This case study summary is based on the opinions expressed by state officials during interviews and email exchanges between 2012 and 2013. It does not reflect AARP policy or opinion.

Overview

In Tennessee, the Bureau of TennCare (TennCare) is the state agency that administers Medicaid. In 2010, Tennessee implemented the CHOICES in Long-Term Care program (CHOICES). Through mandatory managed care arrangements, the statewide program provides long-term services and supports (LTSS) for older adults and people with physical disabilities. TennCare contracts with three managed care organizations (MCOs) to provide LTSS—including home- and community-based services (HCBS), nursing facility care, and behavioral health services—to approximately 32,000 CHOICES beneficiaries. Older adults and people with physical disabilities qualify for CHOICES if they need a level of care that would be provided in a nursing home or if they are at risk for needing such care.1

The TennCare Division of LTSS is primarily responsible for determining readiness, but other divisions within TennCare—such as managed care operations, provider networks, quality oversight, and information technology (IT)—are also involved. In addition, TennCare partners with other state agencies to conduct readiness review. These agencies include the Tennessee Department of Human Services (TDHS), which determines Medicaid eligibility and houses the state’s Adult Protective Services agency; and the Tennessee Department of Commerce and Insurance (TDCI), which regulates insurers, including MCOs.

The primary objectives of the state’s readiness review are to ensure continuity of care for individuals who are already receiving LTSS as they are transitioned into the CHOICES program, and to ensure continuity of payment for providers.2 TennCare’s readiness review process includes reviewing key desk deliverables3 (e.g., written policies, procedures, training manuals, member handbooks, member notices, and other materials) and onsite4 review of critical processes and operating functions (e.g., information systems testing) (see Appendix C).

During desk review, TennCare reviewers examine each item submitted (e.g., tools used for conducting needs assessments and for developing the
plan of care) for content, contract compliance, consistency with related documents, comprehensiveness, and usability—as appropriate. According to one state official: “Usability refers to whether the deliverable can be practically implemented to accomplish a specific objective. For example, if the assessment tool is so comprehensive that it will require four hours to complete, we [TennCare officials] would have concerns regarding the usability of the tool. From a policy and procedural perspective, if a process would require significant resources to manage, we [TennCare officials] would question whether the MCO has sufficient staffing to implement the policy or procedure.”

Throughout the desk review process, TennCare officials maintain an ongoing dialogue with each MCO to collect additional information or clarification as needed. After reviewing the submitted items, TennCare provides each MCO with a written response that includes the following information: (a) items that were approved; (b) suggested revisions or amendments to specific items; (c) concerns or deficiencies that require items to be revised and resubmitted for review; and (d) contractual requirements for which no compliance documents were submitted.

**Readiness to Provide Care Coordination Services**

According to a state official: “Effective care coordination is critical to the success of CHOICES, because it [the program] cannot be successful without this element [care coordination] being done extremely well.” TennCare officials conduct a three-phase onsite review to evaluate an MCO’s care coordination service.

**Phase 1: Onsite Review to Determine Care Coordinator Readiness to Perform CHOICES Consumer Intake, Assessment, and Care-Planning Processes**

During phase one of the process, TennCare officials require care coordinators from each MCO to participate in comprehensive test case scenarios that are videotaped for review, analysis, and discussion with the MCO executives and their contracted care coordinators. Care coordinators from each MCO conduct an intake visit with two apparent CHOICES members. Because of privacy and confidentiality concerns related to the videotaping process, people who participate as consumers in the recorded visits are actually TennCare LTSS nurses; the care coordinators are not aware of this, however, and believe them to be actual TennCare participants who would be enrolled in CHOICES. During intake, care coordinators are required to demonstrate their ability to produce all outputs of the care coordination process, including a comprehensive needs assessment; a risk assessment and signed risk agreement; a plan of care signed by the consumer or his or her representative; and other required forms and service authorizations.

TennCare officials review the recorded sessions and meet with representatives of each of the MCOs to provide feedback regarding the strengths and weaknesses of their care coordination programs. To the extent that any of the care coordination activities are found to be inconsistent with program contract requirements, the MCOs are required to undertake corrective actions. TennCare officials require MCOs to remedy all deficiencies before authorizing an MCO to allow its contracted care coordinators to begin assessing actual CHOICES members.
Phase 2: Onsite Review to Assess Care Coordinator Ability to Authorize Client Services

During phase two, TennCare officials conduct onsite visits to the MCO’s offices to evaluate how the care coordinators authorize services for beneficiaries whose needs have been identified during the videotaped assessment sessions (described above in phase one). This evaluation includes making sure the electronic transmission of the authorized services to the electronic visit verification (EVV) system is successful. State officials also watch a demonstration of how the EVV system will be used to ensure that services are actually delivered in accordance with the plan of care. According to one state official: “With respect to the onsite review of the EVV system, we are focused on ensuring that the care coordinator is able to enter service authorizations in accordance with the plan of care, including the schedule that outlines when care should be provided. We are also looking at the processes that the MCO uses to manage the data generated by the system so we can ensure that services are delivered consistent with what has been authorized under the care plan.”

State officials provided the following example: A member with quadriplegia is unable to get out of bed in the morning until a personal care worker arrives. Thus, care may be scheduled to occur at 8:00 a.m. each day. It is the job of the care coordinator to ensure the service is authorized in the EVV system to reflect this schedule. Data entered into the EVV system should require the service provider to schedule the personal care worker according to the agreed-upon schedule (e.g., 8:00 a.m.). The MCO should have processes in place to monitor whether the service is being provided as scheduled. If a worker does not arrive as scheduled (e.g., the worker has not logged into the EVV system from the client’s home), the EVV system should generate an alert to the service provider and to the MCO. State officials require the MCO to have a process for managing such alerts. In addition, they said, the MCO is required to have a dedicated staff that will follow up with the service provider and with the member to ensure the member’s needs are met and there is no gap in care.

Phase 3: Care Coordination Ride-A-Longs

The final phase of the onsite review of care coordination involves TennCare staff members accompanying care coordinators on intake visits with actual CHOICES members. During the ride-a- longs, TennCare staff evaluate how well care coordinators conduct the following activities with actual beneficiaries: (a) needs assessment; (b) risk assessment; (c) care plan development; (d) ability to accurately respond to client questions; and (e) ability to accurately use supportive tools and technology (e.g., relevant forms, laptops, and document scanners). This process is also used to further identify training needs. Because the process involves actual CHOICES members, it is not videotaped.

In addition to the three-phased onsite review of care coordination processes, state officials emphasize MCOs having knowledgeable, well-trained care coordinators. Although MCOs have primary responsibility for training care coordination staff, TennCare and other state agencies (e.g., the State Office on Aging) also conduct (and fund) care coordinator trainings on an ongoing basis. According to a TennCare official: “This sustained involvement [in care coordinator training] is part of ensuring a quality program. Periodic training gives us [the state] the opportunity to clarify any areas of concern.” In addition, state officials said that state-sponsored training allows them to bring MCOs and their care coordinators up to speed.
on program changes and new policies and procedures. Topics for these state-sponsored training sessions are identified during the videotaped onsite review process (discussed earlier). Past topics have addressed the following:

- **CHOICES eligibility requirements and processes training.** This training is conducted by TDHS—the state agency responsible for determining categorical and financial eligibility for managed LTSS.
- **Consumer direction** training conducted by the fiscal/employer agent.
- **Estate recovery training** conducted by TennCare officials.
- **Ongoing topical training** conducted by TennCare officials.

State officials noted that ongoing topical training allows TennCare staff members to engage care coordinators in conversations regarding specific aspects of the care coordination process. Examples of topics include assessing natural supports; assessing consumer risk; assessing consumer needs; and learning how care coordinators demonstrate cultural sensitivity during the assessment process.

**Determination of LTSS Provider Network Adequacy**

Determining provider network adequacy is a desk-based and an onsite activity. TennCare officials require each contracted MCO to submit provider network files for desk review. Those files are required to demonstrate that the MCO has completed the provider credentialing process. The MCOs are required to follow standards and guidelines for provider credentialing established by the National Committee for Quality Assurance (NCQA). In addition, MCOs must ensure that all LTSS providers—including those credentialed in accordance with NCQA standards and guidelines—are compliant with applicable state laws, regulations, contract requirements, and agency policies. According to one state official: “Our primary readiness review activity for network adequacy involves actual submission and review of network files.”

After desk review of network files has been completed, the TennCare staff goes on site to MCO offices to make sure contracts with LTSS providers have been executed and loaded into the MCO’s IT system. Contracted MCOs are required to meet benchmarks for provider network development established by TennCare officials. Approximately 2 months before they are allowed to begin enrolling beneficiaries, MCOs must demonstrate that 50 percent of fee-for-service (FFS) nursing facilities and 50 percent of previously enrolled FFS HCBS providers (or an equivalent number of qualified new providers) are a part of their provider networks. A month before the program begins enrollment, MCOs must demonstrate that 75 percent of the FFS LTSS providers are in their networks. Ten days before beginning enrollment, 90 percent of the FFS LTSS providers must be in the MCOs’ networks.

In addition to achieving the benchmarks discussed above, MCOs are required to comply with other network adequacy requirements, such as distance and travel time, and appointment and waiting time limitations. In addition to those requirements, Tennessee applies a community standard requirement in rural areas for certain services where there may be insufficient demand to support their availability in that area. For example, distance standards for facility-based adult day care may not exceed 20 miles in urban areas, 30 miles in suburban areas, and 60 miles in rural areas except where community standards apply (e.g., because there is no licensed facility with which to contract in that particular rural area).
Under the community standard, MCOs must provide access to services that is comparable to the access available to individuals with non-Medicaid payment sources (e.g., private pay or long-term care insurance) living in that particular rural area.

TennCare staff members view fully functioning IT systems that have a capacity to process and pay claims in a timely manner as being a critical component to maintaining provider network adequacy.

Advice from State Officials

TennCare officials said they prefer a phased approach to managed LTSS implementation because it gives them time to focus their resources on the MCOs in a particular region, and to integrate lessons as they move to the next phase of implementation. State officials also said that while each state must tailor its readiness review process to its unique needs, states should have a comprehensive strategy for ensuring the readiness of MCOs to perform functions that are necessary to successfully manage the LTSS aspects of the program. For example, officials said that the decision to implement an EVV system proved valuable from a quality management perspective, but was challenging to implement. Thus, they advise states that are considering using this type of system to invest effort in verifying how the EVV system will function before they begin enrolling consumers into their programs and to understand whether each contracted MCO is prepared to operationalize and manage an EVV system on an ongoing basis. In deciding to move forward with an EVV system, they said that states should consider whether an MCO is prepared to deal with issues such as member preferred scheduling, making member-initiated scheduling adjustments, responding in a timely manner to alerts that warn of potential gaps in care, managing exceptions, and reconciling provider claims and payments.

State officials advised states to have a detailed understanding of how MCOs will track members from intake into the new managed LTSS program through care plan development and service initiation. They also advised states to have an in-depth understanding of how MCOs—on an ongoing basis—will ensure that care management functions (e.g., periodic visits, assessments, and care plan updates) are performed in a timely manner.

Although officials recognized that MCOs have primary responsibility for care coordinator training, they also said that states should stay involved in the training efforts. This helps ensure that the state’s vision and expectations are clearly and consistently communicated to frontline staff, and that MCOs are prepared to deliver high quality person-centered support. Another issue that emerged during discussions with state officials was the importance of states having processes in place to ensure that large MCOs with multistate-managed LTSS contracts modify their systems and processes to meet each state’s contractual obligations. They also discussed the importance of states being prepared to invest time ensuring that MCOs without previous Medicaid-managed LTSS experience have adequate knowledge, business processes, and systems in place before the program’s implementation.

During discussions, state officials highlighted the importance of working collaboratively with MCOs during the development of contract requirements, during the implementation process, and on an ongoing basis. This collaboration was viewed by officials as a two-way street: it helps the MCOs to better understand the state’s expectations, and it helps the state understand the practical realities the MCOs face in meeting these expectations.
Officials described this relationship as an “accountable partnership,” meaning the state and the MCOs work together to promote the success of the program (which state officials view as critical for the state, MCO members, and providers). But state officials stressed that the MCOs also know the state will hold them accountable for meeting the program requirements and delivering high-quality services and supports.

Finally, one state official said: “While readiness review is an essential step in any successful managed LTSS program implementation, it is only the first step.” Officials stressed that states must stay intimately involved, have processes in place to quickly identify and resolve issues that may arise, and monitor MCO’s ongoing compliance with contractual obligations. During the initial phases of program implementation, state officials said they held conference calls with each contracted MCO twice daily. They also monitored statistics, such as member and provider calls, and key processes, such as loading new enrollment files. The frequency of calls is reduced over time as state officials become convinced that the transition is proceeding as expected. State officials also said they issue corrective actions as needed to ensure compliance with contract requirements.

Endnotes

1 When the program began in 2010, about 17.5 percent of CHOICES members were receiving HCBS. By June 2012, less than 2 years into statewide implementation of CHOICES, 34.1 percent of CHOICES members were receiving HCBS. According to one state official, this was a “significant step forward in the state’s rebalancing efforts.”

2 To accomplish those goals, TennCare focuses on the following key areas during review:
   ■ Care coordination
   ■ Service authorization and delivery
   ■ Quality monitoring
   ■ Data transfer and management
   ■ Provider network management

3 During desk review, state agency staff review detailed documents submitted to the agency by the MCO that outlines certain processes. For example, the MCO might submit a detailed description of how it will train individuals who manage care coordinators. State agency staff review these documents to ensure they are comprehensive and describe a process that supports agency goals.

4 During onsite review, state officials go to the MCO’s offices to observe particular processes. Officials may, for example, go on site to see for themselves whether the MCO’s IT systems are functioning adequately, or to conduct interviews with care coordinators. They may also inspect the premises to ensure the MCO is prepared to conduct business in accordance with contract requirements.

5 Other outputs include the following: (a) documentation that educational materials about CHOICES were reviewed with the member, including information regarding Federal Estate Recovery Program requirements; (b) signed acknowledgment of the member’s understanding of responsibilities associated with patient liability (e.g., federal post-eligibility provisions), including the potential consequences of nonpayment; (c) information needed by TDHS to determine eligibility for Medicaid reimbursement of LTSS, including proof of resources (as applicable) and a completed and signed MCO-LTC (long-term care) checklist; (d) a signed consumer direction participation form; (e) a signed freedom of choice form, including selection of HCBS providers; (f) a determination regarding whether the member’s needs can be safely and effectively met in a community setting; (g) a determination that the cost of providing services to the individual in a community setting does not exceed the member’s individual cost neutrality cap (e.g., the cost of nursing facility care) or the member’s expenditure cap; and (h) service authorization (including amount, frequency, and duration of each service to be provided and the schedule for delivering the services).

6 An EVV system is a system into which MCOs transmit service authorizations for specified HCBS to HCBS providers, and to the fiscal employer agent for consumer direction. Staff providing HCBS, including
1 Consumer direction is a philosophy and orientation to the delivery of HCBS whereby informed consumers make choices about the services they receive. The unifying force in the range of consumer-directed and consumer-choice models is that individuals have the primary authority to make choices that work best for them, regardless of the nature or extent of their disability or the source of payment for services. Excerpted from National Institute of Consumer-Directed Long-Term Care Services, Principles of Consumer-Directed Home- and Community-Based Services (Washington, DC: National Council on the Aging, 1996); funded by a grant to the National Council on Aging and the World Institute on Disability, and sponsored by the Administration on Aging and the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

2 Two models of Fiscal/Employer Agents (F/EAs) operate under §3504 of the IRS code. F/EAs are most effective for implementing self-direction programs, particularly those that allow participants to have individual budgets, for several reasons. First, using an F/EA provides participants a high degree of control over their workers as their common law employers, while reducing their employer-related burden by managing the payroll and bill payment tasks. Second, using an F/EA provides safeguards for participants by ensuring that all required taxes are paid and all Department of Labor and workers’ compensation insurance requirements are met. Third, using an F/EA can provide fiscal accountability for states. Susan Crisp et al., “Fiscal/Employer Agent Services,” in Developing and Implementing Self-Direction Programs and Policies: A Handbook, May 4, 2010.

3 The Omnibus Budget Reconciliation Act of 1993 (OBRA ’93) requires states to implement Medicaid Estate Recovery Programs. Under certain circumstances, the law requires states to pursue recovering costs for medical assistance consisting of: (a) nursing home or other long-term institutional services; (b) HCBS; (c) hospital and prescription drug services provided while the person was receiving nursing facility or HCBS; and (d) at the state’s option, any other items covered by the Medicaid State Plan.

4 According to TennCare officials, credentialing of LTSS providers must include, at a minimum, the following: (a) proof of a valid license or certification to provide contracted services; (b) proof that the provider is able to comply with all state laws, regulations, policies, and protocols; (c) proof that the provider has not been excluded from participation in the Medicare or Medicaid programs; (d) proof that the provider has a National Provider Identifier (NPI) number, if applicable; (e) proof that the provider has received a Medicaid provider number from TennCare; (f) proof that the provider is able to conduct criminal background checks (including checking the TN Abuse Registry, the TN Felony Offender Registry, the National and TN Sexual Offender Registry, and the List of Excluded Individuals/Entities) on employees who will deliver CHOICES HCBS; (g) proof that the provider has processes in place to provide initial and ongoing education to its employees who serve CHOICES clients; (h) proof that the provider has policies and processes in place to comply with the MCO’s critical incident reporting requirements; and (i) proof that the provider is able to appropriately use the EVV system.

5 NCQA is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. The purpose of the standards and guidelines is to ensure that the MCO has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners and/or programs to provide care to its members.

6 Under a Medicaid FFS delivery system, providers are paid for each service they provide (like an office visit, test, or procedure). Medicaid.gov, Fee-for-Service Delivery System. Accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Fee-for-Service.html.

7 Certain other providers are held to either a distance or a travel time standard. For example, travel time and distance for primary care providers may not exceed 30 miles or 30 minutes in rural areas. The urban standard is 20 miles or 30 minutes.

8 If there is no licensed facility, the service cannot be provided in that area—to people in CHOICES or to anyone, including FFS and private pay individuals. In such cases, TennCare officials encourage MCOs to try to assist in developing new licensed providers, if it is feasible.