Background

The Bureau of TennCare (TennCare) is the state agency that administers Tennessee’s Medicaid program. In 2010, with the implementation of its CHOICES in Long-Term Care program (CHOICES), Tennessee integrated long-term services and supports (LTSS) for the elderly and adults with physical disabilities into TennCare’s existing Medicaid managed care system, which has been in place since 1994. TennCare contracts with three Managed Care Organizations (MCOs) across the state (two in each of the State’s three grand regions) to administer benefits, including physical and behavioral health, for all 1.2 million TennCare participants (enrollment of all populations in Medicaid managed care is mandatory). With the implementation of CHOICES, MCOs also began administering LTSS benefits to include nursing facility (institutional) services and home and community based services (HCBS) for the elderly and adults with physical disabilities.

At implementation, TennCare transitioned nearly 28,000 individuals already receiving Medicaid reimbursed LTSS into CHOICES. Seventeen and one-half (17.5) percent were receiving HCBS, with the remainder receiving services in an institutional setting. As of June 2012, less than two years into statewide implementation, more than thirty-four percent (34.1) of CHOICES members are receiving HCBS, with the remainder receiving services in an institutional setting—a significant step forward in the State’s rebalancing efforts.

Phased Implementation

Having been a managed care program for nearly two decades and with previous large-scale implementations (e.g., competitive procurement and transition of all 1.2 million TennCare members to new MCOs, including integration of physical and behavioral health services), TennCare has learned that a phased implementation is generally the preferred approach. This allows time to focus the Bureau’s primary resources on the MCOs in that region, and to integrate lessons learned into the next phase of implementation. The CHOICES program was implemented first in Middle Tennessee in March 2010 and subsequently in East and West Tennessee in August 2010.

Readiness Review

In order to ensure that MCOs were prepared to begin serving CHOICES members, TennCare conducted a rigorous readiness review process that included the review of key desk deliverables (policies, procedures, etc.), onsite review of critical processes and
operating functions, systems testing, and other verification and validation activities. In many cases, these events occurred concurrently and were inter-related. The Bureau’s approach to readiness focused on key areas that were critical to a successful program implementation, with the two primary objectives being continuity of care for individuals already receiving LTSS at the time of implementation for CHOICES and continuity of payment for providers. These key areas included the following:

- Care Coordination;
- Service authorization and delivery;
- Quality monitoring;
- Data transfer and management;
- Provider network management; and
- Claims Payment.

While the TennCare Division of LTSS maintained primary responsibility for the overall determination of each MCO’s readiness to implement the new program, the success of the readiness review activities also relied on the involvement of many other divisions within TennCare including Managed Care Operations, Provider Networks, Quality Oversight, and Information Technology. TennCare also partnered with other state agencies including the Tennessee Department of Human Services (DHS—which determines Medicaid eligibility and houses the State’s Adult Protective Services agency) and Tennessee Department of Commerce and Insurance (TDCI—the insurance regulator for insurers in the State, including TennCare MCOs) to assure preparedness for implementation.

**Readiness Review: Desk Review of Key Deliverables**

TennCare delineated specific items that each MCO was required to submit for Desk Review. TennCare’s request included items (e.g., policies and procedures, training materials, member handbooks, notices, etc.) required to demonstrate compliance with a specific contractual requirement, as well other documents (e.g., the MCO’s Project Implementation Plan) necessary to confirm the MCO’s readiness to manage the new program. TennCare’s two primary objectives associated with the examination of these items were to verify not only the MCOs’ understanding of contract requirements but also their understanding of the Bureau’s expectations regarding the administration of the LTSS program. In addition, and of no less importance, were other ancillary objectives including physical and behavioral health integration with LTSS, and demonstration of the MCOs’ comprehensive, integrated strategy for operationalizing the vital components of the CHOICES program (e.g., how disease management, medical and behavioral case management, and care coordination functions would be integrated).

Reviewers examined each item submitted for content, contract compliance, consistency with related documents, comprehensiveness, and usability as appropriate (e.g., plan of care and needs assessment tools). While reviewing the items, TennCare maintained an ongoing dialogue with each MCO to collect additional information or clarification as
needed. After reviewing the submitted items, TennCare provided each MCO with a written response including:

- Items that were approved;
- Suggested revisions or amendments to specific item(s);
- Concerns or deficiencies that required item(s) to be revised and resubmitted for review;
- Contractual requirements for which no documents were submitted to demonstrate compliance.

Occurring separately from the Desk Review but involving document examination, TDCI reviewed each MCO’s provider agreement templates and provider manual to ensure compliance with the contract and state and federal law, as well as each MCO’s subcontract with an Electronic Visit Verification (EVV)\(^1\) system vendor and with TennCare’s contracted Fiscal Employer Agent (FEA)\(^2\) for Consumer Direction.

**Readiness Review: Onsite Review of Critical Processes and Operating Functions**

In addition to Desk Review, TennCare conducted Onsite Reviews to see how the items examined in the Desk Review were operationalized and to get a better understanding of how the MCOs would manage the program “on the ground.” TennCare conducted multiple Onsite Reviews with each MCO that focused on different aspects of CHOICES implementation and took different formats. Examples include:

- Readiness to perform CHOICES Care Coordinator Intake, Assessment and Care Planning Processes
  - TennCare required each MCO to participate in comprehensive test case scenarios that were video-taped for review, analysis and discussion with the MCO. Each MCO conducted an intake visit with two prospective CHOICES members, which included CHOICES education, needs assessment, risk assessment/planning and plan of care development. MCOs were required to demonstrate, utilizing care management systems and tools, all outputs of the Care Coordination process, including a signed plan of care, other forms as required, and service authorizations. The “CHOICES members” who participated in the recorded visits were actual TennCare LTSS nurses, but the MCOs were not aware of this and believed them to be actual TennCare participants who would be enrolled in CHOICES at implementation. Subsequently, TennCare reviewed the

---

\(^1\) An electronic system into which MCOs transmit service authorizations for specified HCBS and HCBS providers and Consumer Directed workers check-in and check-out for each of the specified services provided. MCOs use this as one mechanism to monitor service delivery and to immediately resolve potential gaps in care. Certain HCBS providers also submit claims to the MCO through this system.

\(^2\) The FEA provides financial administration and supports brokerage services for all CHOICES members participating in consumer direction.
recordings and met with each of the MCOs to provide feedback regarding strengths as well as opportunities for improvements. To the extent that any activities were not consistent with program requirements, corrective actions by the MCO were required. TennCare required this activity to be successfully completed and all deficiencies remediated prior to authorizing an MCO to begin assessing actual CHOICES members.

- Service Authorization Validation
  - In addition to evaluating the care coordination process, TennCare conducted onsite visits to evaluate the authorization of the services identified in the plan of care from the video-taped assessment session. Included in this evaluation was validation that the transmission of the authorizations to the EVV system were successful, and a demonstration of how the EVV system would be used to monitor service delivery.

- Training
  - Effective care coordination is crucial to the CHOICES program, as it cannot be successful without this element being done extremely well. During Readiness Review, TennCare placed significant emphasis on ensuring that MCOs had knowledgeable, well-trained care coordinators. While the MCOs retained primary responsibility for training care coordination staff, TennCare reviewed each MCO’s training materials during Desk Review, participated in training, and along with other agencies, provided training. Activities that occurred during this portion of Readiness Review include the following:
    - Presentation of specific information to facilitate care coordinators’ understanding of topics that TennCare identified as areas of concern through Readiness Review, (e.g., Consumer Direction, developing risk agreements, explaining the Federal Estate Recovery Program, and transitioning between CHOICES groups);
    - DHS, the state agency responsible for determining categorical and financial eligibility for Medicaid LTSS, trained MCO staff regarding the eligibility process and requirements;
    - The FEA conducted training regarding consumer direction; and
    - Scenario-based training evaluations with newly trained care coordinators. In a group setting, a care coordinator was presented with a scenario and role-played an interaction with a “CHOICES member” (actually a TennCare representative). In this manner, TennCare engaged individual and groups of care coordinators in conversations regarding the specific aspect of care coordination that was addressed in the scenario. Scenario topics included assessing natural supports, risk assessment, needs assessment and cultural sensitivity in the assessment process.
- Care Coordination Ride-a-Longs
  - TennCare staff accompanied care coordinators as they conducted intake visits with actual CHOICES members (this occurred subsequent to the activity previously described) and examined the CHOICES education, needs assessment, risk assessment, and plan of care development processes and the care coordinator’s ability to answer questions and to utilize the MCO’s tools and technology (e.g., laptops, forms, scanners etc.).

- Demonstration of Critical MCO Systems
  - Staff also participated in the examination and evaluation of the MCOs’ case management, eligibility, and claims systems. This included the transmission of data between each system, payment of claims, accuracy of data, and timeliness of data availability.

Readiness Review: Systems Testing

Extensive systems testing was conducted to ensure that enrollment, eligibility, and encounter data could be accurately and effectively transmitted between each MCO and TennCare. In addition, TennCare required each MCO to conduct systems testing with the EVV system vendor and the FEA, including LTSS service authorizations to contract providers and to the FEA, scheduling of specific HCBS in the EVV system, referral of members to the FEA, demonstration of EVV functionality, and claims processing using actual test cases.

Bureau Information Systems (IS) staff, in conjunction with LTSS business owners, performed this critical readiness function. Systems design encapsulated the better part of one year, culminating with one month of end-to-end testing with each MCO prior to “go live”. Test cases were created involving a myriad of possible scenarios for CHOICES members and these were submitted electronically, via a HIPAA compliant format, to the various MCOs. The MCOs had time to load and validate their systems with the test data and upon completion of that task, Bureau staff participated in live Webinar sessions where MCO staff walked through each of the cases and how they loaded them into their systems. In addition, Bureau staff asked questions with regards to each of the independent scenarios that were submitted to the MCO to ensure that there was a holistic understanding of down-stream processes triggered by each transaction, both with respect to the impact on the individual member, as well as the MCO’s business processes. Each MCO had to complete numerous test cases before they were approved for go-live of the CHOICES implementation.

Readiness Review: Key Milestone Deliverables

As specified above, the two primary objectives at implementation were ensuring continuity of care for individuals already receiving LTSS at the time of implementation for CHOICES and continuity of payment for providers. (“Members get services; providers get paid.”) In order to help ensure that these objectives were achieved,
TennCare established milestone deliverables for service authorizations based on each transitioning HCBS member’s plan of care, and for the contracting, credentialing and loading of contract nursing facilities and HCBS providers into the MCOs’ systems.

**Service Authorizations of HCBS**

TennCare facilitated the gathering of plan of care data from Area Agencies on Aging and Disability that had been responsible for reviewing and approving plans of care in the Section 1915(c) waiver that existed prior to integration of LTSS into managed care. In the first phase of CHOICES implementation in Middle Tennessee, plan of care data was collected in paper format. In the second phase of implementation, based on lessons learned, TennCare contracted with an entity to help collect the information in an electronic format for review and validation by the MCO. TennCare requested that providers also provide service authorization data to the MCOs, and MCOs were required to follow up as needed to gather such data, review and validate the AAAD plan of care data with provider service authorizations, reconcile any discrepancies, and authorize the continuation of these services under CHOICES. MCOs were required to submit reports to TennCare documenting the number of members for whom such actions had been completed, with 50%, 75%, 90%, and 100% benchmarks required at specified intervals prior to go-live. Finally, as a “stop-gap” measure, immediately prior to go-live, TennCare issued letters to providers requesting that they continue any services authorized for CHOICES members under the HCBS waiver, with assurance of reimbursement by the MCO.

**Provider Network Files**

In addition, TennCare required that each MCO submit routine provider network files detailing the providers with which credentialing processes had been completed, and contracts executed and loaded into the MCO’s system. 50%, 75%, and 90% benchmarks were established for Nursing Facility as well as HCBS providers, with review based on fee-for-service networks in place prior to the CHOICES program, as well as established access standards for the new program, where applicable.

**Advice to States**

While no transition of this magnitude is ever perfect, TennCare’s Readiness Review process resulted in the successful implementation of the CHOICES program. A similar process was used when the State’s Money Follows the Person Rebalancing Demonstration was “layered onto” the CHOICES program, and is also being followed as the next phase of CHOICES, including level of care changes and a new “At-Risk” group, are established on July 1, 2012.

While each State must tailor their Readiness Review process to their unique program, it is critical that each State have a comprehensive strategy for ensuring the readiness of managed care contractors to perform the functions that are necessary to manage the program.
In Tennessee, the decision to implement an EVV system proved valuable from a quality management perspective, but challenging from an implementation perspective. In retrospect, we would advise States implementing such a system to invest significant energy 1) verifying on the front end the functionality of the new system; and 2) understanding each MCO’s structure and business processes to operationalize the EVV system and to manage it on an ongoing basis, including member preferred scheduling, member-initiated adjustments in scheduling, responding timely to alerts to address potential gaps in care, managing exceptions, and reconciling provider claims and payments.

Similarly, we would advise that States understand in detail how MCOs will track members from referral or intake into the new program through care plan development and service initiation, and how MCOs will, on an ongoing basis, ensure that care management functions (e.g., periodic visits, assessments, plan of care updates, etc.) are performed timely. While States with previous managed LTSS experience clearly have an advantage, it is important that they understand the unique requirements of each State’s particular program, and that they modify their systems and processes accordingly to meet each State’s contractual obligations. States should be prepared to invest even more time in making sure that MCOs without previous LTSS experience have adequate knowledge, business processes, and systems in place prior to the program’s implementation.

Finally, while Readiness Review is an essential step of any successful program implementation, it is only the first step. States must remain integrally involved as the program is implemented with similar processes in place to quickly identify and resolve any issues that may arise, and to monitor the MCO’s ongoing compliance with contractual obligations.