Division of TennCare

Tennessee Department of Finance & Administration

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Quarterly Monitoring Report

(For the period January – March 2023)

Demonstration Year: 3 (1/1/23 - 12/31/23)

Federal Fiscal Quarter: 2/2023 (1/23 - 3/23)

Demonstration Quarter: 1/2023 (1/23 - 3/23)

June 6, 2023

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 home- and community-based services (HCBS). As a means of advancing these goals, the TennCare demonstration authorizes a number of programmatic flexibilities, including extending eligibility to certain groups that would not be eligible for Medicaid under the State Plan; covering a more robust package of benefits than that authorized under the Medicaid State Plan; operating a single, statewide managed care service delivery system; operating a number of HCBS programs for persons with physical, intellectual, and/or developmental disabilities; and various operational efficiencies. Through the TennCare demonstration, the state demonstrates that the careful use of a single, statewide managed care service delivery system can enable the state to deliver high-quality care to all enrollees without spending more than would have been spent had the state continued its Medicaid program.

Key Dates of the Demonstration Quarter

Key dates of approval/operation for the TennCare demonstration during the January-March 2023 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 #
1/20/23	The state notified the public and CMS of a change to the methodology by which uncompensated care payments are made to qualifying hospitals. The change would authorize a one-time, non-recurring payment of $337,040,400 to hospitals through the Charity Care Pool.	6
1/26/23	The Monthly Call for January was held.	60
2/23/23	The Monthly Call for February was held.	60
3/23/23	The Monthly Call for March was held.	60

I. Operational Updates

Progress Towards Milestones

The TennCare III demonstration continues a number of program components from the prior iteration of the TennCare demonstration that are already in operation. In addition, TennCare III includes some new programmatic flexibilities and authorities. In terms of new flexibilities

authorized under TennCare III, the state had completed various milestones by the end of the January-March 2023 quarter, including:

- Submission of the Shared Savings Quality Measures Protocol on March 8, 2021 (approved by CMS on December 27, 2022);
- Submission of the draft Implementation Plan on April 8, 2021, and the revised Implementation Plan on August 16, 2021;
- Submission of the Demonstration Monitoring Protocol on June 7, 2021;
- Submission of the DSIP Claiming Protocol on June 30, 2021 (approved by CMS on December 27, 2022); and
- Submission of the draft Evaluation Design on July 7, 2021, and the revised Evaluation Design on September 9, 2022.

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.

Resumption of Annual Eligibility Reviews

When Congress passed the Families First Coronavirus Response Act (FFCRA) in March 2020, TennCare, like other state Medicaid programs, began maintaining enrollment for virtually all members. Since March 2020, TennCare's enrollment has grown from about 1.4 million members to more than 1.7 million members, primarily as a result of maintaining the enrollment of virtually all members without conducting annual eligibility reviews.

The December 2022 passage of the Consolidated Appropriations Act, 2023, ended FFCRA's continuous coverage requirement for Medicaid, effective April 1, 2023. Accordingly, the state has now resumed its normal eligibility processes and will have initiated a review of every member's eligibility by February 2024. Wherever possible, the state is leveraging existing data sources (e.g., wage data, SNAP enrollment data) to automatically renew the eligibility of members who continue to qualify for TennCare. If the state cannot automatically renew a member's coverage using data that is already available, then the member receives a preprinted renewal packet by mail (or depending on the preferences selected by the member, an email notification to review their renewal information online).

To help ensure that renewal packets reach the intended recipients, the state has made a number of system enhancements to the Tennessee Eligibility Determination System (TEDS). For instance, TEDS sends "pre-renewal" letters to TennCare members before renewal packets are mailed. These letters help the state obtain updated address information from members in advance of the date on which a renewal packet is shipped. In addition, the state is updating address information received automatically through the USPS Returned Mail process, which allows letters to be sent to members immediately after USPS receives an address change. Furthermore, the state is receiving monthly updates from the National Change of Address system prior to the

mailing of renewal packets; the information contained in these updates reduces the likelihood of mail being returned as undeliverable.

Because of the length of time that has elapsed since the state last reviewed members' eligibility, it is anticipated that a number of members who go through the renewal process will no longer qualify for TennCare coverage. These individuals have the opportunity to appeal any such decision prior to disenrollment. The state will also transfer their information to the Health Insurance Marketplace for potential enrollment in subsidized coverage there.

Payments to Tennessee Hospitals for Uncompensated Care

On January 20, 2023, the state notified CMS and the public of a planned modification to the methodology by which uncompensated care payments are made to Tennessee hospitals. Since 2016, the TennCare demonstration has included an Uncompensated Care Fund for Charity Care (also referred to as the "Charity Care Pool"). Funds from the Charity Care Pool are used to support Tennessee hospitals by helping to offset costs associated with uncompensated care provided to the uninsured through charity care programs or self-pay patients. The state distributes an annual total of $252,845,886 from the Charity Care Pool to qualifying hospitals according to an established distribution methodology. The modified distribution methodology announced on January 20 would allow an additional, one-time, non-recurring payment of $337,040,400 to hospitals through the Charity Care Pool.

Additional Program Developments

During the January-March 2023 quarter, the state continued to pursue approval for a number of significant program enhancements and priorities identified by CMS, including the following:

Demonstration Amendment 1 (Services for Persons with Intellectual Disabilities). 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 health care 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.

[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).

As of the end of the January-March 2023 quarter, the state was awaiting CMS approval of Amendment 1.

Demonstration Amendment 2 (Coverage of Adopted Children). On April 8, 2022, the state submitted a proposed demonstration amendment to CMS to extend TennCare coverage to children adopted from state custody in Tennessee who do not otherwise qualify for Medicaid (i.e., do not qualify for IV-E adoption assistance or non-IV-E adoption assistance). Extending TennCare coverage to these children would remove a potential barrier to adoption, as well as promote greater continuity of care for these children as they transition from foster care to permanent homes. Amendment 2 remained under CMS review as of the end of the January-March 2023 quarter.

Demonstration Amendment 3 (HCBS Enhancements). On October 12, 2022, the state submitted Amendment 3 to CMS. Amendment 3 would codify certain enhancements to the HCBS available under the TennCare demonstration via the CHOICES and Employment and Community First (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.

As of the end of the January-March 2023 quarter, CMS's review of Amendment 3 was ongoing.

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 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 January-March 2023 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 the four demonstration amendments described above.

Key Challenges During the Quarter

There were no significant challenges associated with operating the demonstration during this quarter. The state continued making preparations for the anticipated end of the COVID-19 public health emergency, as well as the resumption of eligibility renewals.

Key Achievements During the Quarter

During the quarter, the state continued to expand the availability of TennCare services to eligible Tennesseans, both by covering more benefits and by enrolling new populations.

Dental Services for All Adult Members. Effective January 1, 2023, the state began covering dental services for all adults enrolled in TennCare. (Previously, dental services had been 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 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. Implementation of these services was preceded by extensive communication with providers, changes to the state's dental benefits management contract, a public notice and comment period, and formal notification to CMS on November 1, 2022. As of the end of the first quarter of implementation, a total of 26,054 unique members had received 146,030 unique services.

Re-Opening of CHOICES At Risk Demonstration Group. 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 Tennessee'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 Tennessee'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 had 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. As of the end of the January-

March 2023 quarter, a total of 320 new individuals had been enrolled in CHOICES Group 3 through the At Risk Demonstration Group.

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

The state's program contains three parts:

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

The new Katie Beckett/Medicaid Diversion program began accepting self-referral forms from interested families on November 23, 2020. As of the last day of the January-March 2023 quarter, a total of 2,590 children were enrolled in the program, with 161 enrolled in Katie Beckett (Part A), 2,429 children 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.

Issues or Complaints Identified by Beneficiaries

Eligibility Appeals. Table 2 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 2
Eligibility Appeals for January – March 2023
Compared to the Two Previous Quarters

	Jul – Sep 2022	Oct – Dec 2022	Jan – Mar 2023
No. of appeals received	6,050	4,993	5,207
No. of appeals resolved or withdrawn	6,416	4,960	5,443
No. of appeals taken to hearing	858	687	721

	Jul – Sep 2022	Oct – Dec 2022	Jan – Mar 2023
No. of hearings resolved in favor of appellant	22	14	14

Medical Service Appeals. Table 3 below presents a summary of the medical service appeals handled during the quarter, compared to the previous two quarters.

Table 3
Medical Service Appeals for January – March 2023
Compared to the Two Previous Quarters

	Jul – Sep 2022	Oct – Dec 2022	Jan – Mar 2023
No. of appeals received	2,952	2,894	3,712
No. of appeals resolved	1,498	1,406	1,664
• Resolved at the MCC level	418	398	464
• Resolved at the TSU level	107	126	134
• Resolved at the LSU level	973	882	1,066
No. of appeals that did not involve a valid factual dispute	1,481	1,310	1,681
No. of directives issued	261	255	347
No. of appeals resolved by fair hearing	988	895	1,080
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	361	322	425
Appeals that went to hearing and were decided in the state's favor	566	534	578
Appeals that went to hearing and were decided in the appellant's favor	46	26	63

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 during the quarter (e.g., appeals of PreAdmission Evaluation denials, appeals of PreAdmission Screening and Resident Review determinations, etc.) as compared with the previous two quarters.

Table 4
Long-Term Services and Supports Appeals for January – March 2023
Compared to the Two Previous Quarters

	Jul – Sep 2022	Oct – Dec 2022	Jan – Mar 2023
No. of appeals received	85	57	72
No. of appeals resolved or withdrawn	57	2	2
No. of appeals set for hearing	18	24	26
No. of hearings resolved in favor of appellant	0	0	0

Grievances. Details of grievances received and resolved by TennCare's managed care contractors (MCOs, DBM, and PBM) during the January-March 2023 quarter are included as Attachment A to this Quarterly Monitoring Report. 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. 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 2023 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 oral arguments were heard on October 5, 2022. As of the end of the January-March 2023 quarter, a decision had not been issued.

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.

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's 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 was subsequently 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 state's 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 the January-March 2023 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 generally maintained eligibility for all persons 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. Nonetheless, the agency has been making preparations for the resumption of eligibility renewals in 2023.

Legislative Updates

By the conclusion of the January-March 2023 quarter, Tennessee's legislative session was still weeks from completion, and the outcome of many bills introduced by the General Assembly had yet to be determined. It was observed, however, that assessments used to help fund various aspects of the TennCare program (e.g., the hospital assessment, the nursing facility assessment, etc.) were expected to be renewed for State Fiscal Year 2024.

A summary of state legislation with significant implications for TennCare will be included in the Monitoring Report for the April-June 2023 quarter.

Public Forums

No public forums on the TennCare III demonstration were held during the January-March 2023 quarter. The state's most recent public forum took place on June 30, 2022. As required by STC 61, the state will host a public forum this year to accept comments on the progress of the TennCare demonstration. Details of the event, which is scheduled to take place on June 23, 2023, are available on the TennCare website, and a summary of comments received at the forum will be included in the Monitoring Report for the April-June 2023 quarter.

Enrollment and Member Month Data

Information about TennCare enrollment by category is presented in Table 5.

Table 5
Enrollment Counts for the January – March 2023 Quarter
Compared to the Two Previous Quarters

Demonstration Populations	Jul – Sep 2022	Oct – Dec 2022	Jan – Mar 2023
EG1 Disabled	134,771	135,228	135,221
EG9 H-Disabled	699	1,065	1,089
EG2 Over 65	286	311	334
EG10 H-Over 65	35	45	32
EG3 Children	868,615	876,349	883,891
EG4 Adults	538,183	553,035	567,712
EG5 Duals and EG11 H-Duals 65	165,254	166,885	171,822
EG6E Expan Adult	0	0	0
EG7E Expan Child	1,580	1,577	1,373
EG8, Med Exp Child	0	0	0
Med Exp Child, Title XXI Dem Pop	11,247	11,397	11,927
EG12E Carryover	1,128	1,088	1,022
EG13 Katie Beckett	155	155	161
EG14E Medicaid Diversion	1,802	2,061	2,429
EG15 Continued Eligibility	0	0	0
EG16 MEC Additions	0	0	0
TOTAL*	1,723,755	1,749,196	1,777,013

*** 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 82 percent of TennCare members appearing in one of these categories.

Table 6 below presents the member month reporting by eligibility group for each month in the quarter.

Table 6
Member Month Reporting for January – March 2023

Eligibility Group	January 2023	February 2023	March 2023	Sum for Quarter Ending 3/31/23
EG1 Disabled	136,084	135,356	134,491	405,931
EG2 Over 65	289	308	312	909
EG3 Children	877,178	878,348	880,666	2,636,192
EG4 Adults	556,305	560,549	565,042	1,681,896
EG5 Duals	162,382	162,372	162,249	487,003
EG6E Expan Adult	0	0	0	0
EG7E Expan Child	1,578	1,564	1,354	4,496
EG8 Med Exp Child	0	0	0	0
EG9 H-Disabled	1,022	1,045	1,086	3,153
EG10 H-Over 65	29	27	29	85
EG11 H-Duals	6,806	6,822	6,862	20,490
Med Exp Child, Title XXI Demo Pop	11,302	11,482	11,878	34,662
EG12E Carryover	1,047	1,024	1,007	3,078
EG13 Katie Beckett	156	159	159	474
EG14E Medicaid Diversion	2,178	2,289	2,422	6,889
EG15 Continued Eligibility	0	0	0	0
EG16 MEC Additions	0	0	0	0
TOTAL	1,756,356	1,761,345	1,767,557	5,285,258

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. During the October-December 2022 quarter, the state re-opened enrollment in CHOICES 3 to certain individuals who would not otherwise be eligible for Medicaid. These individuals may receive CHOICES 3 benefits by enrolling in the CHOICES At Risk Demonstration Group, which had been closed from June 30, 2015, through September 30, 2022.

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 7
CHOICES Enrollment and Reserve Slots
for January-March 2023 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sep 2022	Oct – Dec 2022	Jan – Mar 2023
CHOICES 1	Not applicable	14,271	14,252	14,316
CHOICES 2	11,000	9,654	9,448	9,256
CHOICES 3 (SSI recipients)	To be determined	2,063	2,120	2,486
CHOICES 3 (members of the CHOICES At Risk Demo Group)	1,750[2]	N/A	114	320
Total CHOICES	Not applicable	25,988	25,934	26,378
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 members. 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

[2] An enrollment target of 1,750 has been established for the CHOICES at Risk Demonstration Group within CHOICES 3; individuals eligible for Medicaid as SSI recipients who qualify for CHOICES Group 3 benefits do not count against this enrollment target.

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 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 members 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 8.

Table 8
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 members accessing HCBS (E/D), 3/1/09 – 2/28/10	No. of TennCare members accessing HCBS (E/D), 7/1/20 – 6/30/21	Percent increase over a ten-year period	No. of TennCare members accessing HCBS (E/D) on the day prior to CHOICES implementa-tion	No. of TennCare members accessing HCBS (E/D) on 6/30/21	Percent increase from the day prior to CHOICES implementa-tion to 6/30/21
6,226	14,401	131%	4,861[3]	12,291	153%

MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds is detailed in Table 9.

[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 9
CHOICES Transition Allowances
for January-March 2023 Compared to the Two Previous Quarters

Grand Region	Frequency and Use of Transition Allowances					
	Jul – Sep 2022		Oct – Dec 2022		Jan – Mar 2023	
	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	15	$7,672	7	$5,556	33	$10,158
Middle	14	$4,350	18	$7,867	12	$7,288
West	17	$5,859	28	$15,272	24	$13,134
Statewide Total	46	$17,881	53	$28,695	69	$30,580

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, ECF 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 10
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots for January-March 2023 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity[4]	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jul – Sep 2022	Oct – Dec 2022	Jan – Mar 2023
ECF CHOICES 4	1,859	1,589	1,693	1,771
ECF CHOICES 5	2,592	2,335	2,424	2,468
ECF CHOICES 6	1,749	1,520	1,587	1,637
ECF CHOICES 7	50	21	20	16
ECF CHOICES 8	50	24	24	24
Total ECF CHOICES	6,300[5]	5,489	5,748	5,916
Reserve capacity	3,950	3,099	3,393	3,512
Waiver Transitions[6]	Not applicable	80	82	85

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 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 for Group 7, and 15 additional slots for Group 8. Of the 15 slots allocated for Group 8, a total of 5 were assigned to Group 7. Furthermore, because of the higher expected cost of benefits in Group 8, it was possible to convert the remaining 10 slots from Group 8 to a total of 15 slots for Group 6. In the January-March 2023 quarter, a total of 6 FMAP Group 5 slots and 14 FMAP Group 6 slots were moved to Group 4; 1 FMAP Group 6 slot was moved to Group 5; 1 DD Aging Caregiver reserve capacity slot was moved from Group 5 to Group 6; and 4 Priority Group 5 slots were moved to Group 4 based on enrollment need. Additionally, budget reconciliation of slots allowed the addition of 1 reserve capacity slot to Group 4 and 51.5 reserve capacity slots to Group 6.

[5] Budget reconciliation of slots in Quarter 1 opened 52.5 reserve capacity slots to fully fund 6,300 slots defined as the upper limit. These upper limits provide flexibility to move slots as needed, based on 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 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, representing a 9.4 percent decrease.
- 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 14.3 percent to 19.0 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 a 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 11
Katie Beckett, Medicaid Diversion, and Continued Eligibility Enrollment and Reserve Slots for January-March 2023 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jul – Sep 2022	Oct – Dec 2022	Jan – Mar 2023
Katie Beckett	220[7]	152	153	157
Medicaid Diversion	2,700	1,779	2,022	2,402
Continued Eligibility	N/A	0	0	0
Reserve capacity	220	152	153	157

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 2023, 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 Monitoring 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 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.

[7] During the October-December 2022 quarter, Katie Beckett reserve capacity slots were decreased by 22 based on program expenditures, projected per child cost, and the appropriation authority for the program.

Health and Welfare of HCBS Recipients

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

II. Performance Metrics

Progress Toward Goals and Targets in the Monitoring Protocol

STC 55 requires the state to submit to CMS a draft Monitoring Protocol no later than 150 days after the January 8, 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 January-March 2023 quarter, the state was reviewing CMS' comments and preparing to submit a revised version of the Monitoring Protocol during the April-June 2023 quarter.

Impact of the Demonstration in Providing Insurance Coverage

As noted in Section I of this report, the TennCare III demonstration was furnishing health care coverage to 1,777,013 Tennesseans as of the end of the January-March 2023 quarter. This total represents 26 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 March 2023, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the January-March 2023 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

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

- 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 members. The EQRO's report demonstrated generally strong performance by the MCCs, especially in the categories of "active contract status" (93.58 percent accuracy), "provider specialty / behavioral health service code" (95.82 percent accuracy), and "prenatal care services" (97.31 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 first quarter of Calendar Year 2023.

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

Innovative Measures to Improve Health and Ensure Quality

The state has a variety of innovative programs designed to improve the health of TennCare members. Information about three of those programs—Patient Centered Medical Home, Health Starts Provider Partnerships, and BESMART—appears below.

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

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

The PCMH program began with the first group of participating provider organizations on January 1, 2017. As of June 2023, over 800,000 TennCare members are attributed to one of 82 PCMH-participating organizations, and there are over 500 sites associated with these organizations across the state. PCMH providers receive ongoing quality support via one-on-one coaching, webinars and collaboratives. For instance, PCMH organizations recently participated in a webinar on early screening for Diabetes, Hypertension, and Depression.

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 over 30 provider groups across Tennessee, including patient-centered medical homes, long-term services and supports providers, hospitals, and behavioral health providers. An expansion to include one or two large, integrated hospital systems will take place in FY 2024. 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 Partnerships program has impacted over 25,000 unique members and identified needs across various domains, including transportation, housing, utility assistance, and childcare. 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. In FY 2024, the Health Starts Initiative will expand to encompass efforts related to community health workers. TennCare has contracted with the Tennessee Community Health Worker Association to support two critical components of the CHW strategy: (1) the development of CHW program standards that emphasize high-quality CHW programs and (2) to serve as the accreditation entity for CHW programs. Additionally, nine provider organizations across the state will receive funding to implement CHW program standards developed by the Tennessee Community Health Worker Association. These nine organizations will also receive technical support to hire and retain CHWs using evidence-based principles to ensure TennCare members receive high-quality CHW services. Grantees are eligible for assistance for up to two years.

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 MCOs 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 residents—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 summary report of the most recent annual beneficiary survey was attached to the Annual Monitoring Report for Demonstration Year 2. During the January-March 2023 quarter, BCBER made initial preparations for the 2023 survey cycle. Aspects of this process included ensuring that the script used by staff when questioning survey participants was fully updated and ready to deploy, and that a reliable pool of phone numbers was available for use by survey staff.

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, and CMS ultimately approved the document on December 27, 2022. The state's first report—which was included as an attachment to the Annual Monitoring Report—detailed progress on these metrics, described how the shared savings for Demonstration Year 1 were calculated, and offered an accounting of how the shared savings were spent.

III. Budget Neutrality and Financial Reporting Requirements

Budget neutrality was successfully maintained by the state during the January-March 2023 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 and Annual Monitoring Reports.

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Attachment A:
Data on Grievances Received and Resolved by TennCare MCCs During January – March 2023 Quarter

[D1] Plan-Level, Set Indicators

#	Indicator	AMERIGROUP	BlueCare	UnitedHealthcare	Denta Quest	Optum	
IV. Appeals, State Fair Hearings and Grievances							
Subtopic: Grievances							
D1.IV.10	**Grievances resolved**	302	258	37	77	7	
D1.IV.11	**Active grievances**	82	100	18	56		
D1.IV.12	**Grievances filed on behalf of LTSS users**	6	16	0			
D1.IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance**	0	N/A	0			
D1.IV.14	**Number of grievances for which timely resolution was provided**	302	258	37			
Number of grievances resolved by plan during the reporting period related to the following services: (A single grievance may be related to multiple service types and may therefore be coun							
D1.IV.15a	**Resolved grievances related to general inpatient services**	6	N/A	1			
D1.IV.15b	**Resolved grievances related to general outpatient services**	133	N/A	15			
D1.IV.15c	**Resolved grievances related to inpatient behavioral health services**	2	N/A	0			
D1.IV.15d	**Resolved grievances related to outpatient behavioral health services**	5	N/A	2			
D1.IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs**	6	N/A	0		2	
D1.IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services**	0	N/A	0			
D1.IV.15g	**Resolved grievances related to long-term services and supports (LTSS)**	6	N/A	0			
D1.IV.15h	**Resolved grievances related to dental services**	15	N/A	0	77		
D1.IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)**	109	N/A	19			
D1.IV.15j	**Resolved grievances related to other service types**	20	N/A	0			
Number of grievances resolved by plan during the reporting period related to the following reasons: (A single grievance may be related to multiple reasons and may therefore be counted in							
D1.IV.16a	**Resolved grievances related to plan or provider customer service**	18	93	4	4	1	

D1.IV.16b	**Resolved grievances related to plan or provider care management/case management**	1	6	0			
D1.IV.16c	**Resolved grievances related to access to care/services from plan or provider**	195	79	14	4		
D1.IV.16d	**Resolved grievances related to quality of care**	32	85	0	18		
D1.IV.16e	**Resolved grievances related to plan communications**	9	0	0			
D1.IV.16f	**Resolved grievances related to payment or billing issues**	39	1	0	50		
D1.IV.16g	**Resolved grievances related to suspected fraud**	3	N/A	0			
D1.IV.16h	**Resolved grievances related to abuse, neglect or exploitation**	0	N/A	0			
D1.IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)**	0	N/A	0			
D1.IV.16j	**Resolved grievances related to plan denial of expedited appeal**	0	N/A	0			
D1.IV.16k	**Resolved grievances filed for other reasons**	5	N/A	19	1	4	

Attachment B:
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.

Reportable Events and data are tracked and trended by DIDD, the MCOs, and providers in the One Aligned Reportable Event Management System for all LTSS programs, including CHOICES (Groups 2 & 3), Employment and Community First CHOICES, and Katie Beckett. 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. CHOICES and ECF CHOICES providers report Reportable Events to DIDD using an aligned Reportable Event Form. These providers are required to be trained on completing Tier 2 Reportable Event Investigations. Since January 1, 2022, Reportable Event Management is 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 IEA Remediation Reports are submitted for the 1115 waiver program by each MCO. These reports capture how each instance of provider non-compliance with the Final Settings Rule is remediated.
- Reportable Event Management Monthly Reports track all reportable event 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.
- Using the monthly reports, the Quality Assurance team reviews all Reportable Event Management data and generates a report that reviews compliance for investigation and reporting timeframes.