State Profile

Summary of Care Coordination Contract Provisions for Tennessee TennCare CHOICES

This summary was prepared for a study of care coordination in managed long-term services and supports programs, conducted by Truven Health Analytics for the AARP Public Policy Institute.[1] Contracts from the following states were included in the study: AZ, CA, DE, FL, HI, IL, KS, MA, MN, NJ, NM, NY, OH, RI, TN, TX, VA, and WI. The full report and contract summaries from the 18 states are available at www.aarp.org/carecoordination. The full report includes a compilation of findings across the states.

Tennessee Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	All	All TennCare CHOICES members (nursing facility and home- and community-based services) require long-term services and supports, and all receive care coordination.
2) Can eligible members opt out of care coordination?	Other	Members cannot opt out of care coordination entirely, but may opt out of some of the minimum face-to-face contacts.
3) Can members choose or change care coordinators?	Yes	While care coordinators are assigned by contractors, they must honor member requests for new care coordinators, subject to availability. Contractors are required to provide members with education materials upon enrollment into CHOICES that explain how to request a new care coordinator and to have CHOICES member advocates who can assist with this process.

(continued)

AARP Real Possibilities
Public Policy Institute

Element	Contract Requirement	Summary and Notes
Care Coordinator Qualifications		
4) Are care coordinators required to have college or nursing degrees?	Yes	At a minimum, a care coordinator must have a bachelor's degree in social work, nursing, or other health care profession; or be an RN or LPN. Care coordinator's supervisor must be a licensed social worker or RN with at least 2 years of relevant health care experience, preferably in long-term services and supports.
5) Are care coordinators required to have experience in long-term services and supports or disability?	No	Care coordinators are not required by the State to have experience, though care coordinator supervisors are required to have at least 2 years of relevant health care (preferably long-term services and supports) experience.
6) Are care coordinators required to receive training?	Yes	Contractor must provide initial training for care coordinators in topics such as CHOICES program descriptions, enrollment, eligibility, benefits, expenditure and cost caps, and consumer direction. Additionally, the contractor must establish an ongoing training program for care coordinators, which is based on topics arising from the contractor's monitoring of care coordination and the CHOICES program and feedback from TennCare.
Cultural Competency of Care Coordination		
7) Are care coordinators required to speak languages other than English when the other language is used by members?	No	All care coordinators receive initial training, which includes training on cultural competency. Care coordination must be provided with respect for the member and member's family's preferences, interests, needs, culture, language, and belief system. Care coordinators are not required to speak non-English languages.
8) Are translation/interpretation services required when a care coordinator does not speak a member's language?	Yes	Oral interpretation and translation services must be available without cost to all members who need it, regardless of prevalence. In addition, interpretation and translation must be available in multiple formats, such as in person, through sign language, or through telephonic assistance. All vital written materials must be available in Spanish and made available in other languages as needed.
Care Coordinator Assignments, Contact Requirements, and Role		
9) Are care coordinators with certain specialties (e.g., nursing, social work, behavioral health) assigned based on the needs of members?	Yes	Contractor must assign care coordinators to meet the needs of members.

(continued)

Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
10) Is in-person contact required and at what frequency?	Yes	In-person contact is required as follows: In nursing facility, 21+ years of age: • Initial intake visit within 30 calendar days of notice of a member's enrollment in CHOICES; and • Visits at least twice a year with an interval of at least 120 days between visits. In nursing facility, under 21 years of age: • Initial intake visit within 30 calendar days of notice of a member's enrollment in CHOICES; and • Visits at least quarterly with an interval of at least 60 days between visits. In community, nursing facility level of care: • Initial intake visit within 10 business days of notice of a member's enrollment in CHOICES; and • Visits at least quarterly with an interval of at least 60 days between visits. In community, at risk of becoming nursing facility level: • Initial intake visit within 10 business days of notice of a member's enrollment in CHOICES; and • Visits at least semiannually with an interval of at least 120 days between visits (more frequently when appropriate based on the member's needs and/or request).
11) Is telephonic or other remote contact required?	Yes	Additional minimum contact, which may be either by phone or in person, is as follows: For members in nursing facilities: • Quarterly grand rounds For members in the community, nursing facility level of care: • Monthly contact For members in the community, at risk of becoming nursing facility eligible: • Quarterly contact
12) Must initial contact with a new member be made within a specified time period?	Yes	For members in nursing facilities, the care coordinator must perform the initial intake visit within 30 calendar days of notice of the member's enrollment into CHOICES. For members living in the community, the care coordinator must perform the initial intake visit within 10 business days of notice of the member's enrollment into CHOICES.

(continued)

Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
13) Is an assessment required at initial enrollment?	Yes	For members living in the community, an assessment and plan of care must be completed and services initiated within 10 business days of notice of the member's enrollment into CHOICES. For members living in nursing facilities, the care coordinator must conduct a face-to-face visit within 30 days of notice of a member's enrollment, which may include a comprehensive needs assessment if the care coordinator finds that one is needed.
14) Is reassessment required and at what frequency?	Yes	Reassessment of a member's level of care and comprehensive reassessment of need must be conducted at least annually, or whenever the needs of a member change.
15) Does the care coordinator authorize long-term services and supports?	Yes	Care coordinator works with the member to develop a person-centered plan of care, which the contractor must use to authorize appropriate services.
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Yes	Care coordinator retains all roles and responsibilities that he or she has for a member not in consumer direction and has additional duties related to consumer direction, including assisting with the implementation of consumer-directed services and providing ongoing support, such as reviewing and assisting the member with the implementation of the member's back-up plan, coordinating with the fiscal/employer agent, etc. Additionally, the fiscal/employer agent assigns a supports broker to each CHOICES member participating in consumer direction to assist the member in performing certain employer-of-record functions, such as assisting with the enrollment of new workers and providing initial and ongoing training to members and their representatives.
17) Does the care coordinator play a role when members use a transition program such as Money Follows the Person to move out of institutional settings?	Yes	Contractor is responsible for coordinating the transitions of members moving from nursing facilities to the community, under Money Follows the Person (MFP), as well as the broader managed long-term services and supports program. All assessment and planning activities must be completed by the care coordinator. Participation in MFP carries additional documentation and other responsibilities, and must be included in the member's plan of care. Contractors may elect to use a transition team for members transitioning into MFP, but the person performing assessment and planning functions must meet the qualifications of a care coordinator.

(continued)

Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
18) Does the member have a single point of contact who coordinates across specialized coordinators when needed (e.g., coordinates across long-term services and supports, behavioral, medical specialists)?	Yes	Care coordinator is the designated primary contact person for coordination of the member's physical health, behavioral health, long-term care needs, and social support needs.
Care Coordination Role with Family Caregivers		
19) Are family caregivers asked directly about (a) their own health and well-being; (b) level of stress and feelings of being overwhelmed; (c) need for training in assisting the member; and (d) any additional services or supports needed to better carry out their roles?	Yes	Effective January 1, 2015, contractors are required to complete a caregiver assessment encompassing these elements for any caregivers identified during the comprehensive needs assessment process for members living in the community.
20) Does the plan of care address needs of the family caregiver raised during the assessment process?	Yes	Effective January 1, 2015, caregiver needs identified during the caregiver assessment must be included in the plan of care.
21) Are family caregivers given care coordinator contact information?	Yes	Members and member representatives must be provided with contact information. Care coordinators are required to train caregivers on how to contact the care coordinator if the member experiences a significant change in condition or care, a hospitalization, or if the caregiver would like to recommend additional services.
Care Coordination Information Tools		
22) Does the care coordinator have access to centralized member records?	Yes	Contractor must maintain an electronic system to which care coordinators have access that can receive and maintain information from several sources, including Medicare claims, plans of care, assessments, etc.
23) Does the care coordinator have access to an electronic care coordination program?	Yes	Contractor must develop and maintain an electronic case management system with this functionality.
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	Yes	The average weighted care coordinator-to-CHOICES member staffing ratio cannot exceed 1:115, and the weighted maximum caseload for any individual care coordinator cannot exceed 1:165.
25) Does state program monitoring include a specific focus on care coordination?	Yes	Contractor must monitor the care coordination process on an ongoing basis and submit regular reports to the State. The State also conducts on-site and chart audits, ride-along visits, provides technical assistance, and requires corrective action plans and/or issues sanctions at its discretion.

(continued)

Element	Contract Requirement	Summary and Notes
Care Coordination Structures, Policy, and Oversight (continued)		
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	Contractor must monitor the effectiveness of its care coordination processes, immediately remediate all individual findings identified through its monitoring process, and track and trend findings and remediations to identify systemic issues. Additionally, TennCare requires multiple reports at routine intervals (monthly, quarterly, etc.) concerning care coordination and program outcomes, and monitors program outcomes on an ongoing basis.
27) Care coordination entity	Partners permitted	The contract neither requires nor prohibits contractors from using subcontractors to perform care coordination, but requires approval by the State and includes conflict of interest provisions in the event care coordination functions are subcontracted.

Contract Reviewed: Contractor Risk Agreement between the State of Tennessee, d.b.a. TennCare and [name of contractor] *(East/West CRA—May 19, 2008—With Amendment 13, effective January 1, 2014, with selected updates effective January 1, 2015).*

1 Saucier, P. and B. Burwell. 2015. *Care Coordination in Managed Long-Term Services and Supports*. AARP Public Policy Institute.

July 2015

601 E Street, NW
Washington DC 20049

Follow us on Twitter @AARPpolicy
on facebook.com/AARPpolicy
www.aarp.org/ppi

For more reports from the Public Policy Institute, visit http://www.aarp.org/ppi/.

AARP® Real Possibilities
Public Policy Institute