The Changing Role of States in Long-Term Services and Supports

TennCare

CHOICES

in Long-Term Services and Supports

TennCare Overview

- Tennessee’s Medicaid Agency
- Tennessee’s Medicaid Program

- Managed care demonstration implemented in 1994
- Operates under the authority of an 1115 waiver
- Uses managed care to cover persons otherwise not eligible for Medicaid
- *Entire* Medicaid population (1.2 million) is in managed care
- Medical, behavioral and (since 2010) LTSS for E/PD administered by two NCQA accredited “At-Risk” Managed Care Organizations (MCOs) located in each region of the state (*mandatory* enrollment in managed care)
- ICF/IID and 1915(c) ID waivers carved out; populations carved in
- Statewide back-up plan (TennCare Select) manages care for certain special populations (e.g., children receiving SSI, children in State custody, persons enrolled in ID waiver programs) via an ASO (i.e., modified risk) arrangement
- Prescription drugs administered by statewide Pharmacy Benefits Manager
- Dental Services (< 21) administered by statewide Dental Benefits Manager
- MLTSS program is called “CHOICES”
Why Managed Care?

The LTSS System in Tennessee before...

- Fragmented—carved out of managed care program
- Limited options and choices
- Heavily institutional; dependent on new $ to expand HCBS

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<thead>
<tr>
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<th>FY 1999</th>
<th>FY 2009</th>
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<tbody>
<tr>
<td>Nursing Facilities</td>
<td>99.26%</td>
<td>90.68%</td>
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<tr>
<td>HCBS</td>
<td>.74%</td>
<td>9.32%</td>
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Restructuring the LTSS System: Key Objectives

- **Reorganize** – Decrease fragmentation and improve coordination of care.
- **Refocus** – Increase options for those who need LTSS and their families, expanding access to HCBS so that more people can receive care in their homes and communities.
- **Rebalance** – Serve more people using existing LTSS funds.

Setting the Stage

- Announced by the Governor in his *State of the State*
- Key sponsors – members of a bi-partisan Long-Term Care Study Committee
- Passed unanimously by the General Assembly in an election year without a single “no” vote ever—in any committee, sub-committee, or on the floor
- Broad stakeholder engagement
  - Focus on program objectives
    - Improved coordination and quality of care: *Right care, right place, right time*
    - Expanding access to cost-effective HCBS - “There’s no place like home.”
    - More efficient use of LTSS funding – serving more people with existing $
  - Efforts to understand and address key areas of stakeholder concern and preserve core values
Key Design of MLTSS

- Integrated nursing facility (NF) services and HCBS for seniors and adults with physical disabilities into existing managed care program (roughly $1 billion) via an 1115 waiver; ICF/IID and ID waiver services carved out
- Amended contracts with existing MCOs selected via competitive bid process
- Blended capitation payment for physical, behavioral and LTSS
- MCOs at full risk for all services, including NF (not time-limited)
- Enrollment target for HCBS supports controlled growth while developing sufficient community infrastructure to provide care (persons transitioning from a NF and certain persons at risk of NF placement are exempt)
- Cost and utilization managed via individual benefit limits, levels of care (LOC), and individual cost neutrality cap (for those who meet NF LOC)
- Freedom of choice of NF versus HCBS (must be safe and cost neutral)
- Comprehensive person-centered care coordination provided by MCOs
- Consumer directed options for core HCBS using an employer authority model
- Electronic Visit Verification system helps ensure fiscal accountability and provides immediate notification/resolution of potential gaps in care

State Capacity to Administer (i.e., “Manage”) Managed Care

- State Medicaid Agency role and responsibilities
- Detailed program design and contract requirements to ensure member choice, continuity of care and health plan readiness, including aligned financial incentives and enforcement mechanisms
- Comprehensive readiness review strategy
- Ongoing monitoring and quality oversight
State Medicaid Agency

- Organized around the delivery of managed care
  -- Managed Care Operations
  -- Provider Networks/Services
  -- Quality Oversight
  -- LTSS (Audit & Compliance, Quality & Administration)
    "integrated" into the SMA
  -- Member Services
  -- Finance and Budget (Health Care Informatics)

- Contractors include actuary, EQRO, fiscal employer agent for consumer direction, legal consulting services, member services call center, advocacy/outreach call center, medical appeals vendor, MMIS vendor, SPOE, TPL vendor, member satisfaction survey

- Partners/stakeholders include contractors, MCOs, providers/organizations, members/advocacy groups, legislators, and taxpayers

- Integrally involved in day-to-day program management and oversight/monitoring

Detailed program design and contract requirements

- Developed in consultation with partners/stakeholders
- Reviewed and amended at least every 6 months
- Aligned financial incentives and enforcement mechanisms, including CAPs, liquidated damages, and capitation payment withholds


- Contracting considerations for members
  -- Freedom of choice (settings and providers)
  -- Continuity of care
  -- Care coordination (model, processes, timelines, tools and staffing)
  -- Consumer direction
  -- Education/outreach

- Contracting considerations for providers
  -- Any willing qualified provider
  -- Authorizations
  -- Reimbursement
  -- Prompt payment and claims payment accuracy
  -- Training and technical assistance
Comprehensive Readiness Review Strategy

- Review of key desk deliverables
- Onsite review of critical processes and operating functions
  -- Care coordination
  -- Service authorization
  -- Training
  -- Care coordinator ride-alongs
  -- Demonstration of critical MCO systems – case management, tracking, service authorizations, claims
- Systems testing – end-to-end testing of eligibility, enrollment and encounters
- Other verification and validation activities
  -- Key milestone deliverables: provider networks and service authorizations

Ongoing Monitoring and Quality Oversight

- Uniform measures of system performance
- Detailed reporting requirements
- Ongoing audit and monitoring processes
  -- Site inspections and inspections of work performed
- Measures to immediately detect and resolve problems, including gaps in care – Electronic Visit Verification
- Independent review (External Quality Review Organization, Tennessee Department of Commerce and Insurance)
- Key focus on member perceptions of quality
  -- QOL/Member satisfaction survey
  -- Consumer advisory groups
- Advocacy for members across MLTSS system
## Planning and Implementation Timeline

**LTC CCA**
- May 20, 2008 – Passed by the Tennessee General Assembly
- June 17, 2008 – Signed into law

**CMS Approval**
- July 11, 2008 – CHOICES Concept Paper submitted to CMS
- August 29, 2008 - Draft 1115 Waiver Amendment released for 30-day public comment period
- October 2, 2008 – Formal submission of final 1115 Waiver Amendment to CMS
- July 22, 2009 – CMS Terms and Conditions for Approval of 1115 Waiver Amendment

**MCO Contract Amendments**
- June 26, 2009 – CHOICES CRA Amendment submitted to Fiscal Review and LTC Oversight Committees
- August 4, 2009 - Fiscal Review approved CHOICES CRA Amendment

## Planning and Implementation

### Other Key Successor/Dependent Tasks
- Fiscal/Employer Agent contracts for Consumer Direction
- MCO contracts with Electronic Visit Verification vendor
- MCO staff recruitment/training
- MCO network development
- TDCI provider agreement template approval
- HCBS/NF provider education materials/training
- CHOICES rules, policies/processes, training
- IT systems construction/configuration and testing (internal and external)—including eligibility, enrollment, and encounter processing
- Desk Readiness Assessments-policy/process deliverables
- On-site Readiness Assessments of IT systems and operations
- Member education materials/notices

### Phased Implementation
- Middle Region – March 2010
- East/West Region – August 2010
Baseline Data Results

Baseline 2010
Program years 2011 and 2012 (2013 incomplete)

- # of HCBS participants at a point in time (CHOICES implementation for the baseline and the end of each program year thereafter) more than doubled (from 4,861 to 10,482 as of June 30, 2012; 12,559 as of June 30, 2013)
- # of NF residents at a point in time decreased by more than 9% (from 23,076 at implementation to 20,968 as of June 30, 2012; 19,415 as of June 30, 2013)
- Unduplicated HCBS participants across a 12-month period more than doubled (from 6,226 during the year prior to CHOICES to 12,862 during the program year ending June 30, 2012)
- % of NF eligible people entering LTSS choosing HCBS increased from 18.66% prior to CHOICES to 37.46% during the first 2 years of the program
- 37-day reduction in average NF length of stay
- 129 NF-to-community transitions prior to CHOICES compared to 567 and 740 in program years 1 and 2

Access to Home and Community Based Services before and after

- Global budget approach:
  - Limited LTC funding spent based on needs and preferences of those who need care
  - More cost-effective HCBS serves more people with existing LTC funds
  - Critical as population ages and demand for LTC increases

No state-wide HCBS alternative to NF's available before 2003.
CMS approves HCBS waiver and enrollment begins in 2004.
Slow growth in HCBS enrollment reaches 1,131 after two years.
HCBS enrollment at CHOICES implementation.
Well over twice as many people who qualify for nursing facility care receive cost-effective HCBS without a program expansion request.
Additional cost of NF services if HCBS not available approx. $250 million (federal and state).

*Excludes the PACE program which serves 125 people almost exclusively in HCBS, and other limited waiver programs no longer in operation.
Re-Balancing LTSS Enrollment through the CHOICES Program

LTSS Enrollment before CHOICES Program (March/August 2010)
- NF 83%
- HCBS 17%

LTSS Enrollment as of October 1, 2013
- NF 59.59%
- HCBS 40.41%

Nursing Facility Enrollment
- 90% in June 2010, 70% in August 2013

HCBS Enrollment
- 10% in June 2010, 70% in August 2013

Other Successes
- 96.04% of all in-home services scheduled over the last year were provided; of those visits that did not occur as scheduled, the majority (60.5%) were initiated by the member (not the provider); back-up plans required in either case
- 99.69% of all scheduled in-home services provided over the last year were on time

Continued Challenges
- NF reimbursement methodology must reflect higher acuity of NF residents and incent quality (the member’s experience of care)
- Easier to rebalance enrollment than expenditures, particularly if using cost-based NF reimbursement methodology
- Misalignment of Medicare benefits continues to drive Medicaid institutional care
Takeaways and Advice

• Managed care is a set of tools and principles that can help improve coordination, quality and cost-effectiveness of care for the most complex populations. It is up to us to implement those tools in the right way to achieve the desired objectives and preserve core system values.

• Implementing managed care “well” and achieving program objectives requires a significant investment in the State’s capacity to manage managed care.

• It takes time to design and implemented managed care. Moving too quickly will undermine the success of your program.

• While managed care has significant potential for cost containment and even savings, assuming too much too soon will result in unintended negative consequences, and will undermine quality and cost effectiveness goals.

• Be careful not to confuse the success of the model with the success of the implementation.