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 April – June 2021)*

Demonstration Year: 1 (1/8/21- 12/31/21)
Federal Fiscal Quarter: 3/2021 (4/21 - 6/21)
Demonstration Quarter: 2/2021 (4/21 - 6/21)

August 31, 2021

# TennCare III Monitoring Report

Tennessee operates its Medicaid program under the authority of an 1115 demonstration known as TennCare. TennCare is a comprehensive Medicaid reform project, consisting of innovations in a number of aspects of the Medicaid program, including eligibility, benefits, and service delivery systems. The primary goals of the TennCare demonstration include providing high-quality care to enrollees, improving health outcomes for enrollees, and providing enrollees with access to safe and appropriate HCBS. As a means of advancing these goals, the TennCare Demonstration authorizes a number of programmatic flexibilities, including extending eligibility to certain groups that would not be eligible for Medicaid under the State Plan; covering a more robust package of benefits than that authorized under the Medicaid State Plan; operating a single, statewide managed care service delivery system; operating a number of HCBS programs for persons with physical, intellectual, and/or developmental disabilities; and various operational efficiencies. Through the TennCare Demonstration, the State demonstrates that the careful use of a single, statewide service delivery system can enable the State to deliver high-quality care to all enrollees without spending more than would have been spent had the State continued its Medicaid program.

## Key Dates of the Demonstration Quarter

Key dates of approval/operation for the TennCare Demonstration during the April-June 2021 quarter, together with the corresponding Special Terms and Conditions (STCs), if applicable, are presented in Table 1.

**Table 1**
**Key Dates of Approval/Operation in the Quarter**

| Date | Action | STC # |
|---|---|---|
| **4/8/21** | The State submitted to CMS a draft Implementation Plan for the TennCare III Demonstration. | 54 |
| **4/22/21** | The Monthly Call for April was held. | 60 |
| **4/30/21** | The State submitted to CMS enrollment target ranges for CHOICES Group 2 and for all Employment and Community First CHOICES benefit groups. | 33.d.ii and 34.d.ii |
| **5/5/21** | The State submitted to CMS the 2021 update to the Quality Assessment and Performance Improvement Strategy. | 52 |
| **5/27/21** | The Monthly Call for May, which would have been held on this date, was cancelled. | 60 |
| **5/28/21** | The State submitted the Quarterly Monitoring Report for the January – March 2021 quarter to CMS. | 56 |

| Date | Action | STC # |
|---|---|---|
| **6/4/21** | 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 accepted. | 61 |
| **6/7/21** | The State submitted to CMS a draft Monitoring Protocol for the TennCare III Demonstration. | 55 |
| **6/17/21** | CMS provided comments on the State's draft Implementation Plan for the TennCare III Demonstration. | 54 |
| **6/24/21** | The Monthly Call for June was held. | 60 |
| **6/29/21** | The State requested CMS approval of Statewide MCO Contract Amendment 14 and TennCare Select Contract Amendment 50. | 43 |
| **6/30/21** | The State submitted a Designated State Investment Programs (DSIP) claiming protocol to CMS. | 32.m. |
| **6/30/21** | The State submitted point-in-time and annual aggregate data about the CHOICES and ECF CHOICES programs to CMS. | 53.d. |

## I. Operational Updates

### Progress Towards Milestones

The TennCare III Demonstration continues a number of program components from the prior iteration of the TennCare Demonstration that are already in operation. In accordance with the STCs of the TennCare III Demonstration, the State submitted a draft implementation plan to CMS providing details on the State's plan for implementing new flexibilities included in the approval of TennCare III. On June 17, CMS shared comments on the draft implementation plan with the State. Table 2 identifies key milestones contained in the draft implementation plan (incorporating modifications suggested by CMS), as well as the anticipated completion date for each.

**Table 2**
**Milestones for New Programmatic Flexibilities in the TennCare III Demonstration**

| Action Needed | Implementation Timeline |
|---|---|
| *Shared Savings and DSIPs* | |
| Submit Shared Savings Quality Measures Protocol to CMS. | Completed March 8, 2021. |
| Submit DSIP Claiming Protocol to CMS. | Completed June 30, 2021. |
| Submit the DSIP component of the Monitoring Protocol to CMS. | By September 30, 2021. |

| Action Needed | Implementation Timeline |
|---|---|
| Begin implementation of processes for claiming of shared savings dollars. | By December 31, 2021. |
| *Closed Formulary* | |
| Conduct formulary disruption analysis. | By December 31, 2021. |
| Identify viable value-based purchasing models under a closed formulary. | By December 31, 2021. |
| Develop policies and procedures for a closed formulary. | By December 31, 2021. |
| Research and develop key considerations for TennCare-specific medical necessity and exceptions review process for medication requests of specific drugs not included on a closed formulary. | By December 31, 2021. |
| *Suspension of Eligibility for Enrollees Convicted of Fraud* | |
| Promulgate state administrative rules to describe and support the enrollee suspension process and provide for necessary enrollee appeal processes. | To be determined based on the expiration of the COVID-19 public health emergency. |
| Modify the state's eligibility determination system and MMIS to implement the enrollee suspension policy, including suspending eligibility, generating appropriate notices, and transferring the enrollee to the TennCare Select health plan. | To be determined based on the expiration of the COVID-19 public health emergency. |
| Establish a process with the Tennessee Office of Inspector General (OIG) for TennCare to be informed when a TennCare enrollee has been convicted of TennCare fraud. | To be determined based on the expiration of the COVID-19 public health emergency. |

In addition, during the April-June quarter, CMS continued to review a new demonstration amendment that had been submitted during the previous quarter. Amendment 1 would introduce the following modifications to the TennCare program:

- Integration of services for members with intellectual disabilities into the TennCare managed care program[1];
- Transitioning the care of children receiving Supplemental Security Income (SSI) benefits from the TennCare Select health plan to one of the other health plans that serves TennCare members; and
- Assigning to the TennCare Select health plan certain inmates of public institutions who receive inpatient services in a setting located outside the public institution.

### Policy or Administrative Difficulties in Operating the Demonstration

There were no significant administrative difficulties in operating the demonstration during this quarter.

[1] Specific services to be integrated are intermediate care facility services for individuals with intellectual disabilities (ICF/IID services) and 1915(c) waiver home- and community-based services (HCBS).

## Key Challenges During the Quarter

Throughout the January-March 2021 quarter, the State continued to address the threat to public health and safety posed by coronavirus disease 2019 (or "COVID-19"). As the agency in Tennessee state government responsible for providing health insurance to more than 1.5 million individuals, the Division of TennCare has developed a multilayered response to the COVID-19 emergency. Working in tandem with partners and stakeholders at the federal and state levels, TennCare designed and deployed a strategy consisting of such elements as—

- Coordinating with the provider community and TennCare's health plans to ensure access to care for TennCare members in need of testing or treatment for COVID-19;
- Assisting providers in offering covered services to TennCare members via telehealth when medically appropriate;
- Increasing care coordination services for members impacted by COVID-19 who are self-isolated, so that they can receive additional supports as needed;
- Pausing nearly all terminations of eligibility for TennCare and CoverKids (the State's separate CHIP program) members during the COVID-19 emergency;
- Working with TennCare's health plans to streamline or temporarily lift authorization requirements to ensure services are delivered promptly and claims paid quickly;
- Expediting access to home-based care for former nursing facility patients being discharged from hospitals and electing to transition home;
- Enhancing access to prescription drugs by allowing early refills of prescriptions and by allowing 90-day supplies to be prescribed for most medications;
- Obtaining multiple Section 1135 waivers from CMS that provide flexibilities to help ensure that TennCare members receive necessary services;
- Submitting an emergency amendment to the TennCare Demonstration to make retainer payments to providers of HCBS in the Employment and Community First CHOICES program, as well as additional flexibilities to support TennCare HCBS providers during the public health emergency;
- Assisting providers of long-term services and supports in reducing the spread of COVID-19 among individuals who are residents of nursing facilities; and
- Working with the federal government and healthcare providers in Tennessee to provide enhanced financial support for providers disproportionately affected by the COVID-19 emergency, including primary care providers, nursing facilities, dentists, and community mental health centers and other providers of behavioral health services.

Additional resources concerning the State's response to the COVID-19 pandemic are available on a dedicated page of the TennCare website.

## Key Achievements During the Quarter

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

The State's program contains 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 2021 quarter, a total of 821 children were enrolled in the program, with 49 enrolled in Katie Beckett (Part A), 770 enrolled in Medicaid Diversion (Part B), and 2 enrolled in Continued Eligibility (Part C).

### Issues or Complaints Identified by Beneficiaries

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

**Table 3**
**Eligibility Appeals for April – June 2021**
**Compared to the Previous Quarter**

| | Jan – Mar 2021 | Apr – Jun 2021 |
|---|---|---|
| No. of appeals received | 5,136 | 4,869 |
| No. of appeals resolved or withdrawn | 5,423 | 4,636 |
| No. of appeals taken to hearing | 1,579 | 1,271 |
| No. of hearings resolved in favor of appellant | 44 | 41 |

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

**Table 4**
**Medical Service Appeals for April – June 2021**
**Compared to the Previous Quarter**

| | Jan – Mar 2021 | Apr – Jun 2021 |
|---|---|---|
| No. of appeals received | 2,860 | 2,662 |
| No. of appeals resolved | 1,557 | 1,275 |
| • Resolved at the MCC level | 410 | 308 |
| • Resolved at the TSU level | 115 | 60 |
| • Resolved at the LSU level | 1,032 | 907 |
| No. of appeals that did not involve a valid factual dispute | 1,255 | 1,221 |
| No. of directives issued | 292 | 269 |
| No. of appeals resolved by fair hearing | 1,111 | 1,008 |
| No. of appeals that were withdrawn by the enrollee at or prior to the hearing | 324 | 282 |
| Appeals that went to hearing and were decided in the State's favor | 654 | 591 |
| Appeals that went to hearing and were decided in the appellant's favor | 54 | 34 |

By way of explanation:

- The "MCC" level is the level of the Managed Care Contractors. MCCs sometimes reverse their decisions or develop new recommendations for addressing an issue after reviewing an appeal.

- The "TSU" level is the TennCare Solutions Unit. The TSU is a unit within TennCare that reviews requests for hearings. The TSU might overturn the decision of the MCC and issue a directive requiring the MCC to approve provision of the service under appeal. Alternatively, if, following review, TennCare agrees with the MCC's decision, the appeal typically proceeds to TennCare's Legal Solutions Unit (LSU), where it is scheduled for administrative hearing before an Administrative Law Judge.

- The "LSU" level is the Legal Solutions Unit. This unit within TennCare ensures that enrollees receive those procedural rights to which they are entitled under the law. LSU represents TennCare and its MCCs at administrative hearings and takes those steps necessary to ensure that such appeals come to a timely resolution.

LTSS Appeals. The following table provides information regarding certain appeals administered by TennCare's Long-Term Services and Supports Division for the quarter (e.g., appeals of PreAdmission Evaluation denials, appeals of PreAdmission Screening and Resident Review determinations, etc.).

**Table 5**
**Long-Term Services and Supports Appeals for April – June 2021**
**Compared to the Previous Quarter**

| | Jan – Mar 2021 | Apr – Jun 2021 |
|---|---|---|
| No. of appeals received | 101 | 87 |
| No. of appeals resolved or withdrawn | 69 | 49 |
| No. of appeals set for hearing | 21 | 19 |
| No. of hearings resolved in favor of appellant | 0 | 0 |

Grievances. Table 6 presents information about grievances received and resolved by TennCare's managed care contractors (MCOs, DBM, and PBM) during the April-June 2021 quarter. It should be noted that grievances may be resolved in a quarter other than the one in which they are received.

**Table 6**
**Most Common Grievance Categories and Totals, April – June 2021**

| Grievance Category | Number of Grievances Received | Number of Grievances Resolved |
|---|---|---|
| Access and Availability | 209 | 211 |
| Attitude and Service | 184 | 182 |
| Billing and Financial Issues | 120 | 127 |
| Quality of Care/Quality of Service | 170 | 147 |
| Other | 7 | 7 |
| **Total** | 690 | 674 |

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.

### Audits, Investigations, or Lawsuits that Impact the Demonstration

During the April-June 2021 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 have two pending motions before the court: one for class certification and one for preliminary injunction, both of which TennCare opposed. The State filed a timely motion to dismiss the case, which is also pending with the Court. The parties are currently engaged in discovery.

*Dowdy v. Smith* Lawsuit. On March 12, 2021, TennCare member Shannon Dowdy filed suit in federal court against TennCare to obtain private duty nursing care on a 24-hours-a-day/7-days-a-week basis from his TennCare MCO. This level of services is not currently available to Mr. Dowdy under the TennCare program. The plaintiff had previously been receiving 24/7 nursing care through a combination of programs, with the majority of nursing hours furnished through a 1915(c) waiver program for individuals with intellectual disabilities, and the balance of hours provided by his MCO. Mr. Dowdy's complaint alleged that the services delivered through the 1915(c) waiver were insufficiently staffed, meaning that he was being denied necessary care. The plaintiff initially sought a preliminary injunction, but the parties reached an agreement for the provision of hours during the litigation that mooted the request for an injunction. The parties subsequently reached a resolution of the issues in the suit, and the case was dismissed on June 22, 2021.

*Dyersburg Family Walk-In Clinic, Inc. v. Tennessee Department of Finance and Administration, et al.* Lawsuit. On December 22, 2020, Dyersburg Family Walk-In Clinic, Inc., which does business under the registered assumed name Reelfoot Family Walk-In Clinic, filed a federal lawsuit against TennCare in the District Court for the Western District of Tennessee. Reelfoot operates three Rural Health Clinics that receive supplemental payments from TennCare. The lawsuit challenges TennCare requirements related to these supplemental payments and seeks injunctive and declaratory relief. In April 2021, TennCare successfully petitioned to have the case transferred to the District Court for the Middle District of Tennessee.

*EMCF v. TennCare* Lawsuit. In September 2018, Emergency Medical Care Facilities, P.C., filed a complaint for declaratory judgment and injunctive relief against the Division of TennCare in Davidson County Chancery Court. The suit relates to a $50 cap imposed by the agency on payment for emergency room physician services determined to be non-emergent. EMCF alleges that the State implemented this cap through its contractual relationship with its MCOs and not through the rulemaking process. The parties filed cross-motions for summary judgment, and, on September 1, 2020, the Chancellor granted summary judgment to EMCF on their claim that the $50 cap was void. EMCF then voluntarily dismissed their remaining claims pertaining to the determination of payment for the services in question. The State filed a timely appeal of the Chancery Court's ruling on September 29, 2020, and the appeal is currently being considered by the Tennessee Court of Appeals.

*Erlanger Health System v. TennCare* Lawsuit. This declaratory order action was commenced against TennCare regarding the applicability and validity of two TennCare rules that set the reimbursement rates for emergency services provided to TennCare enrollees by non-contract hospitals. The action was later amended to seek invalidation of the related State Plan

Amendments approved by CMS. This administrative declaratory order action has been on appeal to the Tennessee Court of Appeals for review of an evidentiary ruling. On March 3, 2021, the Court of Appeals issued an opinion affirming the lower court's ruling to exclude certain disputed documents. The case was remanded back to the agency for completion of the declaratory order process. A scheduling order has been entered providing for the parties to complete the briefing process by June 24, 2021, with an agency decision to follow within 90 days.

*M.A.C., et al. v. Smith* Lawsuit. Five TennCare members filed a federal lawsuit against TennCare alleging that the Home and Community-Based Services they received through the State's 1915(c) waiver programs are not being fully staffed, resulting in a denial of necessary care and sufficient alternatives to institutionalization. A response to the suit is due on September 27, 2021, and the State is represented by the Tennessee Attorney General's office in the litigation.

*McCutchen et al. v. Becerra* Lawsuit. On May 20, 2021, the State of Tennessee filed a motion to intervene in the federal lawsuit challenging CMS' approval of the TennCare III Demonstration. This lawsuit was filed by the Tennessee Justice Center (TJC), acting on behalf of 14 individual plaintiffs, against CMS in the District Court for the District of Columbia. Both TJC and CMS have indicated that they will not oppose the State's motion to intervene, but the court had not ruled on the motion by the conclusion of the April-June 2021 quarter.

### Unusual or Unanticipated Trends

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

### Legislative Updates

By the conclusion of Tennessee's legislative session on May 8, 2021, a number of pieces of legislation with implications for TennCare had been passed by the General Assembly. Among the most significant new laws were the following:

- Public Chapter 102 establishes a four-year statute of limitations on TennCare estate recovery claims.
- Public Chapter 122 provides for a one-year extension of the ground ambulance provider assessment.
- Public Chapter 191 authorizes the use of HIPAA-compliant audio-only conversation when providing behavioral health provider-based telemedicine services if HIPAA-compliant real-time, interactive audio, video telecommunications, or electronic technology, or store-and-forward telemedicine services are unavailable.
- Public Chapter 346 enables pharmacists to bill TennCare for administering COVID-19 vaccines to TennCare members.

- Public Chapter 357 authorizes certain healthcare professionals licensed in other states to practice telehealth while providing healthcare services on a volunteer basis through a free clinic in Tennessee.
- Public Chapter 459 provides for a one-year extension of the annual hospital assessment.
- Public Chapter 524 adds chiropractic services to the list of healthcare services that may be covered by TennCare, although the legislation does not mandate coverage.
- Public Chapter 530 provides for a one-year extension of the annual nursing home assessment.
- Public Chapter 576 mandates a wage increase for workers in Tennessee's 1915(c) waivers for individuals with intellectual and developmental disabilities.
- Senate Joint Resolution 25 authorizes Tennessee Governor Bill Lee to implement the TennCare III Demonstration Waiver.

Details of the manner in which TennCare implements various provisions of these pieces of legislation will be included in future Monitoring Reports.

### Public Forums

On June 4, 2021, the State notified the public of its intent to host a public forum on July 6 at which comments on the progress of the demonstration would be accepted. Details of the event—including the date, time, and location of the forum—were included in the notice, as were mechanisms for commenting on the progress of the demonstration by mail or email. A summary of comments received at the July 6 forum will be included in the Monitoring Report for the July-September 2021 quarter.

### Enrollment and Member Month Data

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

**Table 7**
**Enrollment Counts for the April – June 2021 Quarter**
**Compared to the Previous Quarter**

| Demonstration Populations | Jan – Mar 2021 | Apr – Jun 2021 |
|---|---|---|
| EG1 Disabled | 134,288 | 134,350 |
| EG9 H-Disabled | 638 | 660 |
| EG2 Over 65 | 296 | 190 |
| EG10 H-Over 65 | 40 | 35 |
| EG3 Children | 814,080 | 825,106 |
| EG4 Adults | 451,565 | 467,207 |
| EG5 Duals and EG11 H-Duals 65 | 156,660 | 159,629 |
| EG6E Expan Adult | 0 | 0 |
| EG7E Expan Child | 1,171 | 1,229 |
| EG8, Med Exp Child | 0 | 0 |

| Demonstration Populations | Jan – Mar 2021 | Apr – Jun 2021 |
|---|---|---|
| Med Exp Child, Title XXI Demonstration Population | 9,670 | 10,190 |
| EG12E Carryover | 1,569 | 1,460 |
| EG13 Katie Beckett | 22 | 52 |
| EG14E Medicaid Diversion | 611 | 783 |
| EG15 Continued Eligibility | N/A | 2 |
| **TOTAL*** | 1,570,610 | 1,600,893 |

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

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

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

**Table 8**
**Member Month Reporting for April – June 2021**

| Eligibility Group | April 2021 | May 2021 | June 2021 | Sum for Quarter Ending 6/30/21 |
|---|---|---|---|---|
| EG1 Disabled | 135,065 | 134,547 | 133,663 | 403,275 |
| EG2 Over 65 | 169 | 170 | 187 | 526 |
| EG3 Children | 816,923 | 820,415 | 823,464 | 2,460,802 |
| EG4 Adults | 455,471 | 460,129 | 464,954 | 1,380,554 |
| EG5 Duals | 149,378 | 150,060 | 150,383 | 449,821 |
| EG6E Expan Adult | 0 | 0 | 0 | 0 |
| EG7E Expan Child | 1,148 | 1,150 | 1,223 | 3,521 |
| EG8 Med Exp Child | 0 | 0 | 0 | 0 |
| EG9 H-Disabled | 612 | 632 | 659 | 1,903 |
| EG10 H-Over 65 | 29 | 34 | 31 | 94 |
| EG11 H-Duals | 6,722 | 6,746 | 6,792 | 20,260 |
| Med Exp Child, Title XXI Demo Pop | 9,364 | 9,543 | 10,212 | 29,119 |
| EG12E Carryover | 1,462 | 1,447 | 1,428 | 4,337 |
| EG13 Katie Beckett | 29 | 43 | 50 | 122 |
| EG14E Medicaid Diversion | 709 | 759 | 786 | 2,254 |
| EG15 Continued Eligibility | 1 | 3 | 3 | 7 |
| **TOTAL** | 1,577,082 | 1,585,678 | 1,593,835 | 4,756,595 |

## Information and Data about the CHOICES Program

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

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

**Table 9**
**CHOICES Enrollment and Reserve Slots**
**for April-June 2021 Compared to the Previous Quarter**

| | Statewide Enrollment Targets and Reserve Capacity[2] | Enrollment and Reserve Slots Being Held as of the End of the Jan – Mar 2021 Quarter | Enrollment and Reserve Slots Being Held as of the End of the Apr – Jun 2021 Quarter |
|---|---|---|---|
| CHOICES 1 | Not applicable | 14,002 | 14,236 |
| CHOICES 2 | 11,000 | 10,168 | 10,172 |
| CHOICES 3 (including Interim CHOICES 3) | To be determined | 2,153 | 2,119 |
| Total CHOICES | Not applicable | 26,323 | 26,527 |
| Reserve Capacity | 300 | 300 | 300 |

The CMS letter approving CHOICES implementation in Middle Tennessee dated February 26, 2010, and STC 53 require specific monitoring and reporting activities that include:

Data and trends of the designated CHOICES data elements: STC 53.d. requires the State to submit to CMS periodic statistical reports about the use of LTSS by TennCare enrollees. Eighteen separate reports of data pertaining to the CHOICES program have been submitted between August 2011 and June 2021.

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

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

declining use of Nursing Facility (NF) services over time, with placement in institutional settings decreasing from 21,530 individuals on June 30, 2011, to 16,126 individuals on June 30, 2020. 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 64 percent admitted to NFs in the tenth 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 ten years later.

By contrast, appropriate use of HCBS by TennCare enrollees grew significantly during these years. The aggregate number of members accessing HCBS increased from 6,226 in the twelve-month period preceding CHOICES implementation in Middle Tennessee to 15,159 after CHOICES had been in place for ten full fiscal years. This trend was mirrored in point-in-time data as well: on the day prior to CHOICES implementation, 4,861 individuals were using HCBS, but the number had grown to 12,206 by June 30, 2020. The percentage of LTSS expenditures devoted to HCBS grew as well, rising from 9.75 percent in the year prior to CHOICES, to 20.79 percent after the CHOICES program had been in place for ten years.

Selected elements of the aforementioned CHOICES data are summarized in Table 10.

**Table 10**
**Changes in Use of HCBS by Persons Who Are Elderly or Disabled (E/D) Before and After CHOICES Implementation**

| Annual Aggregate Data | | | Point-in-Time Data | | |
|---|---|---|---|---|---|
| No. of TennCare enrollees accessing HCBS (E/D), 3/1/09 – 2/28/10 | No. of TennCare enrollees accessing HCBS (E/D), 7/1/19 – 6/30/20 | Percent increase over a ten-year period | No. of TennCare enrollees accessing HCBS (E/D) on the day prior to CHOICES implementa-tion | No. of TennCare enrollees accessing HCBS (E/D) on 6/30/20 | Percent increase from the day prior to CHOICES implementa-tion to 6/30/20 |
| 6,226 | 15,159 | 143% | 4,861[3] | 12,206 | 151% |

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

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

**Table 11**
**CHOICES Transition Allowances**
**for April-June 2021 Compared to the Previous Quarter**

| Grand Region | Jan – Mar 2021 | | Apr – Jun 2021 | |
|---|---|---|---|---|
| | # Distributed | Total Amount | # Distributed | Total Amount |
| East | 17 | $9,259.15 | 12 | $4,476 |
| Middle | 21 | $10,228.00 | 31 | $13,948 |
| West | 7 | $3,676.82 | 23 | $12,563 |
| Statewide Total | 45 | $23,163.97 | 48 | $30,987 |

## Information and Data about the Employment and Community First CHOICES Program

Designed and implemented in partnership with people with intellectual and developmental disabilities, their families, advocates, providers, and other stakeholders, Employment and Community First CHOICES is the first managed LTSS program in the nation that is focused on promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for people with intellectual and other types of developmental disabilities.

As required by STC 34.d., the State offers the following table delineating ECF CHOICES enrollment as of the end of the quarter, as well as information about enrollment targets and the number of available reserve slots. 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 12**
**ECF CHOICES Enrollment, Enrollment Targets, and Reserve Slots for April-June 2021 Compared to the Previous Quarter**

| | Statewide Enrollment Targets and Reserve Capacity[4] | Enrollment and Reserve Slots Filled as of the End of the Jan – Mar 2021 Quarter | Enrollment and Reserve Slots Filled as of the End of the Apr – Jun 2021 Quarter |
|---|---|---|---|
| ECF CHOICES 4 | 928 | 890 | 892 |
| ECF CHOICES 5 | 1,596 | 1,555 | 1,580 |
| ECF CHOICES 6 | 1,032.5 | 1,009 | 1,082 |
| ECF CHOICES 7 | 30 | 30 | 30 |
| ECF CHOICES 8 | 49 | 41 | 47 |
| Total ECF CHOICES | 3,635.5[5] | 3,525 | 3,631 |
| Reserve Capacity | 1,285.5 | 1,129 | 1,224 |
| Waiver Transitions[6] | Not applicable | 66 | 69 |

[4] Enrollment targets and reserve capacity for SFY 2021 were adjusted for new appropriation authority as of July 1, 2020. A total of 300 slots were added to ECF CHOICES Groups 4, 5, and 6: 25 to Group 4, 100 to Group 5, and 175 to Group 6. Revised enrollment targets were sent to CMS in July 2020 due to the loss of previously approved funding for 50 slots each in Groups 7 and 8. Funding for the 175 new slots in Group 6 was moved to Groups 7 and 8 to serve program applicants with severe behavior support needs. Since the expected cost of benefits in Groups 7 and 8 is higher, 1.5 Group 6 slots are needed to cover 1 slot in either Group 7 or 8 (making fewer than 300 new slots available for SFY 2021). During the July-September 2020 quarter, 27 slots were reallocated from Group 6 to Groups 7 and 8. With the 1:1.5 allocation ratio, the transfer resulted in 6 new slots in Group 7, and 12 new slots in Group 8, as well as a loss of 9 reserve capacity slots and 9 total ECF CHOICES slots. More reallocation occurred in the October-December 2020 quarter, with 19 slots moved from Group 5 to Group 6, and 12 slots moved from Group 6 to Groups 7 and 8. The 1:1.5 allocation ratio resulted in 1 new slot in Group 7 and 7 new slots in Group 8, reducing the total number of slots to 3,637. Further reallocation occurred in the January-March 2021 quarter, with 24 slots moved from Group 5 to Group 6; 2 slots from Group 7 to Group 6; and 7.5 slots from Group 6 to Group 8. Use of the 1:1.5 allocation ratio meant 3 new slots in Group 6, and 5 new slots in Group 8, reducing both total slots and Reserve Capacity slots by 1.5. Total Reserve Capacity slots are now 14.5 less than the 1,300 maximum (29 slots moved from Group 6 to Groups 7 and 8 at the 1:1.5 allocation ratio equals a net loss of 14.5 total/Reserve Capacity slots). The April-June 2021 quarter saw 59 slots moved from Group 5 to Group 6.

[5] As provided in the revised enrollment targets submitted to CMS in July 2020, while the combined total of all upper limits is actually 3,700, there would never be a scenario in which all benefit groups would be set at the upper limit, since program funding would be insufficient to cover the cost. These upper limits provide flexibility to move slots as required to meet the needs of program applicants.

[6] Waiver transitions are instances in which an individual enrolled in a 1915(c) HCBS waiver program is transferred into the ECF CHOICES program. Since these individuals have an independent funding source (i.e., the money that would have been spent on their care in the 1915(c) program), their enrollment in ECF CHOICES does not count against the enrollment target. Waiver transition numbers are cumulative since the program began. Group 6 enrollment includes some of these transitions that do not count against the enrollment target.

Data and trends of the designated ECF CHOICES data elements: STC 53.d. requires the State to provide CMS periodic statistical reports about the ECF CHOICES program. To date, the State has submitted baseline data for the year-long period preceding implementation of ECF CHOICES, as well as four years' worth of post-implementation data. In comparing the baseline data with the post-implementation data, several notable trends emerged:

- The number of individuals with intellectual disabilities receiving HCBS through the TennCare program grew from 8,295 in the year preceding implementation of ECF CHOICES to 8,588 after ECF CHOICES had been in place for four years.
- The number of individuals with developmental disabilities other than intellectual disabilities who received HCBS through the TennCare program grew from 0 to 1,718.
- Average LTSS expenditures for individuals with intellectual or developmental disabilities fell from $94,327 per person to $88,008 per person.
- The percentage of working age adults with intellectual or developmental disabilities who are enrolled in HCBS programs, employed in an integrated setting, and earning at or above the minimum wage grew from 14.32 percent to 22.54 percent.

As ECF CHOICES gains enrollment capacity, these trends toward individuals with intellectual and developmental disabilities living independently in the community are expected to accelerate.

### Information and Data about the Katie Beckett, Medicaid Diversion, and Continued Eligibility Groups

The State's Katie Beckett, Medicaid Diversion, and Continued Eligibility groups provide services and supports for children under age 18 with disabilities and/or complex medical needs who are not eligible for traditional Medicaid because of their parents' income or assets. Although the State has long provided Katie Beckett program services to certain TennCare members via its three section 1915(c) HCBS waivers and the ECF CHOICES program, the availability of these services expanded significantly with the implementation of the new Katie Beckett/Medicaid Diversion/Continued Eligibility program on November 2, 2020.

The State offers services to eligible children through a traditional Katie Beckett program, in which members receive the full TennCare benefits package plus essential wraparound HCBS. In addition, the Demonstration includes an innovative Medicaid Diversion component, which furnishes a specified package of essential wraparound services and supports, including premium assistance. The Continued Eligibility element of the State's program ensures that children who would otherwise lose TennCare eligibility because slots in the Katie Beckett program are not available for them are able to remain eligible for the full TennCare benefits package.

As required by STC 35.c., the State offers the following table delineating Katie Beckett, Medicaid Diversion, and Continued Eligibility enrollment as of the end of the quarter, as well as information about enrollment targets and the number of available reserve slots.

**Table 13**
**Katie Beckett, Medicaid Diversion, and Continued Eligibility Enrollment and Reserve Slots For April-June 2021 Compared to the Previous Quarter**

| | Statewide Enrollment Targets and Reserve Capacity | Enrollment and Reserve Slots Filled as of the End of the Jan – Mar 2021 Quarter | Enrollment and Reserve Slots Filled as of the End of the Apr – Jun 2021 Quarter |
|---|---|---|---|
| Katie Beckett | 100[7] | 21 | 49 |
| Medicaid Diversion | 2,700 | 576 | 770 |
| Continued Eligibility | N/A | N/A | 2 |
| Reserve Capacity | 100 | 21 | 49 |

Data and trends of the designated Katie Beckett/Medicaid Diversion data elements: STC 53.d. requires the State to provide CMS periodic statistical reports about the Katie Beckett and Medicaid Diversion groups. The State anticipates submitting baseline data for these groups one year after full program implementation, with trend data to follow on an annual basis thereafter.

### Steps Taken to Ensure Compliance with Regulations Governing HCBS Settings

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

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

[7] At program implementation, 50 slots were available to children who met Tier 1 level of care eligibility (as defined in TennCare rules). The purpose of these Reserve Capacity slots was to ensure that children with the most significant medical needs and disabilities were enrolled into the Katie Beckett group (Part A) before the group was opened for enrollment to other children, subject to available funding. During the April-June 2021 quarter, an additional 50 slots were added for children who meet Tier 2 level of care eligibility requirements (as described in TennCare rules). All available slots for the Katie Beckett group (Part A) are Reserve Capacity slots.

approved Attachment K was subsequently submitted as the public health emergency continued. The extension of Attachment K was approved by CMS for six months after the public emergency ends.

### Health and Welfare of HCBS Recipients

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

## II. Performance Metrics

### Progress Toward Goals and Targets in the Monitoring Protocol

STC 55 requires the State to submit to CMS a draft Monitoring Protocol no later than 150 days after the January 8 start date of the TennCare III approval period. The purpose of the Monitoring Protocol is to define the quantitative and qualitative elements the State will use in its Quarterly and Annual Monitoring Reports to chart progress toward fulfillment of the goals and targets of the TennCare III Demonstration. On June 7, 2021, the State submitted its draft Monitoring Protocol to CMS. As of the end of the April – June 2021 quarter, CMS was reviewing the document.

### Impact of the Demonstration in Providing Insurance Coverage

As noted in Section I of this report, the TennCare III Demonstration furnished health care coverage to 1,600,893 Tennesseans during the April – June 2021 quarter. This total represents approximately 23 percent of the 6.9 million residents living in Tennessee.

### Impact of the Demonstration in Ensuring Access to Care

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 April 2021, TennCare's External Quality Review Organization (EQRO), Qsource, published the results of its provider data validation survey for the January-March 2021 quarter. The EQRO took a sample of provider data files from TennCare's MCCs[8] and reviewed each for accuracy in the following categories:

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

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

The validity of such information is one measure of providers' availability and accessibility to TennCare enrollees. The EQRO's report demonstrated generally strong performance by the MCCs, especially in the categories of "services for children" (95.0 percent accuracy), "primary care services" (95.1 percent accuracy), and "prenatal care services" (98.9 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 2021.

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

Data documenting the effect of the TennCare Demonstration in improving health outcomes and ensuring quality of care will be included in future Quarterly and Annual Monitoring Reports based on the availability of data and in accordance with the Shared Savings Metric Set. In addition, 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 July 2021, approximately 700,000 TennCare members are attributed to one of 79 PCMH-participating organizations, and 94% of these organizations' 449 sites are currently NCQA-PCMH-recognized. In addition, providers have recently been engaged with numerous trainings. In June 2021, 185 PCMH providers attended a webinar about improving member engagement and vaccine hesitancy, and in July 2021, more than 100 PCMH providers participated in a delivery systems transformation conference to hear from subject matter experts on a diverse range of topics.

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 14 provider groups across Tennessee, including patient-centered medical homes, long-term services and supports providers, hospitals, and behavioral health providers. The State is working with each provider partner to screen members for social risk factors, refer them to community resources, and close the loop on referrals to verify that member needs are met. Thus far, the partnership program has impacted over 1,200 unique members and identified needs across various domains, including transportation, housing, utility assistance, and child care. While this effort remains in the early stages, the State has begun gathering data to inform future quality improvement initiatives related to addressing Tennesseans' social risk factors.

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 managed care organizations to treat 2,000 members. By June 2021, the number of BESMART providers had nearly tripled, and the number of unique members served per month had grown to approximately 7,500. Additionally, buprenorphine covered by TennCare is now in the top five controlled substances by claims, meaning that TennCare pays for more buprenorphine to treat opioid use disorder than for short-acting opioids to treat pain.

The focus that TennCare has placed on combatting the opioid epidemic through treatment and other major prevention efforts has also shown tremendous success in reducing the number of newborns with neonatal abstinence syndrome (NAS), or signs and symptoms of opioid withdrawal as an infant due to opioid exposure during the pregnancy. In 2019, the NAS rate in the TennCare population was 20 NAS births per 1,000 live births, as compared with the 2016 rate, which was 28 NAS births per 1,000 live births. A decline in the NAS rate has been achieved for three consecutive years.

### Beneficiary Survey

Every year since 1993, the Boyd Center for Business and Economic Research (BCBER) at the University of Tennessee in Knoxville has conducted a survey of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—to assess their opinions about health care. Respondents provide feedback on a range of topics, including demographics (age, household income, family size, etc.), perceptions of quality of care received, and behavior relevant to health care (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.).

During the April-June 2021 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 immediately thereafter.

### Progress on Shared Savings Metric Set

On March 8, 2021, the State submitted measures for the Shared Savings Metric Set to CMS. The State will report on its progress on these metrics in future Monitoring Reports, as the measures become available each year.

## III. Budget Neutrality and Financial Reporting Requirements

Budget neutrality was successfully maintained by the State during the April-June 2021 quarter. The State's budget neutrality workbook will be submitted as a separate attachment to this Monitoring Report.

## IV. Evaluation Activities and Interim Findings

STC 90 requires the State to submit to CMS a draft Evaluation Design for the approval period of the TennCare III Demonstration (January 8, 2021 – December 31, 2030). This draft Evaluation Design is due no later than 180 days after CMS's January 8 approval of TennCare III. As of the end of the April – June 2021 quarter, the development of the draft Evaluation Design was scheduled for submission in July 2021.

## V. State Contact

Aaron Butler
Director of Policy
Division of TennCare
310 Great Circle Road
Nashville, TN 37243
Phone: 615-507-6448
Email: aaron.c.butler@tn.gov

**Date Submitted to CMS: August 31, 2021**

# Attachment A:
# Health and Welfare of HCBS Participants

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

**Systems:**

- Data describing investigations is entered on an ongoing basis into the Department of Intellectual and Developmental Disabilities (DIDD) Incident and Investigation (I&I) Database. Monthly reports are generated by DIDD and submitted to TennCare. They include data describing substantiated investigations concluded during the month and investigations for which an extension beyond thirty (30) days was granted, including the type of allegation, the reason for the extension, and the date the investigation was completed.
- MCOs continue to be required to maintain LTSS Distinction as part of their NCQA Accreditation process. One of the core areas is case management, which requires the implementation and ongoing maintenance of a critical incident management system to promptly report, track, and follow up on incidents such as abuse, neglect, and exploitation.

**Reports:**

- HCBS Settings Committee Reports are completed quarterly for the 1115 waiver programs by the MCOs. These reports include the total number of proposed or emergency rights restrictions or restraints reviewed during the quarter that are not part of a plan of care or PCSP or BSP, total number of periodic data reviews regarding interventions, the total number of reviews of psychotropic medications conducted during the quarter, the total number of complaints regarding restrictive interventions or settings compliance concerns received and reviewed during the quarter, and a summary of the outcomes of such reviews, including actions pertaining to individual members or providers or to broader systemic improvements.
- Quarterly HCBS Settings Reports are submitted for the 1115 waiver program. These reports aggregate the HCBS Settings data collected and identify trends relating to member concerns with particular providers or provider settings, including steps for remediation to address these concerns.
- 1115 Critical Incident and Reportable Event Quarterly Reports track all critical incidents by incident type, setting, and the provider/staff accused of being responsible. The report includes a narrative describing the MCO's analysis of critical incidents for the reporting period, including trends and patterns; opportunities for improvement; and strategies implemented by the MCO to reduce the occurrence of incidents and improve quality.
- Follow up is completed with MCOs and providers regarding Emergency Department Utilization of 1115 members. Part of the follow-up that is performed as a result of these reports is to ensure serious incidents associated with hospital visits and unplanned hospitalizations are reported.

**Audits:**

- 1115 Existing Member Record Reviews (MRR) are conducted annually. These record reviews include performance measures related to education of members on the identification and reporting of suspected abuse.
- The CHOICES Critical Incident and ECF CHOICES Reportable Event Audit reviews incidents/events for proper reporting within timeframes as outlined in the CRA.