%	58.17%	+2.75%	N

Measure	Baseline Value	Significant Change Threshold	2021 Value	Difference (2021 – Baseline)	Significant Change? (Y/N)
Use of Pharmacotherapy for OUD, Total Rate (OUD)	32.40%	6%	47.98%	+15.58%	Y
Child Measures					
Follow-Up After Hospitalization for Mental Illness Ages 6-17, 30-Day (FUH)	73.11%	5%	72.82%	-0.29%	N
Childhood Immunization Status, Combo 10 (CIS)	35.66%	6%	34.64%	-1.02%	N
Child and Adolescent Well-Care Visits, Total Rate (WCV)	57.65%	6%	51.18%	-6.47%	Y
Maternity Measures					
Timeliness of Prenatal Care (PPC)	83.68%	4%	81.92%	-1.76%	N
Postpartum Care (PPC)	70.20%	5%	72.67%	+2.47%	N
Well-Child Visits in the First 30 Months of Life, First 15 Months (W30)	59.83%	5%	53.55%	-6.28%	Y
LTSS Measure					
HCBS Rebalancing	91.35%	3%	91.41%	+0.06%	N

According to the Effect Size Change Methodology specified in STC 32, one measure—Use of Pharmacotherapy for OUD—showed significant improvement in DY 1 relative to the baseline. Two measures showed significant decline when compared to the baseline—Child and Adolescent Well-Care Visits and Well-Child Visits in the First 30 Months of Life, First 15 Months.

Under the methodology specified in Attachment P, the quality performance adjustment for a year in which performance on any measure exhibits significant decline from the baseline for one year is 0.45.

Calculation of Shared Savings

Under the TennCare III demonstration, the calculation of shared savings uses the following formula:

$$\text{State Shared Savings Amount} = \left(\text{DY Aggregate Budget Neutrality Cap} - \text{DY Aggregate Demonstration Expenditures} \right) \times \text{Quality Performance Adjustment}$$

Applying this methodology, the state's shared savings amount for DY1 is $853,710,287. The data for the aggregate budget neutrality cap and aggregate demonstration expenditures comes from the budget neutrality file submitted to CMS in April 2023 (accompanying the annual monitoring report for Demonstration Year 2). Using the expenditures from that budget neutrality report and the quality performance adjustment described above, shared savings for DY1 are calculated as follows:

$$\$853,710,287 = (\$10,509,435,387 - \$8,612,301,417) \times 0.45$$

The state's total amount of eligible DSIP spending in DY1 was less than the amount of shared savings amount calculated above. Therefore, the state is claiming only the amount of eligible DSIP funding.

Spending of Shared Savings

Below is a description of the state's DSIP investments during DY1. In aggregate, Tennessee spent $457,149,051 on the below programs. Because this amount is lower than the total eligible shared savings claim, this is the amount Tennessee is claiming.

***Safety Net – ID/DD Services*.** Tennessee spent a total of $15,023,051 on a safety net program specifically designed for individuals in intellectual and developmental disabilities in DY1. This safety net program is administered through the state's Department of Intellectual and Developmental Disabilities. The services provided fall into three broad categories: community/family support services, assistive technology services, and residential treatment services. Community/family support services are targeted to qualifying persons with intellectual and developmental disabilities and include therapy, adult day care, supported employment, and other community-based support services. Assistive technology services are targeted to qualifying persons with intellectual and developmental disabilities and include custom positioning and transport equipment including wheelchairs. Residential treatment services are provided to qualifying persons with intellectual and developmental disabilities and include behavior stabilization services and highly-structured ICF services in a residential setting. These services have a direct impact on the health and well-being of qualifying persons with intellectual and developmental disabilities.

Behavioral Health Safety Net. Tennessee spent a total of $26,617,276 on a safety net program specifically designed for behavioral health needs in DY1. This safety net program is administered through the state's Department of Mental Health and Substance Abuse Services. These outpatient services fall into three major categories: behavioral health services, substance abuse treatment services, and children's behavior services. Behavioral health safety net services are targeted to qualifying low-income Tennesseans with severe mental illness. Substance abuse treatment services are targeted to qualifying low-income Tennesseans with Substance Use Disorder (SUD). Children's behavior services are targeted to qualifying low-income Tennesseans whose children are exhibiting disruptive behaviors that are sufficiently severe as to put the child at risk of being removed from the home and placed in custody.

Community and Faith-Based Clinics. Tennessee spent a total of $19,146,665 on a safety net program specifically designed for the physical health needs of low-income Tennesseans in DY1. This safety net program is administered through the state's Department of Health. This program provides safety net health care services provided through a network of designated community and faith-based clinics. These outpatient services have a direct impact on the health and well-being of low-income uninsured Tennesseans.

At-Risk Student Services. Tennessee spent a total of $309,532,051 on health services for at-risk students in DY1. This at-risk program is administered through the state's Department of Education. This program represents investments for services for students in the state's K-12 public schools who are identified as being at-risk. At-risk students are defined as those students meeting direct certification eligibility guidelines pursuant to 42 U.S.C. §§ 1751-1769. This includes children participating in SNAP, TANF and FDPIR.

Health Services for Students. Tennessee spent a total of $81,805,366 on direct health services for students in Tennessee in DY1. This health program is administered through the state's Department of Education. This program enhances access by providing fundings for a variety of provider types for the

state's students in K-12 settings. A total of $23,247,158 was spent on nurses. A total of $26,195,995 was spent on psychologists. A total of $32,362,213 was spent on social workers.

CoverRx Prescription Medication Support. Tennessee spent a total of $5,024,642 on a safety net program specifically designed for pharmaceutical needs in DY1. This safety net program is administered through the Division of TennCare. This program, called CoverRX, provides access to covered prescriptions for low-income Tennesseans who are not eligible for Medicaid and who are not otherwise able to adequately access needed pharmaceuticals.

Demonstration Year 2

Progress on Shared Savings Metric Set and Quality Performance Adjustment

Table 2 illustrates the state's performance on the metrics that comprise the shared savings metric set for Demonstration Year 2.

Table 2. TennCare III Shared Savings Metric Set Performance, Demonstration Year 2

Measure	Baseline Value	Significant Change Threshold	2022 Value	Difference (2022 – Baseline)	Significant Change? (Y/N)
Adult Measures					
Controlling High Blood Pressure (CBP)	64.33%	5%	64.40%	+0.07%	N
Follow-Up After Hospitalization for Mental Illness Ages 18-64, 30-Day (FUH)	55.42%	6%	56.52%	+1.10%	N
Use of Pharmacotherapy for OUD, Total Rate (OUD)	32.40%	6%	54.22%	+21.82%	Y
Child Measures					
Follow-Up After Hospitalization for Mental Illness Ages 6-17, 30-Day (FUH)	73.11%	5%	75.45%	+2.34%	N
Childhood Immunization Status, Combo 10 (CIS)	35.66%	6%	34.35%	-1.31%	N
Child and Adolescent Well-Care Visits, Total Rate (WCV)	57.65%	6%	50.99%	-6.66%	Y
Maternity Measures					
Timeliness of Prenatal Care (PPC)	83.68%	4%	84.07%	+0.39%	N
Postpartum Care (PPC)	70.20%	5%	73.62%	+3.42%	N
Well-Child Visits in the First 30 Months of Life, First 15 Months (W30)	59.83%	5%	60.65%	+0.82%	N
LTSS Measure					
HCBS Rebalancing	91.35%	3%	92.12%	+0.77%	N

According to the Effect Size Change Methodology specified in STC 32, one measure—Use of Pharmacotherapy for OUD—showed significant improvement in DY2 relative to the baseline. One measure—Child and Adolescent Well-Care Visits—showed a significant decline in DY 2 when compared to the baseline.

Demonstration Year 2 was the second consecutive year in which a significant decline relative to the baseline was observed in the Child and Adolescent Well-Care Visits measure. Under the methodology specified in Attachment P, the quality performance adjustment for any year in which performance on one measure exhibits significant decline from the baseline for two consecutive years is 0.35.

Calculation of Shared Savings

Under the TennCare III demonstration, the calculation of shared savings uses the following formula:

$$\text{State Shared Savings Amount} = \left(\text{DY Aggregate Budget Neutrality Cap} - \text{DY Aggregate Demonstration Expenditures} \right) \text{X} \text{ Quality Performance Adjustment}$$

Applying this methodology, the state's shared savings amount for DY2 is $526,852,201. The data for the aggregate budget neutrality cap and aggregate demonstration expenditures comes from the attached budget neutrality file. TennCare is submitting a quarterly budget neutrality file along with this report using the budget neutrality methodology that was still in place for DY2. This file includes up-to-date data for the most accurate calculation possible. Using the expenditures from that budget neutrality report and the quality performance adjustment described above, shared savings for DY1 are calculated as follows:

$526,852,201 = ($11,360,348,088 - $9,855,056,084) X 0.35

The state's total amount of eligible DSIP spending in DY2 was less than the amount of shared savings amount calculated above. Therefore, the is claiming only the amount of eligible DSIP funding.

Spending of Shared Savings

Below is a description of the state's DSIP investments in DY2. In aggregate, Tennessee spent $472,768,438 on the below programs. Because this amount is lower than the total eligible shared savings claim, this is the amount Tennessee is claiming.

***Safety Net – ID/DD Services*.** Tennessee spent a total of $14,776,289 on a safety net program specifically designed for individuals in intellectual and developmental disabilities in DY2. This safety net program is administered through the state's Department of Intellectual and Developmental Disabilities. The services provided fall into three broad categories: community/family support services, assistive technology services, and residential treatment services. Community/family support services are targeted to qualifying persons with intellectual and developmental disabilities and include therapy, adult day care, supported employment, and other community-based support services. Assistive technology services are targeted to qualifying persons with intellectual and developmental disabilities and include custom positioning and transport equipment including wheelchairs. Residential treatment services are provided to qualifying persons with intellectual and developmental disabilities and include behavior stabilization services and highly-structured ICF services in a residential setting. These services have a direct impact on the health and well-being of qualifying persons with intellectual and developmental disabilities.

Behavioral Health Safety Net. Tennessee spent a total of $26,820,869 on a safety net program specifically designed for behavioral health needs in DY2. This safety net program is administered through the state's Department of Mental Health and Substance Abuse Services. These outpatient services fall into three major categories: behavioral health services, substance abuse treatment services, and children's behavior services. Behavioral health safety net services are targeted to qualifying low-income Tennesseans with severe mental illness. Substance abuse treatment services are targeted to qualifying low-income Tennesseans with Substance Use Disorder (SUD). Children's behavior services are targeted to qualifying low-income Tennesseans whose children are exhibiting disruptive behaviors that are sufficiently severe as to put the child at risk of being removed from the home and placed in custody.

Community and Faith-Based Clinics. Tennessee spent a total of $28,185,591 on a safety net program specifically designed for the physical health needs of low-income Tennesseans in DY2. This safety net program is administered through the state's Department of Health. This program provides safety net health care services provided through a network of designated community and faith-based clinics. These outpatient services have a direct impact on the health and well-being of low-income uninsured Tennesseans.

At-Risk Student Services. Tennessee spent a total of $315,187,747 on health services for at-risk students in DY2. This at-risk program is administered through the state's Department of Education. This program represents investments for services for students in the state's K-12 public schools who are identified as being at-risk. At-risk students are defined as those students meeting direct certification eligibility guidelines pursuant to 42 U.S.C. §§ 1751-1769. This includes children participating in SNAP, TANF and FDPIR.

Health Services for Students. Tennessee spent a total of $84,267,903 on direct health services for students in Tennessee in DY2. This health program is administered through the state's Department of Education. This program enhances access by providing fundings for a variety of provider types for the state's students in K-12 settings. A total of $23,961,257 was spent on nurses. A total of $26,978,624 was spent on psychologists. A total of $33,328,022 was spent on social workers.

CoverRx Prescription Medication Support. Tennessee spent a total of $3,530,038 on a safety net program specifically designed for pharmaceutical needs in DY2. This safety net program is administered through the Division of TennCare. This program, called CoverRX, provides access to covered prescriptions for low-income Tennesseans who are not eligible for Medicaid and who are not otherwise able to adequately access needed pharmaceuticals.