Division of TennCare

Tennessee Department of Finance & Administration

Division of TennCare

TennCare III Demonstration

Project No. 11-W-00369/4

Quarterly Monitoring Report

(For the period January – March 2024)

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

Federal Fiscal Quarter: 2/2024 (1/24 - 3/24)

Demonstration Quarter: 1/2024 (1/24 - 3/24)

August 8, 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 January-March 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 #
1/1/24	The state raised the income threshold for pregnant women to qualify for TennCare coverage from 195 percent of the federal poverty level to 250 percent of the federal poverty level.	
1/24/24	The state notified CMS of its intent to adjust the expenditure caps for CHOICES Group 3 and ECF CHOICES.	6
1/25/24	The Monthly Call for January was held.	59
2/22/24	The Monthly Call for February, which would have been held on this date, was cancelled.	59
2/26/24	The state submitted to CMS a draft of its first Interim Evaluation Report.	93
3/24/24	The state implemented modifications to the expenditure caps for CHOICES Group 3 and ECF CHOICES.	
3/28/24	The Monthly Call for September 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); and
- Submission of the draft Evaluation Design on July 7, 2021, and the revised Evaluation Design on September 9, 2022.

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

Resumption of Annual Eligibility Reviews

With the ending of the COVID-19 public health emergency and the Medicaid continuous coverage requirement[1], the state resumed required annual eligibility renewals in April 2023. Before this resumption began, the state worked to increase member awareness of the renewal process by implementing a multitiered outreach approach, including engaging community leaders, creating a media campaign, and direct member targeting. The process of renewing TennCare coverage is available through multiple access points and modalities, with coverage able to be renewed online; by phone, mail, or fax; or in person at any local Department of Human Services county office.

During the January-March 2024 quarter, more than 360,000 TennCare members were due for renewal. The numbers below—gathered during May 2024—reflect the outcomes for those renewals due during the quarter, as well as the cumulative totals for the first twelve months of the state's renewal process.

[1] See Section 6008 of the Families First Coronavirus Response Act.

Table 2
Renewal Numbers for January-March 2024

		January 2024	February 2024	March 2024	Cumulative (Apr 2023 - Mar 2024)
Member's eligibility renewed	Auto-renewed	37,420	54,693	46,109	605,335
	Responded and approved	19,634	15,705	14,373	361,735
Member found ineligible	Responded and ineligible – referred to federal marketplace	8,103	7,420	8,628	142,004
	Failed to return required renewal packet	23,804	29,540	33,162	325,416
	Failed to return required requested additional information	3,439	2,275	2,491	40,536
Eligibility determination pending		12,598	18,577	21,138	63,099
Total		104,998	128,210	125,901	1,538,125

The state submits data to CMS on the status of its renewal work on a monthly basis in accordance with the Consolidated Appropriations Act, 2023, and related CMS guidance. The state also posts information about the renewal process, including updated monthly numbers as well as information for members and other stakeholders, on the TennCare website; information about

the status of the renewal process will also be included in subsequent quarterly and annual Monitoring Reports.

Additional Program Developments

During the January-March 2024 quarter, the state continued to seek approval for a set of demonstration amendments that would expand coverage and benefits under the demonstration. 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 program[2];
- 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 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 January-March 2024 quarter.

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

[2] 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).

- 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 held a federal public comment period on Amendment 5 from November 24 through December 23, 2023. All comments received by CMS during the comment period were supportive of the proposal. As of the end of the January-March 2024 quarter, Amendment 5 remained under CMS review.

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. The state continued to conduct eligibility renewals, as discussed above under the heading of "Resumption of Annual Eligibility Reviews."

Key Achievements During the Quarter

During the quarter, the state extended coverage to more pregnant women while also continuing to expand the availability of TennCare services to eligible Tennesseans by covering more benefits and enrolling new populations.

Expanded Coverage for Pregnant Women. On January 1, 2024, the state expanded its coverage of pregnant women through the TennCare demonstration. Specifically, the income threshold for pregnant women to qualify for TennCare coverage was raised from 195 percent of the federal poverty level to 250 percent of the federal poverty level. The program change is expected to increase program enrollment by approximately 2,400 people.

Adjustments to HCBS Expenditure Caps. On March 24, 2024, the state raised the expenditure limits for HCBS furnished through CHOICES Group 3 and ECF CHOICES Groups 4, 5, and 6. The purpose of the modifications to these expenditure caps is to increase the reimbursement rates for certain HCBS. The adjustments were made after a public notice and comment period was held and 60 days after the state provided formal notification to CMS.

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 1,153 claims had been paid by TennCare's MCOs on behalf of 866 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 January-March 2024 quarter, a total of 109,432 unique members had received 1,043,764 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 2024 quarter, a total of 1,057 new individuals had been enrolled in CHOICES Group 3 through the At Risk Demonstration Group.

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

The state's program contains three parts:

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

The new Katie Beckett/Medicaid Diversion program began accepting self-referral forms from interested families on November 23, 2020. As of the last day of the January-March 2024 quarter, a total of 3,262 children were enrolled in the program, with 184 enrolled in Katie Beckett (Part A), 3,078 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. The increase in appeal activity over the last two quarters reflects the resumption of eligibility redeterminations following the end of the COVID-19 public health emergency. 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 2024
Compared to the Two Previous Quarters

	Jul – Sep 2023	Oct – Dec 2023	Jan – Mar 2024
No. of appeals received	28,417	27,065	34,039
No. of appeals resolved or withdrawn	24,390	25,985	31,429
No. of appeals taken to hearing	2,498	4,340	4,566
No. of hearings resolved in favor of appellant	34	63	44

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 2024
Compared to the Two Previous Quarters

	Jul – Sep 2023	Oct – Dec 2023	Jan – Mar 2024
No. of appeals received	3,611	3,303	3,125
No. of appeals resolved	1,958	1,960	1,773
• Resolved at the MCC level	498	521	490
• Resolved at the TSU level	117	184	95
• Resolved at the LSU level	1,343	1,255	1,188
No. of appeals that did not involve a valid factual dispute	1,583	1,424	1,424
No. of directives issued	344	345	308
No. of appeals resolved by fair hearing	1,359	1,273	1,214
No. of appeals that were withdrawn by the enrollee at or prior to the hearing	489	466	435
Appeals that went to hearing and were decided in the state's favor	817	728	689
Appeals that went to hearing and were decided in the appellant's favor	37	61	64

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 2024
Compared to the Two Previous Quarters

	Jul – Sep 2023	Oct – Dec 2023	Jan – Mar 2024
No. of appeals received	75	91	87
No. of appeals resolved or withdrawn	47	63	49
No. of appeals set for hearing	27	33	29
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 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 January-March 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, and the litigation is now proceeding.

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 January-March 2024 quarter. The state continued to conduct eligibility renewals during the quarter, the eventual result of which will be a decrease in the number of individuals enrolled in the TennCare program.

Legislative Updates

By the conclusion of the January-March 2024 quarter, Tennessee's legislative session was still weeks from completion, and the outcome of many bills introduced by the General Assembly had yet to be determined. It was observed, however, that assessments used to help fund various aspects of the TennCare program (e.g., the hospital assessment, the nursing facility assessment, etc.) were expected to be renewed for State Fiscal Year 2025.

A summary of state legislation with significant implications for TennCare will be included in the

Monitoring Report for the April-June 2024 quarter.

Public Forums

The state's most recent public forum was held on June 23, 2023. A summary of feedback received during the forum was included in the Monitoring Report for the April-June 2023 quarter that was submitted to CMS on September 5, 2023.

Enrollment and Member Month Data

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

Table 6
Enrollment Counts for the January – March 2024 Quarter
Compared to the Two Previous Quarters

Demonstration Populations	Jul – Sep 2023	Oct – Dec 2023	Jan – Mar 2024
EG1 Disabled	137,427	132,537	128,326
EG9 H-Disabled	971	982	986
EG2 Over 65	318	330	304
EG10 H-Over 65	36	28	30
EG3 Children	893,312	873,241	753,436
EG4 Adults	572,341	526,847	455,471
EG5 Duals and EG11 H-Duals 65	180,031	178,787	175,707
EG6E Expan Adult	0	0	0
EG7E Expan Child	2,591	3,463	4,298
EG8, Med Exp Child	0	0	0
Med Exp Child, Title XXI Dem Pop	14,420	18,061	111,678
EG12E Carryover	925	878	848
EG13 Katie Beckett	171	180	192
EG14E Medicaid Diversion	2,732	2,952	3,161
EG15 Continued Eligibility	0	0	0
EG16 MEC Additions	4,946	9,904	15,929
TOTAL*	1,810,221	1,748,190	1,650,366

*** 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 73 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 2024

Eligibility Group	January 2024	February 2024	March 2024	Sum for Quarter Ending 3/31/24
EG1 Disabled	129,995	127,290	124,815	382,100
EG2 Over 65	260	262	234	756
EG3 Children	742,958	730,281	713,561	2,186,800
EG4 Adults	446,599	423,891	396,997	1,267,487
EG5 Duals	164,728	162,380	159,818	486,926
EG6E Expan Adult	0	0	0	0
EG7E Expan Child	3,549	3,945	4,112	11,606
EG8 Med Exp Child	0	0	0	0
EG9 H-Disabled	927	954	966	2,847
EG10 H-Over 65	24	23	29	76
EG11 H-Duals	7,112	7,219	7,303	21,634
Med Exp Child, Title XXI Demo Pop	112,393	111,379	110,578	334,350
EG12E Carryover	844	829	822	2,495
EG13 Katie Beckett	180	184	188	552
EG14E Medicaid Diversion	2,988	3,049	3,136	9,173
EG15 Continued Eligibility	0	0	0	0
EG16 MEC Additions	12,434	14,163	15,845	42,442
TOTAL	1,624,991	1,585,849	1,538,404	4,749,244

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 January-March 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		
		Jul – Sep 2023	Oct – Dec 2023	Jan – Mar 2024
CHOICES 1	Not applicable	14,280	14,029	13,684
CHOICES 2	11,000	8,878	8,759	8,606
CHOICES 3 (SSI recipients)	To be determined	2,098	2,069	1,948
CHOICES 3 (members of the CHOICES At Risk Demo Group)	1,750[3]	729	891	1,057
Total CHOICES	Not applicable	25,985	25,748	25,295
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 separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and June 2023.

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 14,317 individuals on June 30, 2022. According to annual aggregate data contained in the reports, this downward trend was even more pronounced for new LTSS recipients, 81 percent of whom had been admitted to NFs in the year prior to implementation of the CHOICES program, as compared with 63 percent admitted to NFs in the twelfth year of CHOICES. Furthermore, nursing facility expenditures in the year prior

[3] 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.

to CHOICES implementation accounted for more than 90 percent of total LTSS expenditures, whereas the percentage was approximately 80 percent twelve 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 505 transitions happening in the twelfth 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 13,940 after CHOICES had been in place for twelve 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 11,779 by June 30, 2022. The percentage of LTSS expenditures devoted to HCBS grew as well, rising from 9.75 percent in the year prior to CHOICES, to 20.40 percent after the CHOICES program had been in place for twelve 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 – 6/30/22	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 6/30/22	Percent increase from the day prior to CHOICES implementa-tion to 6/30/22
6,226	13,940	124%	4,861[4]	11,779	142%

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

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

Table 10
CHOICES Transition Allowances
for January-March 2024 Compared to the Two Previous Quarters

Grand Region	Frequency and Use of Transition Allowances					
	Jul – Sep 2023		Oct – Dec 2023		Jan – Mar 2024	
	# Distributed	Total Amount	# Distributed	Total Amount	# Distributed	Total Amount
East	14	$6,116	19	$9,819	19	$8,264
Middle	30	$16,676	29	$9,934	12	$5,408
West	28	$19,485	27	$13,802	49	$22,629
Statewide Total	72	$42,277	75	$33,555	80	$36,301

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 January-March 2024 Compared to the Two Previous Quarters

	Statewide Enrollment Targets and Reserve Capacity[5]	Enrollment and Reserve Slots Filled as of the End of Each Quarter		
		Jul – Sep 2023	Oct – Dec 2023	Jan – Mar 2024
ECF CHOICES 4	1,775	1,708	1,691	1,671
ECF CHOICES 5	2,526	2,374	2,326	2,264
ECF CHOICES 6	1,899	1,738	1,808	1,867
ECF CHOICES 7	50	12	13	14
ECF CHOICES 8	50	26	27	28
Total ECF CHOICES	6,300[6]	5,858	5,865	5,844
Reserve capacity	3,950	3,498	3,515	3,521
Waiver Transitions[7]	Not applicable	87	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 submitted baseline data for the year-long period preceding implementation of ECF CHOICES, as well as six years' worth of post-implementation data. In comparing the baseline data with the post-implementation data, several notable trends emerged:

[5] Statewide enrollment targets and reserve capacity were adjusted to reflect new appropriation authority, effective July 1, 2022. A total of 300 reserve capacity slots were added to ECF CHOICES Groups 4, 5, 6, 7, and 8. The distribution of these slots reflects 15 additional slots in Group 4, 60 additional slots in Group 5, 200 additional slots in Group 6, 10 additional slots for Group 7, and 15 additional slots for Group 8. Of the 15 slots allocated for Group 8, a total of 5 were assigned to Group 7. Furthermore, because of the higher expected cost of benefits in Group 8, it was possible to convert the remaining 10 slots from Group 8 to a total of 15 slots for Group 6. In the January-March 2024 quarter, 66 FMAP Group 4 slots were moved back to Group 6; 1 FMAP Group 5 slot was moved back to Group 6; 1 DD Aged Caregiver reserve capacity slot was moved from Group 4 to Group 5; 5 Priority Group slots were moved from Group 4 to Group 6; 13 Priority Group slots were moved from Group 5 to Group 4; and 13 Priority Group slots were moved from Group 5 to Group 6.

[6] 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.

[7] 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.

- The number of individuals with developmental disabilities other than intellectual disabilities who received HCBS through the TennCare program grew from 0 to 2,321.
- Average LTSS expenditures for individuals with intellectual or developmental disabilities fell from $94,327 per person to $88,965 per person, representing a 5.7 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 17.8 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 January-March 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		
		Jul – Sep 2023	Oct – Dec 2023	Jan – Mar 2024
Katie Beckett	300	161	174	184
Medicaid Diversion	4,000	2,646	2,859	3,078
Continued Eligibility	N/A	0	0	0
Reserve capacity	300	161	174	184

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 B to this Quarterly Monitoring Report.

II. Performance Metrics

Progress Toward Goals and Targets in the Monitoring Protocol

STC 55 requires the state to submit to CMS a draft Monitoring Protocol no later than 150 days after the January 8, 2021, start date of the TennCare III approval period. The purpose of the Monitoring Protocol is to define the quantitative and qualitative elements the state will use in its Quarterly and Annual Monitoring Reports to chart progress toward fulfillment of the goals and targets of the TennCare III demonstration. On June 7, 2021, the state submitted its draft Monitoring Protocol to CMS. CMS, in turn, provided feedback on the document on May 31, 2022, 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 1,650,366 Tennesseans as of the end of the January-March 2024 quarter. This total represents 24 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 2024, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the January-March 2024 quarter. The EQRO took a sample of provider data files from TennCare's MCCs[8] and reviewed each for accuracy in the following categories:

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

[8] 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" (93.20 percent accuracy), "primary care services" (94.95 percent accuracy) and "prenatal care services" (96.48 percent accuracy).

Progress in accuracy rates is currently being measured on a quarter-to-quarter basis. Qsource's report concluded that the MCCs "achieved high accuracy rates" for the first quarter of Calendar Year 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 January-March 2024 quarter, BCBER made initial preparations for the 2024 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 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 January-March 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, both because of data limitations and 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. 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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Attachment A:
Data on Grievances Received and Resolved by TennCare MCCs During the January – March 2024 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**	587	223	7	26	**178**	10		
D1.IV.11	**Active grievances**	158	69	5	4	**183**			
D1.IV.12	**Grievances filed on behalf of LTSS users**	37	13	0	4				
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**	587	223	7	26		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 m									
D1.IV.15a	**Resolved grievances related to general inpatient services**	26	0	0	0				
D1.IV.15b	**Resolved grievances related to general outpatient services**	311	0	0	15				
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**	6	0	0	2				
D1.IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs**	5	0	0	0		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)**	12	12	0	4				
D1.IV.15h	**Resolved grievances related to dental services**	40	0	0	0	**178**			
D1.IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)**	104	96	1	5				
D1.IV.15j	**Resolved grievances related to other service types**	78	0	0	0				
Number of grievances resolved by plan during the reporting period related to the following reasons: (A single grievance may be related to multiple reasons and may therefore be counted in multip									
D1.IV.16a	**Resolved grievances related to plan or provider customer service**	105	78	6	6	**1**			

D1.IV.16b	**Resolved grievances related to plan or provider care management/case management**	16	8	0	0				
D1.IV.16c	**Resolved grievances related to access to care/services from plan or provider**	92	78	1	12	**32**	3		
D1.IV.16d	**Resolved grievances related to quality of care**	13	58	0	0	**80**			
D1.IV.16e	**Resolved grievances related to plan communications**	88	0	0	0				
D1.IV.16f	**Resolved grievances related to payment or billing issues**	175	9	0	0	**65**			
D1.IV.16g	**Resolved grievances related to suspected fraud**	1	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)**	13	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**	84	0	0	8	**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.