Division of TennCare

Tennessee Department of Finance & Administration

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Quarterly Monitoring Report

(For the period January – March 2022)

Demonstration Year: 2 (1/1/22- 12/31/22)
Federal Fiscal Quarter: 2/2022 (1/22 - 3/22)
Demonstration Quarter: 1/2022 (1/22 - 3/22)

June 6, 2022

TennCare III Monitoring Report

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

Key Dates of the Demonstration Quarter

Key dates of approval/operation for the TennCare Demonstration during the January-March 2022 quarter, together with the corresponding Special Terms and Conditions (STCs), if applicable, are presented in Table 1.

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
1/7/22	The State submitted an application for a time-limited demonstration amendment to implement certain managed care risk mitigation strategies as part of the State's response to the COVID-19 public health emergency.	6, 7
1/27/22	The Monthly Call for January was held.	60
1/28/22	CMS approved the state's request for a time-limited managed care risk mitigation demonstration amendment.	6, 7
1/28/22	The State provided formal notification to CMS that coverage of certain maternal health enhancements (full coverage for postpartum women for 12 months, and a dental benefits package for pregnant and postpartum women age 21 and older) would begin on April 1, 2022.	6
2/14/22	CMS approved Statewide MCO Contract Amendment 14 and TennCare Select Contract Amendment 50.	43

Date	Action	STC #
2/14/22	The State submitted a proposed reconciliation methodology for funds from the two uncompensated care pools described in STC 67.	69
2/24/22	The Monthly Call for February was held.	60
3/7/22	In response to feedback from CMS, the State submitted a revised version of its Shared Savings Quality Measures Protocol.	32.f.
3/24/22	The Monthly Call for March, which would have been held on this date, was cancelled.	60

I. Operational Updates

Progress Towards Milestones

The TennCare III Demonstration continues a number of program components from the prior iteration of the TennCare Demonstration that are already in operation. In addition, TennCare III includes some new programmatic flexibilities and authorities. In terms of new flexibilities authorized under TennCare III, the State has completed various milestones during Demonstration Year 1, including the submission of the Shared Savings Quality Measures Protocol on March 8, 2021; the submission of the Draft Implementation Plan on April 8, 2021; the submission of the Demonstration Monitoring Protocol on June 7, 2021; and the submission of the DSIP Claiming Protocol on June 30, 2021. The State is awaiting CMS approval of each of these deliverables.

The State has not yet implemented certain flexibilities authorized under the TennCare Demonstration. Specifically, the State has not implemented any new policies related to coverage of prescription drugs or any new policies related to suspension of members convicted of TennCare fraud. The State will work closely with CMS prior to implementing any new policies in these areas.

In addition, during the January-March 2022 quarter, CMS continued to review a new demonstration amendment designed to improve the alignment between the various types of care that TennCare enrollees with intellectual disabilities receive. Currently, these enrollees receive their medical/surgical and behavioral healthcare from MCOs through the managed care program authorized under the Demonstration, and their LTSS outside of managed care. Demonstration Amendment 1 would entail the following modifications to the TennCare program:

- Integration of services for members with intellectual disabilities into the TennCare managed care program[1];

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

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

As of the end of the January-March 2022 quarter, the State was awaiting CMS approval of Amendment 1.

Policy or Administrative Difficulties in Operating the Demonstration

There were no significant administrative difficulties in operating the demonstration during this quarter. During this quarter, the State continued to await CMS approval of Demonstration Amendment 1, which would allow the state to proceed with the planned integration of certain services for members with intellectual disabilities into the larger TennCare managed care program.

Key Challenges During the Quarter

Throughout the January-March 2022 quarter, the State continued to address the threat to public health and safety posed by the novel coronavirus disease 2019 (or "COVID-19"). As the agency in Tennessee state government responsible for providing health insurance to more than 1.6 million individuals, the Division of TennCare has developed a multilayered response to the COVID-19 emergency. Working in tandem with partners and stakeholders at the federal and state levels, TennCare designed and deployed a strategy consisting of such elements as—

- Coordinating with the provider community and TennCare's health plans to ensure access to care for TennCare members in need of testing or treatment for COVID-19;
- Assisting providers in offering covered services to TennCare members via telehealth when medically appropriate;
- Increasing care coordination services for members impacted by COVID-19 who are self-isolated, so that they can receive additional supports as needed;
- Pausing nearly all terminations of eligibility for TennCare and CoverKids (the State's separate CHIP program) members during the COVID-19 emergency;
- Working with TennCare's health plans to streamline or temporarily lift authorization requirements to ensure services are delivered promptly and claims paid quickly;
- Expediting access to home-based care for former nursing facility patients being discharged from hospitals and electing to transition home;
- Enhancing access to prescription drugs by allowing early refills of prescriptions and by allowing 90-day supplies to be prescribed for most medications;
- Obtaining multiple Section 1135 waivers from CMS that provide flexibilities to help ensure that TennCare members receive necessary services;
- Submitting emergency amendments to the TennCare Demonstration to make retainer payments to providers of HCBS in the Employment and Community First CHOICES program; to obtain additional flexibilities to support TennCare HCBS providers during the public health emergency; and to furnish Enabling Technologies to recipients of HCBS;

- Assisting providers of long-term services and supports in reducing the spread of COVID-19 among individuals who are residents of nursing facilities; and
- Implementing targeted, state-directed managed care payments to provide enhanced financial support for providers disproportionately affected by the COVID-19 emergency, including primary care providers, nursing facilities, dentists, and community mental health centers and other providers of behavioral health services.

Additional resources concerning the State's response to the COVID-19 pandemic are available on a dedicated page of the TennCare website.

During the January-March 2022 quarter, the State—acting in close coordination with CMS—requested a time-limited demonstration amendment to help facilitate the State's response to the ongoing COVID-19 public health emergency. The State's proposed amendment would allow the State to implement certain managed care risk mitigation strategies during the public health emergency, and would test whether, in the context of the ongoing COVID-19 public health emergency, certain flexibilities with regard to the federal regulations governing the managed care rate development process, promote the objectives of Medicaid. CMS approved the State's amendment request on January 28, 2022.

Key Achievements During the Quarter

During the quarter, implementation of a number of new TennCare initiatives began. Furthermore, the State achieved notable results in the area of long-term services and supports by enrolling more children in the Katie Beckett program and by making enhancements to HCBS programs.

Implementation of Program Enhancements. The state budget approved for State Fiscal Year 2022 included funding for a number of modifications and enhancements to the TennCare program. These include:

1. Extending TennCare's coverage of postpartum women to 12 months;
2. Establishing a dental benefit for pregnant and postpartum women enrolled in TennCare;
3. Establishing a chiropractic benefit for adults enrolled in TennCare; and
4. Expanding TennCare's coverage of children adopted from state custody.

On January 1, 2022, the State began covering medically necessary chiropractic services for adults enrolled in TennCare. Prior to January 1, chiropractic services were covered only for children under age 21. Like other TennCare benefits, chiropractic services are administered by members' MCOs, which are responsible for ensuring appropriate utilization of services.

In addition, from December 7, 2021, through January 10, 2022, the State held a public notice and comment period on a proposed demonstration amendment (Amendment 2) to expand coverage of children adopted from state custody. TennCare's coverage already includes children adopted from state custody for whom a Title IV-E adoption assistance agreement is in effect, as well as children with special needs receiving non-IV-E adoption assistance from the State. However, there are a number of children in foster care in Tennessee each year who do not qualify for either

form of adoption assistance (federal or state). Under Amendment 2, the State would cover children adopted from state custody who do not qualify for federal or state adoption assistance. Extending coverage to this group of children would remove a potential barrier to adoption, as well as promote greater continuity of care for these children as they transition from foster care to permanent homes. Amendment 2 was submitted to CMS on April 7, 2022.

Furthermore, effective April 1, 2022, the State began extending full coverage for postpartum women for a full 12 months (a significant increase from the previous total of 60 days), and also began providing a dental benefits package for pregnant and postpartum women age 21 and older. A public notice and comment period on these maternal health enhancements was held from December 17, 2021, through January 20, 2022. The State provided formal notification of the enhancements to CMS on January 28, 2022, and implementation began on April 1, 2022.

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

The State's program contains three parts:

- **Katie Beckett (Part A)** – Children with the most severe needs receive the full TennCare benefits package, as well as essential wraparound home and community based services. These individuals are subject to monthly premiums, which are determined on a sliding scale based on the member's household income.
- **Medicaid Diversion (Part B)** – Individuals in this group receive a specified package of essential wraparound services and supports, including premium assistance. These services are intended to prevent or delay the need for traditional Medicaid supports.
- **Continued Eligibility (Part C)** – Children in this group are enrolled in TennCare, have been determined no longer to meet the eligibility requirements for a Medicaid category, meet the criteria for enrollment in Katie Beckett (Part A), but do not have available slots in which to enroll. These individuals receive the full TennCare benefits package.

The new Katie Beckett/Medicaid Diversion program began accepting self-referral forms from interested families on November 23, 2020. As of the last day of the January-March 2022 quarter, a total of 1,331 children were enrolled in the program, with 147 enrolled in Katie Beckett (Part A), 1,184 enrolled in Medicaid Diversion (Part B), and no one enrolled in Continued Eligibility (Part C). See additional discussion of TennCare's Katie Beckett/Medicaid Diversion program below.

Enhancements to Home and Community Based Services. The American Rescue Plan Act of 2021 provides additional federal funding to enhance, expand, and strengthen Medicaid HCBS programs. In accordance with CMS guidance and after an extensive stakeholder input process, the State submitted a proposed HCBS Spending Plan and Narrative to CMS on July 12, 2021, outlining how additional federal resources would be used to strengthen the Demonstration's HCBS programs. The State initially received partial approval of its HCBS spending plan and

narrative on August 2, 2021, and after some minor clarifications, received final approval from CMS on September 22, 2021. The major components of the State's plan to enhance and strengthen HCBS are outlined below:

- **Improving access to HCBS for persons needing supports and family caregivers.** Notably, the State intends to reduce by half the number of persons on the referral list for Employment and Community CHOICES by enrolling an additional 2,000 qualifying individuals into the program. In addition, based on significant input from stakeholders, for individuals who are already enrolled in HCBS programs, the State plans to increase, for a limited period of time, access to flexible family caregiver benefits in order to address the additional stresses from impacts of COVID-19, and ensure the sustainability of these supports going forward. The State also plans to make targeted enhancements to its HCBS benefits package, beginning with Enabling Technology for persons enrolled in CHOICES.
- **Investing in the HCBS Workforce.** The State plans to use additional federal resources to make targeted provider rate increases for services in CHOICES and in Employment and Community First CHOICES that have a direct care component. In addition, the State plans to implement a quality incentive pilot program to incentivize HCBS providers to offer value-based wage increases to their frontline HCBS workers who successfully complete a competency-based training program.
- **Investing in HCBS Provider Capacity.** The State plans to implement a referral incentive program for specified types of HCBS to help providers recruit and retain qualified frontline staff.

Following CMS approval of the State's proposed spending plan as well as state budget expansion approval, TennCare began implementing these initiatives during the October-December 2021 quarter. On November 3, 2021, the State submitted a time-limited demonstration amendment request to reflect the enhancements to the Demonstration's HCBS benefits in the Demonstration. Implementation of these enhancements and the State's larger ARPA HCBS Spending Plan was ongoing during the January-March 2022 quarter.

Issues or Complaints Identified by Beneficiaries

Eligibility Appeals. Table 3 presents a summary of eligibility appeal activity during the quarter, compared to the previous two quarters. It should be noted that appeals (whether related to eligibility, medical services, or LTSS) may be resolved or taken to hearing in a quarter other than the one in which they are initially received by TennCare.

Table 3
Eligibility Appeals for January – March 2022
Compared to the Two Previous Quarters

	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
No. of appeals received	4,663	4,941	5,389
No. of appeals resolved or withdrawn	4,931	4,569	5,556

	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
No. of appeals taken to hearing	1,257	843	1,016
No. of hearings resolved in favor of appellant	42	28	21

Medical Service Appeals. Table 4 below presents a summary of the medical service appeals handled during the quarter, compared to the previous two quarters. As a result of improvements to the methodology by which medical service appeal data is collected, totals for the July-September and October-December 2021 quarters have been updated.

Table 4
Medical Service Appeals for January – March 2022
Compared to the Two Previous Quarters

	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
No. of appeals received	2,826	2,555	2,822
No. of appeals resolved	1,491	1,504	1,361
• Resolved at the MCC level	396	398	393
• Resolved at the TSU level	154	127	114
• Resolved at the LSU level	941	979	854
No. of appeals that did not involve a valid factual dispute	1,255	1,233	1,339
No. of directives issued	267	269	241
No. of appeals resolved by fair hearing	952	988	877
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	306	349	278
Appeals that went to hearing and were decided in the State's favor	598	594	535
Appeals that went to hearing and were decided in the appellant's favor	37	36	41

By way of explanation:

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

- The "TSU" level is the TennCare Solutions Unit. The TSU is a unit within TennCare that reviews requests for hearings. The TSU might overturn the decision of the MCC and issue a directive requiring the MCC to approve provision of the service under appeal. Alternatively, if, following review, TennCare agrees with the MCC's decision, the appeal

typically proceeds to TennCare's Legal Solutions Unit (LSU), where it is scheduled for administrative hearing before an Administrative Law Judge.

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

LTSS Appeals. The following table provides information regarding certain appeals administered by TennCare's Long-Term Services and Supports Division for the quarter (e.g., appeals of PreAdmission Evaluation denials, appeals of PreAdmission Screening and Resident Review determinations, etc.), compared to the previous two quarters.

Table 5
Long-Term Services and Supports Appeals for January – March 2022
Compared to the Two Previous Quarters

	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
No. of appeals received	91	80	75
No. of appeals resolved or withdrawn	56	53	56
No. of appeals set for hearing	26	20	19
No. of hearings resolved in favor of appellant	0	0	0

Grievances. Table 6 presents information about grievances received and resolved by TennCare's managed care contractors (MCOs, DBM, and PBM) during the January-March 2022 quarter. It should be noted that grievances may be resolved in a quarter other than the one in which they are received.

Table 6
Most Common Grievance Categories and Totals, January – March 2022

Grievance Category	Number of Grievances Received	Number of Grievances Resolved
Access and Availability	362	337
Attitude and Service	166	152
Billing and Financial Issues	127	119
Quality of Care/Quality of Service	238	190
Other	32	28
Total	925	826

Each time an enrollee contacted the State or a managed care contractor to voice a complaint, the grievance was logged, and steps were taken to address the enrollee's concern. TennCare and

the managed care contractors review issues, complaints, and grievances raised by enrollees to inform quality improvement efforts.

Audits, Investigations, or Lawsuits that Impact the Demonstration

During the January-March 2022 quarter, the Division of TennCare was involved in several lawsuits. Details of these suits are as follows:

A.M.C., et al. v. Smith Lawsuit. On March 19, 2020, the Tennessee Justice Center filed a federal lawsuit on behalf of a proposed class of plaintiffs against the Division of TennCare. The lawsuit alleges statutory and constitutional deficiencies with TennCare's eligibility redetermination process and the Tennessee Eligibility Determination System. Another allegation within the suit is that TennCare is violating the Americans with Disabilities Act by not providing reasonable accommodations, thereby preventing disabled individuals from participating in the TennCare program. Plaintiffs have two pending motions before the court: one for class certification and one for preliminary injunction, both of which TennCare opposed. The State filed a timely motion to dismiss the case, which is also pending with the Court. The parties are currently engaged in discovery.

Dyersburg Family Walk-In Clinic, Inc. v. Tennessee Department of Finance and Administration, et al. Lawsuit. On December 22, 2020, Dyersburg Family Walk-In Clinic, Inc., which does business under the registered assumed name Reelfoot Family Walk-In Clinic, filed a federal lawsuit against TennCare in the District Court for the Western District of Tennessee. Reelfoot operates three Rural Health Clinics that receive supplemental payments from TennCare. The lawsuit challenges TennCare requirements related to these supplemental payments and seeks injunctive and declaratory relief. In April 2021, TennCare successfully petitioned to have the case transferred to the District Court for the Middle District of Tennessee. On January 13, 2022, Plaintiff voluntarily dismissed all claims in this litigation, and the case has been closed.

EMCF v. TennCare Lawsuit. In September 2018, Emergency Medical Care Facilities, P.C., filed a complaint for declaratory judgment and injunctive relief against the Division of TennCare in Davidson County Chancery Court. The suit relates to a $50 cap imposed by the agency on payment for emergency room physician services determined to be non-emergent. EMCF alleges that the State implemented this cap through its contractual relationship with its MCOs and not through the administrative rulemaking process. The parties filed cross-motions for summary judgment, and, on September 1, 2020, the Chancellor granted summary judgment to EMCF on their claim that the $50 cap was void. EMCF then voluntarily dismissed their remaining claims pertaining to the determination of payment for the services in question. The State filed an appeal, and, on October 7, 2021, the Court of Appeals ruled in the State's favor and reversed the trial court's ruling. The Court of Appeals found that the reimbursement limit fell within the internal management exception of a rule and was not subject to rulemaking requirements. EMCF has filed an application for permission to appeal to the Tennessee Supreme Court, and this application was still pending as of the end of the January-March 2022 quarter.

Erlanger Health System v. TennCare Lawsuit. This declaratory order action was commenced against the State regarding the applicability and validity of two TennCare rules that set the reimbursement rates for emergency services provided to TennCare enrollees by non-contract hospitals. TennCare's Commissioner's Designee issued a declaratory order upholding the rules being challenged by Erlanger, and on November 12, 2021, Erlanger filed a Petition for Judicial Review of the declaratory order in Chancery Court.

M.A.C., et al. v. Smith Lawsuit. Five TennCare members filed a federal lawsuit against TennCare alleging that the Home and Community-Based Services they received through the State's 1915(c) waiver programs are not being fully staffed, resulting in a denial of necessary care and sufficient alternatives to institutionalization. On September 27, 2021, the Tennessee Attorney General's office acting on behalf of TennCare filed a timely motion to dismiss the suit.

McCutchen et al. v. Becerra Lawsuit. On May 20, 2021, the State of Tennessee filed a motion to intervene in the federal lawsuit challenging CMS' approval of the TennCare III Demonstration. This lawsuit was filed by the Tennessee Justice Center (TJC), acting on behalf of 14 individual plaintiffs, against CMS in the District Court for the District of Columbia. On August 5, 2021, the State's motion was granted. The McCutchen suit has subsequently been stayed pending the outcome of a federal comment period on the TennCare III Demonstration.

Unusual or Unanticipated Trends

During this quarter, the State continued to claim the enhanced FMAP authorized under Section 6008 of the Families First Coronavirus Response Act (FFCRA). As a condition of receiving this federal funding, the State is generally maintaining eligibility for all persons currently enrolled in TennCare. TennCare enrollment has continued to increase steadily during the COVID-19 public health emergency while the FFCRA continuous coverage requirement remains in effect.

Legislative Updates

By the conclusion of the January-March 2022 quarter, Tennessee's legislative session was still weeks from completion, and the outcome of many bills introduced by the General Assembly had yet to be determined. It was observed, however, that assessments used to help fund various aspects of the TennCare program (e.g., the hospital assessment, the nursing facility assessment, etc.) were expected to be renewed for State Fiscal Year 2023.

A summary of State legislation with significant implications for TennCare will be included in the Monitoring Report for the April-June 2022 quarter.

Public Forums

No public forums on the TennCare Demonstration were held during the January-March 2022 quarter. The State's most recent public forum took place on July 6, 2021. As required by STC 61, the State will host a public forum this year to accept comments on the progress of the TennCare III Demonstration. Details of the event, which will likely take place in June 2022, will be published on the TennCare website at least 30 days beforehand, and a summary of comments received at the forum will be included in the Monitoring Report for the April-June 2022 quarter.

Enrollment and Member Month Data

Information about TennCare enrollment by category is presented in Table 7.

Table 7
Enrollment Counts for the January – March 2022 Quarter
Compared to the Two Previous Quarters

Demonstration Populations	Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
EG1 Disabled	135,471	135,128	135,299
EG9 H-Disabled	643	660	685
EG2 Over 65	222	251	283
EG10 H-Over 65	33	33	33
EG3 Children	834,726	843,369	851,028
EG4 Adults	482,179	496,980	511,025
EG5 Duals and EG11 H-Duals 65	160,924	161,263	162,427
EG6E Expan Adult	0	0	0
EG7E Expan Child	1,373	1,385	1,289
EG8, Med Exp Child	0	0	0
Med Exp Child, Title XXI Demonstration Population	11,198	11,468	11,896
EG12E Carryover	1,393	1,320	1,256
EG13 Katie Beckett	75	129	149
EG14E Medicaid Diversion	916	1,011	1,238
EG15 Continued Eligibility	4	1	0
TOTAL*	1,629,157	1,652,998	1,676,608

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

The majority of TennCare's enrollment consists of Type 1 EG3 children and Type 1 EG4 adults, with 81 percent of TennCare enrollees appearing in one of these categories.

Table 8 below presents the member month reporting by eligibility group for each month in the quarter.

Table 8
Member Month Reporting for January – March 2022

Eligibility Group	January 2022	February 2022	March 2022	Sum for Quarter Ending 3/31/22
EG1 Disabled	136,191	135,314	134,277	405,782
EG2 Over 65	233	242	243	718

Eligibility Group	January 2022	February 2022	March 2022	Sum for Quarter Ending 3/31/22
EG3 Children	844,213	845,699	848,295	2,538,207
EG4 Adults	500,160	504,505	508,806	1,513,471
EG5 Duals	152,864	152,512	152,359	457,735
EG6E Expan Adult	0	0	0	0
EG7E Expan Child	1,378	1,382	1,280	4,040
EG8 Med Exp Child	0	0	0	0
EG9 H-Disabled	626	649	677	1,952
EG10 H-Over 65	30	26	26	82
EG11 H-Duals	6,573	6,541	6,550	19,664
Med Exp Child, Title XXI Demo Pop	11,398	11,594	11,825	34,817
EG12E Carryover	1,261	1,240	1,211	3,712
EG13 Katie Beckett	134	140	149	423
EG14E Medicaid Diversion	1,103	1,162	1,237	3,502
EG15 Continued Eligibility	1	1	0	2
TOTAL	1,656,165	1,661,007	1,666,935	4,984,107

Information and Data about the CHOICES Program

CHOICES is TennCare's program of managed long-term services and supports for individuals who are elderly and/or have physical disabilities. Implemented in 2010, CHOICES offers nursing facility services (CHOICES 1) and home and community-based services (CHOICES 2 and 3) to eligible individuals via the State's managed care program.

As required by STC 33.d., the State offers the following table delineating CHOICES enrollment as of the end of the quarter, as well as information about the number of available reserve slots.

Table 9
CHOICES Enrollment and Reserve Slots
for January-March 2022 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity[2]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
CHOICES 1	Not applicable	14,325	14,392	14,166

[2] Of the three active CHOICES groups, only CHOICES 2 has an enrollment target. Interim CHOICES 3 closed to new enrollment on June 30, 2015; an enrollment target for CHOICES 3 has not been set at this time.

	Statewide Enrollment Targets and Reserve Capacity[2]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
CHOICES 2	11,000	10,003	9,856	9,651
CHOICES 3 (including Interim CHOICES 3)	To be determined	2,095	2,084	2,041
Total CHOICES	Not applicable	26,423	26,332	25,858
Reserve capacity	300	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STC 53 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 53.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Eighteen separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and March 2022.

Taken together, the reports depict a program evolving according to the characteristics of LTSS recipients, with institutional care available to individuals with the highest acuity of need, and Home and Community-Based Services (HCBS) available to individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point-in-time data revealed declining use of Nursing Facility (NF) services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 16,126 individuals on June 30, 2020. According to annual aggregate data contained in the reports, this downward trend was even more pronounced for new LTSS recipients, 81 percent of whom had been admitted to NFs in the year prior to implementation of the CHOICES program, as compared with 64 percent admitted to NFs in the tenth year of CHOICES. Furthermore, nursing facility expenditures in the year prior to CHOICES implementation accounted for more than 90 percent of total LTSS expenditures, whereas the percentage was approximately 79 percent ten years later.

By contrast, appropriate use of HCBS by TennCare enrollees grew significantly during these years. The aggregate number of members accessing HCBS increased from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 15,159 after CHOICES had been in place for ten full fiscal years. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 12,206 by June 30, 2020. The percentage of LTSS expenditures devoted to HCBS grew as well, rising from 9.75 percent in the year prior to CHOICES, to 20.79 percent after the CHOICES program had been in place for ten years.

Selected elements of the aforementioned CHOICES data are summarized in Table 10.

Table 10
Changes in Use of HCBS by Persons Who Are Elderly or Disabled (E/D) Before and After CHOICES Implementation

Annual Aggregate Data			Point-in-Time Data		
No. of TennCare enrollees accessing HCBS (E/D), 3/1/09 – 2/28/10	No. of TennCare enrollees accessing HCBS (E/D), 7/1/19 – 6/30/20	Percent increase over a ten-year period	No. of TennCare enrollees accessing HCBS (E/D) on the day prior to CHOICES implementa-tion	No. of TennCare enrollees accessing HCBS (E/D) on 6/30/20	Percent increase from the day prior to CHOICES implementa-tion to 6/30/20
6,226	15,159	143%	4,861[3]	12,206	151%

Frequency and use of MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds is detailed in Table 11.

Table 11
CHOICES Transition Allowances
for January-March 2022 Compared to the Two Previous Quarters

	Frequency and Use of Transition Allowances					
	Jul – Sep 2021		Oct – Dec 2021		Jan – Mar 2022	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	11	$5,207	17	$10,960	13	$6,702
Middle	27	$10,758	3	$1,505	17	$9,955
West	17	$6,500	8	$4,125	10	$4,669
Statewide Total	55	$22,465	28	$16,590	40	$21,326

Information and Data about the Employment and Community First CHOICES Program

Designed and implemented in partnership with people with intellectual and developmental disabilities, their families, advocates, providers, and other stakeholders, Employment and Community First CHOICES is the first managed LTSS program in the nation that is focused on promoting and supporting integrated, competitive employment and independent community

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

living as the first and preferred option for people with intellectual and other types of developmental disabilities.

As required by STC 34.d., the State offers the following table delineating ECF CHOICES enrollment as of the end of the quarter, as well as information about enrollment targets and the number of available reserve slots. It should be noted that the number of filled reserve slots does not include slots in a "held" status that have been assigned to a person but for whom actual enrollment is pending an eligibility determination.

Table 12
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots for January-March 2022 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
ECF CHOICES 4	1,346	894	922	1,071
ECF CHOICES 5	2,930	1,591	1,642	1,786
ECF CHOICES 6	1,581.5	1,166	1,242	1,328
ECF CHOICES 7	35	30	23	19
ECF CHOICES 8	50	44	33	28
Total ECF CHOICES	5,942.5[5]	3,725	3,862	4,232
Reserve capacity	3,592.5	1,327	1,470	1,834

[4] Statewide enrollment targets and reserve capacity for DY 1 were adjusted to reflect new appropriation authority, effective July 1, 2021. A total of 300 reserve capacity slots were added to ECF CHOICES Groups 4, 5, 6, 7, and 8. The distribution of these slots reflects 20 additional slots in Group 4, 60 additional slots in Group 5, 200 additional slots in Group 6, and 10 slots each for Groups 7 and 8. Of the 20 slots allocated for Groups 7 and 8, a total of 5 were assigned to Group 7, and 1 was assigned to Group 8. Furthermore, because of the higher expected cost of benefits in Groups 7 and 8, it was possible to convert the remaining 14 slots from Groups 7 and 8 to a total of 21 slots for Group 6. In the fourth quarter, three DD Aging Caregiver reserve capacity slots were reallocated, with 2 moved from Group 4 to Group 6, and 1 moved from Group 5 to Group 6. Statewide enrollment targets and reserve capacity were adjusted to reflect CMS' conditional approval of ARP funding for additional ECF CHOICES slots effective September 22, 2021. A total of 2,000 reserve capacity slots were added to ECF CHOICES, with 400 additional slots in Group 4, 1,275 additional slots in Group 5, and 325 additional slots in Group 6.

[5] As provided in the revised enrollment target ranges submitted to CMS on August 23, 2021, while the combined total of all upper limits is 6,000, there would never be a scenario in which all benefit groups would be set at the upper limit, since program funding would be insufficient to cover. These upper limits provide flexibility to move slots as required to meet the needs of program applicants.

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
Waiver Transitions[6]	Not applicable	74	78	80

Data and trends of the designated ECF CHOICES data elements: STC 53.d. requires the State to provide CMS periodic statistical reports about the ECF CHOICES program. To date, the State has submitted baseline data for the year-long period preceding implementation of ECF CHOICES, as well as four years' worth of post-implementation data. In comparing the baseline data with the post-implementation data, several notable trends emerged:

- The number of individuals with intellectual disabilities receiving HCBS through the TennCare program grew from 8,295 in the year preceding implementation of ECF CHOICES to 8,588 after ECF CHOICES had been in place for four years.
- The number of individuals with developmental disabilities other than intellectual disabilities who received HCBS through the TennCare program grew from 0 to 1,718.
- Average LTSS expenditures for individuals with intellectual or developmental disabilities fell from $94,327 per person to $88,008 per person.
- The percentage of working age adults with intellectual or developmental disabilities who are enrolled in HCBS programs, employed in an integrated setting, and earning at or above the minimum wage grew from 14.32 percent to 22.54 percent.

As ECF CHOICES gains enrollment capacity, these trends toward individuals with intellectual and developmental disabilities living independently in the community are expected to accelerate.

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

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

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

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

As required by STC 35.c., the State offers the following table delineating Katie Beckett, Medicaid Diversion, and Continued Eligibility enrollment as of the end of the quarter, as well as information about enrollment targets and the number of available reserve slots.

Table 13
Katie Beckett, Medicaid Diversion, and Continued Eligibility Enrollment and Reserve Slots For January-March 2022 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jul – Sep 2021	Oct – Dec 2021	Jan – Mar 2022
Katie Beckett	242[7]	69	128	147
Medicaid Diversion	2,700	923	978	1,184
Continued Eligibility	N/A	4	1	0
Reserve capacity	242	69	128	147

Data and trends of the designated Katie Beckett/Medicaid Diversion data elements: STC 53.d. requires the State to provide CMS periodic statistical reports about the Katie Beckett and Medicaid Diversion groups. The State anticipates submitting baseline data for these groups during Calendar Year 2022, with trend data to follow on an annual basis thereafter.

[7] At program implementation, 50 slots were available to children who met Tier 1 level of care eligibility (as defined in TennCare rules). The purpose of these Reserve Capacity slots was to ensure that children with the most significant medical needs and disabilities were enrolled into the Katie Beckett group (Part A) before the group was opened for enrollment to other children, subject to available funding. During the April-June 2021 quarter, an additional 50 slots were added for children who met Tier 2 level of care eligibility requirements (as described in TennCare rules). In the July-September 2021 quarter, an additional 147 slots for children who met Tier 2 requirements were added. During the October-December 2021 quarter, based on the total funding appropriated for the Katie Beckett group and projected utilization per child, an additional 13 slots were added for children who met Tier 2 requirements. In the January-March 2022 quarter, the total Part A slot capacity (and thus new enrollment capacity) was reduced by 25 slots because of increased actual costs per child, but this measure does not impact children already enrolled in the program. All available slots for the Katie Beckett group are Reserve Capacity slots.

Steps Taken to Ensure Compliance with Regulations Governing HCBS Settings

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

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

Health and Welfare of HCBS Recipients

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

II. Performance Metrics

Progress Toward Goals and Targets in the Monitoring Protocol

STC 55 requires the State to submit to CMS a draft Monitoring Protocol no later than 150 days after the January 8, 2021, start date of the TennCare III approval period. The purpose of the Monitoring Protocol is to define the quantitative and qualitative elements the State will use in its Quarterly and Annual Monitoring Reports to chart progress toward fulfillment of the goals and targets of the TennCare III Demonstration. On June 7, 2021, the State submitted its draft Monitoring Protocol to CMS. As of the end of the January – March 2022 quarter, CMS was reviewing the document.

Impact of the Demonstration in Providing Insurance Coverage

As noted in Section I of this report, the TennCare III Demonstration furnished health care coverage to 1,676,608 Tennesseans during the January – March 2022 quarter. This total represents approximately 24 percent of the 6.9 million residents living in Tennessee.

Impact of the Demonstration in Ensuring Access to Care

Ensuring Access Through Contractual Means

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

Measuring Access Through Provider Data Validation

In January 2022, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the October-December 2021 quarter. The EQRO took a sample of provider data files from TennCare's MCCs[8] and reviewed each for accuracy in the following categories:

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. The EQRO's report demonstrated generally strong performance by the MCCs, especially in the categories of "active contract status" (92.5 percent accuracy), "provider specialty / behavioral health service code (95.5 percent accuracy), "services for children" (93.1 percent accuracy), "primary care services" (94.6 percent accuracy), and "prenatal care services" (96.6 percent accuracy).

Progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Qsource's report concluded that the MCCs "achieved high accuracy rates" for the fourth quarter of Calendar Year 2021.

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

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

Data documenting the effect of the TennCare Demonstration in improving health outcomes and ensuring quality of care will be included in future Quarterly and Annual Monitoring Reports based on the availability of data and in accordance with the Shared Savings Metric Set. In addition, the State has a variety of innovative programs designed to improve the health of TennCare members. Information about three of those programs—Patient Centered Medical Home, Health Starts Provider Partnerships, and BESMART—appears below.

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

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

The PCMH program began with the first group of participating provider organizations on January 1, 2017. As of March 2021, approximately 765,000 TennCare members are attributed to one of 83 PCMH-participating organizations, and 95.5 percent of these organizations' 454 sites are currently NCQA-PCMH-recognized. In addition, providers have recently been engaged with coaching and numerous trainings. In March 2021, more than 50 PCMH providers participated in a delivery systems transformation conference to hear from subject matter experts on a diverse range of topics.

Health Starts. The State's Health Starts Provider Partnerships program launched on April 1, 2021. The goal of these partnerships is to improve quality of care for TennCare members by addressing social risk factors in the TennCare population. The partnership program currently involves 14 provider groups across Tennessee, including patient-centered medical homes, long-term services and supports providers, hospitals, and behavioral health providers. The State is working with each provider partner to screen members for social risk factors, refer them to community resources based on identified needs, and close the loop on referrals to verify that member needs are met. Thus far, the partnership program has impacted over 2,500 unique members and identified needs across various domains, including transportation, housing, utility assistance, and child care. While this effort remains in the early stages, the State has begun gathering data to inform future quality improvement initiatives related to addressing Tennesseans' social risk factors.

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

The BESMART Program officially launched on January 1, 2019, and has continued to grow and serve more Tennesseans. As of March 2019, there were approximately 100 high-quality BESMART providers contracted with TennCare managed care organizations to treat 2,000 members. By March 2022, the number of BESMART providers had increased to 390, and the number of unique members served per month had grown to 19,401. Additionally, buprenorphine covered by TennCare remains in the top five controlled substances by claims, meaning that TennCare pays for more buprenorphine to treat opioid use disorder than for short-acting opioids to treat pain.

The focus that TennCare has placed on combatting the opioid epidemic through treatment and other major prevention efforts has also shown tremendous success in reducing the number of newborns with neonatal abstinence syndrome (NAS), or signs and symptoms of opioid withdrawal as an infant due to opioid exposure during the pregnancy. In 2019, the NAS rate in the TennCare population was 20 NAS births per 1,000 live births, as compared with the 2016 rate, which was 28 NAS births per 1,000 live births. A decline in the NAS rate has been achieved for three consecutive years.

Beneficiary Survey

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

A copy of the report of TennCare's most recent annual beneficiary survey was attached to the Annual Monitoring Report for Demonstration Year 1. During the January-March 2022 quarter, BCBER made initial preparations for the 2022 survey cycle. The focal point of these preparations was ensuring that the script used by staff when questioning survey participants was fully updated and ready to deploy.

Progress on Shared Savings Metric Set

On March 8, 2021, the State submitted measures for the Shared Savings Metric Set to CMS. This document is currently under CMS review. The State will report on its progress on these metrics in future Monitoring Reports, as the measures become available each year.

III. Budget Neutrality and Financial Reporting Requirements

Budget neutrality was successfully maintained by the State during the January-March 2022 quarter. The State's budget neutrality workbook for the quarter will be submitted to CMS under separate cover.

IV. Evaluation Activities and Interim Findings

STC 90 requires the State to submit to CMS a draft Evaluation Design for the approval period of the TennCare III Demonstration (January 8, 2021 – December 31, 2030). This draft Evaluation Design was submitted to CMS on July 7, 2021. As of the conclusion of the January-March 2022 quarter, CMS was continuing to review the document.

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

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

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

Once CMS has completed its review of the Evaluation Design, the State will finalize the document, and begin testing its hypotheses and answering its research questions. Summaries of these evaluation activities will be included in future Quarterly Monitoring Reports.

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Attachment A:
Health and Welfare of HCBS Participants

Waiver operations are in compliance. The State system assures HCBS participants' health and welfare via annual member record review regarding instances of abuse, neglect, and exploitation, and semi-annual record review of Critical Incident Management Systems. TennCare is responsible for an annual record review and review/analysis of data. Each MCO is responsible for remediation of individual findings with review/validation by TennCare.

Effective September 1, 2021, TennCare and DIDD launched One Aligned Reportable Event Management (REM) System. The new One Aligned REM Protocol sets forth specific expectations regarding REM processes for people receiving services in all LTSS programs, including CHOICES and Employment and Community First CHOICES. Reportable Events and data are tracked and trended by the Tennessee Department of Intellectual and Developmental Disabilities (DIDD), MCOs, and providers. Managed Care Organizations (MCOs) and DIDD, in collaboration with TennCare and providers, evaluate the trended data to achieve desired Reportable Event Management outcomes—address and prevent instances of abuse, neglect, exploitation, and unexplained death.

The State continues all efforts to ensure the health and welfare of persons served across all LTSS programs. These efforts include movement towards full implementation of an aligned Reportable Event Management system for all populations served in the 1115 Waivers. Effective September 1, 2021, all ECF CHOICES providers began reporting Reportable Events to DIDD using an aligned Reportable Event Form. This form and aligned process is also required for those providers who participate in the CHOICES program, effective September 1. These providers are required to be trained and completing Tier 2 Reportable Event Investigations no later than October 1, 2021. CHOICES-only providers were required to report using the aligned system beginning on January 1, 2022, at which time all Reportable Event Management became fully aligned under the subject matter expertise of DIDD and TennCare jointly.

Systems:

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

Reports:

- HCBS Settings Committee Reports are completed quarterly for the 1115 waiver programs by the MCOs. These reports include the total number of proposed or emergency rights restrictions or restraints reviewed during the quarter that are not part of a plan of care or

PCSP or BSP, total number of periodic data reviews regarding interventions, the total number of reviews of psychotropic medications conducted during the quarter, the total number of complaints regarding restrictive interventions or settings compliance concerns received and reviewed during the quarter, and a summary of the outcomes of such reviews, including actions pertaining to individual members or providers or to broader systemic improvements.

- Quarterly HCBS Settings Reports are submitted for the 1115 waiver program. These reports aggregate the HCBS Settings data collected and identify trends relating to member concerns with particular providers or provider settings, including steps for remediation to address these concerns.
- 1115 Reportable Event Monthly Reports track all reportable incidents by event type, setting, and the provider/staff accused of being responsible. The report includes a narrative describing the MCO's analysis of critical incidents for the reporting period, including trends and patterns; opportunities for improvement; and strategies implemented by the MCO to reduce the occurrence of incidents and improve quality.
- Emergency Department (ED) Utilization Quarterly Report of 1115 members evaluates members who have ED visits. The report allows TennCare to follow up with the MCOs to investigate members who have frequent ED visits.

Audits:

- 1115 Existing Member Record Reviews (MRR) are conducted annually. These record reviews include performance measures related to education of members on the identification and reporting of suspected abuse.
- The CHOICES Critical Incident and ECF CHOICES Reportable Event Audit reviews incidents/events for proper reporting within timeframes as outlined in the CRA.