Tennessee Department of Finance & Administration

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Quarterly Monitoring Report

(For the period January – March 2021)

Demonstration Year: 1 (1/8/21- 12/31/21)
Federal Fiscal Quarter: 2/2021 (1/21 - 3/21)
Demonstration Quarter: 1/2021 (1/21 - 3/21)

May 28, 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 January-March 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 #
1/8/21	CMS approved the TennCare III Demonstration.	
1/21/21	CMS approved MCO Contract Amendment 11 and TennCare Select Contract Amendment 46.	43
1/28/21	The Monthly Call for January was held.	60
2/22/21	The State notified the public of its intent to submit to CMS an amendment to the TennCare III Demonstration. Amendment 1 would integrate certain services for members with intellectual disabilities into TennCare's managed care program, and would also change the manner in which certain members are assigned to TennCare health plans.	7, 12
2/25/21	The Monthly Call for February, which would have been held on this date, was cancelled.	60

Date	Action	STC #
3/1/21	The State submitted the Quarterly Progress Report for the October – December 2020 quarter to CMS.	56
3/8/21	The State submitted its Shared Savings Quality Measures Protocol to CMS.	32.f.
3/25/21	The Monthly Call for March was held.	60
3/29/21	The State initiated the public comment period for its annual update to the managed care Quality Assessment and Performance Improvement Strategy.	52
3/31/21	The State submitted Amendment 1 to the TennCare III Demonstration to CMS.	7

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 providing details on the State's plan for implementing new flexibilities included in the approval of TennCare III. Table 2 identifies key milestones contained in the draft implementation plan, 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.	By June 30, 2021.
Submit DSIP 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.
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.

Action Needed	Implementation Timeline
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) to receive information when a TennCare enrollee has been convicted of TennCare fraud.	To be determined based on the expiration of the COVID-19 public health emergency.

In addition, during this quarter the State submitted a new demonstration amendment to CMS. Amendment 1, which was submitted to CMS on March 31, 2021, 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.

Key Challenges During the Quarter

Throughout the January-March 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;

[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).

- 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 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 healthcare 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

On November 23, 2020, the State launched a new "Katie Beckett" 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 two 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.

The new Katie Beckett/Medicaid Diversion program began accepting self-referral forms from interested families on November 23, 2020. As of the last day of the January-March 2021 quarter, a total of 633 children were enrolled in the program, with 22 enrolled in Katie Beckett (Part A) and 611 enrolled in Medicaid Diversion (Part B).

Issues or Complaints Identified by Beneficiaries

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

Table 3
Eligibility Appeals for January – March 2021

	Jan – Mar 2021
No. of appeals received	5,136
No. of appeals resolved or withdrawn	5,423
No. of appeals taken to hearing	1,579
No. of hearings resolved in favor of appellant	44

Medical Service Appeals. Table 4 below presents a summary of the medical service appeals handled during the quarter.

Table 4
Medical Service Appeals for January – March 2021

	Jan – Mar 2021
No. of appeals received	2,860
No. of appeals resolved • Resolved at the MCC level • Resolved at the TSU level • Resolved at the LSU level	1,557 410 115 1,032
No. of appeals that did not involve a valid factual dispute	1,255
No. of directives issued	292
No. of appeals taken to hearing	1,111
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	324
Appeals that went to hearing and were decided in the State's favor	654

	Jan – Mar 2021
Appeals that went to hearing and were decided in the appellant's favor	54

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.).

Table 5
Long-Term Services and Supports Appeals for January – March 2021

	Jan – Mar 2021
No. of appeals received	101
No. of appeals resolved or withdrawn	69
No. of appeals set for hearing	21
No. of hearings resolved in favor of appellant	0

Grievances. During the January-March 2021 quarter, TennCare's managed care contractors (MCOs, DBM, and PBM) received a total of 636 grievances. The types of grievances most commonly received by the managed care contractors during the quarter, as well as the number of grievances belonging to each category, are as follows:

Table 6
Most Common Grievance Categories and Totals, January – March 2021

Grievance Category	Number of Grievances Received
Access and Availability	97
Attitude and Service	134
Billing and Financial Issues	174
Quality of Care/Quality of Service	166

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. A total of 613 enrollee grievances were resolved by the managed care contractors during the January-March 2021 quarter. It should be noted that grievances may be resolved in a quarter other than the one in which they are received.

Audits, Investigations, or Lawsuits that Impact the Demonstration

During the January-March 2021 quarter, the Division of TennCare was a party to five 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 alleges 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. TennCare is being represented by the Attorney General's office and has until June 1 to respond to the complaint.

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 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.

Unusual or Unanticipated Trends

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

Legislative Updates

By the conclusion of the January-March 2021 quarter, Tennessee's legislative session was more than a month from completion, and the outcome of many bills introduced by the General Assembly was still to be determined. It was observed, however, that assessments used to help

fund various aspects of the TennCare program (e.g., the hospital assessment, the nursing facility assessment, etc.) were expected to be renewed for State Fiscal Year 2022.

A summary of State legislation with significant implications for TennCare will be included in the Monitoring Report for the April-June 2021 quarter.

Public Forums

With the TennCare III Demonstration commencing on January 8, 2021, the State plans to host a public forum on the progress of the demonstration no later than July 8, 2021. Details of this event will be published on the TennCare website at least 30 days beforehand, and a summary of comments received at the forum will be included in the Monitoring Report for the July-September 2021 quarter.

Enrollment and Member Month Data

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

Table 7
Enrollment Counts for the January – March 2021 Quarter

Demonstration Populations	Jan – Mar 2021
EG1 Disabled	134,288
EG9 H-Disabled	638
EG2 Over 65	296
EG10 H-Over 65	40
EG3 Children	814,080
EG4 Adults	451,565
EG5 Duals and EG11 H-Duals 65	156,660
EG6E Expan Adult	0
EG7E Expan Child	1,171
EG8, Med Exp Child	0
Med Exp Child, Title XXI Demonstration Population	9,670
EG12E Carryover	1,569
EG13 Katie Beckett	22
EG14E Medicaid Diversion	611
TOTAL*	1,570,610

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

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

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

Table 8
Member Month Reporting for January – March 2021

Eligibility Group	January 2021	February 2021	March 2021	Sum for Quarter Ending 3/31/21
EG1 Disabled	134,808	134,292	133,592	402,692
EG2 Over 65	256	270	288	814
EG3 Children	804,961	807,685	811,474	2,424,120
EG4 Adults	439,386	444,282	449,495	1,333,163
EG5 Duals	147,104	147,013	147,393	441,510
EG6E Expan Adult	0	0	0	0
EG7E Expan Child	1,205	1,217	1,158	3,580
EG8 Med Exp Child	0	0	0	0
EG9 H-Disabled	637	637	634	1,908
EG10 H-Over 65	39	37	38	114
EG11 H-Duals	6,344	6,356	6,660	19,360
Med Exp Child, Title XXI Demo Pop	9,865	9,806	9,822	29,493
EG12E Carryover	1,581	1,527	1,502	4,610
EG13 Katie Beckett	8	18	22	48
EG14E Medicaid Diversion	426	492	612	1,530
TOTAL	1,546,620	1,553,632	1,562,690	4,662,942

Information and Data about the CHOICES Program

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

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

Table 9
CHOICES Enrollment and Reserve Slots
for January-March 2021

	Statewide Enrollment Targets and Reserve Capacity[2]	Enrollment and Reserve Slots Being Held as of the End of the Jan – Mar 2021 Quarter
CHOICES 1	Not applicable	14,002
CHOICES 2	11,000	10,168
CHOICES 3 (including Interim CHOICES 3)	To be determined	2,153
Total CHOICES	Not applicable	26,323
Reserve Capacity	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. Seventeen separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and June 2020.

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 16,609 individuals on June 30, 2019. 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 63 percent admitted to NFs in the ninth 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 nine years later.

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

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 15,281 after CHOICES had been in place for nine 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 12,484 by June 30, 2019. The percentage of LTSS expenditures devoted to HCBS grew as well, rising from 9.75 percent in the year prior to CHOICES, to 21.01 percent after the CHOICES program had been in place for nine 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), 7/1/16 – 6/30/19	Percent increase over a nine-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 6/30/19	Percent increase from the day prior to CHOICES implementa-tion to 6/30/19
6,226	15,281	145%	4,861[3]	12,484	157%

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

Table 11
CHOICES Transition Allowances for January-March 2021

	Jan – Mar 2021	
Grand Region	# Distributed	Total Amount
East	17	$9,259
Middle	21	$10,228
West	7	$3,677

[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).

Grand Region	Jan – Mar 2021	
	# Distributed	Total Amount
Statewide Total	45	$23,164

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.

Table 12
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots for January-March 2021

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Filled as of the End of the Jan – Mar 2021 Quarter
ECF CHOICES 4	928	890
ECF CHOICES 5	1,655	1,555

[4] Enrollment targets and reserve capacity for SFY 2021 were adjusted for new appropriation authority as of July 1, 2020. A total of 300 slots were added to ECF CHOICES Groups 4, 5, and 6: 25 to Group 4, 100 to Group 5, and 175 to Group 6. Revised enrollment targets were sent to CMS in July 2020 due to the loss of previously approved funding for 50 slots each in Groups 7 and 8. Funding for the 175 new slots in Group 6 was moved to Groups 7 and 8 to serve program applicants with severe behavior support needs. Since the expected cost of benefits in Groups 7 and 8 is higher, 1.5 Group 6 slots is needed to cover 1 slot in either Group 7 or 8 (making fewer than 300 new slots available for SFY 2021). During the July-September 2020 quarter, 27 slots were reallocated from Group 6 to Groups 7 and 8. With the 1:1.5 allocation ratio, the transfer resulted in 6 new slots in Group 7, and 12 new slots in Group 8, as well as a loss of 9 reserve capacity slots and 9 total ECF CHOICES slots. More reallocation occurred in the October-December 2020 quarter, with 19 slots moved from Group 5 to Group 6, and 12 slots moved from Group 6 to Groups 7 and 8. The 1:1.5 allocation ratio resulted in 1 new slot in Group 7 and 7 new slots in Group 8, reducing the total number of slots to 3,637. Further reallocation occurred in the January-March 2021 quarter, with 24 slots moved from Group 5 to Group 6; 2 slots from Group 7 to Group 6; and 7.5 slots from Group 6 to Group 8. Use of the 1:1.5 allocation ratio meant 3 new slots in Group 6, and 5 new slots in Group 8, reducing both total slots and Reserve Capacity slots by 1.5. Total Reserve Capacity slots are now 14.5 less than the 1,300 maximum (29 slots moved from Group 6 to Groups 7 and 8 at the 1:1.5 allocation ratio equals a net loss of 14.5 total/Reserve Capacity slots).

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Filled as of the End of the Jan – Mar 2021 Quarter
ECF CHOICES 6	973.5	1,009
ECF CHOICES 7	30	30
ECF CHOICES 8	49	41
Total ECF CHOICES	3,635.5[5]	3,525
Reserve Capacity	1,285.5	1,129
Waiver Transitions[6]	Not applicable	66

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 three 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 8,637 after ECF CHOICES had been in place for three years.
- The number of individuals with developmental disabilities other than intellectual disabilities who received HCBS through the TennCare program grew from 0 to 1,492.
- Average LTSS expenditures for individuals with intellectual or developmental disabilities fell from $94,327 per person to $85,790 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 21.07 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.

[5] As provided in the revised enrollment targets submitted to CMS in July 2020, while the combined total of all upper limits is actually 3,700, 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.

Information and Data about the Katie Beckett and Medicaid Diversion Groups

The State's Katie Beckett and Medicaid Diversion 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 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.

As required by STC 35.c., the State offers the following table delineating Katie Beckett and Medicaid Diversion 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 and Medicaid Diversion Enrollment and Reserve Slots
For January-March 2021

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of the Jan – Mar 2021 Quarter
Katie Beckett	50[7]	21
Medicaid Diversion	2,700	576
Reserve Capacity	50	21

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.

[7] At program implementation, all available slots for the Katie Beckett group are Reserve Capacity slots. These slots are available only to children who meet Tier 1 level of care eligibility (as defined in TennCare rules). The purpose of these Reserve Capacity slots is to ensure that children with the most significant medical needs and disabilities are enrolled into the Katie Beckett group before the group is opened for enrollment to other children, subject to available funding.

Steps Taken to Ensure Compliance with Regulations Governing HCBS Settings

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

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

Health and Welfare of HCBS Recipients

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

II. Performance Metrics

Progress Toward Goals and Targets in the Monitoring Protocol

STC 55 requires the State to submit to CMS a draft Monitoring Protocol no later than 150 days after the January 8 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. As of the end of the January – March 2021 quarter, the State's preparation of the draft Monitoring Protocol was in process.

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 1,570,610 Tennesseans during the January – March 2021 quarter. This total represents approximately 23 percent of the 6.9 million residents living in Tennessee.

Impact of the Demonstration in Ensuring Access to Care: Provider Data Validation

In January 2021, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the October-December 2020 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 to patients under age 21
- Services to patients age 21 or older (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" (95.8 percent accuracy), "provider specialty / behavioral health service code" (97.2 percent accuracy), "services to patients under age 21" (96.8 percent accuracy), "primary care services" (95.2 percent accuracy), and "prenatal care services" (97.3 percent accuracy).

Progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Compared with the period of July-September 2020, the MCCs—according to the report—"maintained high accuracy rates" for the fourth quarter of 2020.

Impact of the Demonstration in Ensuring Quality of Care

Data documenting the effect of the TennCare Demonstration in 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.

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.).

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

During the January-March 2021 quarter, BCBER published a summary of the results of the most recent survey titled "The Impact of TennCare: A Survey of Recipients, 2020". Although the findings of a single survey must be viewed in context of long-term trends, several results from the report are noteworthy:

- Satisfaction with TennCare remained high. Ninety-four percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction tied for the second highest in the program's history and was the fourth time in a row that a satisfaction level of at least 94 percent had been attained. In addition, 2020 was the twelfth straight year in which survey respondents had reported satisfaction levels exceeding 90 percent.
- The uninsured rate in Tennessee rose for adults but remained the same for children. The reported percentage of uninsured adults rose from 8.1 percent in 2019 to 9.9 percent in 2020. This result was not entirely unexpected, as the pandemic was predicted to cause a loss of employment—and therefore health insurance—for a significant number of Tennesseans. Nonetheless, the reported percentage of uninsured children did not increase in 2020, remaining at the 2019 level of 2.8 percent.
- TennCare members were less likely to use the emergency room for initial medical care. While heads of households with TennCare continued to seek initial medical care for themselves at hospitals six percent of the time, the likelihood of seeking such care for their children fell from six percent in 2019 to three percent in 2020.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 94 percent reporting satisfaction with the program. This positive feedback is a strong indication that TennCare is providing satisfactory medical care and meeting the expectations of those it serves."

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 January-March 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 is due no later than 180 days after CMS's January 8 approval of TennCare III. During this quarter, the development of the draft Evaluation Design was in process.

V. State Contact

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Attachment A:
Health and Welfare of HCBS Participants

During the first quarter of 2021, the State continued all efforts to ensure the health and wellbeing of persons served across all LTSS programs. These efforts include the following systems, reports, and audits:

Systems:

- Data describing investigations is entered on an ongoing basis into the Department of Intellectual and Developmental Disabilities (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.