Pre Admission Evaluation (or PAE) Process Improvements

On November 1, 2014, working closely with stakeholder groups representing applicants and members served in the CHOICES program and the nursing home industry, TennCare implemented certain improvements to the medical eligibility process and criteria for nursing facility (NF) level of care (LOC). This is the level of care for CHOICES Group 1 (NF services) and CHOICES Group 2 (comprehensive home and community based services or HCBS as an alternative to NF care). The medical eligibility application is called a Pre Admission Evaluation or PAE.

The most significant change pertains to the Safety Determination process – TennCare's review of safety concerns when a person's assessed acuity score is less than the 9 points (on a scale of 1-26) that would automatically result in approval of NF LOC.[1] The new rule defines the revised process for submitting a Safety Determination Request, as well as notice and appeal rights pertaining to such determinations.

We believe these PAE process improvements have helped to ensure that an applicant's functional and medical needs, as well as other safety concerns are being brought forward in the PAE review process, helping TennCare to determine the most appropriate level of care for the individual as early in the process as possible.

Since implementing the changes, we are approving around 40 PAEs each month based on safety. Having the documentation necessary to review for safety at the time of PAE submission has also resulted in a sharp decline in appeal volume. Our monthly average has decreased from 124/month to 64/month.

This suggests that the good work that was done in partnership with you is having a positive impact on people seeking LTSS, as well as providers.

The Quality Improvement in Long Term Services and Supports (QuILTSS) Initiative

In 2013, TennCare, with the assistance of Lipscomb University School of TransformAging (through a Robert Wood Johnson Foundation grant), launched this value based purchasing initiative.

TennCare solicited input regarding the most important aspects of quality *from the member's perspective* from individuals receiving services, family members and service providers through 18 community forums in 9 cities across the state, in addition to an on-line survey. Lipscomb University published a Technical Assistance report analyzing the stakeholder input and experience of other selected states in similar payment reform efforts (available at http://www.lipscomb.edu/transformaging/tareport).

TennCare then hosted a series of smaller stakeholder meetings over several months to design a quality framework to measure quality from the perspective of the resident. Because of efforts already underway to restructure NF reimbursement, we began with implementation for NF services first.

Implementation of the quality framework for NF services included two phases: Transition (or "Bridge") Payments; and full implementation of a Value-Based Purchasing Model. The quality framework, including explanation of the bridge payment year process is available at

[1] This (the "need for inpatient care") is one of two components of level of care eligibility set forth in TennCare rule 1200-13-01-.10(4)(b). The other is "medical necessity of care." NF applicants must also be appropriate for NF care in accordance with federal PASRR regulations.

https://tn.gov/assets/entities/tenncare/attachments/QuiltssFramwork.pdf. Since August 2014, we have been engaged in the Transition (or "Bridge") phase.

Our efforts began with extensive training for NFs (including recorded videos on-line) to describe exactly what was being sought from them and provided various resources for them to be successful. NFs complete an on-line submission form each quarter that demonstrates their actions related to quality improvement. They are required to describe and submit documentation verifying the input that they have received from residents, families and employees and actions they have taken based on this input to pursue improvements. NFs also have the opportunity to complete a self-assessment of Culture Change/Person-Centered Practices and to pursue improvements based on that assessment. Finally, the submission form also includes information about staff retention, the presence of a resident/family council and the accommodations that the facilities provide to include residents and family members in service planning. This NF-submitted information is combined with key data points from CMS' Nursing Home Compare database. Submissions, and supporting documentation are evaluated by TennCare and point values are assigned. The assigned point values are then converted into quarterly supplemental rate adjustment payments.

To date, we have received 3 quarterly submissions from a total of 289 NFs (out of 295 who accept Medicaid). We have completed 2 quarterly payments, totaling nearly $9 million. The Q3 payment should be made in April 2015. Over the 3 submissions, average scores have increased from 46 in the first submission, to 61 in the second, and to 65 in the third. The 29% increase in scores has been accomplished by more facilities seeking the input of residents, families and staff, more facilities completing self-assessments of Culture Change/Person-Centered Planning, and by more facilities taking demonstrable actions to improve quality from the resident's perspective. We continue to see NFs engaging in quality improvement and making progress towards a more home-like environment through innovative and often inexpensive quality improvement activities.

You can read more about QuILTSS at: https://tn.gov/tenncare/topic/quiltss.

CHOICES member reassignment Phase 2: April 1, 2015

In Tennessee, there are three Managed Care Organizations contracted with TennCare to coordinate healthcare and long-term care services needs for Medicaid recipients. Prior to January 1, 2015, there were only two MCOs serving members in each grand region of the state. On January 1, 2015, all three MCOs began serving members in each grand region of the state. This allows members to have more choices regarding MCO selection in each region.

The transition to statewide contracts included TennCare reassigning approximately 1/3 of the TennCare population, including CHOICES members, to the MCO that is new in each grand region. This member reassignment is taking place in two phases for CHOICES members, allowing MCOs to focus more time on each member in order to help make their transition as seamless as possible. Phase 1 of member reassignment, comprised of general membership and CHOICES members, was completed on January 1, 2015 and Phase 2, comprised of CHOICES members only, is scheduled to be completed on April 1, 2015.

CHOICES members selected for Phase 2 of reassignment were mailed two notices. The first notice, mailed on December 29, 2014, communicates to the member that they have been selected for reassignment. The second notice, mailed on February 13, 2015, included information on how to opt out of reassignment if the member does not want to change to the new MCO. It also included a form for

members to complete and send to TennCare if they want to stay in their current MCO. Members who do not opt out before April 1, 2015 will have a 45 day period after their reassignment to in which they can request to move back to their previous MCO. This 45 day period will conclude on May 15, 2015.

CMS HCBS Setting Rule

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) issued new federal regulations which strengthen person centered planning requirements and which define and describe the requirements for home and community-based settings.

The new federal regulations are intended to ensure that services individuals receive under Medicaid HCBS programs are not *"institutional in nature,"* and that individuals receiving Medicaid-reimbursed HCBS have opportunities for community integration and full access to the benefits of community living.

While the rule explicitly pertains to services provided under 1915(i) and 1915(c) authorities, CMS has made clear its intent to uniformly apply the new rules to HCBS provided under all applicable Medicaid authorities, including 1115 waivers.

Settings which do not comport with these requirements will not be eligible for federal Medicaid funding for HCBS programs. States are required to evaluate the settings in which HCBS are currently provided to determine their compliance with the new rule, and to develop transition plans where needed to achieve compliance in order to continue receiving federal Medicaid reimbursement.

There are a number of activities the State has undertaken in order to assess its compliance with the new rule, and to develop plans to make any changes that are needed to come into compliance. HCBS Waiver residential and day service providers are assessing their programs and service settings to determine compliance with the Rule. This includes DIDD residential and day service providers as well as CHOICES Assisted Living, Adult Care Homes and adult day service providers. Providers are required to engage persons supported, families and advocates in their assessments. All submissions are made in a web-based portal using a standard Self-Assessment tool. All assessments are due by March 31st and many providers have already made their submissions. For any areas that a provider identifies that is non-compliant with the Rule, that provider must also submit a transition plan detailing their action steps and timelines for meeting compliance requirements. TennCare, DIDD and the MCOs are reviewing the submissions and will be working with providers to ensure transition plans are adequate to come into compliance with the Rule. Once all submissions are completed, the State will be able to assess not only individual provider compliance but also from an overall statewide perspective, the level of compliance with the Rule and the specific areas in which we as a State need to work with providers to come into compliance.

In addition, each person receiving services will participate in an Individual Experience Survey that will help to measure compliance from the perspective of the individuals receiving services and supports. This are cumbersome processes, but an excellent exercise that will help the State progress in person-centered thinking, planning and practices that ensure all individuals served in Medicaid HCBS programs are fully integrated in their communities.

You can read more about these changes and the State's assessment and transition planning activities at: https://tn.gov/tenncare/topic/transition-plan-documents-for-new-federal-home-and-community-based-services.

Group 3 Eligibility Changes

Effective July 1, 2015 (and contingent on approval of the proposed FY 2016 budget by the General Assembly), TennCare will no longer apply higher income limits called institutional income standards (300% of the SSI Federal Benefit Rate—currently $2,199 per month) in order for people to qualify not just for Home and Community Based Services (HCBS) in CHOICES Group 3, but also for Medicaid/TennCare.

CHOICES Group 3 provides HCBS for people with lesser needs who would not qualify for care in a nursing home.

Tennessee is one of a relatively small (but growing) number of states who make HCBS available to people who don't qualify for nursing home care. We are not aware of any other states that are applying institutional income standards to a non-nursing home eligible population.

Institutional income standards were created under federal law for people who are "continuously confined" in an institution, or who need the level of care provided in an institution, but are receiving HCBS instead. These higher income standards allow people who need long-term care services to qualify *for Medicaid* (*all* Medicaid benefits, not just LTSS) when they otherwise would not.

If this budget item is approved, starting July 1, 2015, people would need to qualify for SSI (Supplemental Security Income from the Social Security Administration) in order to enroll in Group 3.

This is how the CHOICES program was originally designed in 2008 and approved by CMS in 2009. Application of the higher institutional income limits to the CHOICES Group 3 (non-nursing home eligible) population was required by CMS through December 31, 2013 because of federal maintenance of effort provisions of the ARRA (American Recovery and Reinvestment Act) and the ACA (Affordable Care Act). When these requirements expired in December 2013, TennCare was able to continue to keep this eligibility pathway open through the end of FY 2015.

These changes will not impact people already enrolled in CHOICES Group 3. People enrolled in CHOICES Group 3 as of June 30, 2015 can continue to qualify for and receive HCBS (and other Medicaid services) so long as they continue to be "at risk" of nursing home placement (i.e., have a single significant deficiency in activities of daily living and need ongoing assistance to delay or prevent nursing home placement) and meet the financial eligibility criteria currently applicable to these services (i.e., the higher institutional income limits).

Because State resources are limited and the population who is aging and who has disabilities is expected to grow exponentially, it is important for the sustainability of the program that we target limited resources to people who need it the most—both from a functional and a financial perspective.

Amendment 18 to the TennCare Demonstration:
Coverage of Assisted Care Living Facility Services in CHOICES Group 3

TennCare has requested CMS approval of Amendment 18 to the TennCare demonstration. This amendment would allow Assisted Care Living Facility services to be included as a benefit for members

enrolled in CHOICES Group 3. This amendment was previously submitted to CMS in 2013 based on input from members, advocates and providers, but was then placed on hold until CMS released the HCBS Setting Rule. Now that the State has a process in place for ensuring that all existing and new Assisted Care Living Facility settings will be compliant with the Rule, TennCare has asked CMS once again to review and approve this waiver amendment.

TennCare has requested approval for an effective date of July 1, 2015 for this amendment.

Amendment 24 to the TennCare Demonstration:
Community Living Supports (CLS) and Community Living Supports Family Model (CLS-FM)

TennCare has submitted Amendment 24 to CMS requesting approval for Community Living Supports (CLS) and Community Living Supports – Family Model (CLS-FM) as community based residential alternative services in the CHOICES program. These benefits will offer another option for people who need more supports than can be provided in the home, and who may lack the availability of natural supports that would allow them to continue living safely in the community. CLS and CLS-FM provide residential services based on the member's level of need for supports to live in the community.

CLS provides residential services for up to four individuals in one home with minimal supports up to 24/7 supports based on the member's needs. CLS-FM is an adult foster care model that provides services in a family home for up to three individuals who are not related to the family model caregivers. CLS-FM also provides minimal to up to 24/7 supports as needed based on the member's needs. Both CLS and CLS-FM will include multiple levels of reimbursement depending on the needs of the person receiving support.

The development and implementation of a plan to expand appropriate cost-effective community-based residential alternatives to institutional care is required pursuant to the Long-Term Care Community Choices Act, which authorized the CHOICES program in 2008 (see TCA 71-5-1411), and is an important part of the State of Tennessee's plan for compliance with the ADA.

Providers of the new services will be licensed by the Department of Intellectual and Developmental Disabilities (DIDD), pursuant to statutory requirements set forth in Title 33 of the Tennessee Code Annotated and in Rule Chapter 0940-05 of the Department of Mental Health and Substance Abuse Services. Providers licensed under these statutory and regulatory licensing requirements have delivered services to individuals with intellectual disabilities in TennCare's Section 1915(c) waiver programs for many years.

To ensure quality of care, TennCare intends to contract with the Department of Intellectual and Developmental Disabilities (DIDD), the operating agency for the state's three Section 1915(c) waivers for individuals with intellectual disabilities, to conduct quality monitoring surveys of providers of CLS and CLS-FM services. We will thus build on a well-developed quality strategy that has been hailed by CMS in the most recent evidentiary review of the 1915(c) waivers as a "model of best practices" to establish performance measures and processes for discovery, remediation, and ongoing data analysis and quality improvement regarding CLS services. In addition to providing data specific to the quality of services offered in the CHOICES program, this will ensure that TennCare has a comprehensive perspective of quality performance and strategies for quality improvement across the LTSS system as a whole. TennCare also intends to work with Area Agencies on Agency and Disability to ensure the availability of Ombudsmen services for individuals receiving CLS and CLS-FM services and will begin participating in

National Core Indicators Aging and Disabilities to assess quality of life, community integration, and person-centered services for CHOICES members.

TennCare has requested approval for an effective date of July 1, 2015 for this amendment.

I/DD System Restructure

In 2013, TennCare began an extensive stakeholder process to gather input regarding a comprehensive redesign of the service delivery system for individuals with intellectual and developmental disabilities.

This resulting plan includes the renewal of two of the State's Section 1915(c) home and community based services waivers for people with intellectual disabilities. Upon renewal, one of those waivers will have an individual cost neutrality cap, based on the comparable cost of institutional care. To ensure continuity of services, prior to application of the individual cost cap, persons determined by the State to be receiving services in excess of the cap will be transitioned to a different waiver which will continue to have an aggregate cost cap. We anticipate approval of the renewal of these waivers by the end of the month.

The plan also includes a proposed new Managed Long Term Services and Supports (MLTSS) program for people with intellectual and developmental disabilities, specifically geared toward promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for all individuals with intellectual and developmental disabilities: ***Employment and Community First CHOICES***.

In addition to prioritizing key program goals, the goal of the these changes is to provide services more cost-effectively in order to expand access to HCBS and serve more people over time, including people with intellectual and developmental disabilities.

You can read more about the proposed redesign of home and community based services for individuals with intellectual and developmental disabilities at: https://tn.gov/tenncare/topic/hcbs-for-individuals-with-intellectual-and-developmental-disabilities.

New State Website Launch:

Communication and information sharing is vital to the service of TennCare members. Information at our finger tips helps us to be more efficient and provide a better service to the community. With that in mind we wanted to make you aware that the state of Tennessee's website, and subsequently all state department websites, are in the process of being redesigned. The new websites will launch this spring (2015). All state agencies have been tasked with updating website information. This includes reviewing old or outdated links, documents, stored phone numbers and removing information that is no longer active or accurate.

We are aware that many of you include links to the various TennCare program webpages in your member or provider communications. Current links you may have saved, bookmarked or use in regular communications will change once the new website is launched. **This includes the links in this update.** We would ask that going forward you verify **all links** before adding them to any communication to ensure the information being provided is accurate and helpful. We encourage you to periodically visit the TennCare website to find new or updated information. We make it a practice to highlight new

information for our stakeholders and want to make sure you have access to all the tools and resources you need to provide a high quality service to the citizens of Tennessee.

If you have questions or concerns about information on any of the TennCare webpages, or identify changes you think would be helpful, please reach out and let us know.