

I. **Description of how the state’s oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations.**

The modification of the state’s oversight systems to embed regulatory criteria into ongoing operations is included in the Statewide Transition Plan (STP) which was approved on April 13, 2016 (and later amended on July 31, 2018). Information regarding these modifications is outlined below, with page references to the specific action steps described in the STP:

- A. **HCBS Definitions and Provider Qualifications (STP pages 6 and 9-10):** Changes to waiver definitions, as well as strengthened language and requirements related to the care planning process and participant rights, were included in waiver renewal applications and amendments.
- B. **State Statutes (STP pages 7 and 9):** The Tennessee Code Annotated (T.C.A.) sections related to the state’s Department of Mental Health and Substance Abuse Services (DMHSAS), Department of Intellectual and Developmental Disabilities (DIDD), Department of Health (DOH), and Department of Human Services (DHS) were amended to include compliance with the new federal HCBS Settings Rule (the Rule).
- C. **State Rules and Regulations (STP pages 7 and 10):** TennCare collaborated with DMHSAS, DIDD, DOH, and DHS to complete state rule revisions required to come into compliance with the Rule.
- D. **State Protocols, Procedures, and Policies, including Quality Management Practices (STP pages 8 and 11):** Amendment of TennCare’s Needs Assessment and Plan of Care Protocols to incorporate the Rule requirements, as well as amendment of DIDD protocols concerning HCBS settings.
- E. **Training Requirements (STP pages 8, 11-15, and 27-28):**
 - 1. Amendments to the DIDD Provider Manual to strengthen the Rule compliance;
 - 2. Amendments to the managed care organizations’ (MCOs) Contractor Risk Agreements (CRAs) to include references to Rule requirements related to provider credentialing and re-credentialing and ongoing education and training;
 - 3. Where possible, ensuring consistency across provider credentialing requirements between the MCOs and DIDD, as it relates to the Rule; and
 - 4. Ensuring all training related to the Rule is developed and conducted in a consistent manner across the MCOs and DIDD.
- F. **State Contracts, Rate Methodology, and Billing Practices (STP pages 8-15):**
 - 1. Amendments to the MCO CRAs to include references to the Rule as follows:
 - a. The plan of care process, including expectations related to employment and community integration;
 - b. Requiring MCOs to verify provider compliance with the Rule when credentialing and re-credentialing HCBS providers;
 - c. MCO Provider Agreements to contain language requiring providers to maintain compliance with the Rule; and
 - d. Require ongoing education and training on the Rule.
 - 2. Amendments to the DIDD 1915(c) Waiver Interagency Agreement as follows:

- a. Require that DIDD ensure new providers are compliant with the Rule prior to contracting;
 - b. Require ongoing compliance monitoring for existing HCBS requirements; and
 - c. Amendments to the DIDD Provider Agreement to include language requiring providers comply with the Rule.
3. Revision of rate methodologies and service definitions for 1915(c) waivers to better align with the intent of the Rule and incentivize providers that offer services in a more integrated manner.

II. **Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance.**

The state's processes for assessing providers for initial compliance and conducting ongoing monitoring for continued compliance with the Rule are included in the Statewide Transition Plan (STP) which was approved on April 13, 2016 (and later amended on July 31, 2018). Information regarding these modifications is outlined below, with page references to the specific action steps described in the STP:

A. **Assessing for Initial Compliance**

1. **Provider Self-Assessment and Transition to Compliance (STP pages 16-30):**

- a. Providers conducted self-assessments for compliance with the rule from October 2014 to March 2015. TennCare's contracted entities (DIDD and the MCOs) worked with providers from April – September 2015 on validating the self-assessment and approving provider transition plans, as applicable. **(Provider setting types assessed and an overview of the provider assessment questions outlined on STP pages 17-18.)**
*** Note:** In order to identify settings for which heightened scrutiny should be applied, TennCare incorporated questions regarding the presumption of institutional characteristics into the self-assessment tool. **(Additional details regarding the Heightened Scrutiny Process are outlined on STP pages 20-23)**
- b. The state conducted provider education and training sessions on how to complete the self-assessment. Providers were given the applicable Provider Self-Assessment Tool and the Assessment Tool instructions.
- c. Providers submitted their self-assessments along with specific evidence of compliance for review by TennCare or its designee (DIDD or the MCOs). Additional evidence may have been requested during the validation process. **(Validation process outlined on STP pages 18-20.)**
- d. Providers who self-reported or were assessed upon review and validation to be non-compliant with the Rule were required to submit a Provider Transition Plan describing their proposed plan for coming into compliance, along with associated timelines.
- e. Completed and validated Provider Transition Plans were reviewed and approved by DIDD or the MCO, as applicable, and implementation was monitored based on the approved timelines, with oversight by TennCare. **(Details regarding DIDD and MCO the**

approval and monitoring of implementation for Provider Transition Plans are outlined on STP pages 25-27.)

- f. Providers that were unwilling or unable to come into compliance were required to cooperate with transition assistance to ensure all individuals served were transitioned to an appropriate provider type that was determined to be compliant with the Rule, or that had approved transition plan that was believed to be adequate to bring the provider into the compliance, while maintaining continuity of services. **(Transition of beneficiaries to compliant providers is outlined on STP pages 17 and 28-30.)**
 2. **Contracted Entity Analysis (STP pages 24-25):** DIDD and the MCOs were asked to summarize the self-assessment results to identify areas where more training and clear policy development and implementation were needed.
 3. **Implementation of Initial Individual Experience Assessment (IEA) (STP pages 30-31):** Initial IEAs were completed by the individual’s Independent Support Coordinator (ISC), case manager, or care coordinator (as applicable), between February 2015 and January 2016, during the individuals’ person-centered support plan review to ensure compliance with the Rule requirements. Any modifications to the Rule requirements for the individual were reviewed to determine compliance with requirements for an individualized assessed need and appropriately documented in the member’s person-centered support plan.
- B. Achieving Initial Compliance (STP pages 31-32)**
1. TennCare submitted an amendment to the originally proposed STP with specific outcomes, remediation activities, and milestones for achieving compliance with the Rule.
 2. The state submitted an amendment to its three 1915(c) waivers that amended each waiver-specific transition plan, with timelines and milestones for achieving compliance with the Rule requirements.
 3. For providers needing assistance with coming into compliance, the state:
 - a. Facilitated focus groups of compliant and non-compliant providers to talk through provider-specific issues and problem-solve how to achieve compliance together.
 - b. Provided one-on-one technical assistance, as requested.
- C. Assuring Ongoing Compliance (STP page 32)**
- a. **1915(c) Waiver providers, Katie Beckett providers and ECF CHOICES providers**
 - i. DIDD is the credentialing authority for 1915(c) waivers and the Katie Beckett Part B program and the delegated authority for Katie Beckett Part A and ECF CHOICES.¹ All new applicants are required to have policies and procedures in place which comport with the Settings Rule prior to becoming an approved provider. The Regional Provider Development Unit is responsible for ensuring critical elements are in place prior to service provision.
 - ii. All new applicants applying to become credentialed providers must complete an agency self-assessment for residential and select non-residential services to ensure their policies and practices are consistent with the Settings Rule requirements. In the “Evidence” section of the self-assessments, applicants must note the specific name of the policy or document which shows proof of

¹ This includes provider agencies who provide Community Living Supports (CLS) through the ECF program.

where the agency's plan to comply may be found. The Regional Provider Development Unit is responsible for reviewing self-assessments for verification that evidence is documented where indicated (see [New Provider Credentialing Application](#)).

- iii. Providers who currently have a signed contract and wish to add additional services to their contract must also submit the appropriate self-assessment to ensure they are in compliance with the Settings Rule (see [Expansion Credentialing Application](#)).
- iv. DIDD Housing Inspectors complete [life safety inspections](#) for all new supported living and semi-independent living homes prior to occupancy and complete continued occupancy inspections every 24-30 months. While the intention of these inspections is to assess for physical aspects of the home for safety during fire and other emergencies, these inspections include a look at HCBS compliance with physical location and accessibility. These and any other discoveries made with HCBS compliance are sent to the provider supports teams for follow up.
- v. Similar to the home inspections process, licensure reviews assess for physical location and accessibility compliance with the Initial application by a new applicant for a license to operate a newly established facility/service that require an individual license.(see [Initial Application](#) and accompanying [Application Fact Sheet](#)).
- vi. DIDD has a [Community Transitions Policy](#) in place which outlines a person-centered process for people supported that want to move to another residential provider, change independent support coordinators, or move to a different location. The guidelines ensure the process is led by the person, that people can live where and with whom they choose, receive services from their provider of choice, and the setting is safe and accessible. All transitions must be approved by the Regional Office Transitions Unit.

b. CHOICES-only Providers²

- i. MCOs are the credentialing authority for providers serving individuals only in the CHOICES program, which includes providers who provide CLS for CHOICE members. (**Note:** Providers that serve both CHOICES and ECF CHOICES program enrollees are credentialed by DIDD, as described above). Similar to DIDD's process for credentialing, all new CHOICES-only providers are required to have policies and procedures in place which comport with the Settings Rule prior to becoming an approved provider.
- ii. New providers are responsible for conducting a self-assessment. Two joint provider self-assessment tools—one for residential and one for non-residential services—are used across the three contracted MCOs. This reduces

² Some providers may be credentialed for both CHOICES and ECF CHOICES services. Providers serving both programs are credentialed by DIDD, while providers only serving the CHOICES program are credentialed by the MCOs. Additionally, MCOs are responsible for credentialing provider agencies who provide CLS and only serve the CHOICES program.

administrative burden on provider applicants by allowing them to complete one self-assessment and submit it to all MCOs for which they seek credentialed status. Providers are required to submit policies, procedures, and other applicable documentation as evidence to support their self-assessment responses. The MCO's Provider Relations Unit is responsible for reviewing each self-assessment and supporting documentation submitted to verify compliance.

- iii. The MCO Provider Relations Units will conduct a site visit with the provider applicant to verify implementation of policies and procedures, as described in the self-assessment and supporting documentation. Applicants determined to be noncompliant following the self-assessment or site visit will have the opportunity to submit additional or updated information within 14 or 30 days, depending on the scope of noncompliant elements. Provider applicants that fail to submit additional or updated information, as requested, will be denied credentialing status with the MCO.
 - iv. The MCO will conduct a site visit with the provider during the annual recredentialing process to ensure ongoing compliance with the Settings Rule and other required policies and procedures identified during initial credentialing.
 - v. CHOICES Care Coordinators will conduct regular face-to-face visits with members at the site where the individual is receiving residential services and will report any compliance deficiencies to the MCO Provider Relations Unit.
- c. Incorporation of the IEA (described above) into all initial and annual person-centered plan reviews.
 - d. The addition of monitoring performance measures to the Quality Assurance Unit's monitoring methodologies ensure compliance with the HCBS Settings and Person-Centered Planning (PCP) Rules.
 - e. Renaming and expanding the role of an existing Care Coordination Unit (now the Person-Centered Practices Unit) to monitor and ensure PCP practices are implemented effectively and a person's experience with HCBS settings is congruent with the intent of the Rule.
 - f. Revision of the Plan of Care document used by MCOs to a standardized template that aids in facilitating person-centered planning practices.
 - g. Annual consumer/family satisfaction surveys that include questions relevant to HCBS Settings and PCP Rules (NCI surveys).
 - h. Exploration of the use of national accreditation standards to support ongoing compliance monitoring efforts.
 - i. Training TennCare Audit & Compliance and LTSS Person-Centered Practices staff in Person-Centered Thinking, Planning and Practices to ensure staff are knowledgeable on how to ensure the Rule is adhered to.

III. Description of a beneficiary's recourse to notify the state of provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.

Recourse for provider non-compliance with the Settings Rule is available to enrollees through 1) the grievance system implemented by the entity responsible for coordinating their HCBS, and 2) participation in the Individual Experience Assessment.

Beneficiary Grievance System

A. TennCare HCBS Program Coordination

TennCare enrollee HCBS services are coordinated by two entity types—managed care organizations (MCOs) and the Department of Intellectual and Developmental Disabilities (DIDD). The MCOs coordinate services for enrollees in the CHOICES program, which serves individuals age 65 and over and individuals age 21 and older with physical disabilities, and the Employment and Community First (ECF) CHOICES program, which primarily serves individuals age 21 and older with intellectual or developmental disabilities (I/DD)³. TennCare’s requirements for MCOs, including the requirements for an enrollee grievance system, are outlined in the MCO Contractor Risk Agreement (CRA).

DIDD coordinates services for enrollees receiving HCBS through one of the state’s three 1915(c) waiver programs. As it is a Tennessee government agency, requirements for DIDD-coordinated services are outlined in an Interagency Agreement with TennCare.

B. Definition of Grievance

The TennCare MCO CRA defines a grievance as

A complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights regardless of whether remedial action is requested. Grievance includes an enrollee’s right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. See 42 C.F.R. §438.400(b)

Under this definition, provider non-compliance with the HCBS Settings Rule is considered a failure to respect the enrollee’s rights.

³ ECF CHOICES participants are enrolled in one of five groups based on level of care (LOC) and service types. Two of the groups provide services to enrollees under the age of 21. ECF CHOICES Group 4 includes participants under the age of 21 with I/DD living at home with family who meet the nursing facility (NF) LOC and are receiving HCBS as an alternative to NF care, or who are at-risk of NF placement in the absence of HCBS. ECF CHOICES Group 7 participants are children under the age of 21 who live at home with family and have I/DD and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at significant risk of harm, threaten the sustainability of the family living arrangement, and place the child at risk of placement outside the home.

C. Grievance System Implementation Requirements

1. Implementation Requirements for MCOs

The TennCare MCO CRA outlines the following requirements related to the implementation of a grievance system:

A.1 Definitions

Grievance System - The processes the CONTRACTOR implements to handle grievances, as well as the processes to collect and track information about them. See 42 C.F.R. §438.400(b).

A.2.19.1.3 Grievance System

... the CONTRACTOR shall have its own internal system for processing grievances filed with the CONTRACTOR. As distinguished from an “appeal”, a “grievance” includes a complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. The CONTRACTOR shall have a formally structured internal Grievance System in place for handling enrollee grievances in accordance with 42 C.F.R. §438.402(a)-(b), and 42 C.F.R. §438.228(a) and in accordance with the definition of “Grievance” found in section A.1. of this Contract.

A.2.19.1.5 Reasonable Assistance with Grievances and Requests for Appeals

The CONTRACTOR must give enrollees any reasonable assistance in completing grievance and appeal forms and other procedural steps related to a grievance or appeal. This includes availability of enrollee support staff, auxiliary aids and services, such as interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability. See 42 C.F.R. §438.406(a); 42 C.F.R. §438.228(a).

A.2.19.1.6.1 Acknowledgement of Grievance

In accordance with 42 C.F.R. §438.406(b) and 42 C.F.R. §438.228(a), CONTRACTOR shall acknowledge receipt of an enrollee grievance.

A.2.19.1.7 Decision-Makers

The CONTRACTOR shall ensure that decision-makers on grievances, and decision-makers responsible for rendering a medical review of CONTRACTOR’s proposed adverse benefit determination during the Reconsideration stage of the appeal process, were not either:

- *Involved in any previous level of review or decision-making relating to the grievance or benefit appeal, or (A.2.19.1.7.1)*

- *Subordinates of any individual who was involved in a previous level of review or decision-making relating to the grievance or benefit appeal. See 42 C.F.R. §438.406(b)(2)(i); 42 C.F.R. §438.228(a). (A.2.19.1.7.2)*

A.2.19.1.8 Clinical Expertise of Decision Maker

The CONTRACTOR shall require that decision-makers on grievances and decision-makers on any aspect of the appeal process (such as the Reconsideration decision) are individuals with appropriate clinical expertise, as determined by applicable law, in treating the enrollee's condition or disease if:

- *The decision hinges on whether a benefit request meets medical necessity, (A.2.19.1.8.1)*
- *The decision concerns whether to grant a request for expedited resolution of an appeal, or concerns a grievance about a previous denial of an expedited resolution request, or (A.2.19.1.8.2)*
- *The decision hinges on the decision-maker's assessment of clinical issues. See 42 C.F.R. §438.406(b)(2)(ii)(A) – (C); 42 C.F.R. §438.228(a). (A.2.19.1.8.3)*

A.2.19.1.9 Information to be Considered

The CONTRACTOR's decision-makers shall take into account all comments, documents, records, and other information submitted during the grievance, prior authorization, or appeal process without regard to whether such information was submitted or considered in the initial adverse benefit determination. See 42 C.F.R. §438.406(b)(2)(iii); 42 C.F.R. §438.228(a).

A.2.19.14

The CONTRACTOR shall have a designated business unit responsible for processing grievances and appeals in accordance with applicable law and TENNCARE requirements. CONTRACTOR's appeals unit shall include sufficient numbers of appropriately trained and licensed physicians, clinicians, and support staff necessary to timely process appeals in accordance with potentially evolving regulatory and TENNCARE requirements.

A.2.19.11 Record Keeping and Tracking

The CONTRACTOR must maintain records of grievances and appeals and shall make such records readily available to TENNCARE or to CMS upon request. See 42 C.F.R. §438.416(a); 42 C.F.R. §438.416(c).

2.19.11.1

The CONTRACTOR's record of each grievance and appeal shall include:

- *A general description of the reason for the appeal or grievance. (A.2.19.11.2)*
 - *The date received. (A.19.11.2.2)*
 - *The date of each review or, if applicable, review meeting. (A.19.11.2.3)*
 - *The date of resolution and how it was resolved. (A.19.11.2.4)*
 - *The identity of the enrollee for whom the appeal or grievance was filed. See 42 C.F.R. §438.416(b)(1)-(6). (A.19.11.2.5)*

2. Implementation Requirements for DIDD

The Interagency Agreement between TennCare and DIDD for coordination of HCBS for enrollees in 1915(c) waiver programs outlines the following requirement for the implementation of a grievance system:

A.18 *The Contractor shall implement and comply with a TennCare-approved grievance and appeals process and, as required by TennCare, provide expert testimony by appropriate professionals during contested case hearings.*

Adequate policies and procedures for ensuring there is a complaint/grievance system is reviewed in the credential process as explained in Part II of this document.

D. Grievance Reporting Processes for Enrollees

1. MCO Reporting Processes for Enrollees

Per Section A.2.19.10 of the CRA, MCOs are required to allow enrollees to file an oral or written grievance with the entity at any time. Each of the MCOs have established multiple avenues for enrollees and/or their representatives to submit a complaint or grievance related to provider services and care, including:

- Reporting a complaint or grievance to the enrollee's Care Coordinator (for CHOICES enrollees) or Support Coordinator (for ECF CHOICES enrollees),
- Contacting the MCO's CHOICES Consumer Advocate or ECF CHOICES Member Advocate, and
- Calling the MCO's toll free help desk phone number.

2. DIDD Reporting Processes for Enrollees

There are three levels at which a 1915(c) HCBS enrollee can report a complaint: (1) provider level, (2) DIDD regional level, referred to as the Customer Focused Service (CFS) unit, and (3) Medicaid Agency level.

- Complaint Resolution System (Provider Agency)
 - DIDD requires that all contracted waiver providers have a Complaint Resolution System, notify each person supported and or their legal representative of their complaint Resolution system and how to access it. Under the provider’s Complaint Resolution System, Providers are expected to resolve all complaints in a timely manner, and within 30 calendar days of the date that the complaint was filed.
- Customer-Focused Services (Regional DIDD)
 - In the event the Complainant is not satisfied with the outcome from the CRS, the complaint involves agency management, or if they wish to file a complaint with CFS unit directly, the enrollees in DIDD-coordinated 1915(c) HCBS waiver programs and/or their representatives may file a complaint against a DIDD staff member, provider, vendor, volunteer, or contractor directly with the Customer Focused Service (CFS) unit at any time. Complaints may be filed in person, or via telephone or written communication (text, email, or mail). The contact information for DIDD’s CFS Unit is available on DIDD’s website under contact information.
- Medicaid Agency (TennCare)
 - In the event the Complainant is not satisfied with the outcome or if they wish to file a complaint with TennCare directly, they will be referred to TennCare’s LTSS Director of ID Services or their designee. The Complainant may contact the TennCare Long-Term Services and Supports (LTSS) Help Desk via telephone (1-877-224-0219) or email (LTC.Operations@tn.gov).
- Independent Support Coordinator
 - Enrollees and/or their representatives may also contact their Independent Support Coordinator (ISC) or Case Manager, as applicable, to submit a complaint.

3. Beneficiary Support System

TennCare contracts with Disability Rights Tennessee (DRT) to serve as the beneficiary support system for enrollees receiving managed LTSS through the CHOICES, or ECF CHOICES. DRT is an independent entity of TennCare MCOs that provides support to applicants and enrollees before and after enrollment, pursuant to 42 C.F.R § 438.71. DRT is available to assist applicants and enrollees with navigation of the appeals and grievances processes upon request. HCBS program enrollees and/or their representatives can submit a complaint or grievance to DRT via an online form, email, or toll-free phone number. DRT submits

complaints and grievances received to the appropriate MCO for resolution on behalf of the member and/or their representative. Per TennCare CRA Section A.2.18.11, the MCOs shall, as required by TennCare, collaborate with DRT for the purpose of addressing enrollee grievances and appeals.

4. Community Living Supports (CLS) Ombudsman

Per TennCare Rule 1200-13-01-.05(6)(p)(3), enrollees choosing to receive CLS or CLS-FM (Family Model) services, including enrollees identified for transition to CLS or CLS-FM, will have access to a CLS Ombudsman. The CLS Ombudsman is contracted with an agency that is separate and distinct from TennCare and the MCOS and DIDD. The CLS Ombudsman's responsibilities include providing advocacy for individuals receiving CLS and CLS-FM services, including assisting individuals in the resolution of problems and complaints regarding CLS and CLS-FM services.

E. Acknowledgement and Resolution of Enrollee Grievances

1. MCO Requirements for Acknowledgement and Resolution

The TennCare CRA outlines timeframe requirements for the MCOs to acknowledge and resolve grievances filed by enrollees and/or their representatives. The MCO shall issue a written acknowledgement of receipt of the grievance within five business days, unless the grievance is resolved within five business days of receipt (**CRA Section A.2.19.10.3**). Grievances shall be resolved and the MCO shall provide written, dated notice of the grievance resolution within 90 calendar days from the day the grievance is received (**CRA Section A.2.19.10.2**) in a language and format that meets 42 C.F.R. § 438.10 (**CRA Section A.2.19.10.4**).

2. DIDD Requirements for Acknowledgement and Resolution

Complaint Resolution System (Provider Agency)

- Providers must attempt to resolve all complaints within 30 days of the date that the complaint was filed.

Customer-Focused Services (Regional DIDD)

- Per the 1915(c) waivers, which outlines the agency's TennCare-approved complaint resolution process, the DIDD Regional Complaint Resolution Coordinator or Customer Focused Service (CFS) Unit shall attempt to make contact with the complainant (via phone, email, etc.) within two (2) business days of receiving the complaint. Complaints filed shall be resolved no later than thirty (30) calendar days from receipt of the complaint. Additional time may be allotted on a case-by-case

basis. CFS Coordinator will notify the complainant of the outcome of the formal complaint within five (5) business days.

TennCare

- In the event the person filing the complaint is not satisfied with the outcome or if a complaint is filed directly with TennCare, the complaint will be referred to the LTSS Director of ID Services or designee. Upon receiving a complaint, the LTSS Director of ID Services, or their designee, will acknowledge receipt of the complaint and determine from the Complainant, any provider, DIDD, or MCO staff involved in attempts to resolve the issue prior to the Complainant's contact with TennCare, and the extent to which prior DIDD, MCO, or provider actions have been successful in resolving the problem. The LTSS Director of ID Services, or their designee, will inform the Complainant of the intent to resolve the complaint within 30 calendar days. TennCare and DIDD will work cooperatively to achieve complaint resolution. Once TennCare and appropriate DIDD staff have agreed on a course of action to resolve the problem, the complainant and any providers involved will be notified in writing of the proposed solution and expected date of resolution. After it has been determined that the complaint can be closed, the Complainant will receive written notification from the LTSS Director of ID Services, or their designee including the date the customer service complaint was considered resolved and closed, a summary of information discovered, and remedial actions taken.

F. Grievance Recordkeeping Requirements

1. MCO Recordkeeping Requirements

TennCare CRA Section A.2.19.11 requires MCOs to maintain records of grievances in accordance with 42 C.F.R. §438.416(a); 42 C.F.R. 416(c). Such records should be available to TennCare or CMS upon request. Records of each grievance shall include:

- A general description of the reason for the grievance.
- The date received.
- The date of each review, or if applicable, review meeting.
- The date of resolution and how it was resolved.
- The identify of the enrollee for whom the grievance was filed.

2. DIDD Recordkeeping Requirements

i. Complaint Resolution System (Provider Agency)

Per DIDD's provider manual, providers are required to have a complaint resolution system, maintain a complaint contact log, and document and trend complaint activity.

- ii. **Customer-Focused Services (Regional DIDD)**
DIDD collects information regarding waiver participant familiarity with the complaint process through the participant satisfaction survey. Information collected is compiled and reported to TennCare in the monthly Quality Management Report. Data files, which are available to TennCare upon request, are also completed by DIDD Complaint Resolution Staff for each complaint with data detailing the number and type of complaints received, referral sources, remedial actions, and timeframes for achieving resolution. TennCare monitors DIDD complaint remedial actions on a monthly basis through the Quality Monitoring Report and advises DIDD of any that require further action.

- iii. **TennCare (State Medicaid Agency)**
The LTSS Director of ID Services, or their designee, maintains a separate customer service complaint log for each 1915(c) waiver program. Entries to the complaint log will include the following elements:
 - The name of the waiver participant(s)
 - Social security numbers of the participant(s) (if not available from the complainant, to be retrieved from the InterChange System)
 - The name and phone number of the individual reporting the complaint
 - The nature of the complaint(s) or problem(s)
 - The date the Department of Intellectual and Developmental Disabilities (DIDD) was notified of the complaint. If the complainant expressly requests that DIDD not be notified, the reason must be documented.
 - If the complaint is such that appeal rights are involved, documentation that the complainant was informed of such rights.
 - If appeal is requested by the complainant, documentation of the date of referral to the appropriate entity with request for a copy of the final directive.
 - Any actions taken to research, investigate, or resolve the complaint or problem, including dates of such action
 - The results of complaint investigations, including complaints that were validated and a general description of actions taken to resolve complaints (e.g., Corrective Action Plans)

G. Reporting Grievance Information to TennCare

1. MCO Requirements for Reporting Grievance Information

MCO are required to maintain records of grievances in accordance with 42 C.F.R. §438.416(a), (c),⁴ and they are required to submit a Member Experience Report which includes a complaint report for CHOICES, ECF CHOICES, and Katie Beckett programs.⁵ This

⁴ Contractor Risk Agreement A.2.19.11.1

⁵ Contractor Risk Agreement A.2.25.9.9

report track the total number of CHOICES/ECF/Katie Beckett members' complaints overall and by certain categories (Quality of Care, Attitude and Service, Billing and Financial Issues, and other) and the number and percentage of complaints with/without timely notification and resolution.

2. DIDD Requirements for Reporting Grievance Information

DIDD collects information regarding waiver participant familiarity with the complaint process through the participant satisfaction survey. Information collected is compiled and reported to TennCare in the monthly Quality Management Report. Data files, which are available to TennCare upon request, are also completed by DIDD Complaint Resolution Staff for each complaint with data detailing the number and type of complaints received, referral sources, remedial actions, and timeframes for achieving resolution. TennCare monitors DIDD complaint remedial actions on a monthly basis through the Quality Monitoring Report and advises DIDD of any that require further action.

H. Provision of Information and Training Related to the Grievance System

1. MCO Provision of Grievance Process Information to Enrollees

The MCOs shall inform its assigned enrollees about the toll-free number for filing oral grievances and appeals (**CRA Section 2.19.12.1**). Information about the enrollees' grievance and appeals rights shall also be included in the Member Handbook (**CRA Section 2.19.12.2.3**). In addition, the MCOs' Member Handbooks shall include information about the member advocate, including but not limited to the role of the member advocate CHOICES, ECF CHOICES, and 1915(c) waiver programs and how to contact the member advocate for assistance (**CRA Section 2.17.4.6.22**).

The MCOs shall also explain and provide member education materials to each CHOICES and ECF CHOICES enrollee and shall require that ICF/IDD providers and Independent Support Coordinators explain and provide such member education materials to 1915(c) waiver enrollees upon enrollment (**CRA Section A.2.17.7.1**). Member education materials shall include information about the role of the member advocate and how to contact the advocate for assistance (**CRA Section A.2.17.7.3.5**). Case files for enrollees receiving CHOICES, ECF CHOICES, and 1915(c) waiver HCBS shall include evidence that the enrollee has been provided with the required member education materials and that the Care Coordinator or Support Coordinator has reviewed the materials with the enrollee and/or their representative and assisted with any questions related to the materials (**CRA Section A.2.9.7.11.6.4.2**).

2. MCO Provision of Grievance Process Information to Providers

The MCOs shall issue a provider manual to all contract providers, either electronically or via hard copy (**CRA Section A.2.18.5**) that includes information about the enrollee grievance

and appeal processes (**CRA Section A.2.18.6.3.16**). They shall also include information about enrollee grievance and appeal rights in all provider and subcontractor contracts (**CRA Section A.2.19.12.2.2**) and provider training materials (**CRA Section A.2.19.12.2.4**).

3. MCO Provision of Beneficiary Support System Information to Enrollees

The MCOs shall include information on the beneficiary support system in the member handbook, as well as education materials provided to enrollees in the CHOICES, ECF CHOICES, and 1915(c) waiver programs. Information should include, but not be limited to, help with filing complaints or appeals, finding the status of a complaint or appeal, and resolving related issues related to rights and responsibilities (**CRA Sections A.2.17.4.6.21 and A.2.17.7.6**).

4. MCO Training Related to the Beneficiary Support System

The MCOs are required to provide initial and ongoing training to Care Coordinators on information related to the beneficiary support system, including but not limited to how to obtain assistance with choice counseling, filing complaints or appeals, finding the status of a complaint or appeal, and resolving issues related to rights and responsibilities (**CRA Section A.2.9.7.13.21.32**).

In addition, the MCOs shall, as requested by TennCare, train the beneficiary support system contractor (DRT) on the MCO's process for addressing member grievances and appeals (**CRA Section A.2.18.11.2**).

5. Provision of Information Related to the CLS Ombudsman for Enrollees

Per TennCare Rule 1200-13-01-.05(6)(p)(3), CLS and CLS-FM providers shall ensure that every enrollee receiving CLS and CLS-FM services knows how to contact the CLS Ombudsman and that contact information for the ombudsman is available in the enrollee's residence in a location of their choosing.

Individual Experience Assessment (IEA)

As stated in the CMS-approved Statewide Transition Plan, all members receiving HCBS services are required to participate in an Individual Experience Assessment (IEA) upon initiation of services, and at least on an annual basis thereafter. The IEA verifies provider compliance with enrollee rights outlined in the HCBS Settings Final Rule. IEA responses that indicate a restriction of rights must be remediated within thirty calendar days. DIDD and the MCOs must submit a quarterly IEA remediation report, which shows that all responses indicating a restriction have been appropriately remediated.

