



Tennessee Department of Finance & Administration

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Quarterly Monitoring Report

(For the period April – June 2024)

Demonstration Year: 4 (1/1/24 - 12/31/24)

Federal Fiscal Quarter: 3/2024 (4/24 - 6/24)

Demonstration Quarter: 2/2024 (4/24 - 6/24)

October 1, 2024

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 April-June 2024 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 #
4/25/24	The Monthly Call for April, which would have been held on this date, was cancelled.	59
4/29/24	The state submitted to CMS enrollment target ranges for CHOICES Groups 2 and 3 and for all Employment and Community First CHOICES benefit groups.	33.d.ii and 34.d.ii
5/23/24	The Monthly Call for May was held.	59
5/30/24	The state published the details (including date, time, and location) of a public forum at which comments on the progress of the TennCare demonstration would be held.	60
6/27/24	The Monthly Call for June was held.	59
6/28/24	The state held a public forum to accept comments on the progress of the TennCare demonstration.	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 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); and
- Submission of the draft Evaluation Design on July 7, 2021, the revised Evaluation Design on September 9, 2022, and the first Interim Evaluation Report on February 26, 2024.

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.

Additional Program Developments

During the April-June 2024 quarter, the state continued to seek approval for program enhancements via a set of demonstration amendments. Details are as follows:

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 program¹;

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).

- 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 April-June 2024 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 April-June 2024 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.

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 quarter, the state obtained CMS approval of a key demonstration amendment while also continuing to expand the availability of TennCare services to eligible Tennesseans by covering more benefits and enrolling new populations.

Approval of Demonstration Amendment 5 (Supporting Strong Families). On November 13, 2023, the state submitted Demonstration Amendment 5 to CMS. Amendment 5 proposed to enhance coverage, benefits, and supports for TennCare members via the following program changes:

- Expanding access to care for low-income parents and caretaker relatives of dependent children by aligning TennCare's income standard for these individuals with the federal poverty level (i.e., 100 percent of the FPL);
- Covering a supply of 100 diapers per month for TennCare-enrolled children under age 2; and
- Enhancing the HCBS available under the demonstration, with particular emphasis on supporting employment.

CMS approved Amendment 5 on May 17, 2024. Amendment 5 is expected to enhance coverage and benefits for children and their caregivers and to strengthen the employment supports available to persons with disabilities under the TennCare demonstration.

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 will help bolster breastfeeding as an option for families who want to breastfeed their infant but who need additional supports to do so successfully. As of the end of the January-March 2024 quarter, a total of 1,593 claims had been paid by TennCare's MCOs on behalf of 1,247 unduplicated members.

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 April-June 2024 quarter, a total of 118,900 unique members had received 1,187,836 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 April-June 2024 quarter, a total of 1,138 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 April-June 2024 quarter, a total of 3,629 children were enrolled in the program, with 199 enrolled in Katie Beckett (Part A), 3,430 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 April – June 2024
Compared to the Two Previous Quarters

	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024
No. of appeals received	27,065	34,039	37,720
No. of appeals resolved or withdrawn	25,985	31,429	35,869

	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024
No. of appeals taken to hearing	4,340	4,566	4,638
No. of hearings resolved in favor of appellant	63	44	62

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 April – June 2024
Compared to the Two Previous Quarters

	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024
No. of appeals received	3,303	3,125	2,950
No. of appeals resolved	1,960	1,773	1,724
• Resolved at the MCC level	521	490	431
• Resolved at the TSU level	184	95	110
• Resolved at the LSU level	1,255	1,188	1,183
No. of appeals that did not involve a valid factual dispute	1,424	1,424	1,270
No. of directives issued	345	308	311
No. of appeals resolved by fair hearing	1,273	1,214	1,208
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	466	435	488
Appeals that went to hearing and were decided in the state’s favor	728	689	624
Appeals that went to hearing and were decided in the appellant’s favor	61	64	71

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 April – June 2024
Compared to the Two Previous Quarters

	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024
No. of appeals received	91	87	86
No. of appeals resolved or withdrawn	63	49	46
No. of appeals set for hearing	33	29	44
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 April-June 2024 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 April-June 2024 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. Recently, a bench trial was conducted. Post-trial briefing concluded in early March 2024, and a decision is expected in Calendar Year 2024.

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. On May 25, 2023, the Tennessee Supreme Court reversed the Court of Appeals and held that the \$50 cap should have been promulgated as a rule under the state's administrative procedures act.

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.

McCutchen et al. v. Becerra Lawsuit. In 2021, the Tennessee Justice Center, acting on behalf of 14 individual plaintiffs, filed a federal lawsuit challenging CMS' approval of the TennCare III demonstration. On August 5, 2021, the state intervened in the litigation. The McCutchen suit was subsequently stayed pending the outcome of a federal comment period on the TennCare III demonstration. In December 2023, Plaintiffs filed their Second Amended Complaint, which reduced the number of claims and individual plaintiffs.

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. Briefing on the matter is expected to conclude in July 2024, with a decision expected thereafter.

Unusual or Unanticipated Trends

There were no unusual or unanticipated trends during the April-June 2024 quarter.

Legislative Updates

The Tennessee General Assembly passed a number of pieces of legislation with implications for the TennCare program during the April-June 2024 quarter. The enacted pieces of legislation with the most significant impact on the TennCare program were the following:

- The General Assembly appropriated funding for coverage of additional working individuals with disabilities and authorized TennCare to seek demonstration authority to implement this new coverage. (TennCare subsequently submitted Amendment 6 to the demonstration on August 21, 2024.)
- The General Assembly authorized funding for an access/quality improvement program for Tennessee hospitals.
- The General Assembly passed legislation to raise the personal needs allowance for persons receiving long-term services and supports under the demonstration.
- In addition, assessments used to help fund various aspects of the TennCare program (i.e., the hospital assessment, the nursing facility assessment, and the ground ambulance provider assessment) were renewed for another year.

Public Forums

In compliance with the federal regulation at 42 CFR § 431.420(c) and the Special Terms and Conditions of the TennCare demonstration, TennCare hosted a public forum in Nashville on June 28, 2024. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The June 28 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address and a physical address at which comments would be accepted. Input received during the event touched on such subjects as the possibility of expanding coverage of the newly implemented diaper benefit to individuals with intellectual disabilities, challenges faced by TennCare in supporting employment for individuals with disabilities, and member concerns about losing TennCare coverage.

Copies of the written comments received during the public forum process are included as Attachment B to this Quarterly Monitoring Report.

Enrollment and Member Month Data

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

Table 6
Enrollment Counts for the April – June 2024 Quarter
Compared to the Two Previous Quarters

Demonstration Populations	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024
EG1 Disabled	132,537	128,326	127,664
EG9 H-Disabled	982	986	919

Demonstration Populations	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024
EG2 Over 65	330	304	271
EG10 H-Over 65	28	30	32
EG3 Children	873,241	753,436	713,856
EG4 Adults	526,847	455,471	397,394
EG5 Duals and EG11 H-Duals 65	178,787	175,707	172,182
EG6E Expan Adult	0	0	0
EG7E Expan Child	3,463	4,298	5,948
EG8, Med Exp Child	0	0	0
Med Exp Child, Title XXI Dem Pop	18,061	111,678	124,339
EG12E Carryover	878	848	811
EG13 Katie Beckett	180	192	206
EG14E Medicaid Diversion	2,952	3,161	3,611
EG15 Continued Eligibility	0	0	0
EG16 MEC Additions	9,904	15,929	19,504
TOTAL*	1,748,190	1,650,366	1,566,737

* 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 71 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 April – June 2024

Eligibility Group	April 2024	May 2024	June 2024	Sum for Quarter Ending 6/30/24
EG1 Disabled	128,174	126,481	125,367	380,022
EG2 Over 65	215	217	213	645
EG3 Children	704,150	692,288	677,248	2,073,686
EG4 Adults	381,947	360,780	336,124	1,078,851
EG5 Duals	160,764	158,030	155,621	474,415
EG6E Expan Adult	0	0	0	0
EG7E Expan Child	4,644	5,253	5,517	15,414
EG8 Med Exp Child	0	0	0	0
EG9 H-Disabled	907	907	893	2,707
EG10 H-Over 65	33	33	27	93
EG11 H-Duals	7,391	7,457	7,436	22,284

Eligibility Group	April 2024	May 2024	June 2024	Sum for Quarter Ending 6/30/24
Med Exp Child, Title XXI Demo Pop	119,976	120,992	122,108	363,076
EG12E Carryover	813	812	793	2,418
EG13 Katie Beckett	192	197	204	593
EG14E Medicaid Diversion	3,263	3,421	3,571	10,255
EG15 Continued Eligibility	0	0	0	0
EG16 MEC Additions	19,204	19,338	19,343	57,885
TOTAL	1,531,673	1,496,206	1,454,465	4,482,344

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 8
CHOICES Enrollment and Reserve Slots
for April-June 2024 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		
		Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024
CHOICES 1	Not applicable	14,029	13,684	13,815
CHOICES 2	11,000	8,759	8,606	8,622
CHOICES 3 (SSI recipients)	To be determined	2,069	1,948	1,968

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Being Held as of the End of Each Quarter		
		Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024
CHOICES 3 (members of the CHOICES At Risk Demo Group)	1,750 ²	891	1,057	1,138
Total CHOICES	Not applicable	25,748	25,295	25,543
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

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.

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 implementation	No. of TennCare members accessing HCBS (E/D) on 6/30/23	Percent increase from the day prior to CHOICES implementation 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 is detailed in Table 10.

Table 10
CHOICES Transition Allowances
for April-June 2024 Compared to the Two Previous Quarters

Grand Region	Frequency and Use of Transition Allowances					
	Oct – Dec 2023		Jan – Mar 2024		Apr – Jun 2024	
	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	19	\$9,819	19	\$8,264	15	\$12,067
Middle	29	\$9,934	12	\$5,408	31	\$17,034
West	27	\$13,802	49	\$22,629	22	\$12,824
Statewide Total	75	\$33,555	80	\$36,301	68	\$41,925

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).

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 11
ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots
for April-June 2024 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024
ECF CHOICES 4	1,790	1,691	1,671	1,680
ECF CHOICES 5	2,499	2,326	2,264	2,208
ECF CHOICES 6	1,911	1,808	1,867	1,963
ECF CHOICES 7	50	13	14	14
ECF CHOICES 8	50	27	28	27
Total ECF CHOICES	6,300 ⁴	5,865	5,844	5,892
Reserve capacity	3,950	3,515	3,521	3,549
Waiver Transitions ⁵	Not applicable	88	88	88

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

⁴ 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.

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, however, waiver transitions do count against the enrollment target. Waiver transition numbers are cumulative since the program began. Note that this change is not yet reflected in the STCs.

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:

- 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. 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 with the implementation of the new Katie Beckett/Medicaid Diversion program on November 2, 2020.

The state offers services to eligible children through a traditional Katie Beckett program (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 April-June 2024 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024
Katie Beckett	300	174	184	199
Medicaid Diversion	4,000	2,859	3,078	3,430
Continued Eligibility	N/A	0	0	0
Reserve capacity	300	174	184	199

Data and trends of the designated Katie Beckett/Medicaid Diversion data elements: STC 52.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 soon, 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.

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 C 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, 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 1,566,737 Tennesseans as of the end of the April-June 2024 quarter. This total represents 23 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 June 2024, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the April-June 2024 quarter. The EQRO took a sample of provider data files from TennCare's MCCs⁶ and reviewed each for accuracy in the following categories:

- Active contract status
- Provider address
- Provider specialty / behavioral health service code

⁶ TennCare's Pharmacy Benefits Manager (PBM) was not included in the survey.

- 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 "provider specialty / behavioral health service code" (93.01 percent accuracy) and "services for adults" (90.96 percent accuracy).

Progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Qsource's report concluded that the MCCs "achieved high accuracy rates" in eight out of ten data elements for the second quarter of Calendar Year 2024.

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 the most recent count, approximately 697,000 TennCare members are attributed to one of 81 PCMH-participating organizations, and there are 499 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 to reduce unnecessary utilization of the emergency department.

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 the upcoming year. 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 44,000 unique members and identified needs across various domains, including transportation, housing, utility assistance, and childcare. The state is utilizing findings and data from the first three years of program implementation to inform future quality improvement initiatives related to addressing Tennesseans' social risk factors. Recently, the Health Starts Initiative expanded to encompass efforts related to community health workers. TennCare has contracted with the Tennessee Community Health Worker Association (TNCHWA) 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, eight provider organizations across the state received funding to implement CHW program standards developed by the Tennessee Community Health Worker Association. These grantees also receive technical support to hire and retain CHWs using evidence-based principles to ensure TennCare members receive high-quality CHW services. All grantees will continue this work in the year ahead by applying for CHW Organization accreditation facilitated by TNCHWA and by outlining how their organization plans to continue integrating CHWs into their care models after the grant period ends. The CHW Infrastructure Grants will expand to include up to 15 more organizations in State Fiscal Year 2025.

In other Health Starts news, the state selected the organization findhelp as the vendor for its closed-loop referral system, Tennessee Community Compass (TCC). TCC 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. TCC will launch with two large integrated hospital systems in State Fiscal Year 2025.

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 2023, the number of BESMART providers had increased to 525, and the number of unique members served per month had grown to 26,443. 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 2021 rate, which was 21.35 NAS births per 1,000 live births. A decline from the 2018 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 3. During the April-June 2024 quarter, BCBER's process of gathering survey data from thousands of Tennessee households commenced. As of the end of the quarter, the survey phase was expected to be completed by the end of the summer, with data analysis and preparation of a summary report to follow shortly thereafter.

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 most recent Annual Monitoring Report—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.

III. Budget Neutrality and Financial Reporting Requirements

Budget neutrality was successfully maintained by the state during the April-June 2024 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.

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, 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.

V. State Contact

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Date Submitted to CMS: October 1, 2024

Attachment A:

Data on Grievances Received and Resolved by
TennCare MCCs During the April – June 2024 Quarter

[D1] Plan-Level, Set Indicators

#	Indicator	AMERIGROUP	BlueCare	TennCare Select	UnitedHealthcare	Denta Quest	Optum
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IV. Appeals, State Fair Hearings and Grievances

Subtopic: Grievances

D1.IV.10	Grievances resolved	633	203	14	45	207	10
D1.IV.11	Active grievances	208	68	5	12	208	
D1.IV.12	Grievances filed on behalf of LTSS users	35	13	0	6		
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	1		
D1.IV.14	Number of grievances for which timely resolution was provided	633	203	14	44		10

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 counted in more than one category.)

D1.IV.15a	Resolved grievances related to general inpatient services	9	0	0	2		
D1.IV.15b	Resolved grievances related to general outpatient services	363	0	0	11		
D1.IV.15c	Resolved grievances related to inpatient behavioral health services	5	0	0	0		
D1.IV.15d	Resolved grievances related to outpatient behavioral health services	5	0	0	5		
D1.IV.15e	Resolved grievances related to coverage of outpatient prescription drugs	15	0	0	0		3
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)	5	5	0	4		
D1.IV.15h	Resolved grievances related to dental services	37	N/A	N/A	0	207	
D1.IV.15i	Resolved grievances related to non-emergency medical transportation (NEMT)	99	99	2	21		
D1.IV.15j	Resolved grievances related to other service types	95	0	0	2		

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 multiple categories.)

D1.IV.16a	Resolved grievances related to plan or provider customer service	49	79	5	11	5	1
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[illegible]

Attachment B:
Written Comments Received During the 2024 Public
Forum Process

From: Stacy Gordon <[REDACTED]>
Sent: Monday, June 3, 2024 8:46 PM
To: PUBLIC.NOTICE TENNCARE
Subject: [EXTERNAL] June 28th.2024
Attachments: 20240531_114526.jpg

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

This is a comment submission for the public forum for the TNCARE demonstration. Attached is a screenshot of my less than 2 weeks notice of being dropped. I have had TNCARE for over 5 yrs and NOTHING has changed in my household. I am zero income, no resources, with a stack of medical issues. The only reason why I'm not homeless, is because a stranger took me into their house and pays all my bills except for food which is covered by snap. I HAVE A PENDING CLAIM WITH DISABILITY FILED BUT it takes forever to get through the process. 8 prescriptions a month some of those lifesaving . Heart medication, thyroid medication, and I am in pain management for chronic illnesses on narcotics. I have upcoming surgeries being booked. There SHOULD be a financial spend down option for those who don't have those 2 types of cancer, dependants, or and other qualifications to fit in those SMALL groups. Without pain management, I cannot take care of myself that includes getting out of bed to bathe or go to the bathroom. I live RURAL ,there is no medical care where I live. I'm traveling 400 miles a month just to get to my doctors because none are available where I live covered by Medicaid.

I DO NOT qualify for MARKETPLACE. They quoted me the max premium at \$9,000 a month. I don't qualify for private insurance because of pre-existing health conditions nor would I have the money to pay it. The health department does not treat what I have .

You guys do understand, that this it's going to cause a lot of people to go into withdrawal such as myself of a multiple medications. This is going to affect mental capacity and Medicaid doing this is going to spike the suicide rate STATEWIDE which is already high in chronic pain patients. I DON'T EVEN HAVE TIME TO OBTAIN CHOICES . I NEED HOME HEALTH CARE with NO pain mgt. My house is not handicapped wheelchair accessible. So what does Medicaid expect the poor people to do that live ALONE & RURAL with no access to healthcare MRIs etc. Even if it was accessible you can't get there if you can't get out of bed which by the way is increasing blood clot risk. ERs are going to be flooded with people like me. Medicaid is causing a whole bunch of issues which I'm sure the government doesn't care about because it's not been but haveth they no soul at all ????

Medicaid should be available for people that are at least filed social security, with the pending claim and zero income. I am zero income I am way below your minimum guideline. I have no uterus thanks to cancer so go in and getting pregnant is not an option. Which by the way now you're just going to have a lot of people getting pregnant just to keep their insurance. The whole thing is ridiculous and in the long term it is not beneficial for Medicaid it's hurting your pocket not helping it. Even the state burying people off of untreated chronic conditions such as heart etc things that I have is going to cost govt money. All because Medicaid cut them off from treatment and they cannot afford their medications even on GoodRx if they could even get it written and nowhere provides pain management except pain management clinics. Rapidly cutting somebody off from just their narcotic alone is a really low ball move completely heartless.

Stacy Gordon

From: Stacy Gordon <[REDACTED]>
Sent: Monday, June 10, 2024 9:22 PM
To: PUBLICE.NOTICE TENNCARE
Subject: [EXTERNAL] Re: My info

Stacy Gordon
[REDACTED]

Please send me somebody that's not connected to choices because apparently they don't help you after you lose your insurance. Once I lose it that's when I need help !!!! I won't be able to do anything. I mean absolutely nothing. Zero income with a pending disability claim... Which I will not be able to walk the steps to follow through with my disability claim either because they want too much information and I will not be able to handle that any longer.

Thank you for your time & help.

On Mon, Jun 10, 2024, 9:18 PM Stacy Gordon <[REDACTED]> wrote:

Whoever received my comment through here was compassionate enough to have CHOICES contact me a lady named " Meg " called. I cannot reach her again, I lost her contact info and she gave it to me. I no longer qualify for Medicaid and apparently after a choices case manager called me today I don't qualify for choices either BECAUSE YOU HAVE to need home health Care at THAT TIME & have Medicaid. I ONLY NEED home health care after I'm bedridden because TennCare is taken away my insurance which takes away all of my medication and treatments for chronic conditions. Will be too late you're taking my insurance BEFORE NEED CHOICES. I don't qualify for the marketplace or private insurance as I have zero income and no job because I'm disabled. I have a pending disability claim but no decision. I have LESS than 30 days BEFORE I LOSE ability to walk, get out of bed, and anything else. I will have to come off of my heart meds, thyroid meds pain medication and everything else that makes me functional WITH NO TAPER. MANY of these cause seizures, etc to drastically cut with no taper not to mention I probably won't live regardless.

Why would Medicaid NOT allow people who are uninsurable any other way, filed for disability, & zero income to keep their insurance? I have no one to take care of me, no family ,no friends and the state is leaving me by myself pretty much to die and suffer.

I'm only 45 years old & top it off you kicked me off my insurance right at my birthday !! It is so cold and callous. Premeditated, it should really be a crime to do this. You're dropping somebody that's in pain management and following all their tight strict rules, long term suffering from residual side effects of chemo I'm barely making it as it is. However at least I'm still functional. NO treatment. No meds of ANY KIND leaves me NO ADLs WITHOUT HELP. NO store runs, no way to make food, or put up orders being delivered off my SNAP benefits .

I am BEGGING you to have somebody contact me .
I NEED HELP while I CAN STILL handle business.

Which is before I lose my medication and treatments I am receiving for these health problems. The emergency room is not going to write all of the medications that I have in fact I live in the middle of nowhere they don't even have MRI, CT etc. They don't offer that kind of treatment I am RURAL. I have play this game before in an emergency and they told me they cannot treat me and the ambulance only takes you to that ER because, they take you to the closest

THANK YOU FOR YOUR TIME & I'M PRAYING THAT YOU HAVE A SOLUTION & SEND SOMEONE.
BECAUSE...this is ALL MEDICAID FAULT.

Leave somebody with zero income with zero options unless they NEED healthcare while still on Medicaid. I only need home health care or assisted living because I'm going to lose ALL treatments.
Including Oncology because Medicaid seems to think only breast and cervical cancer is important.

From: alan johnson <[REDACTED]>
Sent: Saturday, June 8, 2024 7:17 AM
To: PUBLICE.NOTICE TENNCARE
Subject: [EXTERNAL]

Please don't take my plan away I had a stroke in 17 received ssdi an only get 1216\$ monthly I have not worked since accepted,I need my PARTS A,B,an C it's the only way I can survive letter said I make to much?? But was told not to worry I'm All set for 2024 . Iv filled a appeal please don't take away my benefits! Please don't. I'm a nervous wreck about my meds I cannot afford I'm on 11 .. for stroke,heart, blood pressure, diabetes type 2 also on eliques.. thanks for your time! Please don't forget me, help me.

Attachment C:
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.