1-1-2020

Division of TennCare Annual Report FY 2019

Tennessee. Department of Human Services.

Division of TennCare

FY 2019 *Annual Report*

Executive Leadership

TennCare is the state of Tennessee's Medicaid program that provides health care for approximately 1.4 million Tennesseans and operates with an annual budget of approximately $12 billion. TennCare members are primarily low-income pregnant women, children and individuals who are elderly or have a disability. TennCare covers approximately 20 percent of the state's population, 50 percent of the state's births, and 50 percent of the state's children.

TennCare is one of the oldest Medicaid managed care programs in the country, having begun on January 1, 1994. It is the only program in the nation to enroll the entire state's Medicaid population in managed care. The TennCare program operates under a Section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) in the United States Department of Health and Human Services. Unlike traditional fee-for-service Medicaid, TennCare is an integrated, full-risk, managed care program. TennCare services are offered through managed care entities. Medical, behavioral and Long-Term Services and Supports are covered by "at-risk" Managed Care Organizations (MCOs). All of TennCare's MCOs are ranked among the top 100 Medicaid health plans in the country.

The care provided by TennCare's MCOs is assessed annually by the National Committee for Quality Assurance (NCQA) as part of the state's accreditation process. In addition to the MCOs, there is a Pharmacy Benefits Manager for coverage of prescription drugs and a Dental Benefits Manager for coverage of dental services to children under age 21.

As a leader in managed care Long-Term Services and Supports (LTSS), the state successfully implemented TennCare CHOICES in 2010 bringing LTSS into the managed care model. These services are provided in Nursing Facilities (NFs) and Intermediate Care Facilities for persons with intellectual disabilities (ICF/IID), as well as by Home and Community Based Service providers. In 2016, the Employment and Community First CHOICES program launched providing supports for people with intellectual and developmental disabilities targeted to employment and independent community living.

The Division of TennCare is within the Department of Finance and Administration which is the state agency charged with the responsibility of administering the TennCare program. The Division of TennCare includes the CoverKids and CoverRx programs.

Our Mission

Improving lives through high-quality, cost-effective care.

Our Vision

A healthier Tennessee.

Executive *Leadership*

Gabe Roberts
Deputy Commissioner

Stephen Smith
Deputy Director/Chief of Staff

Brooks Daverman
Deputy Director/Chief Operating Officer

Hugh Hale
Chief Information Officer

Drew Staniewski
General Counsel

William Aaron
Chief Financial Officer

Kimberly Hagan
Director of Member Services

Aaron Butler
Director of Policy

"Ultimately, leadership is not about glorious crowning acts. It's about keeping your team focused on a goal and motivated to do their best to achieve it, especially when the stakes are high and the consequences really matter. It is about laying the groundwork for others' success, and then standing back and letting them shine."
– Chris Hadfield, astronaut & former Commander of the International Space Station

Keith Gaither
Director of Managed Care Operations

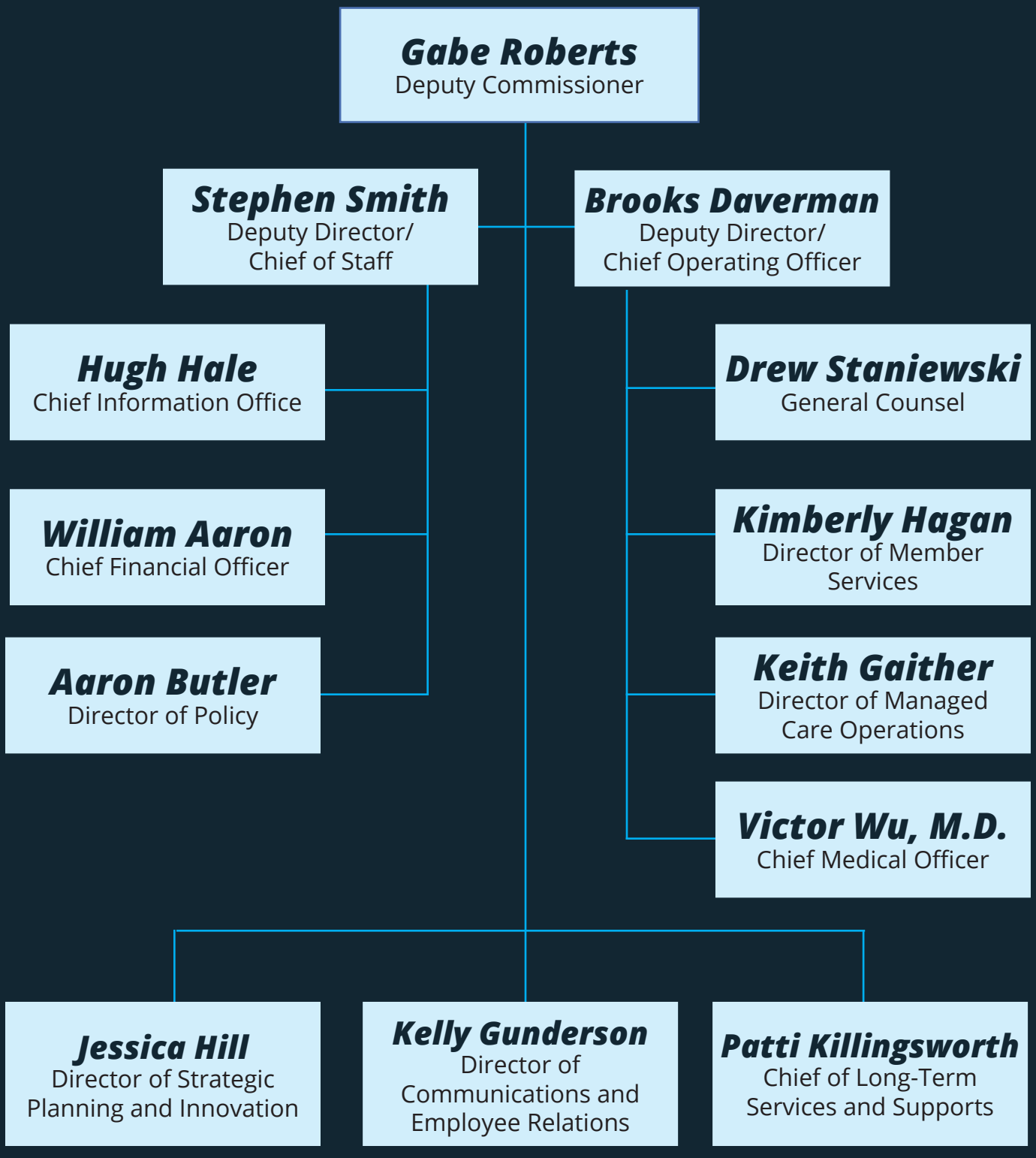
Victor Wu, M.D.
Chief Medical Officer

Jessica Hill
Director of Strategic Planning and Innovation

Kelly Gunderson
Director of Communications and Employee Relations

Patti Killingsworth
Chief of Long-Term Services and Supports

Organizational *Chart*



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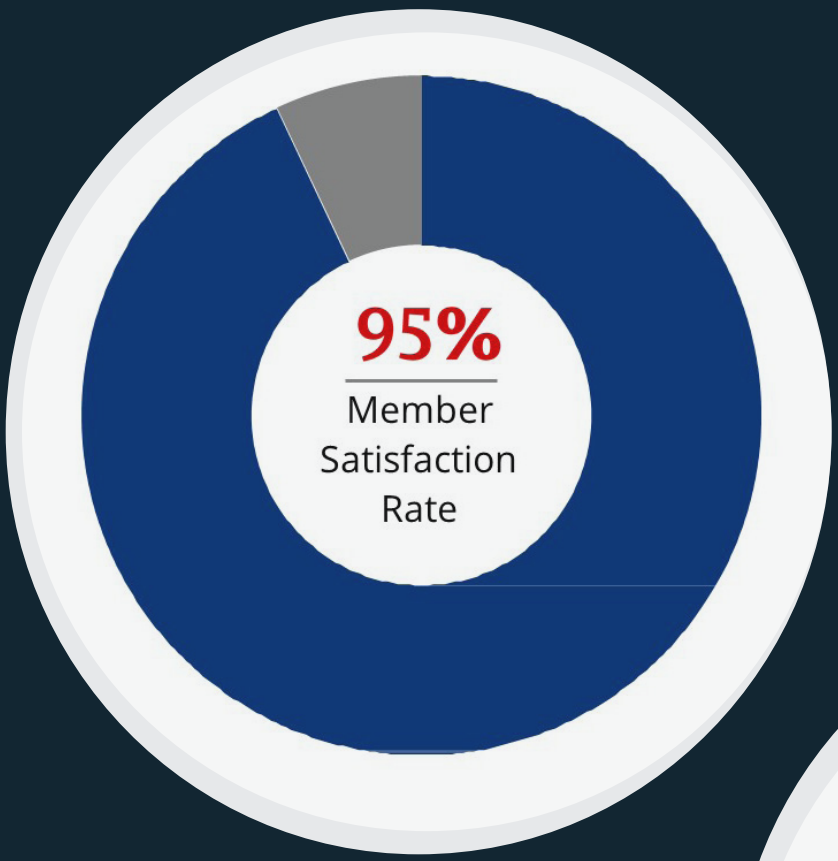
Program *Snapshot*

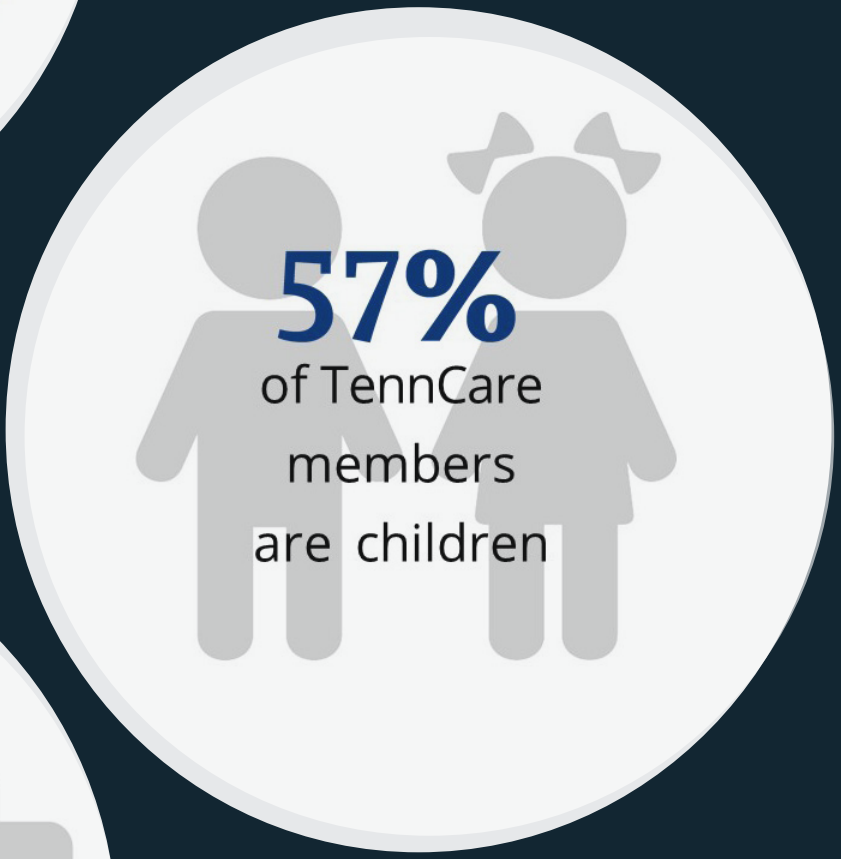
TennCare covers ***pregnant women, children, parents or caretaker relatives of minor children, older adults,*** and ***adults with disabilities.***

More TennCare members who need Long-Term Services & Supports ***choose to be served at home and community rather than in a nursing home.***

Tennessee is currently the only state that has its ***entire Medicaid population enrolled into managed care.***

TennCare operates with an ***annual budget of approximately $12 billion*** and ***current enrollment is approximately 1.4 million Tennesseans.***





91%

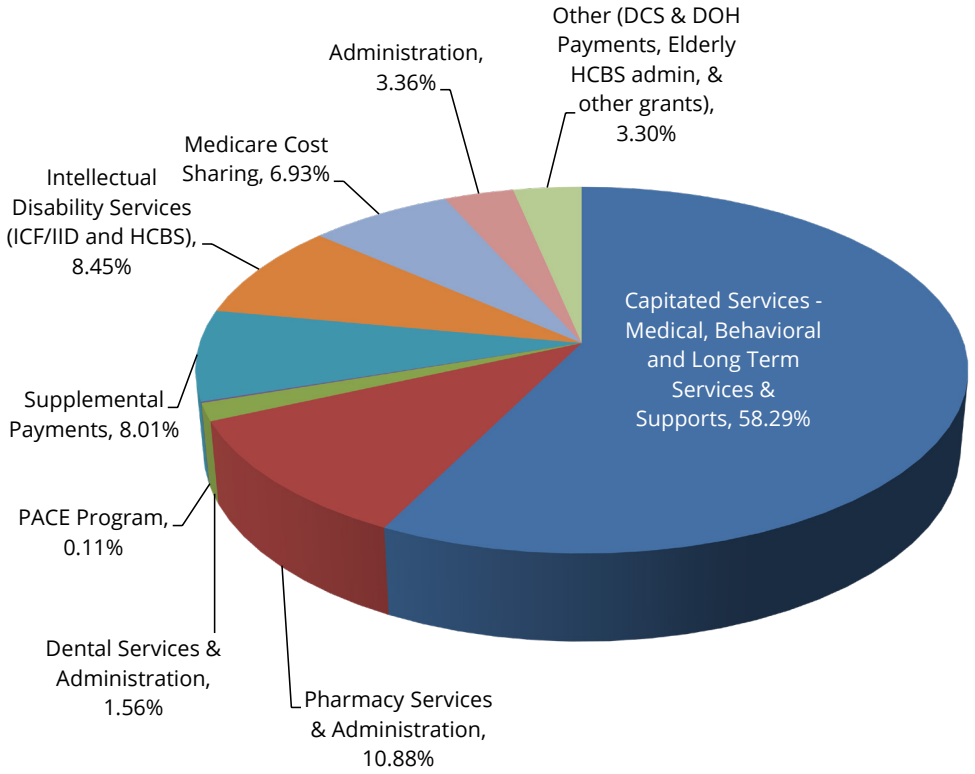
More than 90% of surveyed members say they initially receive care from a doctor's office or clinic

Program Expenditures

FY19 Expenditures by Category

Capitated Services - Medical, Behavioral and Long Term Services & Supports[1]	6,986,884,000
Pharmacy Services & Administration	1,197,581,100
Dental Services & Administration	170,831,800
PACE Program	14,064,300
Supplemental Payments	451,106,800
Intellectual Disability Services (ICF/IID and HCBS Waivers)	960,068,700
Medicare Cost Sharing[2]	753,852,600
Administration	504,686,700
Other (DCS & DOH Payments, Elderly HCBS admin, & other grants)	419,334,700
Total	**11,458,410,700**

[1]This figure is the total of capitation payments which is inclusive of all medical and behavioral health services as well as the long term services and supports for CHOICES and ECF CHOICES members.
[2]Includes Medicare Part D Clawback.



Enrollment Eligibility by Race and Age

Enrollment on January 1, 2019

Race	0 to 20	21 to 64	65+	Grand Total
Black	181,956	113,798	12,960	308,714
Hispanic	1,531	313	57	1,901
Other[1]	218,050	112,376	13,957	344,383
White	381,500	263,890	39,034	684,424
Grand Total	783,037	490,377	66,008	1,339,422

[1] Other includes "unspecified" as the Federal Marketplace (the primary application portal during this reporting year) does not require race to be provided.

Medical Services

Providers with Paid Claims	FY19 Recipients	Expenditures Per Recipient	FY19 Expenditures[1]
11,968	1,211,198	$3,262.97	$3,952,104,130

[1]Total expenditure includes the total of administration fees paid to contracted MCO's, based on the allocated proprotion of total Medical and Behavioral Health expenditure incurred in SFY18.

Mental Health Clinics and Institutional Services

Providers with Paid Claims	FY19 Recipients	Expenditures Per Recipient	FY19 Expenditures[1,2]
4,269	277,119	$1,854.78	$513,994,131

[1]Excludes case management services, transportation and other community services where payment to provider was a capitated arrangment.
[2]Total expenditure includes the total of administration fees paid to contracted MCO's, based on the allocated proprotion of total Medical and Behavioral Health expenditure incurred in SFY19.

TennCare Expenditures & Recipients by County

County	Enrollment on 1-Jan-19	Estimated 2019 Population	% of County on TennCare	Total Service Expenditure[1]	Expenditure per Member
ANDERSON	15,729	76,931	20%	$115,079,553	$7,316
BEDFORD	11,790	49,487	24%	$60,313,421	$5,116
BENTON	3,848	15,921	24%	$27,886,976	$7,247
BLEDSOE	2,893	14,996	19%	$15,641,175	$5,407
BLOUNT	20,340	132,919	15%	$136,080,043	$6,690
BRADLEY	21,137	107,209	20%	$144,563,474	$6,839
CAMPBELL	11,744	39,848	29%	$85,222,699	$7,257
CANNON	3,054	14,157	22%	$18,265,784	$5,981
CARROLL	7,087	27,827	25%	$50,370,179	$7,107
CARTER	12,238	56,077	22%	$81,667,093	$6,673
CHEATHAM	6,225	40,388	15%	$42,773,965	$6,871
CHESTER	3,663	17,750	21%	$19,507,061	$5,325
CLAIBORNE	8,422	31,867	26%	$56,548,434	$6,714
CLAY	1,969	7,653	26%	$15,469,161	$7,856
COCKE	10,787	35,303	31%	$65,218,550	$6,046
COFFEE	12,937	55,953	23%	$82,206,899	$6,354
CROCKETT	3,562	14,467	25%	$22,686,476	$6,369
CUMBERLAND	11,773	60,481	19%	$77,249,563	$6,562
DAVIDSON	125,507	708,041	18%	$801,376,548	$6,385
DECATUR	2,766	11,754	24%	$22,186,113	$8,021
DEKALB	4,981	19,633	25%	$32,050,519	$6,435
DICKSON	10,348	53,985	19%	$69,308,237	$6,698
DYER	9,787	37,808	26%	$54,449,758	$5,563
FAYETTE	6,522	41,303	16%	$39,766,227	$6,097
FENTRESS	5,526	18,233	30%	$38,208,519	$6,914
FRANKLIN	7,322	41,927	17%	$50,969,503	$6,961
GIBSON	12,124	49,994	24%	$94,533,711	$7,797
GILES	5,818	29,181	20%	$40,051,508	$6,884
GRAINGER	5,651	23,356	24%	$33,103,765	$5,858
GREENE2	14,935	69,382	22%	$158,544,219	$10,616
GRUNDY	4,186	13,171	32%	$28,076,074	$6,707
HAMBLEN	15,615	64,906	24%	$103,444,514	$6,625
HAMILTON	62,048	366,858	17%	$420,948,954	$6,784
HANCOCK	2,171	6,498	33%	$13,714,387	$6,317

TennCare Expenditures & Recipients by County

County	Enrollment on 1-Jan-19	Estimated 2019 Population	% of County on TennCare	Total Service Expenditure[1]	Expenditure per Member
HARDEMAN	6,406	25,088	26%	$45,812,143	$7,151
HARDIN	6,605	25,639	26%	$50,504,131	$7,646
HAWKINS	12,603	56,622	22%	$79,107,615	$6,277
HAYWOOD	5,107	17,464	29%	$29,310,770	$5,739
HENDERSON	6,748	28,214	24%	$41,817,775	$6,197
HENRY	7,198	32,496	22%	$41,912,412	$5,823
HICKMAN	5,574	24,505	23%	$33,799,138	$6,064
HOUSTON	1,933	8,143	24%	$16,938,904	$8,763
HUMPHREYS	4,189	18,370	23%	$28,204,943	$6,733
JACKSON	2,649	11,731	23%	$16,231,233	$6,127
JEFFERSON	11,859	54,793	22%	$84,901,364	$7,159
JOHNSON	4,202	17,760	24%	$26,715,556	$6,358
KNOX	73,529	468,678	16%	$521,428,748	$7,091
LAKE	1,996	7,621	26%	$14,788,099	$7,409
LAUDERDALE	7,188	26,789	27%	$39,655,887	$5,517
LAWRENCE	10,163	43,493	23%	$64,558,135	$6,352
LEWIS	2,834	11,890	24%	$19,691,893	$6,948
LINCOLN	6,937	33,891	20%	$41,763,623	$6,020
LOUDON	8,431	53,423	16%	$52,514,505	$6,229
MACON	6,284	24,215	26%	$32,305,955	$5,141
MADISON	23,372	98,527	24%	$184,206,268	$7,881
MARION	6,474	28,863	22%	$37,408,485	$5,778
MARSHALL	6,504	32,837	20%	$40,443,074	$6,218
MAURY	17,359	93,508	19%	$114,330,154	$6,586
MCMINN	11,836	53,445	22%	$74,213,598	$6,270
MCNAIRY	6,637	26,069	25%	$43,701,897	$6,585
MEIGS	2,990	12,183	25%	$16,469,575	$5,508
MONROE	10,743	46,832	23%	$65,850,860	$6,130
MONTGOMERY	35,326	208,464	17%	$192,218,996	$5,441
MOORE	795	6,386	12%	$5,252,964	$6,608
MORGAN	4,259	21,825	20%	$29,565,784	$6,942
OBION	7,519	30,235	25%	$45,577,330	$6,062
OVERTON	4,839	22,338	22%	$29,804,750	$6,159
PERRY	1,822	8,008	23%	$12,425,097	$6,819

County	Enrollment on 1-Jan-19	Estimated 2019 Population	% of County on TennCare	Total Service Expenditure[1]	Expenditure per Member
PICKETT	1,052	5,122	21%	$7,370,181	$7,006
POLK	3,889	16,928	23%	$20,782,321	$5,344
PUTNAM	17,183	78,134	22%	$120,036,365	$6,986
RHEA	8,580	33,004	26%	$57,691,047	$6,724
ROANE	10,864	52,851	21%	$81,854,493	$7,534
ROBERTSON	12,414	71,726	17%	$76,015,754	$6,123
RUTHERFORD	50,651	330,869	15%	$263,176,693	$5,196
SCOTT	7,229	22,025	33%	$48,413,460	$6,697
SEQUATCHIE	3,715	15,452	24%	$21,685,442	$5,837
SEVIER	19,049	100,927	19%	$101,589,944	$5,333
SHELBY	237,438	946,532	25%	$1,291,011,889	$5,437
SMITH	4,046	19,844	20%	$24,613,811	$6,083
STEWART	2,849	13,251	21%	$18,112,934	$6,358
SULLIVAN	31,189	156,640	20%	$190,314,313	$6,102
SUMNER	27,310	188,858	14%	$157,481,263	$5,766
TIPTON	12,156	63,109	19%	$66,174,204	$5,444
TROUSDALE	1,878	8,561	22%	$11,721,577	$6,242
UNICOI	3,978	17,792	22%	$31,583,340	$7,940
UNION	4,946	19,325	26%	$28,579,082	$5,778
VAN BUREN	1,298	5,663	23%	$10,881,057	$8,383
WARREN	10,560	40,717	26%	$67,675,422	$6,409
WASHINGTON	22,913	131,123	17%	$166,842,454	$7,282
WAYNE	3,034	16,645	18%	$23,299,390	$7,679
WEAKLEY	6,876	33,147	21%	$49,312,382	$7,172
WHITE	6,754	27,124	25%	$40,609,907	$6,013
WILLIAMSON	12,106	235,521	5%	$70,488,599	$5,823
WILSON	18,050	140,489	13%	$109,911,608	$6,089
Other3	29,875			$90,966,537	$3,045
Total	1,369,297	6,826,985	20%	$8,539,110,194	$6,236

1. Service Expenditures include Medical, Pharmacy, Long-Term Services and Supports, Dental, Behavioral Health Services, MCO administrative costs and Part D payments on behalf of Dual eligible members. Payments on behalf of Dual eligible members for Part D drug coverage totaled $216,802,600. ASO administration and Part D payments were allocated across counties relative to the county's proportion of total expenditure.
2. Greene County expenditures include costs associated with Intermediate Care Facilities for Individuals with Intellectual Disabilities, causing the per-member cost to appear higher when comparing it with those of the other counties.
3. This category reflects recipients who are Tennessee residents for which their domicile is temporarily located outside of the state.
4. The total service expenditure reflects total amount payment in Edison, 'Cty Rpt Adj' tab D11, the total expenditure based on incurred claims cross counties are proportional in terms of total amount in Edison.

Program Overview
Quality Improvement

TennCare Kids

TennCare Kids is a full program of checkups and health care services for children from birth through age 20 who have TennCare. These services make sure that babies, children, teens, and young adults receive the health care they need.

Statewide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Screening Rates increased from 2018 to 2019 by 2% from 77% to 79%.

Patient Centered Medical Home (PCMH)

The TennCare PCMH program is a comprehensive care delivery model designed to improve the quality of primary care services, the capabilities and practice standards of primary care providers. Under this model, primary care providers provide a holistic approach to manage member's health needs.

Patient Centered Medical Home Results: Improvements in quality of care in primary health from 2016-2018

4,103
additional people with diabetes had their high blood pressure controlled

1,784
additional people with diabetes benefited from eye examinations to test for complications of diabetes

19,523
additional adults had their BMI measured and documented

38,352
additional children and teens had their BMI measured and documented

38,226
additional children and teens obtained nutritional counseling

6,936
additional children ages 7-11 years had a visit with a primary care physician

"By becoming a [PCMH], our practice is more patient centered. We have been more able to streamline our case management and coordination of care. We have improved our efficiency by offering same day appointments and patient care hours outside our normal business day, including Saturday clinics."

- PCMH Administrator

The PCMH program launched in January of 2017 with 29 organizations. By the second year of the program, the total number of organizations is 65.

Patient Centered Medical Home Results

$12.6 million in quality outcome payments since program launch

Outcome payments awarded to high performing PCMH providers for performance in 2017 and 2018.

$78M invested in primary care services

This investment, made over the first three years of the program in the form of activity payments, is paid to PCMH providers to provide care coordination for patients

"The activity payments have enabled us to hire more care coordinators"

- Participating PCMH Provider

"We are better able to treat the whole person"

- Participating PCMH Provider

2019	Wave 1	Wave 2	Total
Number of PCMHs	28	37	65
Number of Sites	174	240	414
Total number of members	247,877	233,767	481,644

Outcome Payments for Wave 1

- Wave 1 and Wave 2 providers received outcome payments for performance in 2018.
- 53 out of 65 (Wave 1 and Wave 2) organizations received an outcome payment from at least one MCO.
- The outcome payments reflect the primary care organizations' dedication to improving quality, as well as decreasing total cost of care and utilization.
- Approximately $11.1 million dollars was paid out to these organizations for 2018 performance.

Program Overview
Medical Appeals

TennCare members have the right to file a medical appeal if services have been denied, delayed, reduced, suspended, or terminated. The TennCare Solutions Unit (TSU) assists members with their medical appeals working closely with providers and TennCare managed care organizations.

Medical Appeals Resolution Report: January to December 2019

	2019 Total	Avg/Month
Total Appeals Resolved	5,948	496
Managed Care Contractor		
Initial Requests Approved	14	1
Reconsideration	1,416	118
Total Resolved by MCC	1,430	119
% Resolved by MCC	24%	
Processing		
Withdrawn	35	3
Untimely/Ineligible	19	2
Informal Resolution	73	6
Provider Withdraw	4	0
Overturned	610	51
Total Resolved	741	62
% Resolve	12%	
Office of Fair Hearing (OFH)		
Withdrawn	1,181	98
Withdrawn Service Approved	138	12
Default Dismissal	998	83
Petitioner Prevails	143	12
State Prevails	1,304	109
Evacuation or Other Service Ordered	14	1
Total Resolved by OFH	3,778	315
% Resolved by OFH	64%	

Program Overview
Dental

Dental Services

Services delivered through Dental Benefits Manager (DBM)

Providers with Paid Claims	FY19 Recipients	Expenditures Per Recipient	FY19 Expenditures[1]
1,525	469,007	$364.24	$170,831,800

[1]Amount includes administrative costs but does not include Health Department Dental Program cost of $6,490,800 which is included on page 1 in the Other (DCS & DOH Payments, Elderly HCBS admin, & other grants) category.

The TennCare Dental Program is responsible for assuring that members have access to high quality cost effective oral health care including preventive, restorative, and surgical care. This care is administered through a contracted Dental Benefits Manager (DBM).

Major projects include:

1) Leveraging the Patient Centered Dental Home (PDCH) to continually improve the quality of care rendered to members,
2) Increase provider utilization of minimally invasive services that prevent or arrest oral diseases such as topical fluorides , dental sealants and Silver Diamine fluoride (SDF),
3) Reduce the number of opioid prescriptions written by participating dentists through provider education.

Patient-Centered Dental Home (PCDH)

A PCDH is defined as a place where a child's oral health care is delivered in a comprehensive, continuously accessible, coordinated and family-centered way by a dentist participating in the TennCare program. Provider acceptance and engagement of member assignments is essential to the success of the program for TennCare beneficiaries.

- Success is evaluated through reports that track patient engagement, quality of care and provider performance.
- The Provider Performance Report (PPR) is an individual confidential report card sent to participating dentists on a quarterly basis that allows them to see how their practice compares with that of their peers and the overall network average in cost, access, and preventive care. Sharing confidential feedback results in continuous quality improvement as providers strive to meet or exceed network benchmarks.

The vast majority of TennCare members are satisfied with their dental care, dental plan, dental benefits and dentist!

DentaQuest®

Impact

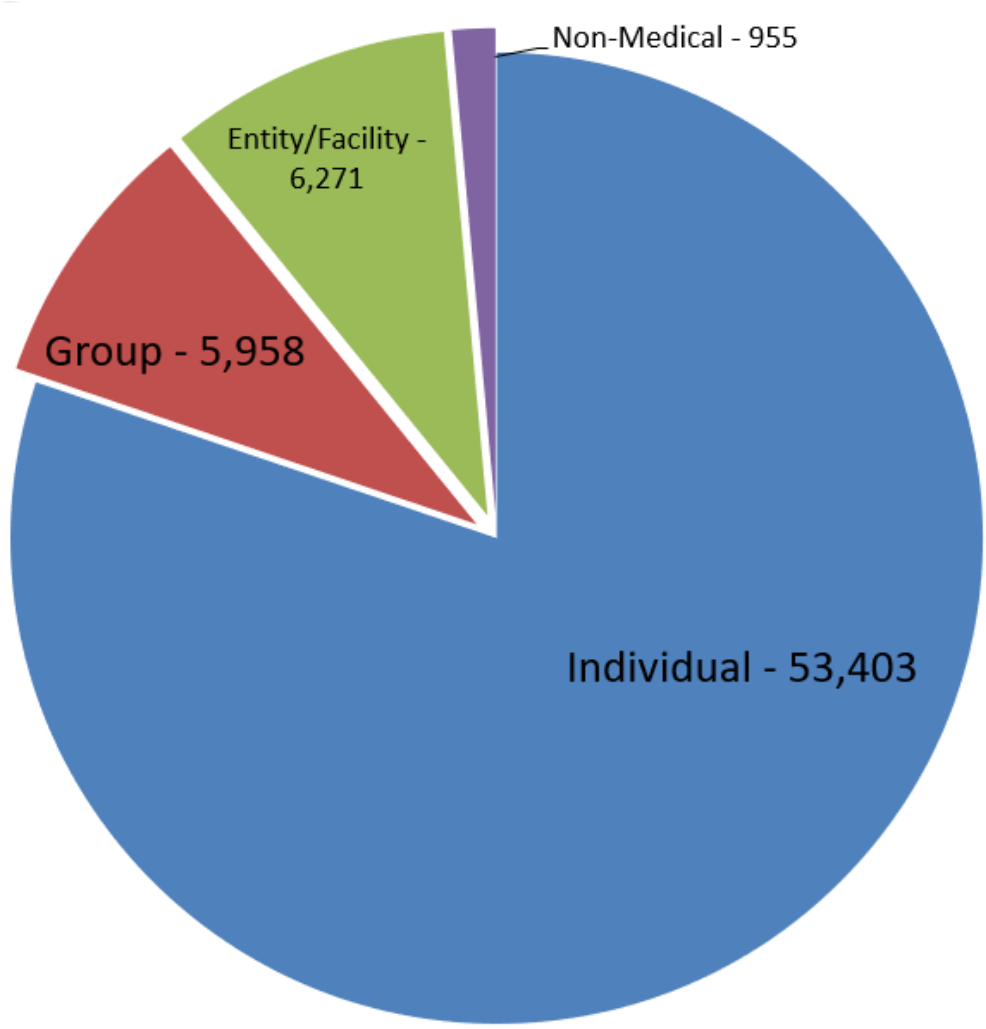
- Through our TennCare DBM contract with DentaQuest, the proportion of children members who received dental treatment in 2019 based on TennCare's dental utilization measure was 57.5%.
- The 2019-member satisfaction survey revealed that the vast majority of members are satisfied with their dentist (97%), the dental care they received (97%), and with the DentaQuest dental plan (99%).
- The provider satisfaction survey for 2019 revealed that 88% of providers were "very satisfied" or "somewhat satisfied" with DentaQuest, while 99% indicated that they "definitely" or "probably" will continue to be a provider for DentaQuest.
- In 2019, for the very first time, TennCare's dental program began posting educational dental prevention materials on TennCare's Facebook, Twitter, and Instagram pages to increase member outreach and share initiatives with both members and providers on the various social media platforms.
- To more effectively communicate with the dental provider network, the TennCare dental program required the DBM to begin contacting its network providers through email, in addition to the other various forms of communication that were already in place, such as mail and fax. This has been effective and well received by the providers because it allowed them to electronically click on links and attachments, rather than having to manually search and input links.

Program Overview
Provider Services

TennCare Provider Services coordinates provider activities including provider registration with the TennCare program. The TennCare Provider Services division is responsible for three primary functions. First, all providers seeking participation in the Medicaid/TennCare program are required to enroll with TennCare. This process is managed by the Provider Registration Team to ensure compliance with federal regulations at 42 CFR 455.410 and 455.450 requiring that all participating providers are screened according to their categorical risk level, upon initial enrollment and upon re-enrollment or revalidation of enrollment. Once providers are enrolled with TennCare, they are eligible to contract with any of our Managed Care Contractors. The Provider Networks Team oversees and monitors network access requirements for our Managed Care Contractors.

The Electronic Health Records (EHR) Provider Incentive Payment Program processes attestations from providers seeking an incentive payment authorized as part of the HITECH Act (part of the American Re-Investment and Recovery Act (ARRA) of 2009). Data flow between all Provider Services teams as well as other TennCare divisions and our Managed Care Contractors is also managed within Provider Services.

66,587 TennCare Registered Providers – September 2019:



FY2019 Milestones

Procurement activities began for a new Certified Provider Management Module and Centralized Credentialing during FY2019. The anticipated go-live for the new Certified Provider Management Module is Spring 2021.

TennCare also expanded its opioid use disorder (OUD) treatment network during FY2019.

- Access standards were developed and implemented for OUD treatment providers contracted to treat with buprenorphine.
- Geographic access requirements were put in place.
- Non-Dual member/provider ratio requirements were established.
- Capacity slot availability requirements by Grand Region.
- Each TennCare MCO is in compliance with these standards as of this report.

Program Overview
Phamarcy Services

Pharmacy Services

Pharmacy Services

Services delivered through Pharmacy Benefits Manager (PBM)

Providers with Paid Claims	FY19 Recipients	Expenditures Per Recipient	FY19 Expenditures[1]
12,412	1,051,224	$1,139.23	$1,197,581,100

[1]Amount includes administrative costs paid to the PBM.

In FY19, TennCare filled 13,604,733 prescriptions which averages to be 37,273 prescriptions filled per day.

Pharmacy Benefits Manager Readiness Activities

In January 2019, TennCare announced that Optum Rx., Inc. would replace Magellan Medicaid Administration as TennCare's Pharmacy Benefits Manager (PBM). Although Optum will not start processing pharmacy claims for TennCare until January 1, 2020, the company began readiness activities in March 2019. Priorities during this period of transition included the following:

- Establishing and managing a pharmacy network;
- Building a claims processing system and loading it with all information (member data, edits specific to TennCare's outpatient formulary, clinical/quantity requirements, etc.) necessary for adjudication of claims;
- Creating a call center and website to assist patients and providers; and
- Helping TennCare negotiate and collect supplemental rebates from pharmaceutical manufacturers.

During the April-June 2019 quarter, preparations focused on the proper transfer to OptumRx of various types of pharmacy data, including those involving historical claims, prior authorization, TennCare's drug formulary, supplemental rebates, and drug pricing.

Division of TennCare | CoverRx

CoverRx

FY 2019 Milestones (July 1, 2018 – June 30, 2019)

- **Electronic Application:** CoverRx through its PBM, Magellan Medicaid Administration, successfully launched its electronic online application to simplify and expedite the application process in October 2108 ;
- **Pharmacy Benefits Manager Readiness Activities:** Similar to readiness activities as TennCare, CoverRx will transition to OptumRx as the program's Pharmacy Benefits Manager. Beginning January 1, 2020, OptumRx will be responsible for processing all applications for enrollment and reenrollment in the CoverRx program. During the April-June 2019 quarter, preparations focused on transfer to OptumRx of membership enrollment historical data and OptumRx's development of online real time application processes.

Voluntary Reversible Long-Acting Contraception (VRLAC)

FY 2019 (July 1, 2018 – June 30, 2019)

TennCare continues to remove barriers to acess for Voluntary Reversible Long-Acting Contraceptive (IUDs and implants) for women.

- **Outpatient Consignment Program:** Successful transfer of the consignment program to a new Specialty Pharmacy offering more widespread exposure throughout the state; and allowing for the addition of the CoverKids population;
- **Inpatient Postpartum Program:** Increased expansion in the number of hospitals participating in the program and increased utilization within individual hospitals.

Medication Therapy Management (MTM) Program

Medication therapy management (MTM) program is defined as distinct service or group of services which optimizes therapeutic outcomes for individual TennCare members. MTM services include medication reviews, pharmacotherapy consult, anticoagulation management, immunizations, health and wellness programs and many other clinical services.

Pharmacists provide MTM services to help TennCare members get the best benefits from their medications by managing drug therapy and by identifying, preventing, and resolving medication-related problems.

Pharmacist Participation in MTM in Medicaid Pilot Program

The MTM pilot program launched in February 2018 and authorizes qualified Tennessee-licensed pharmacists to provide MTM services to eligible TennCare members under a collaborative practice agreement (CPA) with TennCare Patient Centered Medical Homes (PCMH) and Health Link (THL) organizations.

MCO Credentialing:

- Amerigroup has at least 33 pharmacists credentialed
- UnitedHealthcare Community Plan has at least 35 pharmacists credentialed.
- BlueCare has 19 credentialed pharmacists.

MTM Claims Paid During FY2019:

- $11,600 in MCO claims were paid between July 2018 to August 2019.

Pharmacy Program
Opioid Strategy

As the state's Medicaid system, Division of TennCare is an essential component of the states' overall opioid strategy. In addition to partnering with multiple state agencies and with the governor's office, TennCare also has its own opioid strategy and initiatives to combat the crisis focused on primary, secondary and tertiary prevention of opioid addiction. Primary prevention aims to limit opioid exposure for non-chronic opioid users to prevent the progression to chronic opioid use. Secondary prevention is the early detection and intervention to reduce the impact of opioid misuse in those already using opioids, and lastly tertiary prevention is addiction and recovery support for individuals with opioid dependence and misuse.

PRIMARY PREVENTION

TennCare contracts with a Pharmacy Benefit Manager (PBM) to administer the TennCare pharmacy benefit. As part of the contract agreement with the PBM and at the direction of TennCare, the PBM implements and operationalizes point-of-sale (POS) edits at the time a prescription is processed at the pharmacy. The process of implementing new POS edits has been iterative over the years to ensure the best outcomes for our members and has focused on opioid prescriptions for many years. TennCare now has a coverage benefit limit in place for opioids.

A brief overview of key TennCare Point-of-Sale (POS) edits are as follows:

- Key edits prior to 2016:
  * Therapeutic duplication edit in place at POS for multiple short-acting or long-acting narcotics.
  * Quantity limits in place for all short-acting and long-acting narcotics.
  * Adopted recommendation from Drug Utilization Review (DUR) board to edit early refills at 95% for all controlled substances.
- 2016: Prior authorization duration for opioids reduced from 6 months to 3 months.
- 2016: For all children with acute pain and for the first fill for adults with acute pain, TennCare no longer covers more than a 7-day supply of short-acting narcotics.
- 2017: Chronic opioid users are restricted to 200 MME per day.
- 2018: The most recent POS edits were for first time or non-chronic opioid users. TennCare now covers opioid prescriptions for up to 15 days in a 180-day period at a maximum dosage of 60 morphine milligram equivalents per day (MME per day).

Effective January 16, 2018, TennCare and its PBM implemented a point-of-sale (POS) edit on agents in the Short-Acting and Long-Acting Narcotics classes of the Preferred Drug List (PDL). For first time or non-chronic opioid users, TennCare will cover opioid prescriptions for up to 15 days in a 180-day period at a maximum dosage of 60 morphine milligram equivalents per day (MME per day). After the first-fill prescription (less than or equal to 5 days), a member can receive up to an additional 10 days of opioid treatment with prior authorization (PA). Some clinical exceptions (e.g. patients with sickle cell, new diagnosis of cancer, hospice) exist to these POS edits through prior authorization. The goal of this policy change is to reduce overexposure to opioids both in dosage and duration for first-time and acute opioid users. The medical evidence strongly shows that increased duration both in dosage and in length of exposure greatly increases the risk of long-term chronic opioid use and other potential negative health outcomes associated with chronic opioid use and misuse. By reducing the coverage of opioids for first-time and non-chronic users, TennCare's goal is to reduce the number of members who progress to becoming chronic opioid users over time.

As of 2017, TennCare no longer covers a prescription for a patient receiving a short-acting or long-acting opioid with a cumulative daily MME greater than 200 MME. This recommendation was a part of the CDC chronic pain guidelines. The goal of this policy is to slowly reduce the dosage among chronic users to reduce the potential for overdose or diversion.

Prior Authorization (PA) requirements and POS edits also help to mitigate the risks of improper usage of opioids. The following requirements are in place to mitigate the risks of improper use of opioids/ controlled substances:

- All long-acting narcotics require prior authorization.
- After the first-fill prescription (less than or equal to 5 days), a member can receive up to an additional 10 days of opioid treatment at a maximum dose of 60 MME per day in each 180 day period with prior authorization.
- All controlled substances have associated measures that mitigate risk of improper use including POS edits, quantity limits, prospective DUR edits and prior authorization requirements that discourage unsuitable use, Prescription Monitoring Program (PMP) checks, and appropriate monitoring.

The length of time the PA remained active before needing to be renewed for short-acting narcotics was also reduced from 6 months to 3 months in 2016. The goal of this policy change was to prevent abuse and overutilization of the narcotic prescription.

TennCare has also changed the Preferred Drug List (PDL) over time to prevent abuse of opioids and other controlled substances. The changes to the PDL include shifting agents with high-risk of abuse potential to non-preferred status as well as applying monthly quantity limits first to individual agents and later on a cumulative basis. For example, in 2014 TennCare started only approving non-preferred short-acting narcotics if a patient could not use any preferred agents due to a contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage with all preferred agents. More recently, TennCare is attempting to prevent exposure to high dosages of opioids by limiting benefit covered days of supply and daily morphine milligram equivalents (MME) for non-chronic or new users of opioids.

SECONDARY PREVENTION

TennCare has partnered with the Managed Care Organizations (MCOs) and the Pharmacy Benefits Manager (PBM) to use data analytics to identify potential clinical risk for women of child bearing age using opioids. This model uses risk stratification to identify women into different severity categories which include risk groupings such as:

- High risk for developing opioid addiction or opioid use disorder
- Oral Contraceptive non-compliance on opioid therapy
- Potential pregnancy with concurrent opioid use
- Previous delivery with diagnosis of Neonatal Abstinence Syndrome (NAS)

This MCOs use information from the model to provide appropriate forms of member engagement, outreach and possible intervention. Based on the clinical risk, women are connected with prenatal care, early prevention and screening services, access to voluntary reversible long acting contraception, or primary and mental health care among other outreach activities.

The MCOs performed over 16,600 outreach/engagement attempts to high-risk women of child-bearing age.

Additionally, TennCare has worked diligently to decrease barriers to Voluntary Reversible Long Acting Contraception (VRLACs) for women with the goal of reducing infants born with Neonatal Abstinence Syndrome (NAS). In 2016, the MCOs worked effectively with TennCare to make VRLACs more readily available at the time of delivery to increase utilization. All three MCOs agreed to unbundle the reimbursement for VRLACs from the global obstetric billing to facilitate rapid access to all forms of contraception rather than waiting until a follow-up visit to place the VRLAC.

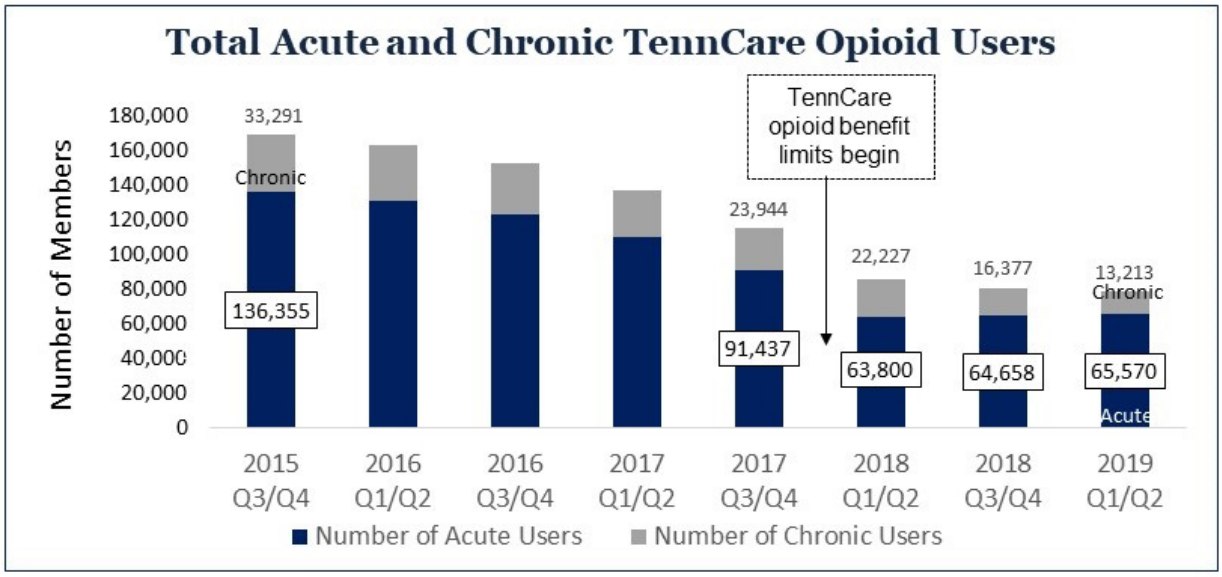
TERITIARY PREVENTION

TennCare's Managed Care Organizations are increasing access to comprehensive medication assisted treatment (MAT) for members with substance abuse disorder (SUD) and opioid use disorder (OUD) through a dedicated MAT provider network, which was officially launched in January 2019. Behavioral health counseling and therapy is a necessary component of MAT treatment that providers in the network must have means to provide. By participating in the network, providers receive enhanced resources and support from the MCOs. The network officially launched on January 1, 2019 and there are currently 180 newly contracted, high-quality MAT providers that have partnered with at least one of TennCare's three MCOs. Overall, the MCOs have received a positive response from the provider community thus far and are successfully contracting with providers from across the state to provide addiction treatment and recovery services. TennCare will continue to grow this network and support providers in providing high-quality care.

OUTCOMES & DATA

Overall, the number of TennCare new, acute opioid users has declined by 52% since 2015. The largest decrease occurred following the implementation of new TennCare opioid benefit limits.

Overall, the number of TennCare new, acute opioid users has declined by 50.2% since 2016.

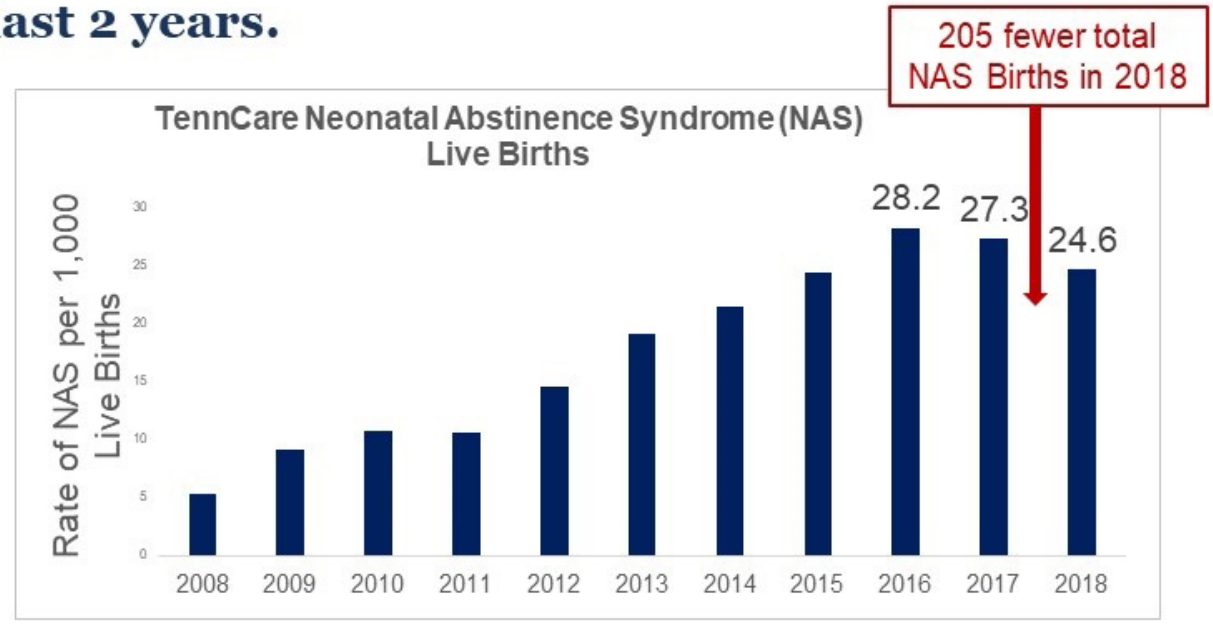


*Data is based on pharmacy claims paid by TennCare

- TennCare has cut the number of opioid pills dispensed by more than a third since 2015.
- Throughout 2019, 180 high-quality providers provided opioid use disorder treatment and recovery services to 6,125 members through the network

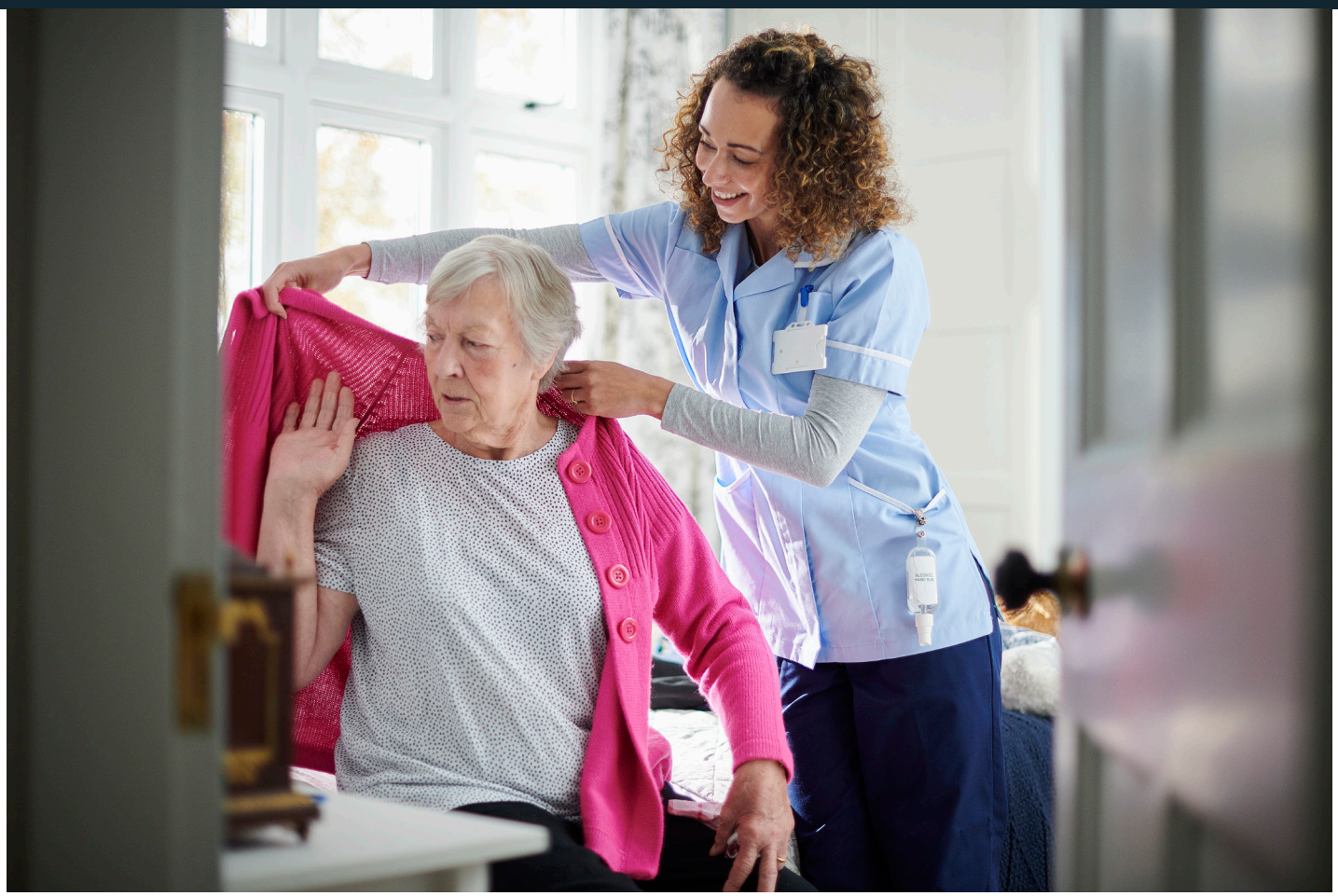
- Tennessee is the only state in the country that is reporting a decline in the number of NAS cases.
- There were 205 fewer NAS births in 2018 compared to 2017

NAS Rates for TennCare Members have decreased for the last 2 years.



Tennessee has experienced a 12.8% decrease in NAS births since 2016

Program Overview
Long-Term Services & Supports



CHOICES Program

TennCare CHOICES in Long-Term Services and Supports (LTSS) program (or "CHOICES" for short) was implemented in 2010 as part of our managed care program. In addition to providing Medicaid-reimbursed nursing facility services, it offers home and community-based services (HCBS) for adults (age 21 and older) with a physical disability and seniors (age 65 and older). These services can be provided in the home, on the job, or in the community to assist with daily living activities and support people to work and be actively involved in their local community.

CHOICES Enrollment

Category of Service	Number of Recipients (6/30/18)	Number of Recipients (6/30/19)	% Change
Employment & Community First CHOICES	2,529	2,804	10.87%
Home and Community Based Services	12,208	12,265	0.467%
Nursing Facility Services	16,747	16,670	-0.46%

Employment and Community First CHOICES Program

Employment and Community First CHOICES is an HCBS program implemented as part of our managed care program in July 2016 that provides essential services and supports (HCBS, physical and behavioral health, pharmacy and dental services) in a coordinated and cost-effective manner for people with intellectual and other developmental disabilities (I/DD). It is considered a national model in part because it is specifically designed to align incentives around helping people with I/DD achieve employment and live as independently as possible in their communities. The program offers a more cost-effective way of serving people with I/DD while also demonstrating improved employment, health and quality of life outcomes.

In addition to these managed LTSS programs, TennCare has three Section 1915(c) HCBS waivers. These waivers are operated by the Department of Intellectual and Developmental Disabilities (DIDD) and offer a broad array of services to individuals with intellectual disabilities who would otherwise require the level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Beneficiary Support System

In compliance with federal managed care regulations, TennCare implemented a Beneficiary Support System (BSS) aimed at assisting TennCare applicants and members—in particular those receiving managed LTSS—in navigating the health care delivery system. TennCare's BSS includes the availability of choice counseling for TennCare members (to assist with health plan selection), and an "Ombudsman" program for people receiving LTSS through managed care—CHOICES and Employment and Community First CHOICES. Regionally located Area Agencies on Aging and Disability provide choice counseling services. Disability Rights Tennessee, the State Protection and Advocacy organization, is contracted in the new Ombudsman-like role and provides additional resource to individuals in navigating LTSS grievance and appeal processes.

Completion of Statewide Transition Plan

In January 2014, the Centers for Medicare and Medicaid Services (CMS) issued a new federal rule, often referred to as the HCBS Settings Rule, that applies to HCBS funded through Medicaid. The rule defines the qualities that settings must meet in order for Medicaid HCBS to be reimbursed in those settings. Most importantly, the rule reflects the intent of CMS to ensure that individuals receiving Medicaid-reimbursed HCBS have full access to the benefits of community living, are able to receive services in the most integrated setting and can exercise personal choice and freedom.

To comply with the HCBS Settings Rule, every state was required to submit to CMS for review and approval a Statewide Transition Plan that would define the specific actions the state would take to assess each of the settings in which HCBS are provided, and the specific actions it would take to bring all settings into compliance. Tennessee's plan was the first Statewide Transition Plan in the country to receive full CMS approval.

In early 2019, working in partnership with DIDD, health plan partners, providers and advocacy partners, Tennessee also became the first state in the country to complete implementation of its Statewide Transition Plan, achieving compliance with the federal HCBS rule. Tennessee continues to be viewed as a leader in implementing the HCBS settings rule with fidelity, with CMS citing multiple examples of Tennessee's work as promising practices for other states.

Implementation of new Nursing Facility payment system that drives improved quality:

TennCare's Quality Improvement in Long-Term Services and Supports (QuILTSS) value-based payment initiative is driving person-centered delivery system transformation and improving the quality of care and quality of life experienced by nursing home residents in Tennessee through payment reform. As part of the QuILTSS initiative, a new payment approach for Medicaid Nursing Facility (NF) services was launched effective July 1, 2018.

Under the new payment system, nearly every component of a Nursing Facility's per diem rate depends in part on the facility's performance and/or improvement on measures that are part of a Quality Framework (see figure on page 47) developed with input from people who receive NF services and their families, as well as advocates and providers. In addition to quality "informed" components of each NF's rate, a specified amount of the total Medicaid funding for NF services is set aside each fiscal year for purposes of calculating a specific quality incentive component of each NF provider's per diem payment. In 2018, the amount of funding set aside for this component was required to be no less than $40 million or four percent (4%) of the total projected fiscal year expenditures for NF services, whichever is greater. In each subsequent year, the amount of funding set aside for the quality-based component will increase at two (2) times the rate of inflation and will then increase or decrease at a rate necessary to ensure that the quality-based component of the reimbursement methodology remains at ten percent (10%). The quality incentive component of each NF provider's per diem payment is calculated based on the facility's volume of Medicaid resident days and the percentage of total quality points earned for each measurement period. Also in 2018, the Tennessee Health Care Association (the NF industry association) proposed and lobbied for the successful passage of legislation that embeds the 10% quality threshold goal as part of the statute to ensure it remains a critical component of NF reimbursement and continues to drive a person-centered approach to quality performance and improvement.

NF QuILTSS *Quality Framework*

Phase 1 (Bridge)

Retrospective quarterly adjustments to per diem rates focused on QI *activities* (i.e., process measures)

Phase 2 (Full Model)

Component of prospective per diem payment based on quality *outcome performance* compared against benchmarks

Improvements in person-centered care delivery model evaluated through a point system and rewarded as part of the NF payment

Satisfaction
35 points

Member	(15)
Family	(10)
Staff	(10)

Culture Change/Quality of Life
30 Points

Respectful treatment	(10)
Member choice	(10)
Member/family input	(5)
Meaningful activities	(5)

Staffing/Staff Competency
25 Points

RN hours per day	(5)
CNA hours per day	(5)
Staff Retention	(5)
Consistent Staff Assignment	(5)
Staff Training	(5)

Clinical Performance
10 Points

Antipsychotic Medication	(5)
Urinary Tract Infection	(5)

Bonus Points: **10** QI initiatives

CMS approval of 1915(c) amendments for value-based employment and day services and reimbursement:

Building on lessons learned from Employment and Community First CHOICES, TennCare and DIDD worked with providers and stakeholders to secure federal approval of amendments to each of the state's three Section 1915(c) waivers operated by DIDD. The amendments, which substantively change definitions and payment for Employment and Day Services, are designed to help people with intellectual disabilities enrolled in these programs achieve competitive, integrated employment and increase their full participation in their communities. In addition, they allow for increased flexibility in how services are provided.

The amendments introduce new pre-employment services with outcome-based reimbursement approaches and incentivize and reward best practice job coaching through a tiered and phased payment structure, similar to that used in Employment and Community First CHOICES. This will better align reimbursement with employment and community outcomes, provide a path forward for people with disabilities who want to explore employment opportunities, and give people enrolled in the waivers more flexibility in choosing how to spend their days. CMS approved these amendments in September 2018. Preparation for their implementation continued through the remainder of the 2018-2019 period.

Program Overview
Strategic Planning & Innovation

The Strategic Planning & Innovation (“SPI”) division leads new, innovative initiatives to improve health and health care across Tennessee through partnership with providers, payers, and other key stakeholders. SPI has overseen the Tennessee Health Care Innovation Initiative, which is changing the way that health care is paid for in Tennessee. The state wants to move from paying for volume to paying for value. The mission of this initiative is to reward health care providers for better outcomes including, high quality and efficient treatment of medical conditions, and help maintaining people’s health over time.

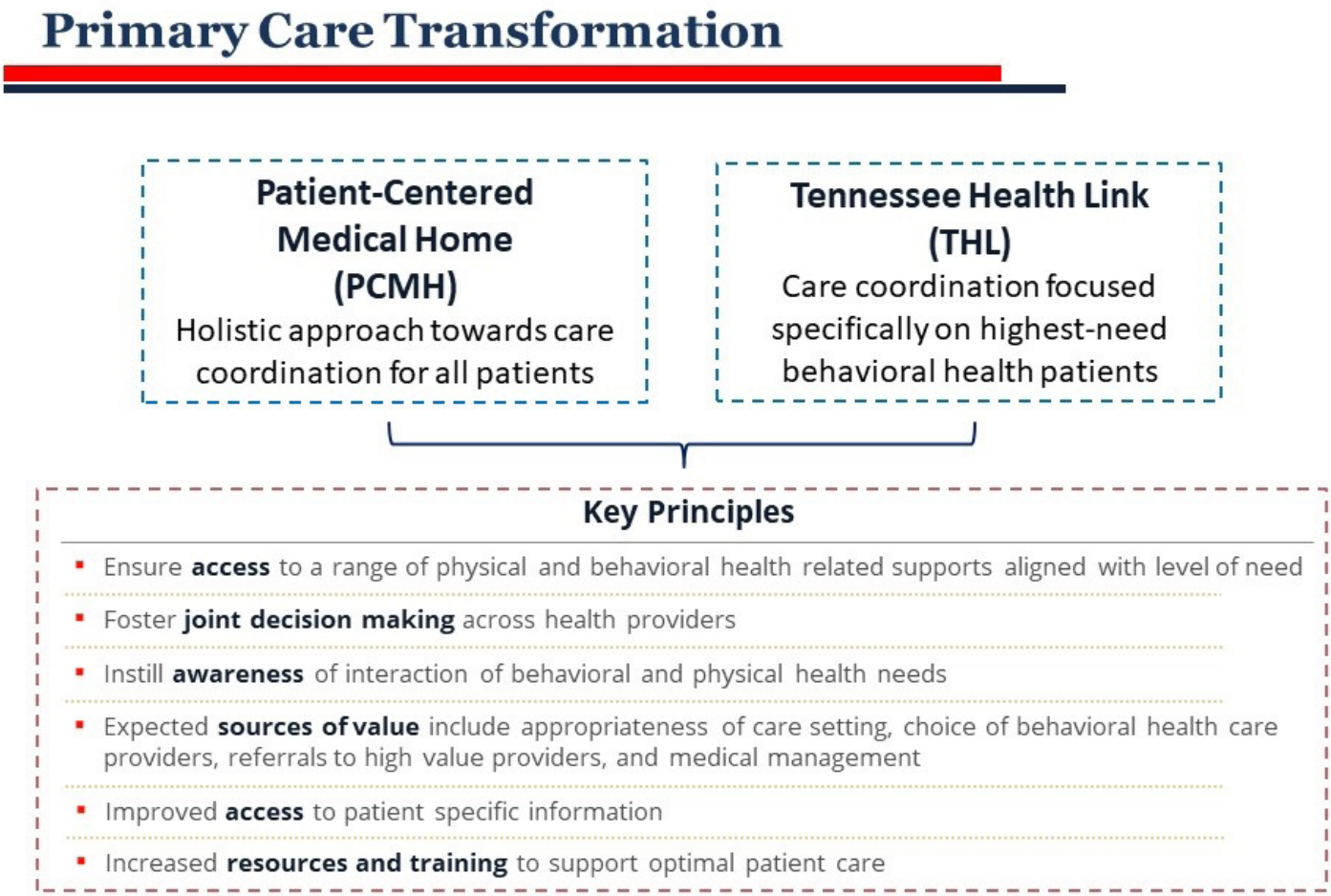
The Initiative includes three strategies:

- **Primary care transformation:** Focuses on the role of the primary care and behavioral health providers in promoting the delivery of preventive services and managing chronic illnesses over time. This includes two programs: Patient Centered Medical Homes (PCMH) and Tennessee Health Link.
- **Episodes of care:** Focuses on the health care delivered in association with acute or specialty-driven health care events such as a surgical procedure or an inpatient hospitalization.
- **Long Term Services and Supports:** Focuses on improving quality and shifting payment to outcomes-based measures for the Quality-and-Acuity-Based Payment for Nursing Facilities and Home and Community Based Services ("QuILTSS") program and for enhanced respiratory care.

Using these strategies we are bringing together health care providers and clinicians, employers, major insurance companies, and patients and family members to reform the health care payment and delivery system in our state.

Delivery System *Transformation*

TennCare is seeing positive results from its delivery system transformation strategies.



Patient-Centered Medical Homes (PCMH)

TennCare's Patient-Centered Medical Homes launched in January 2017 and serves children and adults through care coordination of primary care services.

- **Quality improvement** - Overall, quality has improved for PCMH members, with improvements observed on 16 of 18 core quality measures. The largest improvement was seen in the metric "Diabetes Care – Controlling High Blood Pressure (BP < 140/90)" which improved by 68% per year.

- **Cost savings** - The first year of the program increased the total cost of care due to additional payments to PCPs and an increase in appropriate care, such as office and clinic care services and home and community-based care. Total cost of care for PCMH members decreased in the second year of the program due to positive utilization trends toward more cost-effective services such as a reduction in emergency department costs and ancillary services like duplicate labs and diagnostic testing.
- PCMH providers in the second year of the program were more effective at getting members who have not been to a PCP in the past two years to complete a preventive care visit (compared to non-PCMH). This means that as the program progresses the number of members not seeing their PCP will gradually reduce.

Tennessee Health Link (THL)

Tennessee Health Link launched in December 2016 and aims to coordinate bettwer health care services for TennCare members with the highest behavioral health needs. Since the launch of the program results include:

- **Better physical health care for THL members due to care coordination** – Improved diabetes care, BMI percentile, more PCP visits. 9 out of 18 of the core quality measures improved, with 77 percent of physical health measures and 22 percent of behavioral health measures improving.
- **Cost savings** – Total cost of care for members in the program was increasing by 17 percent per year in the two years before program launch, but increased by only 1 percent per year in the two years following program launch.
- **Data Transparency** - Providers appreciate the data transparency from the Care Coordination Tool to identify gaps in care, contact patients proactively (e.g. following a discharge), and better treat the whole patient (e.g. THL providers can see when their patient goes to PCMH or hospital).

Episodes of Care

Incentivizes high quality, cost-effective acute and specialty care

Episodes Impact on Quality of Care

Oppositional Defiant Disorder:
Episodes in which children receive unnecessary medication decreased from 23% to 3.6%
(2015 – 2018)

Gastrointestinal Hemorrhage:
Follow-up care within the post-trigger window increased from 49.0% to 50.1%
(2016 – 2018)

Perinatal:
Group B Streptococcus screening increased from 87.8% to 95.2%
(2014 – 2018)

Asthma:
Patient on appropriate medication increased from 60.3% to 69.5%
(2016 – 2018)*
*Metric changed in 2016

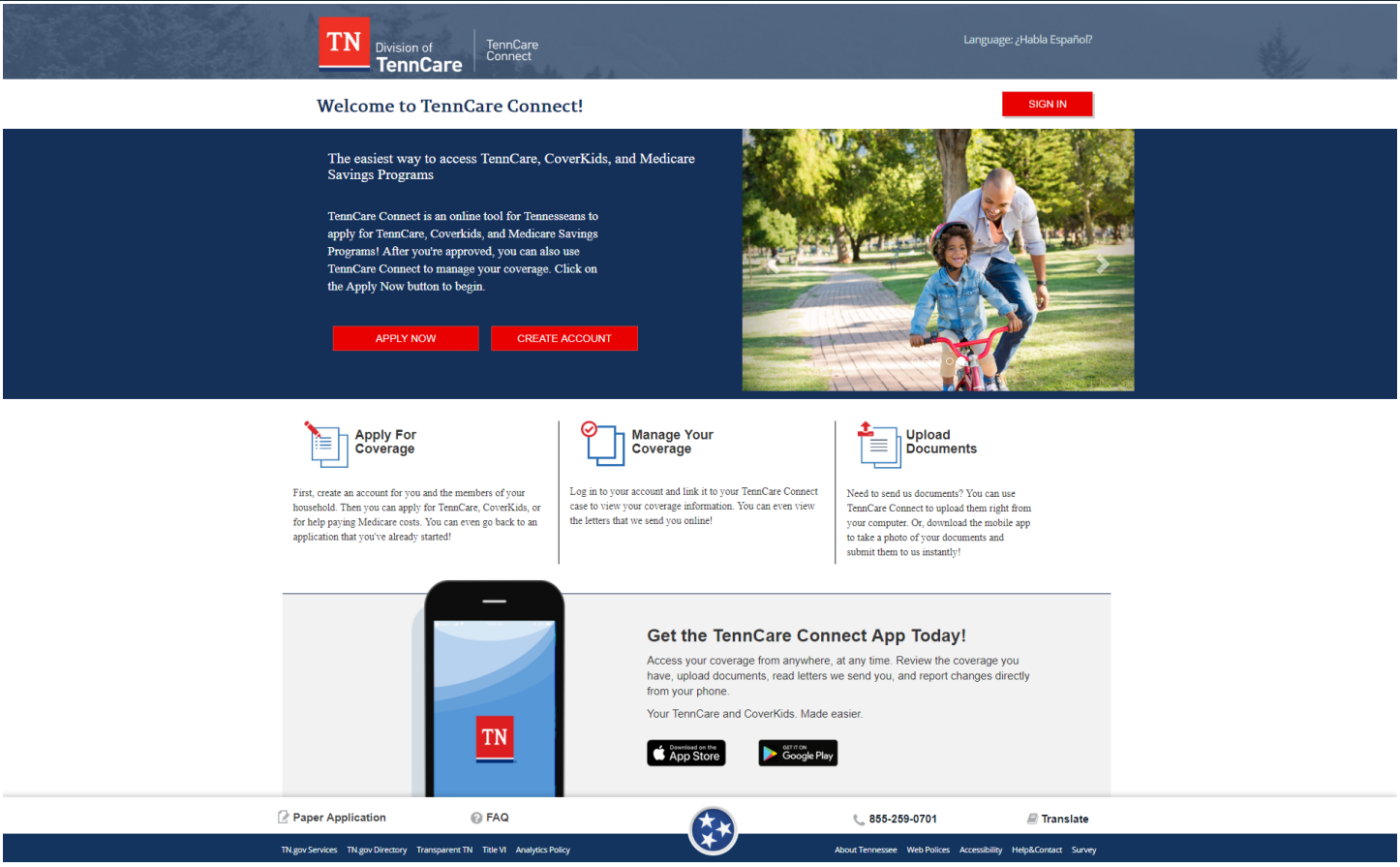
Asthma:
Avoidable hospital admissions decreased from 6.0% to 2.8%
(2014 – 2018)

Chronic Heart Failure:
Follow-up care within the post-trigger window increased from 56.2% to 57.0%
(2016 to 2018)

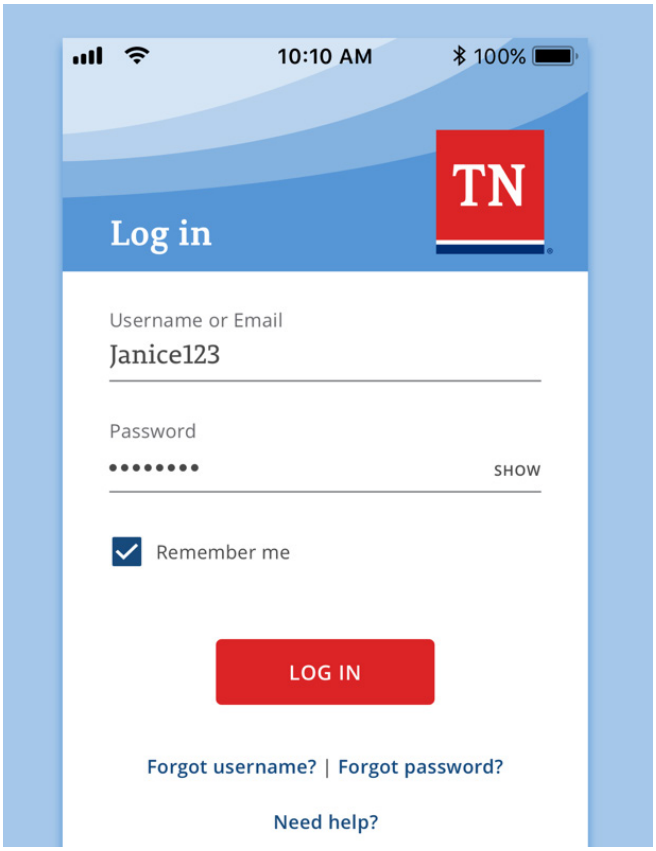
- Quality has improved or maintained across the majority of episodes. From 2017 to 2018, 80% of quality metrics tied to gain-sharing improved or maintained performance, and 86% of quality metrics not tied to gain-sharing improved or maintained performance.
  - 471 fewer asthma acute exacerbations in an inpatient setting from 2014 to 2018.
  - 641 fewer children with non-comorbid oppositional defiant disorder receiving inappropriate medications.

- The cost of care decreased compared to a projection of 3 percent medical inflation. The majority of episodes in performance in 2018 have lowered spend (22 out of 27 episode types).
- Provider groups have introduced a variety of changes and innovations to improve quality and reduce spend.
  - In the perinatal episode, many provider groups improved their prenatal group B streptococcus screening rates.
  - In the asthma acute exacerbation episode, there have been notable reductions in hospitalizations for asthma attacks.
  - In the ODD episode, provider groups improved their ability to capture other behavioral health diagnoses occurring alongside ODD.

TennCare Connect



The Division of TennCare launched its new eligibility determination system called TennCare Connect in October 2018. This pilot launch replaced outdated technology systems and streamlined inefficient, manual operations to improve the application and appeals process for all TennCare and CoverKids programs. The full statewide launch was in March 2019. TennCare verifies data submitted through TennCare Connect using information from the federal health insurance marketplace, as well as other state and federal databases such as the Social Security Administration and IRS.



TennCare Connect is the public-facing self-service application website where Tennesseans can apply for TennCare or CoverKids. TennCare Connect allows Tennesseans to apply for and manage their TennCare and CoverKids benefits online. The launch of TennCare Connect also included a mobile application that allows users to download to their smart phone and view notices, make account changes, and upload documents. TennCare Connect is also the call center that offers customer service assistance as well as telephonic application and annual renewal processing for Tennesseans applying for TennCare or CoverKids. **Tennesseans can visit www.tenncareconnect.tn.gov or call 855-259-0701.**

TennCare Connect offers easier access to a member's benefit information. It also allows new applicants easier access for submitting an application and submitting requested documents to assist in the eligibility determination process. If an applicant or member does not have access to a computer they can visit their local Department of Human Services office and someone will help you apply for TennCare using a kiosk that is connected to TennCare Connect. If an individual has a disability they can call their local Area Agency on Aging and Disability (AAAD) and someone will come to their house.

TennCare Demonstration *Amendments*

Amendment 35: Substance Use Disorder Services

In May 2018, TennCare submitted Demonstration Amendment 35 to CMS. Amendment 35 would modify the TennCare benefits package to cover residential substance use disorder (SUD) treatment services in facilities with more than 16 beds. The federal government classifies such facilities as "institutions for mental diseases" (IMDs), and federal law prohibits the expenditure of federal Medicaid dollars for services delivered to adults in these facilities.

Historically, TennCare's managed care organizations (MCOs) were permitted to cover residential treatment services in IMDs, if the MCO determined that such care was medically appropriate and cost-effective as compared to other treatment options. However, CMS issued regulations restricting the ability of MCOs to pay for services in these facilities. Specifically, the new federal regulation limits this option to treatment stays of no more than 15 days per calendar month. TennCare is seeking authority with Amendment 35 to allow enrollees to receive short-term services in IMDs beyond the 15-day limit in federal regulation, up to 30 days per admission. Throughout late 2018 and early 2019, TennCare and CMS continued their negotiations concerning Amendment 35 and a decision is pending.

Amendment 36: Family Planning Providers

The Division of TennCare submitted Amendment 36 to CMS on August 10, 2018. Amendment 36 grew out of Tennessee's 2018 legislative session and, in particular, Public Chapter No. 682, which established that it is the policy of the state of Tennessee to favor childbirth and family planning services that do not include elective abortions within the continuum of care or services, and to avoid the direct or indirect use of state funds to promote or support elective abortions. Amendment 36 requests authority for TennCare to establish state-specific criteria for providers of family planning services, and to exclude any providers that do not meet these criteria from participation in the TennCare program. As specified in Public Chapter No. 682, TennCare is proposing to exclude any entity that performed or operated or maintained a facility that performed more than 50 abortions in the previous year, including any affiliate of such an entity. A decision of Amendment 36 remains pending with CMS.

Amendment 37: Modifications to Employment and Community First CHOICES

TennCare submitted Amendment 37 to CMS on November 8, 2018. Amendment 37 primarily concerns modifications to be made to Employment and Community First (ECF) CHOICES, TennCare's managed long-term services and supports program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated living as the first and preferred option for people with intellectual and developmental disabilities. The primary modification to ECF CHOICES contained in Amendment 37 is the addition of two new benefits and two new benefit groups in which the services would be available:

- Employment and Community First CHOICES Group 7 would serve a small group of children who live with their family and have intellectual and/or developmental disabilities (I/DD) and severe co-occurring behavioral health and/or psychiatric conditions. These children—who are at significant risk of placement outside the home (e.g., state custody, hospitalization, residential treatment, incarceration)—would receive family-centered behavioral health treatment services with family-centered home and community-based services (HCBS).
- Employment and Community First CHOICES Group 8 would serve adults with I/DD and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment to achieve and maintain stable, integrated lives in their communities. Individuals in Group 8 would receive short-term intensive community-based behavioral-focused transition and stabilization services and supports.
- Other changes to Employment and Community First CHOICES contained in Amendment 37 include modifications to expenditure caps for existing benefit groups within the program, revised eligibility processes to facilitate transitions from institutional settings to community-based settings, and modifications and clarifications to certain ECF CHOICES service definitions.

Amendment 38: Workforce and Community Engagement Requirements

TennCare submitted Amendment 38 to CMS on December 28, 2018. Demonstration Amendment 38 implements a state law (Public Chapter No. 869) enacted by the Tennessee General Assembly in 2018. This law directed TennCare to seek federal authorization to establish reasonable work and community engagement requirements for non-pregnant, non-elderly, non-disabled adults enrolled in the TennCare program who do not have dependent children under the age of six. The legislation also required TennCare to seek approval from the U.S. Department of Health and Human Services (HHS) to use funds from the state's Temporary Assistance for Needy Families (TANF) program to support implementation of the community engagement program. TennCare engaged in extensive preparations and public notice activities related to Amendment 38. Among these activities were the following:

- A stakeholder meeting in Nashville in August 2018, in which more than 70 individuals representing advocacy organizations, health care providers, managed care organizations, legislators and legislative staff, state agencies, and other interested parties participated;
- A public notice and comment period that ran from September 24 through October 26, 2018, during which time a draft amendment outlining TennCare's proposal was posted and more than 150 sets of written comments were received; and
- Public hearings during October 2018 in each grand region of the state.
- Feedback gathered in all of these forums informed the demonstration amendment that was submitted to CMS. A decision on Amendment 38 remains pending with CMS.