Tennessee Department of Finance & Administration

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Quarterly Monitoring Report

(For the period July – September 2021)

Demonstration Year: 1 (1/8/21- 12/31/21)
Federal Fiscal Quarter: 4/2021 (7/21 - 9/21)
Demonstration Quarter: 3/2021 (7/21 - 9/21)

December 6, 2021

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 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 July-September 2021 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 #
7/6/21	The State held a public forum to accept comments on the progress of the TennCare III Demonstration.	61
7/7/21	The State submitted to CMS a draft Evaluation Design for the TennCare III Demonstration.	90
7/12/21	The State submitted an Initial Spending Plan and Narrative for federal funds available under Section 9817 of the American Rescue Plan Act to enhance, expand, and strengthen HCBS.	N/A
7/22/21	The Monthly Call for July, which would have been held on this date, was cancelled.	60
8/2/21	CMS approved Statewide MCO Contract Amendment 12 and TennCare Select Contract Amendment 48.	43
8/2/21	The State received partial approval of its ARPA Section 9817 HCBS Initial Spending Plan and Narrative.	N/A
8/16/21	The State submitted to CMS a revised Implementation Plan for the TennCare III Demonstration that incorporated suggestions received from CMS.	54

Date	Action	STC #
8/23/21	The State submitted updated enrollment target ranges for ECF CHOICES, reflecting additional enrollment anticipated as a result of the State's plan to expand HCBS.	34
8/26/21	The Monthly Call for August was held.	60
8/31/21	The State submitted the Quarterly Monitoring Report for the April – June 2021 quarter to CMS.	56
9/22/21	The State received full approval of its ARPA Section 9817 HCBS Initial Spending Plan and Narrative.	N/A
9/23/21	The Monthly Call for September, 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 accordance with the STCs of the TennCare III Demonstration, the State submitted a draft implementation plan to CMS in April 2021 to provide details on the State's plan for implementing new flexibilities included in the approval of TennCare III. In June 2021, CMS shared comments on the draft implementation plan with the State, and a revised version of the plan was subsequently submitted to CMS on August 16, 2021. Table 2 identifies key milestones contained in the implementation plan (incorporating modifications suggested by CMS), as well as the anticipated completion date for each.

Table 2
Milestones for New Programmatic Flexibilities in the TennCare III Demonstration

Action Needed	Implementation Timeline
Shared Savings and DSIPs	
Submit Shared Savings Quality Measures Protocol to CMS.	Completed March 8, 2021.
Submit DSIP Claiming Protocol to CMS.	Completed June 30, 2021.
Submit the DSIP component of the Monitoring Protocol to CMS.	By September 30, 2021.
Begin implementation of processes for claiming of shared savings dollars.	By December 31, 2021.
Closed Formulary	
Conduct formulary disruption analysis.	By December 31, 2021.
Identify viable value-based purchasing models under a closed formulary.	By December 31, 2021.
Develop policies and procedures for a closed formulary.	By December 31, 2021.

Action Needed	Implementation Timeline
Research and develop key considerations for TennCare-specific medical necessity and exceptions review process for medication requests of specific drugs not included on a closed formulary.	By December 31, 2021.
Suspension of Eligibility for Enrollees Convicted of Fraud	
Promulgate state administrative rules to describe and support the enrollee suspension process and provide for necessary enrollee appeal processes.	To be determined based on the expiration of the COVID-19 public health emergency.
Modify the state's eligibility determination system and MMIS to implement the enrollee suspension policy, including suspending eligibility, generating appropriate notices, and transferring the enrollee to the TennCare Select health plan.	To be determined based on the expiration of the COVID-19 public health emergency.
Establish a process with the Tennessee Office of Inspector General (OIG) for TennCare to be informed when a TennCare enrollee has been convicted of TennCare fraud.	To be determined based on the expiration of the COVID-19 public health emergency.
Programmatic Changes	
Identify the need or opportunity for changes in coverage or benefits.	To be determined.
Notify the public of all planned changes to coverage and benefits and solicit public input according to the processes specified in federal regulation.	To be determined.
Amend managed care contracts as necessary to support changes to benefits or coverage, and engage in readiness review activities with managed care contractors as needed.	To be determined.
Amend the state's administrative rules to describe and support changes to coverage or benefits.	To be determined.
Notify CMS of planned changes to benefits or coverage, including documentation of the state's compliance with public notice requirements, at least 60 days in advance of implementation.	To be determined.
Implement change to benefits or coverage.	To be determined.

In addition, during the July-September quarter, CMS continued to review a new demonstration amendment that had been submitted during the previous quarter. Amendment 1 would introduce the following modifications to the TennCare program:

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

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 July-September 2021 quarter, the State continued to address the threat to public health and safety posed by coronavirus disease 2019 (or "COVID-19"). As the agency in Tennessee state government responsible for providing health insurance to more than 1.5 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 an emergency amendment to the TennCare Demonstration to make retainer payments to providers of HCBS in the Employment and Community First CHOICES

[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).

program, as well as additional flexibilities to support TennCare HCBS providers during the public health emergency;
- Assisting providers of long-term services and supports in reducing the spread of COVID-19 among individuals who are residents of nursing facilities; and
- Working with the federal government and health care providers in Tennessee 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.

Key Achievements During the Quarter

During the July-September 2021 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.

During the July-September 2021 quarter, the State began the process for implementing each of these initiatives, including scheduling rulemaking hearings to update the State's administrative rules, updating member materials, amending MCO contracts, and preparing submissions for CMS approval (as applicable). Implementation of each of these items is anticipated to be begin in the near future. The State will work closely with CMS in the implementation of each of these initiatives, including items where no additional authority is needed (e.g., adding an adult chiropractic benefit to the TennCare benefits package) and any items where new demonstration authority may be needed (i.e., expanding TennCare's coverage of adopted children).

Katie Beckett/Medicaid Diversion Program. On November 23, 2020, the State launched a new Katie Beckett/Medicaid Diversion program. 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 July-September 2021 quarter, a total of 996 children were enrolled in the program, with 69 enrolled in Katie Beckett (Part A), 923 enrolled in Medicaid Diversion (Part B), and 4 enrolled in Continued Eligibility (Part C).

Enhancements to Home and Community Based Services. The American Rescue Plan Act provides 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 State'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.

Taken together, these initiatives represent a significant investment in access to HCBS for persons in Tennessee and in the quality of HCBS available in Tennessee. Following receipt of final CMS approval on September 22, 2021, the State is in the process of planning for implementation of each of these components. On August 23, 2021, the State submitted updated enrollment target ranges for ECF CHOICES for the remainder of the program year in anticipation of the additional enrollment planned. In addition, the State will work with CMS to secure any additional authority needed to implement the components of the HCBS spending plan described above (e.g., amending the demonstration to add Enabling Technology as a CHOICES benefit).

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 July – September 2021
Compared to the Two Previous Quarters

	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
No. of appeals received	5,136	4,869	4,663
No. of appeals resolved or withdrawn	5,423	4,636	4,931
No. of appeals taken to hearing	1,579	1,271	1,257
No. of hearings resolved in favor of appellant	44	41	42

Medical Service Appeals. Table 4 below presents a summary of the medical service appeals handled during the quarter, compared to the previous two quarters.

Table 4
Medical Service Appeals for July – September 2021
Compared to the Two Previous Quarters

	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
No. of appeals received	2,860	2,662	2,813
No. of appeals resolved	1,557	1,275	1,400
• Resolved at the MCC level	410	308	324
• Resolved at the TSU level	115	60	154
• Resolved at the LSU level	1,032	907	922
No. of appeals that did not involve a valid factual dispute	1,255	1,221	1,340
No. of directives issued	292	269	266

	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
No. of appeals resolved by fair hearing	1,111	1,008	1,035
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	324	282	299
Appeals that went to hearing and were decided in the State's favor	654	591	587
Appeals that went to hearing and were decided in the appellant's favor	54	34	36

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 July – September 2021
Compared to the Two Previous Quarters

	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
No. of appeals received	101	87	91
No. of appeals resolved or withdrawn	69	49	56
No. of appeals set for hearing	21	19	26
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 July-September 2021 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, July – September 2021

Grievance Category	Number of Grievances Received	Number of Grievances Resolved
Access and Availability	305	275
Attitude and Service	219	289
Billing and Financial Issues	120	155
Quality of Care/Quality of Service	157	240
Other	38	36
Total	839	995

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

In Tennessee, each agency of state government is authorized to operate for a set period of time, at the conclusion of which a Performance Audit (sometimes referred to as a "sunset audit") is conducted to determine whether the agency should be continued, restructured, or terminated. On September 14, 2021, the Tennessee Comptroller of the Treasury released a Performance Audit Report of selected programs and activities of the Division of TennCare. This sunset audit, which covers the period from July 1, 2019, through May 31, 2021, was designed to assist the Joint Government Operations Committee of the Tennessee General Assembly in determining whether the TennCare agency should continue in its current form past June 30, 2022, or whether it should be restructured or terminated. The audit ultimately identified no findings regarding TennCare's performance.

The summary report did include four observations regarding the TennCare program. These were:

1. Division management should continue their efforts to obtain reliable telehealth claims data to monitor and track the utilization of telehealth services.
2. Division management and the managed care organizations increased their Buprenorphine Enhanced Supportive Medication Assisted Recovery and Treatment (BESMART) provider network.[2]

[2] BESMART is a program of buprenorphine-based medication assisted treatment (MAT) for individuals with opioid use disorder (OUD).

3. Project Iris status, update.[3]
4. BlueCare's electronic visit verification system allowed personal care providers to override a system control, resulting in BlueCare paying unsupported claims.

In addition, the Performance Audit Report made note of three emerging issues:

1. Children who age out of the Katie Beckett program at their 18th birthday will lose services unless they qualify for services through adult programs.
2. While TennCare members' neonatal abstinence syndrome birth rates decreased in 2017, 2018, and 2019, division management expects an increase in neonatal abstinence syndrome births in 2020 due to the COVID-19 pandemic.
3. Once the public health emergency ends, Division of TennCare management will implement the established plan to renew members' eligibility.

All of the observations and emerging issues identified in the 2021 Performance Audit Report will inform TennCare's strategic planning. TennCare's 2021 Performance Audit Report will be attached to the upcoming Annual Monitoring Report for this Demonstration Year.

During the July-September 2021 quarter, the Division of TennCare was also 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.

Dowdy v. Smith Lawsuit. On March 12, 2021, TennCare member Shannon Dowdy filed suit in federal court against TennCare to obtain private duty nursing care on a 24-hours-a-day/7-days-a-week basis from his TennCare MCO. This level of services is not currently available to Mr. Dowdy under the TennCare program. The plaintiff had previously been receiving 24/7 nursing care through a combination of programs, with the majority of nursing hours furnished through a 1915(c) waiver program for individuals with intellectual disabilities, and the balance of hours provided by his MCO. Mr. Dowdy's complaint alleged that the services delivered through the 1915(c) waiver were insufficiently staffed, meaning that he was being denied necessary care. The plaintiff initially sought a preliminary injunction, but the parties reached an agreement for the provision of hours during the litigation that mooted the request for an injunction. The parties

[3] Project Iris is an ongoing project to modernize the State's Medicaid Management Information System (MMIS).

subsequently reached a resolution of the issues in the suit, and the case was dismissed on June 22, 2021.

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.

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 a timely appeal of the Chancery Court's ruling on September 29, 2020, and the appeal is currently being considered by the Tennessee Court of Appeals.

Erlanger Health System v. TennCare Lawsuit. This declaratory order action was commenced against TennCare 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. The action was later amended to seek invalidation of the related State Plan Amendments approved by CMS. This administrative declaratory order action has been on appeal to the Tennessee Court of Appeals for review of an evidentiary ruling. On March 3, 2021, the Court of Appeals issued an opinion affirming the lower court's ruling to exclude certain disputed documents. The case was remanded back to the agency for completion of the declaratory order process. A scheduling order has been entered providing for the parties to complete the briefing process by June 24, 2021, with an agency decision to follow within 90 days.

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. As of the end of the July-September 2021 quarter, the McCutchen suit had 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

The Tennessee General Assembly was not in session during the July-September 2021 quarter. Nonetheless, the State's next Quarterly Monitoring Report will address a Special Session in which the General Assembly participated in October 2021.

Public Forums

In compliance with the federal regulation at 42 CFR § 431.420(c) and the Special Terms and Conditions of the TennCare III Demonstration, the State hosted a public forum on July 6, 2021. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The July 6 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address at which comments would be accepted. Ultimately, approximately 80 sets of comments were received, some of which were presented verbally at the July 6 meeting, and others of which were submitted by mail or email. Most of the comments expressed concern with either the potential impact of the TennCare III Demonstration on members' abilities to access health care, or the effect on vulnerable populations of integrating care for individuals with intellectual disabilities into the managed care program (the subject of proposed Demonstration Amendment 1). A more comprehensive summary of comments received is available in Attachment A to this Quarterly Monitoring Report.

Enrollment and Member Month Data

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

Table 7
Enrollment Counts for the July – September 2021 Quarter
Compared to the Two Previous Quarters

Demonstration Populations	Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
EG1 Disabled	134,288	134,350	135,471
EG9 H-Disabled	638	660	643
EG2 Over 65	296	190	222
EG10 H-Over 65	40	35	33
EG3 Children	814,080	825,106	834,726
EG4 Adults	451,565	467,207	482,179
EG5 Duals and EG11 H-Duals 65	156,660	159,629	160,924
EG6E Expan Adult	0	0	0
EG7E Expan Child	1,171	1,229	1,373
EG8, Med Exp Child	0	0	0
Med Exp Child, Title XXI Demonstration Population	9,670	10,190	11,198
EG12E Carryover	1,569	1,460	1,393
EG13 Katie Beckett	22	52	75
EG14E Medicaid Diversion	611	783	916
EG15 Continued Eligibility	N/A	2	4
TOTAL*	1,570,610	1,600,893	1,629,157

*** 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 July – September 2021

Eligibility Group	July 2021	August 2021	September 2021	Sum for Quarter Ending 9/30/21
EG1 Disabled	136,489	135,741	134,663	406,893
EG2 Over 65	201	202	199	602
EG3 Children	826,009	829,325	832,270	2,487,604
EG4 Adults	469,890	475,377	480,070	1,425,337
EG5 Duals	150,719	150,706	150,748	452,173
EG6E Expan Adult	0	0	0	0

Eligibility Group	July 2021	August 2021	September 2021	Sum for Quarter Ending 9/30/21
EG7E Expan Child	1,293	1,347	1,364	4,004
EG8 Med Exp Child	0	0	0	0
EG9 H-Disabled	632	629	633	1,894
EG10 H-Over 65	31	32	30	93
EG11 H-Duals	6,742	6,733	6,731	20,206
Med Exp Child, Title XXI Demo Pop	10,744	10,995	11,201	32,940
EG12E Carryover	1,405	1,384	1,361	4,150
EG13 Katie Beckett	58	63	75	196
EG14E Medicaid Diversion	838	880	924	2,642
EG15 Continued Eligibility	2	2	4	8
TOTAL	1,605,053	1,613,416	1,620,273	4,838,742

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 July-September 2021 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
CHOICES 1	Not applicable	14,002	14,236	14,325
CHOICES 2	11,000	10,168	10,172	10,003
CHOICES 3 (including Interim CHOICES 3)	To be determined	2,153	2,119	2,095

[4] 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[4]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
Total CHOICES	Not applicable	26,323	26,527	26,423
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 June 2021.

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[5]	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 July-September 2021 Compared to the Two Previous Quarters

	Frequency and Use of Transition Allowances					
	Jan – Mar 2021		Apr – Jun 2021		Jul – Sep 2021	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	17	$9,259	12	$4,476	11	$5,207
Middle	21	$10,228	31	$13,948	27	$10,758
West	7	$3,677	23	$12,563	17	$6,500
Statewide Total	45	$23,164	66	$30,987	55	$22,465

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

[5] 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).

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 July-September 2021 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity[6]	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
ECF CHOICES 4	948	890	892	894
ECF CHOICES 5	1,656	1,555	1,580	1,591
ECF CHOICES 6	1,253.5	1,009	1,082	1,166
ECF CHOICES 7	35	30	30	30
ECF CHOICES 8	50	41	47	44
Total ECF CHOICES	3,942.5[7]	3,525	3,631	3,725
Reserve capacity	1,291	1,129	1,224	1,327
Waiver Transitions[8]	Not applicable	66	69	74

[6] Statewide enrollment targets and reserve capacity for this Program Year (State Fiscal Year 2022) 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.

[7] As provided in the revised enrollment target ranges submitted to CMS in April 2021, while the combined total of all upper limits is actually 4,000, 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.

[8] 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.

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.

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 July-September 2021 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jan – Mar 2021	Apr – Jun 2021	Jul – Sep 2021
Katie Beckett	247[9]	21	49	69
Medicaid Diversion	2,700	576	770	923
Continued Eligibility	N/A	N/A	2	4
Reserve capacity	247	21	49	69

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 one year after full program implementation, with trend data to follow on an annual basis thereafter.

Steps Taken to Ensure Compliance with Regulations Governing HCBS Settings

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

[9] 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 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). During the July-September 2021 quarter, an additional 147 slots for children who met Tier 2 requirements were added. All available slots for the Katie Beckett group (Part A) are Reserve Capacity slots.

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 B 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 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 July – September 2021 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 1,629,157 Tennesseans during the July – September 2021 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 July 2021, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the April-June 2021 quarter. The EQRO took a sample of provider data files from TennCare's MCCs[10] and reviewed each for accuracy in the following categories:

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

- 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" (95.2 percent accuracy), "provider specialty / behavioral health service code (95.1 percent accuracy), "services for children" (97.4 percent accuracy), "primary care services" (96.5 percent accuracy), and "prenatal care services" (98.4 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 second quarter of Calendar Year 2021.

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 October 2021, approximately 700,000 TennCare members are attributed to one of 79 PCMH-participating organizations, and 95.5 percent of these organizations' 449 sites are currently NCQA-PCMH-recognized. In addition, providers have recently been engaged with numerous trainings. In September 2021, more than 50 PCMH providers attended a webinar about improving antidepressant medication management and adherence, and subsequently 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 2,000 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 June 2021, the number of BESMART providers had nearly tripled, and the number of unique members served per month had grown to approximately 7,500. Additionally, buprenorphine covered by TennCare is now 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.).

During the July-September 2021 quarter, BCBER's process of gathering survey data from thousands of Tennessee households was completed, and analysis of the data commenced. Furthermore, BCBER began drafting a summary report addressing such topics as satisfaction with coverage from TennCare, the insurance status of Tennesseans, and the impact of COVID-19 on health care received by survey participants. This report was expected to be finalized and published during the October-December 2021 quarter.

Progress on Shared Savings Metric Set

On March 8, 2021, the State submitted measures for the Shared Savings Metric Set to CMS. 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 July-September 2021 quarter. The State's budget neutrality workbook will be submitted as a separate attachment to this Monitoring Report.

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 July – September 2021 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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Date Submitted to CMS: December 6, 2021

Attachment A:
Summary of Comments Received During the Public Forum on the Progress of the TennCare III Demonstration

From June 4, 2021, through July 9, 2021, the State held a public comment period on the progress of the TennCare III Demonstration. Feedback could be submitted throughout the public comment period via mail or email, or comments could be presented verbally during an in-person public forum held on July 6, 2021. The State received approximately 80 sets of comments from individuals and organizations during the public comment period. These comments are organized into three main topics and summarized below.

Services for Individuals with Intellectual Disabilities

A number of commenters expressed concern about the State's proposal to integrate services for members with intellectual disabilities into the larger TennCare managed care program (the subject of proposed Demonstration Amendment 1). In particular, several commenters expressed concern that benefits for individuals with intellectual disabilities would be reduced under managed care, or that members would no longer be able to obtain care from their preferred providers. Some commenters expressed the view that the planned transition to managed care is financially motivated and speculated that it could result in less access to HCBS.

The State thanks the commenters for the many thoughtful comments it received in response to its planned integration of services for individuals with intellectual disabilities into managed care, both during prior public comment periods and during this public forum. The State believes strongly that integrating services for individuals with intellectual disabilities into the managed care program will result in better alignment and coordination of care for these members. The demonstrated success of the CHOICES and Employment and Community First CHOICES MLTSS programs are a clear indication of the promise of this integrated approach to care delivery.

As with all TennCare populations and as required under federal regulations, MCOs will be required to contract with a network of qualified providers that is sufficient to provide care to their members and will be required to provide all medically necessary care in accordance with the member's plan of care. The State is committed to rigorous monitoring and oversight of its contracted MCOs in order to ensure that members have adequate access to and receive medically necessary services. As noted in response to prior public comment periods, the State does not intend to utilize a capitation (or risk)-based payment for these services at this time. Using flexibility provided under federal regulations, MCOs will be reimbursed for the services they provide, such that there is no incentive to reduce or deny services. The State will continue to evaluate the payment approach going forward, and should a risk-based payment approach be adopted in the future, will establish actuarially sound rates, with sufficient checks and balances to ensure that individuals continue to receive the services they need to live successfully in the community and achieve their individualized goals.

One commenter opposed the transition of HCBS to managed care because it would bolster reliance on consumer direction (viewed as akin to a stressful job). Other commenters expressed concern that the State's emphasis on competitive, integrated employment for persons with disabilities was inappropriate for beneficiaries enrolled in 1915(c) waivers, or that the MCOs would be incentivized to

focus resources on individuals most likely to achieve desired employment outcomes. Some commenters expressed concern that employment would be mandatory for all individuals enrolled in 1915(c) waivers. Another commenter noted that the State's emphasis on employment for individuals with ID would increase their income, thereby placing their eligibility for TennCare at risk.

Mandatory employment is not a feature of the State's proposal to transition services for individuals with intellectual disabilities into managed care. The State believes strongly in the value of competitive, integrated employment for all persons, and in providing meaningful opportunities for individuals with disabilities to identify and work toward their own education, employment, and/or community living goals. The State notes that it is concurrently seeking CMS approval of a Medicaid State Plan Amendment to disregard a significant amount of earned income for members enrolled in 1915(c) HCBS waivers, thus helping to ensure that members who are successful in achieving their employment-related goals are not at risk of losing their Medicaid eligibility. No members will be required to participate in consumer direction.

Some commenters expressed concern about the timing of the State's proposal to integrate services for individuals with intellectual disabilities into managed care. Some commenters perceived the timing to be accelerated (or "rushed"). Others suggested that integrating services for individuals with intellectual disabilities should not be implemented during a pandemic. Several commenters viewed the transition as especially problematic in light of staffing shortages in providers' offices caused by the pandemic.

The State respectfully disagrees with commenters suggesting that the planned implementation of managed care for HCBS has been rushed. The State's Medicaid agency and Department of Intellectual and Developmental Disabilities have worked diligently to plan the transition for many months, including extensive readiness review activities with the MCOs and with multiple opportunities for stakeholder input and engagement throughout the planning process. The State also believes the transition to managed care can be implemented safely and effectively under current conditions and does not believe it is in the best interests of the State or its Medicaid beneficiaries to postpone the implementation of managed care indefinitely due to the COVID-19 pandemic. The State acknowledges that there is currently a national need for qualified direct support professionals (DSPs) and other healthcare professionals, both prior to and during the COVID-19 public health emergency. Under the State's proposed managed care integration, MCOs will be required to contract with a network of providers that is sufficient to provide medically necessary services to all members in accordance with the member's plan of care. This includes continuity of existing services and providers for an initial period following implementation. The State is committed to continuing its work with healthcare providers, individuals with disabilities and their families, the advocacy community, and other stakeholders to identify strategies to strengthen the HCBS workforce.

Several commenters criticized the State's public notice process regarding proposed Demonstration Amendment 1 (entailing the integration of services for members with intellectual disabilities into the larger TennCare managed care program). These individuals suggested that many individuals affected by the proposal were unaware of it, and that the details of the proposal offered by the State were limited.

The State disagrees with these comments. The State notes that it held two public comment periods on the changes proposed in Amendment 1, from November 9 through December 11, 2020, and from February 22 through March 5, 2021. Both of these public comment periods entailed notices on the State's website, notices in major newspapers across the state, and public hearings. In addition, members of the public had opportunities to comment on corresponding amendments to the State's 1915(c) waivers. The State disagrees with commenters suggesting that its public notice processes were insufficient. The State has received numerous public comments on its proposal to integrate services for individuals with intellectual disabilities into managed care, and the State thanks the many individuals and organizations who have taken time to provide input.

Impact of the TennCare III Demonstration

A number of commenters expressed concern about the impact that the TennCare III Demonstration could have on members' ability to access health care. Several commenters, for example, suggested that the "shared savings" component of TennCare III incentivizes the State to limit spending on medical care, either by reducing benefits, or by not increasing reimbursement rates for TennCare providers, or even by disenrolling people from TennCare. Several commenters speculated that TennCare III will lead to negative outcomes for vulnerable populations, generally in the form of reduced access to care or benefit reductions. One commenter urged the State to introduce assurances in the TennCare III Demonstration that provider reimbursement rates would not be reduced in the future.

The State appreciates the many thoughtful comments it received about the accessibility and quality of care available under the TennCare Demonstration. The State, like these commenters, is committed to ensuring that TennCare provides high-quality care to members that improves health outcomes. The State, however, respectfully disagrees that the TennCare III Demonstration will lead to reductions in access to coverage or benefits. While the impact of TennCare III (like all Medicaid demonstration projects) must be evaluated over time, no such reductions have occurred since the approval of TennCare III. Likewise, the State emphatically disagrees that implementation of TennCare III in January of this year has led to harm for vulnerable populations or any Medicaid beneficiary in Tennessee. The State believes strongly that the TennCare III Demonstration establishes a framework in which additional resources can be invested into the TennCare program to enhance coverage, benefits, quality of care, and health outcomes. As a 100 percent managed care program, the State generally does not establish reimbursement rates for services provided under the demonstration; however, the State disagrees that there is anything inherent to the TennCare Demonstration that either incentivizes provider rate reductions or makes such reductions more likely.

Some commenters anticipated TennCare III's aggregate cap would not keep pace with the needs of the TennCare population (especially the aging segment of that population known as "baby boomers"), and that program reductions would inevitably result. One commenter characterized TennCare III's financing model as capped funding that could not be adjusted if there were an economic downturn, a natural disaster, or any other crisis requiring greater Medicaid expenditures. Other commenters observed that the financing model contained in the TennCare III Demonstration had been opposed by some

stakeholders prior to implementation, and concluded—as a result—that it should never have been implemented. Some commenters opined that the lower budget neutrality cap implemented for TennCare III ensures that shared savings obtained by the State will be meager and, therefore, inadequate to achieve meaningful investments in health. One of these commenters encouraged the State to seek a less restrictive budget neutrality cap from the new presidential administration.

The State appreciates the comments it received on the financing and budget neutrality aspects of the TennCare III Demonstration. Under the demonstration's STCs, the State's budget neutrality expenditure limit is adjusted for inflation and for population growth, with provisions that allow for additional adjustments due to unforeseen circumstances outside of the State's control, such as a public health crisis or major economic event. The State is confident that the budget neutrality framework for the TennCare III Demonstration is reasonable and that it adequately accounts for factors such as increases in TennCare enrollment and medical inflation. The State believes that the budget neutrality framework is an effective basis for the TennCare III Demonstration and does not intend to seek any adjustments at this time.

Multiple commenters suggested that, rather than continue implementation of TennCare III, the State focus on the needs of individuals with intellectual and developmental disabilities by eliminating waiting lists for HCBS services. Other commenters expressed concern the TennCare III Demonstration was not being used to expand TennCare eligibility to additional populations, such as individuals whose income is too high for them to qualify for Medicaid but too low to qualify for subsidized coverage on the health insurance exchange.

The State thanks these commenters for their comments and shares their concern for enhancing coverage. While these commenters expressed a belief that implementation of TennCare III stands in opposition to expanding coverage, this is not the case. Since the implementation of TennCare III in January 2021, the State has begun implementing plans to add 2,000 new slots to Employment and Community First CHOICES (the State's MLTSS program for individuals with intellectual or developmental disabilities), halving the program's referral list. (While the initial funding for these new program slots comes in part from funds appropriated under the American Rescue Plan Act, those funds are time-limited. Individuals' ongoing enrollment in Employment and Community First CHOICES will be predicated on the programmatic flexibilities and structures available under TennCare III.) In addition, the State is proceeding with plans to expand coverage of adopted children under the demonstration. It is anticipated that these are first of a number of potential expansions in coverage possible under TennCare III.

Some commenters expressed doubt that shared savings achieved by the State under the demonstration would be reinvested in the TennCare program, suggesting that there were inadequate rules and a lack of transparency about how the money in question would be spent.

Whether TennCare III ultimately leads to enhancements in Medicaid coverage and benefits is a key question in determining whether or not TennCare III is an effective framework for organizing a state's Medicaid program. The State believes strongly that TennCare III provides an effective framework for such enhancements and has committed publicly multiple times that shared savings achieved under the

TennCare III Demonstration will be used for the benefit of the TennCare program. As noted in this public forum, the State has already planned a number of near-term enhancements to coverage and benefits under TennCare III. These include (1) extending Medicaid postpartum coverage, (2) establishing a dental benefit for pregnant and postpartum women, (3) establishing a chiropractic benefit for adults, and (4) enhancing Medicaid coverage of adopted children in Tennessee, with longer-term goals to include eliminating all waiting lists for Medicaid HCBS programs. The State believes these are the first of what will be many opportunities to enhance coverage and benefits under the TennCare III Demonstration. In terms of transparency, the State notes that changes to Medicaid coverage and benefits continue to be subject to federal public notice requirements (as specified in the demonstration's STCs), the administrative rulemaking process, and the state budget process, in addition to other regular opportunities for public input (such as this public forum). Stakeholder input and transparency continues to be an important priority for TennCare.

A number of commenters objected to the pharmacy flexibilities granted to the State by the TennCare III Demonstration, with particular emphasis on the flexibility to operate a closed drug formulary. Concerns tended to focus on the possibility that TennCare members would be denied life-saving medications on the grounds that less expensive, less effective medications in the same drug classes would be available. Other commenters questioned the authority granted to the State to operate a closed formulary while simultaneously receiving rebates from drug manufacturers.

Both prior to and following the approval of TennCare III, both the State and CMS have given significant consideration to the concerns of some stakeholders regarding TennCare's pharmacy flexibilities. In requesting this flexibility, the State has always affirmed that maintaining the highest standard of patient care and ensuring access to medically necessary medications remain the State's paramount concern even with the potential introduction of a closed formulary. In approving this flexibility, CMS has established firm "guardrails" and protections around the use of this flexibility to ensure that Medicaid beneficiaries continue to access needed medications. These include, but are not limited to: (1) limiting the application of the closed formulary to adults age 21 and older; (2) requiring the State's formulary to meet the standards for Essential Health Benefit plans, which will align the State's coverage with requirements for plans in the individual insurance market and the standards that are applicable to Medicaid Alternative Benefit Plans under Section 1937 of the Social Security Act; and (3) requiring the State's formulary to comply with statutory requirements for coverage of mental health medications, agents used in medication-assisted treatment, and other protected class drugs. Most notably, under the TennCare III Demonstration, the State must maintain an exception process for beneficiaries to request and gain access to clinically appropriate drugs not on the State's formulary, thus ensuring that beneficiaries are able to access all necessary and appropriate drugs, regardless of the drug's formulary status. These protections ensure that beneficiaries will continue to have access to needed medications.

Some commenters expressed opposition to the flexibility granted to the State by the TennCare III Demonstration to temporarily suspend the Medicaid eligibility of a TennCare member convicted of Medicaid fraud. These commenters believed that the policy does not further the purposes of the

Medicaid Act and that other legal remedies are already available to punish individuals found guilty of Medicaid fraud.

The State respectfully disagrees with these commenters. The State does not believe it is unreasonable that some meaningful accountability should be in place for individuals who abuse Medicaid benefits. Under the terms of the demonstration, any suspension for fraud is limited to no more than 12 months, and individuals subject to this policy will receive all relevant protections, including advance notice of their suspension and their right to appeal any suspension implemented under this policy. This policy will enhance the integrity of the Medicaid program, helping to ensure the appropriate use of public resources dedicated to assisting needy individuals and families, while also providing robust beneficiary protections. This policy is also broadly consistent with existing policy under Section 1128 of the Social Security Act to exclude individuals convicted of fraud from the Medicaid program.

A number of commenters objected to the ongoing waiver of retroactive eligibility contained in the TennCare III Demonstration. Although the waiver no longer applies to pregnant or postpartum women or to children (effective June 30, 2021), commenters opposed the existence of the waiver altogether. These commenters indicated that retroactive eligibility is a means for individuals diagnosed with a serious health problem to obtain medical care without incurring substantial debt, either prior to applying for TennCare coverage, or after having temporarily lost TennCare coverage. They also cited the benefits of retroactive eligibility for providers, who would be compensated for services that would otherwise likely go unpaid.

The State thanks these commenters for their comments. The State's longstanding policy of beginning coverage on the day of an individual's application is reasonable and necessary for the State to meaningfully manage the care of its members (a key goal of the TennCare Demonstration). In fact, contrary to the State's and CMS' goal of promoting coverage and preventative care, retroactive eligibility incentivizes individuals to delay applying for coverage until they experience a serious health care event. In the decades that the State's policy has been in place, the State has adopted a number of strategies to help ensure that individuals applying for coverage can access care quickly, which include: (1) the use of presumptive eligibility for a number of populations, and (2) partnerships with nursing facilities, hospitals, and other medical institutions to facilitate the timely submission of applications when needed. The efficiencies realized as a direct result of the retroactive eligibility waiver have contributed to expansions of coverage and benefits under the TennCare Demonstration.

A few commenters expressed concern that the new demonstration project could result in TennCare's managed care program being released from federal regulations governing managed care arrangements in Medicaid. This possibility was viewed as a threat to the actuarial soundness of the State's managed care program. Other commenters objected to the managed care system altogether, characterizing TennCare MCOs as motivated primarily by financial gain and describing difficulties for members in obtaining services.

These commenters are incorrect. Nothing in the TennCare III Demonstration purports to waive the regulations governing Medicaid managed care programs.[1] Under the TennCare Demonstration, Tennessee continues to be subject to these regulations. The State disagrees with commenters objecting to the use of Medicaid managed care in general. Under the TennCare Demonstration, Tennessee has long demonstrated that the use of managed care promotes the delivery of care that is both high-quality and cost-effective.

Several commenters objected to the ten-year approval period of the TennCare III Demonstration. An approval period of three or five years was generally viewed as preferable by these commenters, since it would require the State not only to solicit feedback from the public more often, but also to change course on policies that had proven ineffective or counterproductive.

The State respectfully disagrees with these commenters. The policies envisioned and authorized under TennCare III—including (1) monitoring state expenditures relative to the State's budget neutrality model, (2) determining the amount (if any) of shared savings/DSIP funding the State may be eligible to access based on its performance in the prior year, (3) investing those savings to improve Medicaid coverage and benefits under the demonstration, and (4) evaluating the impact of those investments and making adjustments and refinements—are inherently policies that will take time to fully implement and evaluate. The 10-year approval of TennCare III thus creates a framework that allows (and in fact incentivizes) the State to implement long-term strategies for reforming the service delivery system and improving health outcomes in a way that is simply not possible when a state's demonstration authority is limited to as little as three years. By their nature, healthcare interventions are complex and take time to plan, implement, and demonstrate results. The 10-year approval of TennCare III acknowledges this reality, while still providing a meaningful framework for monitoring and oversight.

The State notes that the TennCare III Demonstration provides a robust framework for transparency and oversight, including multiple mechanisms to ensure ongoing transparency, communication, and opportunities for stakeholder input. These include the following:

- At least annually, the State will host a forum at which members of the public have an opportunity to comment or otherwise provide input on the progress of the demonstration (STC 61);
- Any changes to the demonstration must go through a prescribed public notice and input process prior to implementation; notably, this includes even program changes not otherwise subject to the demonstration amendment process (STCs 6, 7, and 12);
- The State will submit regular monitoring reports to CMS (available publicly online) and participate in monitoring calls with CMS at least monthly (STCs 56 and 60); and
- The State will produce interim evaluation reports throughout the life of the demonstration to ensure the demonstration is on track to achieve its intended goals; each evaluation report must be made publicly available on the State's website (STCs 94 and 95).

[1] The TennCare III Demonstration continues a longstanding waiver of 42 CFR § 438.52 to allow the State to contract with one pharmacy benefits manager and one dental benefits manager.

The State welcomes public input on all aspects of its Medicaid program and the TennCare Demonstration and is committed to working closely with CMS and other stakeholders over the life of the demonstration to provide opportunities for public input and to ensure that the demonstration adequately meets the needs of Medicaid beneficiaries in Tennessee.

One commenter supported a number of facets of the TennCare III Demonstration approved by CMS, including—

- **Greater administrative flexibility, since states are most capable of assessing the needs of their Medicaid populations;**
- **Requirements that flexibilities not be used to limit coverage or services;**
- **Guarantees that shared savings will be reinvested in the TennCare program; and**
- **Opportunities for public input on proposed program changes.**

The State thanks the commenter for these comments.

The Public Forum

Some commenters criticized the State's public notice and transparency process for the July 6 public forum on the progress of the TennCare Demonstration. Commenters recommended variously that the date, time, and location of future forums be publicized differently on the State's website; that the State provide online streaming options to facilitate remote participation in future forums; that the State hold more frequent public forums on the progress of the TennCare Demonstration; that the State develop an email distribution list to notify interested persons about future forums and other TennCare-related matters; and that the State provide more granular information at future forums to help members of the public better understand what kind of progress is actually being achieved by TennCare III.

The State will take these recommendations into consideration in planning future forums on the progress of the TennCare Demonstration.

Attachment B:
Health and Welfare of HCBS Participants

During the July-September 2021 quarter, the State continued all efforts to ensure the health and wellbeing of persons served across all LTSS programs. These efforts include movement towards implementation of an aligned Reportable Event Management system for all populations served in the 1115 Waiver. Effective September 1, 2021, all ECF CHOICES providers began reporting Reportable Events to the Department of Intellectual and Developmental Disabilities (DIDD) using an aligned Reportable Event Form. In addition, this form and aligned process is required for providers who also participate in the CHOICES program, effective September 1, and these providers are required to be trained and completing Tier 2 Reportable Event Investigations no later than October 1, 2021. However, CHOICES-only providers are permitted to continue operating in the Critical Incident system until January 1, 2022, at which time all Reportable Event Management will be fully aligned under the subject matter expertise of DIDD and TennCare jointly. In addition, as detailed below, the State continues its efforts through the current systems, reports, and audits until such time as full alignment in the new system is achieved.

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 Critical Incident and Reportable Event Quarterly Reports track all critical incidents by incident 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.

- Follow up is completed with MCOs and providers regarding Emergency Department Utilization of 1115 members. Part of the follow-up that is performed as a result of these reports is to ensure serious incidents associated with hospital visits and unplanned hospitalizations are reported.

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.