Tennessee Department of Finance & Administration

Division of TennCare

TennCare III Demonstration

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Quarterly Monitoring Report

(For the period January – March 2025)

Demonstration Year: 5 (1/1/25 - 12/31/25)

Federal Fiscal Quarter: 2/2025 (1/25 - 3/25)

Demonstration Quarter: 1/2025 (1/25 - 3/25)

June 20, 2025

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 2025 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 #
2/28/25	A demonstration monitoring call was held.	59
3/25/25	The state notified the public of its intent to implement certain benefit enhancements to the CHOICES program, effective July 1, 2025.	6
3/26/25	A demonstration monitoring call was held.	59

I. Operational Updates

Progress Towards Milestones

The TennCare III demonstration continues a number of program components from the prior iteration of the TennCare demonstration that are already in operation. In addition, TennCare III includes some new programmatic flexibilities and authorities. In terms of new flexibilities authorized under TennCare III, the state has completed various milestones, 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 draft Demonstration Monitoring Protocol on June 7, 2021, and the revised Demonstration Monitoring Protocol on May 24, 2023;
- Submission of the DSIP Claiming Protocol on June 30, 2021 (approved by CMS on December 27, 2022);
- Submission of the draft Evaluation Design on July 7, 2021, and revised versions of the Evaluation Design on September 9, 2022 and September 20, 2024; and
- Submission of the first Interim Evaluation Report on February 26, 2024, and a revised version of the Report on September 20, 2024.

Additional Program Developments

During the January-March 2025 quarter, the state continued to seek approval for program enhancements via a set of demonstration amendments. Details are as follows:

Demonstration Amendment 6 (Work Incentives Group). On August 21, 2024, the state submitted Demonstration Amendment 6 to CMS. Amendment 6 proposes to establish a Work Incentives Group within the TennCare program for working persons with disabilities. This Work Incentives Group will provide a pathway to TennCare coverage for persons who would otherwise qualify for CHOICES or ECF CHOICES but who have excess income or resources due to employment.

To qualify in the new Work Incentives Group, individuals must meet the following criteria:

- Must be 18 years of age or older (no maximum age);
- Must meet the level of care criteria for TennCare's existing programs for persons with disabilities (i.e., CHOICES or ECF CHOICES); and
- Must have earned income.

The proposed Work Incentives Group will be open to individuals with disabilities at any income level. Enrollees in the new Work Incentives Group will be required to pay premiums as a condition of receiving TennCare coverage.

As of the end of the January-March 2025 quarter, CMS' review of Amendment 6 was ongoing.

Demonstration Amendment 7 (Program Enhancements). On October 29, 2024, the state submitted another demonstration amendment to CMS. Amendment 7 is designed to enhance benefits, promote access to care, improve quality outcomes, and improve transparency and program administration. The proposal consists of three primary components:

- Covering the full continuum of care for individuals with serious mental illness and serious emotional disturbance;

- Implementing an access/quality improvement program for Tennessee hospitals in which additional payments are earned by achieving agreed-upon quality performance benchmarks; and
- Improving home- and community-based services furnished by TennCare through the CHOICES, ECF CHOICES, and Katie Beckett/Medicaid Diversion programs.

CMS' review of Amendment 7 was ongoing as of the end of the end of the January-March 2025 quarter.

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 certain 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.

As of the end of the January-March 2025 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 2025 quarter.

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 demonstration amendments described above.

[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).

Key Challenges During the Quarter

There were no significant challenges associated with operating the demonstration during this quarter.

Key Achievements During the Quarter

During the January-March 2025 quarter, the state continued to expand the availability of TennCare services to eligible Tennesseans by covering more benefits and enrolling new populations.

Implementation of Diaper Benefit. On August 7, 2024, TennCare became the first Medicaid program in the nation to cover the cost of diapers (up to 100 per month) for members under age two. The state's new diaper benefit is part of a multi-pronged strategy to improve maternal and child health outcomes in Tennessee and to support Tennessee families, elements of which include—

- Providing 12 months of postpartum coverage for pregnant women enrolled in TennCare;
- Providing coverage of lactation support services for new mothers and infants enrolled in TennCare;
- Reducing enrollment "churn" by implementing 12 months of continuous eligibility for children enrolled in TennCare;
- Increasing TennCare's coverage of pregnant women to 250 percent of the federal poverty level;
- Covering the parents of dependent children who do not qualify for subsidized Marketplace coverage; and
- Providing a supply of diapers for infants and children under age 2 enrolled in TennCare.

The purpose of the diaper program is to support improved health outcomes for infants enrolled in TennCare by helping to prevent the types of health conditions that can arise when infants go without diaper changes at regular intervals. Since diapers are typically a requirement for children to attend childcare, early childhood education, or early intervention services, TennCare's diaper benefit will also help ensure that TennCare-enrolled children are able to participate in these activities (and consequently, that the parents of TennCare-enrolled children are able to attend work or school). As of the end of the January-March 2025 quarter, nearly eight months after program implementation, a total of 50,305 unique members had accessed the diaper benefit. The program has grown to include 407 pharmacy locations participating across 90 counties.

Lactation Support Services. On June 1, 2023, the state began covering lactation support services for new mothers enrolled in TennCare. Lactation support services include education, counseling, and assistance for common breastfeeding issues, along with skilled, evidence-based care for more complex lactation issues. Research consistently shows that breastfeeding has a variety of health benefits for mothers and infants, including lower risk of ear infections, sudden infant death syndrome, obesity, type 1 diabetes, and asthma. Breastfeeding can have a positive

economic impact on families as well, as formula can be a significant expense for families. The new lactation support benefit helps bolster breastfeeding as an option for families who want to breastfeed their infant but who need additional supports to do so successfully. According to data gathered upon the conclusion of the January-March 2025 quarter, a total of 3,300 lactation support services claims had been paid by TennCare on behalf of 2,567 mothers enrolled in TennCare.

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 January-March 2025 quarter, a total of 154,270 unique members had received 1,807,395 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 2025 quarter, a total of 1,411 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 end of the January-March 2025 quarter, a total of 4,833 children were enrolled in the program, with 249 enrolled in Katie Beckett (Part A), 4,584 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 3 presents a summary of eligibility appeal activity during the quarter, compared to the previous two quarters. It should be noted that appeals (whether related to eligibility, medical services, or LTSS) may be resolved or taken to hearing in a quarter other than the one in which they are initially received by TennCare.

Table 3
Eligibility Appeals for January – March 2025
Compared to the Two Previous Quarters

	Jul – Sep 2024	Oct – Dec 2024	Jan – Mar 2025
No. of appeals received	32,884	22,050	21237
No. of appeals resolved or withdrawn	32,231	25,231	24788
No. of appeals taken to hearing	4,821	5,085	4510
No. of hearings resolved in favor of appellant	65	48	39

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

Table 4
Medical Service Appeals for January – March 2025
Compared to the Two Previous Quarters

	Jul – Sep 2024	Oct – Dec 2024	Jan – Mar 2025
No. of appeals received	2,786	2,525	2,995
No. of appeals resolved	1,552	1,433	1,325
• Resolved at the MCC level	416	372	384
• Resolved at the TSU level	115	108	126
• Resolved at the LSU level	1,021	953	815
No. of appeals that did not involve a valid factual dispute	1,171	1,038	1,205
No. of directives issued	300	287	354
No. of appeals resolved by fair hearing	1,047	953	842
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	330	323	336
Appeals that went to hearing and were decided in the state's favor	632	571	419
Appeals that went to hearing and were decided in the appellant's favor	59	59	60

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 5
Long-Term Services and Supports Appeals for January – March 2025
Compared to the Two Previous Quarters

	Jul – Sep 2024	Oct – Dec 2024	Jan – Mar 2025
No. of appeals received	105	129	145
No. of appeals resolved or withdrawn	58	53	80
No. of appeals set for hearing	41	44	61
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 2025 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 2025 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. Following a bench trial in November 2023, the Court issued a Memorandum Opinion in August 2024, finding that the Plaintiffs had met their burden on several of the claims raised but had not met their burden on several others. The Court did not order specific relief but did order the parties to participate in mediation, which is ongoing. The litigation remains pending.

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. A second case challenges the State Plan Amendments (SPAs) containing the same reimbursement rates. On August 24, 2023, the

Chancery Court ruled against TennCare and held the rules and SPAs to be invalid. The state has appealed these rulings, and the appeals are currently pending with the Court of Appeal.

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 bid protest by Rhythm and uphold TennCare's award of its Managed Care Organization (MCO) contracts. Final briefing is expected to conclude this spring, and a hearing will follow. After the hearing, the Chancellor will issue a decision in the case.

Ritter v. F&A, et al. Lawsuit. This case originated in state court as judicial review of an administrative appeal regarding TennCare services. Although a stay was initially entered, the court ultimately granted the state's motion and dismissed the appeal for lack of subject matter jurisdiction, while also awarding fees and costs to the petitioner. In January 2025, the state appealed the award of fees and costs to the Court of Appeals.

Unusual or Unanticipated Trends

There were no unusual or unanticipated trends during the January-March 2025 quarter.

Legislative Updates

By the conclusion of the January-March 2025 quarter, Tennessee's legislative session was in progress. A summary of state legislation with significant implications for TennCare will be included in the Monitoring Report for the April-June 2025 quarter.

Public Forums

The state's most recent public forum on the progress of the TennCare III demonstration was held on June 28, 2024. A summary of feedback received during the forum and copies of the written public comments received by the state were included in the Monitoring Report for the April-June 2024 quarter. The state's next public forum is scheduled for June 27, 2025.

Enrollment and Member Month Data

Information about TennCare enrollment by category is presented in Table 6.

Table 6
Enrollment Counts for the January – March 2025 Quarter
Compared to the Two Previous Quarters

Demonstration Populations	Jul – Sep 2024	Oct – Dec 2024	Jan – Mar 2025
EG1 Disabled	123,484	121,473	120,530
EG9 H-Disabled	947	938	959
EG2 Over 65	257	235	281
EG10 H-Over 65	28	42	31
EG3 Children	688,237	679,515	671,626

Demonstration Populations	Jul – Sep 2024	Oct – Dec 2024	Jan – Mar 2025
EG4 Adults	350,920	342,243	339,111
EG5 Duals and EG11 H-Duals 65	164,871	158,796	158,884
EG6E Expan Adult	0	0	0
EG7E Expan Child	7,985	10,241	11,055
EG8, Med Exp Child	0	0	0
Med Exp Child, Title XXI Dem Pop	130,336	136,055	139,921
EG12E Carryover	781	742	701
EG13 Katie Beckett	219	227	254
EG14E Medicaid Diversion	3,983	4,251	4,635
EG15 Continued Eligibility	0	0	0
EG16 MEC Additions	18,986	15,893	17,758
TOTAL*	1,491,034	1,470,651	1,465,746

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

Table 7 below presents the member month reporting by eligibility group for each month in the quarter.

Table 7
Member Month Reporting for January – March 2025

Eligibility Group	January 2025	February 2025	March 2025	Sum for Quarter Ending 3/31/25
EG1 Disabled	121,411	119,871	118,585	359,867
EG2 Over 65	223	222	208	653
EG3 Children	659,872	651,800	654,210	1,965,882
EG4 Adults	325,186	319,537	317,815	962,538
EG5 Duals	147,733	145,517	144,519	437,769
EG6E Expan Adult	0	0	0	0
EG7E Expan Child	10,368	10,227	10,515	31,110
EG8 Med Exp Child	0	0	0	0
EG9 H-Disabled	923	930	935	2,788
EG10 H-Over 65	27	24	25	76
EG11 H-Duals	7,959	7,967	7,997	23,923
Med Exp Child, Title XXI Demo Pop	139,774	139,829	138,849	418,452
EG12E Carryover	705	689	681	2,075
EG13 Katie Beckett	233	239	252	724

Eligibility Group	January 2025	February 2025	March 2025	Sum for Quarter Ending 3/31/25
EG14E Medicaid Diversion	4,377	4,533	4,606	13,516
EG15 Continued Eligibility	0	0	0	0
EG16 MEC Additions	16,540	16,744	16,954	50,238
TOTAL	1,435,331	1,418,129	1,416,151	4,269,611

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 as of the end of the quarter, as well as information about the number of available reserve slots.

Table 8
CHOICES Enrollment and Reserve Slots
for January-March 2025 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 2024	Oct – Dec 2024	Jan – Mar 2025
CHOICES 1	Not applicable	13,981	13,833	13,565
CHOICES 2	11,000	8,715	8,767	8,759
CHOICES 3 (SSI recipients)	To be determined	1,972	1,983	1,950
CHOICES 3 (members of the CHOICES At Risk Demo Group)	1,750[2]	1,317	1,375	1,411

[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. The target of 1,750 is based on legislative appropriations.

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Jul – Sep 2024	Oct – Dec 2024	Jan – Mar 2025
Total CHOICES	Not applicable	25,985	25,958	25,685
Reserve Capacity	300	300	300	300

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STC 52 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 52.d. requires the state to submit to CMS periodic statistical reports about the use of LTSS by TennCare members. Twenty-one separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and June 2024.

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 14,819 individuals on June 30, 2023. 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 60 percent admitted to NFs in the thirteenth 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 thirteen 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 412 transitions happening in the thirteenth 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 13,472 after CHOICES had been in place for thirteen 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 11,656 by June 30, 2023. The percentage of LTSS expenditures devoted to HCBS grew as well, rising from 9.75 percent in the year prior to CHOICES, to 21.26 percent after the CHOICES program had been in place for thirteen years.

Selected elements of the aforementioned CHOICES data are summarized in Table 9.

Table 9
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), 7/1/21 – 6/30/23	Percent increase over a twelve-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 6/30/23	Percent increase from the day prior to CHOICES implementa-tion to 6/30/23
6,226	13,472	116%	4,861[3]	11,656	140%

MCO-distributed transition allowances (CHOICES approval letter dated February 26, 2010): The allocation of CHOICES transition allowance funds during DY 4 is detailed in Table 10.

Table 10
CHOICES Transition Allowances
for January-March 2025 Compared to the Two Previous Quarters

	Frequency and Use of Transition Allowances					
	Jul – Sep 2024		Oct – Dec 2024		Jan – Mar 2025	
Grand Region	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	11	$7,892	10	$5,428	12	$10,803
Middle	30	$15,163	26	$12,313	19	$12,672
West	31	$19,153	33	$20,068	18	$15,028
Statewide Total	72	$42,208	69	$37,809	49	$38,503

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.

[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).

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 11
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots for January-March 2025 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 2024	Oct – Dec 2024	Jan – Mar 2025
ECF CHOICES 4	1,705	1,666	1,666	1,643
ECF CHOICES 5	2,239	2,172	2,140	2,109
ECF CHOICES 6	2,281	2,048	2,133	2,198
ECF CHOICES 7	26	15	19	17
ECF CHOICES 8	50	28	26	28
Total ECF CHOICES	6,301[4]	5,929	5,984	5,995
Reserve capacity	3,951	3,680	3,701	3,706
Waiver Transitions[5]	Not applicable	0	0	0

Data and trends of the designated ECF CHOICES data elements: STC 52.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 seven years' worth of post-implementation data. In comparing the baseline data with the post-implementation data, several notable trends emerged:

[4] On July 1, 2024, funding was obtained to raise the number of reserve capacity slots from 6,300 slots to 6,600. However, because of the need to allocate slots for all prior waiver transitions, the upper limit was reduced. These upper limits provide flexibility to move slots as needed, based on the needs of program applicants.

[5] Waiver transitions are instances in which an individual enrolled in a 1915(c) HCBS waiver program is transferred into the ECF CHOICES program. Prior to November 1, 2023, a waiver transition did not count against the enrollment target. Beginning on November 1, 2023, however, waiver transitions do count against the enrollment target. Waiver transition numbers are cumulative since the program began. On July 8, 2024, all waiver transitions were assigned a slot and are accounted for within the enrollment targets. Note that this change is not yet reflected in the STCs but is proposed as one of several changes in Amendment 7.

- The number of individuals with developmental disabilities other than intellectual disabilities who received HCBS through the TennCare program grew from 0 to 3,200.
- Average LTSS expenditures for individuals with intellectual or developmental disabilities fell from $94,327 per person to $90,425 per person, representing a 4.1 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 17.2 percent.

Since 2021, the state has made significant investments in reducing the referral list for ECF CHOICES. 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.

The state offers services to eligible children through a traditional Katie Beckett program (also called "Part A"), in which members receive the full TennCare benefits package plus essential wraparound HCBS. In addition, the demonstration includes a Medicaid Diversion component (also called "Part B"), which furnishes a specified package of essential wraparound services and supports, including premium assistance. In addition, a 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 12
Katie Beckett, Medicaid Diversion, and Continued Eligibility Enrollment and Reserve Slots for January-March 2025 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 2024	Oct – Dec 2024	Jan – Mar 2025
Katie Beckett	300	215	223	249

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jul – Sep 2024	Oct – Dec 2024	Jan – Mar 2025
Medicaid Diversion	4,700[6]	3,924	4,189	4,584
Continued Eligibility	N/A	0	0	0
Reserve capacity	300	215	223	249

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.

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.

[6] During the July-September 2024 quarter, a total of 700 Medicaid Diversion slots were added as part of budget rebalancing, thereby bringing the total number of Medicaid Diversion slots to 4,700.

II. Performance Metrics

Progress Toward Goals and Targets in the Monitoring Protocol

STC 54 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, and the state submitted a revised version of the document that addressed CMS' input on May 24, 2023.

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 1,465,746 Tennesseans as of the end of the January-March 2025 quarter. This total represents 21 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 2025, TennCare's External Quality Review Organization (EQRO), Health Services Advisory Group, published the results of its provider data validation survey for the January-March 2025 quarter. The EQRO took a sample of provider data files from TennCare's MCCs[7] and reviewed each for accuracy in the following categories:

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

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

- 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 "provider specialty / behavioral health service code" (92.23 percent accuracy) and "prenatal care services" (94.70 percent accuracy).

Progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Health Services Advisory Group's report concluded that the MCCs "achieved high accuracy rates" in seven out of ten data elements for the first quarter of Calendar Year 2025.

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. Additionally, the participants also have access to web-based MCO portals that allow providers to identify and track closure of gaps in care linked to specific quality measures and to receive notification when a member has an emergency department visit or inpatient stay. To ensure that the principles of the PCMH model are actually incorporated into health care offered 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 the most recent count, approximately 656,740 TennCare members are attributed to one of 78 PCMH-participating organizations, and there are 493 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 learning collaborative in Memphis to close quality gaps in care related to diabetes, such as Diabetes Eye Exam, Blood Pressure Control for Patients with Diabetes, and Glycemic Status <8%.

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. While over 30 providers—including patient-centered medical homes, long-term services and supports providers, and behavioral health providers—have phased out of the program and are currently engaging in sustainability efforts, active cohorts of the partnerships include two large hospital systems and two birthing hospitals. 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 60,000 unique members and identified needs across various domains, including transportation, housing, utility assistance, and childcare. The state is utilizing findings and data from the program implementation to inform future quality improvement initiatives related to addressing Tennesseans' social risk factors. As a part of TennCare's Health Starts Community Health Worker Strategy, TennCare contracted with the Tennessee Community Health Worker Association (TNCHWA). In State Fiscal Year 2025, TNCHWA developed CHW program standards that emphasize high-quality CHW programs and an accreditation process for CHW programs. Since State Fiscal Year 2024, fifteen provider organizations across the state have received funding through the CHW Infrastructure Grant to implement CHW program standards developed by the TNCHWA. These grantees also receive technical support to hire and retain CHWs using evidence-based principles to ensure TennCare members receive high-quality services. Through engagement in the Infrastructure Grant, provider organizations apply for the CHW Program accreditation facilitated by TNCHWA. Thus far, four provider organizations have achieved accreditation. By the conclusion of the grant, grantees will outline how their organization plans to continue integrating CHWs into their care models after the grant period ends.

In other Health Starts news, the state selected the organization findhelp as the vendor for its closed-loop referral system, Tennessee Community Compass. Tennessee Community Compass is a free, statewide tool connecting Tennesseans to local, community-based resources to address health and social needs. The tool will help TennCare MCOs and providers screen for social needs; create referrals to community resources based on identified needs using the resource directory; and provide opportunities for CBOs, MCOs, and providers to track the outcome of the referrals. Data from the system will be used by the state to enhance the strategic direction of Health Starts. Tennessee Community Compass recently launched with its first phase of providers. In the coming months, the state will select additional partners to implement Tennessee Community Compass.

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 December 2024, the number of BESMART providers had increased to 585, and the number of unique members served per month had grown to 23,860. 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 2018, the NAS rate in the TennCare population was 23.99 NAS births per 1,000 live births, as compared with the 2022 rate, which was 19.05 NAS births per 1,000 live births. A decline from the 2018 NAS rate has been achieved for four 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 4. During the January-March 2025 quarter, BCBER made initial preparations for the 2025 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 second report—which was included as an attachment to the Annual Monitoring Report for DY 3—detailed progress on these metrics, described how the shared savings for Demonstration Years 1 and 2 were calculated, and offered an accounting of how the shared savings were spent.

The Shared Savings Quality Measures Protocol was rescinded in August 2023 as part of Demonstration Amendment 4.

III. Budget Neutrality and Financial Reporting Requirements

Budget neutrality was successfully maintained by the state during the January-March 2025 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 89 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 90, the state submitted a revised draft Evaluation Design to CMS on September 9, 2022, followed by another draft on September 20, 2024.

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.

On February 26, 2024, in compliance with STC 93, the state submitted to CMS a draft of its first Interim Evaluation Report. The findings of the report are generally positive, as indicated by the following assessment from the "Conclusions" section: "Despite the challenges associated with the COVID-19 public health emergency, TennCare III has helped make progress toward the goals outlined for this evaluation, notably in efforts to improve access to care." The report does note that definitive conclusions about the impact of TennCare III are difficult to draw because of the distorting effect of the COVID-19 public health emergency (PHE) on data collection efforts and on use of the healthcare system by TennCare members, and because as the first Interim Evaluation Report produced during the demonstration, it covers only a limited time period following the demonstration's initial approval. With the end of the PHE, however, some of the

obstacles to research and analysis have been removed, with more definitive conclusions on several key research questions expected to be available in the state's second Interim Evaluation Report. In response to feedback from CMS, the state submitted a revised version of the first Interim Evaluation Report on September 20, 2024, and CMS approved the state's Interim Evaluation Report on November 18, 2024.

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Attachment A:
Data on Grievances Received and Resolved by TennCare MCCs During the January – March 2025 Quarter

[D1] Plan-Level, Set Indicators							
#	Indicator	Wellpoint	BlueCare	TennCare Select	UnitedHealthcare	DentaQuest	Optum
IV. Appeals, State Fair Hearings and Grievances							
Subtopic: Grievances							
D1.IV.10	**Grievances resolved**	594	203	11	59	**174**	12
D1.IV.11	**Active grievances**	212	82	5	120	**198**	
D1.IV.12	**Grievances filed on behalf of LTSS users**	11	12	0	26		
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	0	0	0		
D1.IV.14	**Number of grievances for which timely resolution was provided**	594	203	11	28		12
D1.IV.15a	**Resolved grievances related to general inpatient services**	17	0	0	1		
D1.IV.15b	**Resolved grievances related to general outpatient services**	409	0	0	19		
D1.IV.15c	**Resolved grievances related to inpatient behavioral health services**	5	0	0	1		
D1.IV.15d	**Resolved grievances related to outpatient behavioral health services**	10	0	0	2		
D1.IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs**	12	0	0	1		4
D1.IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services**	0	0	0	0		
D1.IV.15g	**Resolved grievances related to long-term services and supports (LTSS)**	6	11	0	3		
D1.IV.15h	**Resolved grievances related to dental services**	14	NA	NA	0	**174**	

D1.IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)**	65	110	3	19		
D1.IV.15j	**Resolved grievances related to other service types**	56	0	0	14		
D1.IV.16a	**Resolved grievances related to plan or provider customer service**	31	51	2	0	**13**	
D1.IV.16b	**Resolved grievances related to plan or provider care management/case management**	23	1	0	0		
D1.IV.16c	**Resolved grievances related to access to care/services from plan or provider**	218	108	4	1	**39**	5
D1.IV.16d	**Resolved grievances related to quality of care**	63	32	5	6	**55**	
D1.IV.16e	**Resolved grievances related to plan communications**	21	0	0	0		
D1.IV.16f	**Resolved grievances related to payment or billing issues**	209	11	0	0	**67**	
D1.IV.16g	**Resolved grievances related to suspected fraud**	2	0	0	0		
D1.IV.16h	**Resolved grievances related to abuse, neglect or exploitation**	0	0	0	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)**	12	0	0	0		
D1.IV.16j	**Resolved grievances related to plan denial of expedited appeal**	0	0	0	0		
D1.IV.16k	**Resolved grievances filed for other reasons**	15	1	0	1	**0**	3

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. The 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 accessible through Formstack. 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.