Division of TennCare

Tennessee Department of Finance & Administration

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Quarterly Monitoring Report

(For the period July – September 2022)

Demonstration Year: 2 (1/1/22- 12/31/22)
Federal Fiscal Quarter: 4/2022 (7/22 - 9/22)
Demonstration Quarter: 3/2022 (7/22 - 9/22)

December 6, 2022

TennCare III Monitoring Report

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

Key Dates of the Demonstration Quarter

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

Table 1
Key Dates of Approval/Operation in the Quarter

Date	Action	STC #
7/1/22	The State submitted to CMS updated operational procedures for determining individuals for whom reserve slots will be held in the CHOICES and Employment and Community First CHOICES programs.	33.d.iv.A and 34.d.iv.A
7/13/22	CMS sent the State written feedback on its draft Evaluation Design.	90
7/19/22	The State notified the public of its intent to submit to CMS an amendment to the TennCare III demonstration. Amendment 4 would effectuate certain modifications to the demonstration requested by CMS that relate to budget neutrality, reinvestments in the TennCare program, and pharmacy benefits.	7, 12
7/28/22	The Monthly Call for July was held.	60
7/29/22	CMS approved Statewide MCO Contract Amendment 15 and TennCare Select Contract Amendment 51.	43
8/2/22	The State submitted a revised DSIP Claiming Protocol that incorporated feedback received from CMS.	32.m

Date	Action	STC #
8/25/22	The Monthly Call for August, which would have been held on this date, was cancelled.	60
8/30/22	The State submitted Demonstration Amendment 4 to CMS.	
9/2/22	The State submitted to CMS the Quarterly Monitoring Report for the April – June 2022 quarter.	56
9/9/22	The State submitted a revised Evaluation Design that incorporated feedback received from CMS.	91
9/22/22	The Monthly Call for September, which would have been held on this date, was cancelled.	60
9/23/22	The State notified the public of its intent to cover dental services for all adults enrolled in TennCare effective January 1, 2023.	6

I. Operational Updates

Progress Towards Milestones

The TennCare III Demonstration continues a number of program components from the prior iteration of the TennCare Demonstration that are already in operation. In addition, TennCare III includes some new programmatic flexibilities and authorities. In terms of new flexibilities authorized under TennCare III, the State has completed various milestones during Demonstration Year 1, including the submission of the Shared Savings Quality Measures Protocol on March 8, 2021; the submission of the draft Implementation Plan on April 8, 2021, and the revised Implementation Plan on August 16, 2021; the submission of the Demonstration Monitoring Protocol on June 7, 2021; the submission of the DSIP Claiming Protocol on June 30, 2021; and the submission of the draft Evaluation Design on July 7, 2021. Over the course of the last two quarters, CMS provided feedback on three of these documents: the Demonstration Monitoring Protocol (on May 31, 2022), the DSIP Claiming Protocol (on June 17, 2022), and the Evaluation Design (on July 13, 2022). The State, in turn, submitted a revised version of the DSIP Claiming Protocol to CMS on August 2, 2022, and a revised version of the Evaluation Design on September 9, 2022. An updated version of the Demonstration Monitoring Protocol is planned for submission during the October-December 2022 quarter.

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

Demonstration Amendment 1 (Services for Persons with Intellectual Disabilities)

In addition, during the July-September 2022 quarter, CMS continued to review a demonstration amendment designed to improve the alignment between the various types of care that TennCare

enrollees with intellectual disabilities receive. Currently, these enrollees receive their medical/surgical and behavioral healthcare from MCOs through the managed care program authorized under the Demonstration, and their LTSS outside of managed care. Demonstration Amendment 1 would entail the following modifications to the TennCare program:

- Integration of services for members with intellectual disabilities into the TennCare managed care program[1];
- Transitioning the care of children receiving Supplemental Security Income (SSI) benefits from the TennCare Select health plan to one of the other health plans that serves TennCare members; and
- Assigning to the TennCare Select health plan certain inmates of public institutions who receive inpatient services in a setting located outside the public institution.

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

Demonstration Amendment 2 (Coverage of Adopted Children)

On April 8, 2022, the State submitted another proposed demonstration amendment to CMS. In Amendment 2, the State requests authority to extend TennCare coverage to children adopted from state custody in Tennessee who do not otherwise qualify for Medicaid (e.g., do not qualify for IV-E adoption assistance or non-IV-E adoption assistance). Extending TennCare coverage to these children will remove a potential barrier to adoption, as well as promote greater continuity of care for these children as they transition from foster care to permanent homes. Amendment 2 was under CMS review as of the end the July-September 2022 quarter.

Demonstration Amendment 3 (HCBS Enhancements)

During the July-September 2022 quarter, the State held a public notice and comment period on another proposed amendment to the TennCare III demonstration. Amendment 3 would codify certain enhancements to the HCBS available under the TennCare demonstration via the CHOICES and ECF CHOICES programs. The specific changes proposed in Amendment 3 are:

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

[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).

The State's public comment period on Amendment 3 lasted from June 29 through August 1, 2022. As of the end of the July-September 2022 quarter, the amendment was being finalized for submission to CMS in October 2022.

Demonstration Amendment 4 (Modifications to TennCare III Requested by CMS)

On June 30, 2022, the State received a letter from CMS regarding the TennCare III demonstration. The CMS letter requested that the State submit a demonstration amendment to effectuate a limited number of modifications to the demonstration.

In response, the State submitted a demonstration amendment ("Amendment 4") to address the following areas identified by CMS:

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

Amendment 4 was submitted to CMS on August 30, 2022. As of the end of the July-September 2022 quarter, CMS's review of the amendment was ongoing.

Policy or Administrative Difficulties in Operating the Demonstration

There were no significant administrative difficulties in operating the demonstration 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, and
- Demonstration Amendment 2, which would extend TennCare coverage to children adopted from state custody who do not receive federal or state adoption assistance.

Key Challenges During the Quarter

Throughout the July-September 2022 quarter, the State continued to address the threat to public health and safety posed by the novel coronavirus disease 2019 (or "COVID-19"). As the agency in Tennessee state government responsible for providing health insurance to more than 1.7 million individuals, the Division of TennCare has developed a multilayered response to the COVID-19 emergency. Working in tandem with partners and stakeholders at the federal and state levels, TennCare designed and deployed a strategy consisting of such elements as—

- Coordinating with the provider community and TennCare's health plans to ensure access to care for TennCare members in need of testing or treatment for COVID-19;

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

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

Key Achievements During the Quarter

During the quarter, the State made preparations to cover dental services for all adults enrolled in TennCare. 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 re-opening the CHOICES At Risk Demonstration Group to new enrollment.

Dental Services for Adults. On September 23, 2022, the State launched a public notice and comment period on a significant change to the TennCare program. Effective January 1, 2023, the State will cover dental services for all adults enrolled in TennCare. (Currently, dental services are covered for children under age 21, pregnant and postpartum women, and certain adults receiving long-term services and supports.) Dental benefits covered for adults age 21 and older will include services from nearly 20 categories, including—but not limited to—diagnostic x-rays and exams, preventive cleanings, restorative (fillings), crowns, partial dentures, complete dentures, tooth extractions, and palliative treatment.

As of the end of the July-September 2022 quarter, the State's public notice and comment period was scheduled to last through October 24, with formal notification to CMS expected to follow shortly thereafter.

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

The State's program contains three parts:

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

The new Katie Beckett/Medicaid Diversion program began accepting self-referral forms from interested families on November 23, 2020. As of the last day of the July-September 2022 quarter, a total of 1,931 children were enrolled in the program, with 152 enrolled in Katie Beckett (Part A), 1,779 enrolled in Medicaid Diversion (Part B), and no one enrolled in Continued Eligibility (Part C). See additional discussion of TennCare's Katie Beckett/Medicaid Diversion program below.

Re-Opening of CHOICES At Risk Demonstration Group. One change to the TennCare program contained in the budget passed by the Tennessee General Assembly for State Fiscal Year 2022 entails re-opening enrollment in a demonstration population within the CHOICES program. CHOICES, which provides managed long-term services and supports (MLTSS) for persons who are elderly or who have physical disabilities, consists of three benefit groups. CHOICES Groups 1 and 2 provide assistance to individuals who meet TennCare's level of care criteria for nursing facility care and receive either LTSS in a nursing facility (Group 1) or home- and community-based services (HCBS) in lieu of nursing facility care (Group 2). CHOICES Group 3, by contrast, consists of adults who do not meet TennCare's level of care criteria for nursing facility care but who, absent additional supports, are considered at risk of needing institutional care. These individuals receive a targeted package of HCBS intended to prevent or delay the need for nursing facility care.

Under the terms of the TennCare demonstration, CHOICES Group 3 is open to individuals who are eligible for Medicaid as SSI recipients and to non-Medicaid-eligible individuals who qualify in

the CHOICES At Risk Demonstration Group. The CHOICES At Risk Demonstration Group provides a pathway for individuals who are not otherwise eligible for Medicaid to be eligible for TennCare and to receive CHOICES Group 3 HCBS. The CHOICES At Risk Demonstration has been closed to new enrollment since June 30, 2015. On June 8, 2022, the State announced its intent to re-open the group to 1,750 new enrollees beginning on October 1, 2022. A public notice and comment period was held on the planned changes from June 8 through July 8, 2022. The State provided formal notification to CMS on July 29, 2022, and CMS acknowledged the changes on September 22, 2022. Implementation began as planned on October 1, 2022.

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 2022
Compared to the Two Previous Quarters

	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
No. of appeals received	5,389	5,778	6,050
No. of appeals resolved or withdrawn	5,556	5,898	6,416
No. of appeals taken to hearing	1,016	1,052	858
No. of hearings resolved in favor of appellant	21	29	22

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 2022
Compared to the Two Previous Quarters

	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
No. of appeals received	2,822	3,070	2,952
No. of appeals resolved	1,361	1,553	1,498
• Resolved at the MCC level	393	489	418
• Resolved at the TSU level	114	106	107
• Resolved at the LSU level	854	958	973
No. of appeals that did not involve a valid factual dispute	1,339	1,445	1,481
No. of directives issued	241	251	261

	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
No. of appeals resolved by fair hearing	877	972	988
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	278	321	361
Appeals that went to hearing and were decided in the State's favor	535	601	566
Appeals that went to hearing and were decided in the appellant's favor	41	36	46

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 2022
Compared to the Two Previous Quarters

	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
No. of appeals received	75	81	85
No. of appeals resolved or withdrawn	56	64	57
No. of appeals set for hearing	19	19	18
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 2022 quarter. It should be noted that grievances may be resolved in a quarter other than the one in which they are received.

Table 6
Most Common Grievance Categories and Totals, July – September 2022

Grievance Category	Number of Grievances Received	Number of Grievances Resolved
Access and Availability	192	159
Attitude and Service	454	432
Billing and Financial Issues	275	269
Quality of Care/Quality of Service	205	227
Other	22	2
Total	1,148	1,089

Each time an enrollee contacted the State or a managed care contractor to voice a complaint, the grievance was logged, and steps were taken to address the enrollee's concern. TennCare and the managed care contractors review issues, complaints, and grievances raised by enrollees to inform quality improvement efforts.

Audits, Investigations, or Lawsuits that Impact the Demonstration

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

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

EMCF v. TennCare Lawsuit. In September 2018, Emergency Medical Care Facilities, P.C., filed a complaint for declaratory judgment and injunctive relief against the Division of TennCare in Davidson County Chancery Court. The suit relates to a $50 cap imposed by the agency on payment for emergency room physician services determined to be non-emergent. The parties filed cross-motions for summary judgment, and, on September 1, 2020, the Chancellor granted summary judgment to EMCF on their claim that the $50 cap was void. EMCF then voluntarily dismissed their remaining claims pertaining to the determination of payment for the services in question. The State filed an appeal, and, on October 7, 2021, the Court of Appeals ruled in the

State's favor and reversed the trial court's ruling. The Court of Appeals found that the reimbursement limit fell within the internal management exception of a rule and was not subject to rulemaking requirements. EMCF then filed an application for permission to appeal to the Tennessee Supreme Court, and this application was accepted. Briefing on the appeal has been completed, and—as of the end of the April-June 2022 quarter—the parties were awaiting the scheduling of oral arguments.

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

M.A.C., et al. v. Smith Lawsuit. On July 2, 2021, 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. This motion was denied on December 20, 2021, and the parties are currently engaged in extensive discovery.

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

Rhythm Health Tennessee, Inc. v. State Protest Committee, et al. Lawsuit. On September 12, 2022, Rhythm Health Tennessee, Inc., filed a Petition for Writ of Certiorari in the Davidson County Chancery Court against several parties, including TennCare, the Central Procurement Office, and the State Protest Committee. The petition challenges the Protest Committee's decision to deny the protest by Rhythm and uphold TennCare's award of its Managed Care Organization (MCO) contracts. The Tennessee Attorney General's office, acting on behalf of the state defendants, filed a timely answer to the petition and the litigation remains pending.

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 2022 quarter. The next legislative session is expected to commence in January 2023.

Public Forums

The State's most recent public forum was held on June 30, 2022. A summary of feedback received during the forum was included in the Monitoring Report for the April-June 2022 quarter that was submitted to CMS on September 2, 2022.

Enrollment and Member Month Data

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

Table 7
Enrollment Counts for the July – September 2022 Quarter
Compared to the Two Previous Quarters

Demonstration Populations	Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
EG1 Disabled	135,299	135,716	134,771
EG9 H-Disabled	685	673	699
EG2 Over 65	283	287	286
EG10 H-Over 65	33	37	35
EG3 Children	851,028	859,756	868,615
EG4 Adults	511,025	524,001	538,183
EG5 Duals and EG11 H-Duals 65	162,427	164,596	165,254
EG6E Expan Adult	0	0	0
EG7E Expan Child	1,289	1,513	1,580
EG8, Med Exp Child	0	0	0
Med Exp Child, Title XXI Demonstration Population	11,896	11,142	11,247
EG12E Carryover	1,256	1,174	1,128
EG13 Katie Beckett	149	155	155
EG14E Medicaid Diversion	1,238	1,509	1,802
EG15 Continued Eligibility	0	0	0
TOTAL*	1,676,608	1,700,559	1,723,755

*** 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 nearly 82 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 2022

Eligibility Group	July 2022	August 2022	September 2022	Sum for Quarter Ending 9/30/22
EG1 Disabled	135,610	134,913	134,131	404,654
EG2 Over 65	266	263	271	800
EG3 Children	859,934	863,480	864,992	2,588,406
EG4 Adults	525,880	531,228	535,516	1,592,624
EG5 Duals	155,785	156,080	156,229	468,094
EG6E Expan Adult	0	0	0	0
EG7E Expan Child	1,517	1,550	1,568	4,635
EG8 Med Exp Child	0	0	0	0
EG9 H-Disabled	661	683	694	2,038
EG10 H-Over 65	32	29	30	91
EG11 H-Duals	6,492	6,475	6,460	19,427
Med Exp Child, Title XXI Demo Pop	11,048	11,119	11,190	33,357
EG12E Carryover	1,140	1,123	1,105	3,368
EG13 Katie Beckett	154	154	153	461
EG14E Medicaid Diversion	1,591	1,705	1,797	5,093
EG15 Continued Eligibility	0	0	0	0
TOTAL	1,700,110	1,708,802	1,714,136	5,123,048

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 2022 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity[2]	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
CHOICES 1	Not applicable	14,166	14,317	14,271
CHOICES 2	11,000	9,651	9,711	9,654
CHOICES 3 (including Interim CHOICES 3)	To be determined	2,041	2,068	2,063
Total CHOICES	Not applicable	25,858	26,096	25,988
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. Nineteen separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and June 2022.

Taken together, the reports depict a program evolving according to the characteristics of LTSS recipients, with institutional care available to individuals with the highest acuity of need, and Home- and Community-Based Services (HCBS) available to individuals whose needs can be safely and effectively met at home or in other non-institutional settings. Point-in-time data revealed declining use of Nursing Facility (NF) services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 14,236 individuals on June 30, 2021. 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 62 percent admitted to NFs in the eleventh 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 eleven years later. In addition, transitions of individuals from NFs to HCBS settings increased over time as well, with 129 such transitions

[2] Of the three active CHOICES groups, only CHOICES 2 has an enrollment target. An enrollment target for CHOICES 3 has not been set at this time.

occurring during the year prior to CHOICES implementation, and 697 transitions happening in the eleventh year of the program.

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 14,401 after CHOICES had been in place for eleven 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 12,291 by June 30, 2021. The percentage of LTSS expenditures devoted to HCBS grew as well, rising from 9.75 percent in the year prior to CHOICES, to 21.11 percent after the CHOICES program had been in place for eleven 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), 7/1/20 – 6/30/21	Percent increase over a ten-year period	No. of TennCare enrollees accessing HCBS (E/D) on the day prior to CHOICES implementation	No. of TennCare enrollees accessing HCBS (E/D) on 6/30/21	Percent increase from the day prior to CHOICES implementation to 6/30/21
6,226	14,401	131%	4,861[3]	12,291	153%

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.

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

Table 11
CHOICES Transition Allowances
for July-September 2022 Compared to the Two Previous Quarters

Grand Region	Frequency and Use of Transition Allowances					
	Jan – Mar 2022		Apr – Jun 2022		Jul – Sep 2022	
	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	13	$6,702	13	$7,314	15	$7,672
Middle	17	$9,955	26	11,130	14	$4,350
West	10	$4,669	18	$6,407	17	$5,859
Statewide Total	40	$21,326	57	$24,851	46	$17,881

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.

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 2022 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
ECF CHOICES 4	2,020	1,071	1,366	1,589
ECF CHOICES 5	2,331	1,786	2,147	2,335
ECF CHOICES 6	1,796.5	1,328	1,432	1,520
ECF CHOICES 7	50	19	19	21
ECF CHOICES 8	50	28	29	24
Total ECF CHOICES	6,247.5[5]	4,232	4,993	5,489
Reserve capacity	3,897.5	1,834	2,600	3,099
Waiver Transitions[6]	Not applicable	80	80	80

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

[4] Statewide enrollment targets and reserve capacity for DY 2 were adjusted to reflect new appropriation authority, effective July 1, 2022. A total of 300 reserve capacity slots were added to ECF CHOICES Groups 4, 5, 6, 7, and 8. The distribution of these slots reflects 15 additional slots in Group 4, 60 additional slots in Group 5, 200 additional slots in Group 6, 10 additional slots in Group 7, and 15 additional slots in Group 8. Of the 15 slots allocated for Group 8, a total of 5 were reassigned to Group 7, and 10 were reallocated to Group 6 at the 1:1.5 ratio, meaning that the 10 slots from Group 8 became 15 slots in Group 6. All 300 slots are reserve capacity slots. It should be noted that 369 FMAP slots were moved from Group 5 to Group 4 based on enrollment need.

[5] As provided in the revised enrollment target ranges submitted to CMS on May 2, 2022, while the combined total of all upper limits is 6,300, 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.

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

- The number of individuals with intellectual disabilities receiving HCBS through the TennCare program fell from 8,295 in the year preceding implementation of ECF CHOICES to 8,283 after ECF CHOICES had been in place for five years.
- The number of individuals with developmental disabilities other than intellectual disabilities who received HCBS through the TennCare program grew from 0 to 1,844.
- Average LTSS expenditures for individuals with intellectual or developmental disabilities fell from $94,327 per person to $85,449 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 18.97 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 2022 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jan – Mar 2022	Apr – Jun 2022	Jul – Sep 2022
Katie Beckett	242[7]	147	151	152
Medicaid Diversion	2,700	1,184	1,479	1,779
Continued Eligibility	N/A	0	0	0
Reserve capacity	242	147	151	152

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

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 emergency amendment to the State's 1115 demonstration was submitted to CMS. One component of the amendment was a request to

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

temporarily provide services in alternative settings, including settings that do not comply with the HCBS settings requirement at 42 CFR § 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time. The purpose of the request was to minimize the spread of infection during the COVID-19 pandemic. This amendment was approved and incorporated into the STCs as Attachment K to the TennCare Demonstration on June 19, 2020. A request to extend the approved Attachment K was subsequently submitted as the public health emergency continued. The extension of Attachment K was approved by CMS for six months after the public emergency ends.

Health and Welfare of HCBS Recipients

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

II. Performance Metrics

Progress Toward Goals and Targets in the Monitoring Protocol

STC 55 requires the State to submit to CMS a draft Monitoring Protocol no later than 150 days after the January 8, 2021, start date of the TennCare III approval period. The purpose of the Monitoring Protocol is to define the quantitative and qualitative elements the State will use in its Quarterly and Annual Monitoring Reports to chart progress toward fulfillment of the goals and targets of the TennCare III Demonstration. On June 7, 2021, the State submitted its draft Monitoring Protocol to CMS. CMS, in turn, provided feedback on the document on May 31, 2022. As of the end of the July – September 2022 quarter, the State was reviewing CMS' comments and preparing a revised version of the Monitoring Protocol.

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 1,723,755 Tennesseans during the July – September 2022 quarter. This total represents nearly 25 percent of the 6.9 million residents living in Tennessee.

Impact of the Demonstration in Ensuring Access to Care

Ensuring Access Through Contractual Means

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

Measuring Access Through Provider Data Validation

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

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. The EQRO's report demonstrated generally strong performance by the MCCs, especially in the categories of "provider specialty / behavioral health service code (97.25 percent accuracy), "primary care services" (95.50 percent accuracy), and "prenatal care services" (97.96 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 2022.

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.

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

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 June 2022, approximately 775,000 TennCare members are attributed to one of 83 PCMH-participating organizations, and there are 484 sites associated with these organizations across the state. In addition, providers have recently been engaged with coaching and technical assistance through webinars and conferences. In June 2022, PCMH organizations participated in a webinar on improving HPV vaccination rates and addressing vaccine hesitancy given by Dr. Heather Brandt, Director of the HPV Cancer Prevention Program and Co-associate Director for Outreach at St. Jude Comprehensive Cancer Center.

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. An expansion to include 15 additional provider groups is expected to take place by the end of Calendar Year 2022. 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 12,000 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 is utilizing findings and data from the first year of program implementation 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 2022, the number of BESMART providers had increased to 400, and the number of unique members served per month had grown to 19,471. Additionally, buprenorphine covered by TennCare remains in the top five controlled substances by claims, meaning that TennCare pays for more buprenorphine to treat opioid use disorder than for short-acting opioids to treat pain.

The focus that TennCare has placed on combatting the opioid epidemic through treatment and other major prevention efforts has also shown tremendous success in reducing the number of newborns with neonatal abstinence syndrome (NAS), or signs and symptoms of opioid withdrawal as an infant due to opioid exposure during the pregnancy. In 2019, the NAS rate in the TennCare population was 20.15 NAS births per 1,000 live births, as compared with the 2016 rate, which was 28 NAS births per 1,000 live births. A decline in the NAS rate has been achieved for three consecutive years.

Beneficiary Survey

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

A copy of the report of TennCare's most recent annual beneficiary survey was attached to the Annual Monitoring Report for Demonstration Year 1. During the July-September 2022 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 2022 quarter.

Progress on Shared Savings Metric Set

On March 8, 2021, the State submitted measures for the Shared Savings Metric Set to CMS. Following receipt of CMS feedback, the State submitted a modified version of the Shared Savings Metric Set measures on March 7, 2022. This document is currently under CMS review. The State will report on its progress on these metrics in future Monitoring Reports, as the measures become available each year.

III. Budget Neutrality and Financial Reporting Requirements

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

IV. Evaluation Activities and Interim Findings

STC 90 requires the State to submit to CMS a draft Evaluation Design for the approval period of the TennCare III Demonstration (January 8, 2021 – December 31, 2030). A draft Evaluation Design was submitted to CMS on July 7, 2021, and CMS provided written feedback on the document on July 13, 2022. In compliance with the requirements of STC 91, the State submitted a revised draft Evaluation Design to CMS on September 9, 2022.

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

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

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

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

V. State Contact

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Attachment A:
Health and Welfare of HCBS Participants

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

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

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

Systems:

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

Reports:

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

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

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

Audits:

- 1115 Existing Member Record Reviews are conducted annually. These record reviews include performance measures related to education of members on the identification and reporting of suspected abuse.
- The CHOICES and ECF CHOICES Reportable Event Audit reviews reportable events for proper reporting within timeframes as outlined in the Contractor Risk Agreement.