Amendment #7
TennCare II demonstration (No. 11-W-00151/4)

1. Explanation of the public process used by the state to reach a decision regarding the Amendment.

Tennessee has met the public notice requirements required by STC #16. One of the processes outlined in 59 Fed. Reg. 49249 (September 27, 1994) as an acceptable method for accomplishing public notice is enactment of a proposal by the state legislature prior to submission of the demonstration Amendment proposal.

Amendment #7 is based on the passage, by unanimous vote of both houses of the Tennessee General Assembly, of the Long-Term Care Community Choices Act of 2008. By the time of the bill's passage in late May, virtually every member of the Tennessee General Assembly had signed on in support of the legislation. Due to a groundswell of grassroots advocacy support, the legislation has the distinction of having passed through every assigned committee of both the House and the Senate without a single "no" vote.

In developing the legislation, TennCare officials held over two dozen working sessions and informational meetings with more than 20 key stakeholder groups representing the elderly and adults with physical disabilities. The bill was developed in collaboration with the bipartisan Joint Legislative Study Committee on Long-Term Care and included significant stakeholder involvement and support from groups such as AARP, Tennessee Disability Coalition, Independent Living Centers, Tennessee Alzheimer's Association, Tennessee Aging and Disability Resource Connection, Tennessee Commission on Aging and Disability, Area Agencies on Aging and Disability, Tennessee Ombudsman Program, and numerous provider organizations representing the full spectrum of long-term care services.

From the larger group, a core group of representative stakeholders was established and more actively engaged to review materials and to advise regarding program design. This working partnership was key to the successful development and passage of the legislation and, going forward, will play a critical role in the successful planning and implementation of the program.

In addition to accomplishing the above public notice activities, the state has submitted Amendment #7 to the TennCare Oversight Committee in accordance with T.C.A. § 5-15-508(d) and to the Tennessee Justice Center in accordance with the *Grier* Revised Consent Decree (Modified), Section D.4. The state also placed the draft proposed Amendment on its website at www.tennessee.gov/tenncare and requested additional public comments prior to submitting the Amendment to CMS.

The authorizing legislation calls for a new Oversight Committee from the Legislature to be established just for this program. The House members of the Committee have recently been appointed by the Speaker. Three of the five appointees were members of the Joint Legislative Study Committee on Long Term Care; one was the Study Committee chair and one is the Speaker Pro Tempore of the House. We anticipate that Senate appointees will also include key leaders of the General Assembly with a long-standing commitment to home and community-based services (HCBS) who were actively engaged in the earlier study of the long-term care system and in the

development of the legislation which calls for its fundamental transformation. Their involvement in the future will provide a mechanism for ongoing review and input regarding the design, implementation, and operation of the program, and will also help in assuring continued public input on the project as it evolves.

The name of the new program is TennCare CHOICES in Long-Term Care. The word "choices" is capitalized in order to emphasize one of the basic principles of the program—that participants will have choices in long-term care services and supports that are not available to them today.

2. A detailed description of the Amendment including impact of beneficiaries, with sufficient supporting documentation.

With this Amendment, Tennessee will fully integrate nursing facility services and home and community-based alternatives to institutional care for adults who are elderly and/or physically disabled into its existing managed care program and implement a seamless system of comprehensive services that will better meet the needs of these persons and their families. The Amendment does not include the state's current 1915(c) waivers for persons with mental retardation; nor does it include the state's PACE program.

Specifically, the new TennCare CHOICES in Long-Term Care program will demonstrate the following:

a. We can provide home and community-based services (HCBS) for elderly and/or physically disabled persons who would otherwise require Nursing Facility services, and we can provide these services for individuals at a cost that does not exceed the individual cost neutrality test used in a Section 1915(c) waiver; and

b. Through improved coordination of care and use of more cost-effective home and community-based alternatives, we can expand access to home and community-based services for persons who do not yet meet a Nursing Facility level of care, but who are "at risk" of needing Nursing Facility services (similar to the new State plan option under Section 1915(i)), thereby delaying or preventing the need for more expensive institutional care.

In addition, Tennessee will demonstrate how a state that has traditionally invested most of its long-term care resources in institutional programs can devote a greater proportion of those resources to cost-effective home and community-based programs, without increasing overall expenditures or compromising quality of care.

Under this proposal, TennCare beneficiaries who need long-term care services will have access to the following:

- A Single Point of Entry that will provide one stop shopping for information counseling, and assistance regarding long-term care programs and services, in order to support informed decision-making;
- Streamlined eligibility determination processes;
- Integration and coordination of all of the Medicaid-reimbursed services members need, including acute care, primary care, behavioral health services, and long-term care;
- Expanded access to cost-effective home and community-based alternatives to institutional care;

- An expanded array of home and community-based options such as community-based residential alternatives to institutional care for persons who can no longer live alone; Nursing Facility services will continue as an integral part of the long-term care continuum for persons with the highest levels of need;
- A more robust HCBS infrastructure, including new providers as well as the expansion of the service capacity of existing LTC providers, that will be needed to meet the increased demands for services in home and community-based settings;
- Consumer-directed options that offer more choices regarding the kinds of long-term care services people need, where they are provided, and who will deliver them, with appropriate mechanisms in place to assure accountability for taxpayer funds;
- Support and assistance such as adult day care and respite that "wrap around" family and other caregivers who are meeting the needs of the elderly and adults with physical disabilities; and
- Increased opportunities to provide feedback regarding customer perceptions of quality, with immediate identification and resolution of issues and improved quality of services.

The impact of the changes on beneficiaries should be overwhelmingly positive, as demonstrated by the support for the proposal of many advocacy groups, including, but not limited to, the AARP, the Tennessee Disability Coalition, the Tennessee Alzheimer's Association, Independent Living Centers, Nursing Facility and HCBS provider associations, and others mentioned in Item #1 of this Amendment request.

The five major components of the new program are (a) eligibility, (b) benefits, (c) access, (d) quality assurance, and (e) financing. The state has proposed the use of several "levers," such as enrollment caps, expenditure caps, and benefit limits, to ensure that the program operates within available resources in serving the most people possible and achieving program objectives. These "levers" are described below. Section (f) below discusses implementation.

(a) Eligibility.

The state's current 1915(c) Elderly and/or Disabled waiver will be absorbed by the new program envisioned here. We are not proposing an eligibility expansion in this Amendment, except that we intend to continue to serve persons who are currently eligible for our Section 1915(c) Elderly and/or Disabled waiver, as well as persons who would have been eligible for this waiver in the future, had it continued. Those who would not be eligible for TennCare unless they are receiving HCBS services as an alternative to institutional care under 42 C.F.R § 435.217 will be identified as a "demonstration population" under this Amendment.

The target groups for TennCare CHOICES are identified in Table 1.

Table 1
Eligibility for TennCare CHOICES

Target groups	Description	Already Medicaid eligible?	Enrollment in CHOICES capped?
1	Persons who are receiving Medicaid-reimbursed care in a NF	Yes	No

Target groups	Description	Already Medicaid eligible?	Enrollment in CHOICES capped?
2	Persons age 65 and older and adults age 21 and older with physical disabilities who meet NF level of care, need HCBS as an alternative to NF care, and who qualify as SSI recipients or who would qualify in the institutional category by virtue of receiving HCBS, should the state's 1915(c) waiver be continued	Yes—as SSI recipients, or in the institutional category by virtue of receiving HCBS (pursuant to 42 C.F.R. § 435.217) SSI recipients are independently Medicaid eligible; those whose eligibility is dependent on 42 C.F.R. § 435.217 are not already eligible and will be a demonstration population under this Amendment.	Yes, at the state's discretion, but not less than 6,000
3	Persons age 65 and older and adults age 21 and older with physical disabilities who do not meet NF level of care but who, in the absence of HCBS, are "at risk" of institutionalization	Yes	Yes, at the state's discretion, but not less than 10% of the enrollment cap for Target Group 2

Persons will be identified for Target Groups 1, 2, or 3 through a functional level of care (LOC) assessment, with eligibility determined by the Bureau of TennCare. Individuals in Target Group 2 who are not already Medicaid-eligible will also be required to have their financial eligibility for NF care determined in order to participate in this program.

The Bureau of TennCare will determine level of care eligibility and approve the enrollment of non-institutionalized persons for Target Groups 2 and 3. In order to assure that HCBS program enrollment does not exceed the capacity of the state to provide services safely and effectively and within available state resources, the state reserves the right to establish yearly enrollment caps, if necessary, for both of these groups. The enrollment cap for Target Group 2 will not be less than 6,000 at any given time; this is the number of unduplicated participants in the state's existing 1915(c) waiver that will be in place, pending CMS approval of a 1915(c) amendment which adds 2,300 persons to the state's currently approved waiver authority to serve 3,700 unduplicated waiver participants. If an enrollment cap is necessary for Target Group 3, it will be, at a minimum, 10% of the size of the enrollment cap being used for Target Group 2.

It is necessary for the state to retain the authority to implement yearly enrollment caps, because of the difficulty in anticipating the number of persons who may need HCBS and because our HCBS infrastructure will require expansion in order to serve all such persons. Tennessee's long-term care system has traditionally been focused on institutional placements, with 98% of long-term care funding going to Nursing Facilities and only 2% to community alternatives. These yearly enrollment caps will allow the state to address financial and infrastructure capacities while ensuring quality of care for eligible members.

There are currently almost 4,000 people being served in the state's 1915(c) waiver; the number is increasing each week. Should the state establish an enrollment cap for Target Group 2, the state will reserve capacity for persons in Target Group 1 receiving NF services who may elect to transition to cost-effective home and community-based care. Individuals transitioning from a nursing facility to the community after having resided in the NF for a minimum of 180 days will not be subject to an enrollment cap. Should any enrollment cap(s) established by the state for Target Groups 2 or 3 result in a waiting list for HCBS, the state will maintain separate statewide waiting lists for Targets Groups 2 and 3, as applicable. Persons on a waiting list for Target Group 2 will have prioritization for enrollment.

The state will be responsible for management of the statewide waiting list(s); criteria for assigning prioritization of persons on the waiting list(s) and movement off the waiting list(s) are under development.

(b) TennCare CHOICES benefits.

We are proposing to add the following list of LTC benefits to the benefits approved for the TennCare demonstration. These benefits will be covered only for persons in one of the Target Groups. None of the benefits, other than Nursing Facility care, is presently covered in the Medicaid State plan.

Table 2
TennCare CHOICES Benefits for Persons in Target Groups 1, 2, or 3

TennCare CHOICES Benefits[1]	Target Group	Limit
Nursing facility care	1	As medically necessary
Community-based residential alternatives	2	Not applicable
Personal care visits	2 and 3	2 visits per day
Attendant care	2 and 3	1080 hours per calendar year
Homemaker services	2 and 3	3 visits per week
Home-delivered meals	2 and 3	1 meal per day
Personal Emergency Response Systems	2 and 3	Not applicable
Adult day care	2 and 3	2080 hours per calendar year
In-home respite care	2 and 3	216 hours per calendar year
In-patient respite care	2 and 3	9 days per calendar year
Assistive technology	2 and 3	$900 per calendar year
Minor home modifications	2 and 3	$6,000 per project $10,000 per calendar year $20,000 per lifetime
Pest control	2 and 3	9 units per calendar year

[1] All of the benefits other than Nursing Facility care are provided subject to an individual cost-neutrality test, which is the same test as that used in a 1915(c) waiver. For persons in Target Group 3, the total cost of the HCBS services received from the selection identified in Table 2 shall not exceed $15,000 per calendar year, excluding the cost of minor home modifications.

The above services are currently covered under the state's 1915(c) waiver, with the exception of community-based residential alternatives other than Assisted Care Living Facility Services. Coverage limitations are as specified in the existing 1915(c) waiver, pending submission and approval of an amendment which seeks certain clarifications and/or modifications of the state's coverage policy.

For persons transitioning from Group 1 to Group 2, MCOs will be able to offer, as a cost-effective alternative to continued institutional care, a per person transition allowance not to exceed two thousand dollars ($2,000) for items such as, but not limited to, the first month's rent and/or utility deposits, kitchen appliances, furniture, and basic household items.

Care coordination of all TennCare primary, acute, behavioral, and LTC services will be provided by the MCO, rather than being provided as a separate service as is the case in the current 1915(c) waiver. Once the state has determined Level of Care (LOC) eligibility and eligibility for Target Groups 2 or 3, TennCare MCOs will be responsible for performing a comprehensive individualized needs assessment for each participant based upon protocols developed by the Bureau of TennCare. The purpose of the assessment will be to identify participants' long-term care needs, the resources available to meet those needs, and gaps in care which are (or soon will be) unmet after using other available supports. The MCOs will then be responsible for developing a plan of care with active participation of the participant and family or other caregivers that addresses the identified gaps in care and builds on and does not supplant family and other caregiving supports. Persons who meet the nursing facility level of care will be given the choice of whether to receive care in a nursing facility or in a cost-neutral home and community-based setting.

The state shall put in place, through regulations and contract requirements, safeguards to help ensure that such assessment and care planning processes are person-centered, fair, objective, and consistent with the needs of the individual. Participants will have the ability to request an objective review of the care plan if they feel it does not appropriately and/or adequately address their individualized needs. To the extent that a managed care plan chooses to subcontract with another entity for any of these assessment and care planning functions, such contracted entity shall not provide any direct long-term care service which may create a conflict of interest.

Participants may elect to have such care provided through HCBS provider agencies, or may choose consumer-directed options. These include, but are not limited to, the ability to select, hire, supervise, and fire persons delivering unskilled hands-on or support services such as personal care services; personal care assistant/attendant services; homemaker services; and in-home respite services; the ability to direct and supervise a paid personal aide in the performance of a health care task; and the ability to manage, using the services of a fiscal intermediary, an individual home and community-based services budget based on the functional assessment performed by the Managed Care Organization and the availability of family and other caregivers who can help provide needed support.

The community-based residential alternatives mentioned in Table 2 may include, but not be limited to, assisted care living facility services, adult foster care homes, supported living assistance, and companion care models contingent upon statutory licensure authority or other regulatory standards for the applicable service type. The state will define covered residential models and will develop appropriate statutory and/or regulatory requirements for each service

type prior to its implementation in TennCare CHOICES. The primary focus will be on the development of small, family-type homes, rather than large congregate settings.

The combined cost of the services in Table 2 that are provided to an eligible participant in Target Group 3 shall not exceed $15,000 per calendar year, excluding the cost of minor home modifications.

In no case shall the cost of services provided in the home and community-based setting to an eligible participant in Groups 2 or 3 exceed the cost neutrality test used in 1915(c) waivers. This cost neutrality cap set forth in Section 1915(c)(4)(A) shall be individually applied as it is under the state's existing 1915(c) waiver for the elderly and disabled populations.

(c) Access.

Tennessee will broaden the scope of services being offered by our current Managed Care Organizations (MCOs) to include a range of alternatives for those enrollees who need long-term care. TennCare CHOICES will be a seamless delivery system with managed care contractors responsible for all of the covered primary, acute, behavioral, and long-term care services for members who need them. Bringing all of these services under a single MCO will help ensure better access to care, as well as coordination and continuity of care, for participants who need long-term care—particularly at critical transition points—and will also ensure that families who have a member in need of long-term care will be able to share both a single MCO and a network of acute and primary care providers. The MCOs will be required to meet the conditions of 42 C.F.R. § 438.206(b) with respect to enrollment of HCBS providers as well as other types of providers.

In addition, we will require that the MCOs meet geographic access standards for TennCare CHOICES services, as well as the geographic access standards that they are already required to meet for the regular TennCare program. We will expect to see growth in the availability of home and community-based providers as the CHOICES program evolves, and we will include in our contracts with MCOs an expectation that they will increase the availability of CHOICES providers in order to meet contractually-defined access standards.

(d) Quality assurance.

Assuring quality care for program enrollees is a major component of the new program. We already require that MCOs participating in the TennCare program be NCQA-accredited. The state would like to expand our HEDIS reporting to include additional measures for CHOICES participants. However, most such measures would only be reliable to the extent that CMS can provide timely access to Medicare data for dual eligible members. We are therefore requesting that CMS make this data available to Tennessee so that we can implement meaningful quality monitoring strategies for assuring that program enrollees are receiving appropriate care and so that we can accurately evaluate the effects of the program. Reliable encounter data is the basis of sound HEDIS reporting. For more than a decade, CMS has required that MCOs participating in Medicare submit data regarding HEDIS performance measures. Clearly, CMS recognizes the value of an integrated approach to delivering care and to ensuring quality of care for dual eligible individuals. With timely access to Medicare data, the state can begin to measure health outcomes for dual eligible members across LTC services and settings in a meaningful way and to make changes that will help to improve both coordination of care and quality of care over time.

The state will implement a quality management strategy which includes, at a minimum, measures of health outcomes, needs assessments and care planning processes, care coordination, and management of transitions for CHOICES members, with a core focus on customer perceptions of quality throughout all aspects of the system.

The state will develop needs assessment and care planning protocols that MCOs will be required to follow. Consumer feedback surveys will provide opportunity for CHOICES members to provide immediate feedback regarding assessment and care planning processes. Separate consumer feedback surveys will gather critical information regarding members' perspectives of the quality of care coordination and of actual service delivery.

MCOs will be required to implement an electronic visit verification system (i.e., an automated system used by service providers to log each visit from the member's home). This will offer MCOs and TennCare continuous insight regarding service provision and will help to immediately identify and measure service gaps. Contractor risk agreements with MCOs will specify service gap ratios, monthly reporting requirements, and the responsibilities of MCOs to immediately identify and address gaps in LTC services. Aggressive contract compliance and monitoring strategies will not be dependent solely on annual reviews, but rather will help to identify problems early and will work with MCOs to ensure overall system improvements.

The state is also working on developing Consumer Protection legislation which may include provisions to address such issues as mandatory criminal background checks, reporting and investigation of suspected abuse and/or neglect, mortality reviews, reviews of member deaths, and protections pertaining to public guardianship. This legislation will help to establish a regulatory framework which will help the state to ensure the health and safety of all CHOICES members, including those who choose to age in place and remain in the community.

(e) Financing.

A global budget strategy will be achieved through capitation payments to managed care contractors that encompass the full continuum of long-term care services for persons who are elderly or adults who have physical disabilities—institutional as well as home and community-based alternatives. Payments for LTC services will follow the person into the most appropriate and cost-effective LTC setting of his choice, resulting in a more equitable balance between the proportion of Medicaid LTC expenditures for Nursing Facility services and expenditures for home and community-based services and supports.

Because the full continuum of LTC services will be encompassed in the capitation payment to managed care contractors, financial incentives will be properly aligned for MCOs to encourage use of lower-cost home and community-based alternatives to nursing facility care, when members can be safely and cost-effectively supported in the home and/or community setting, and when members choose such settings over institutional care. Capitation payments will project moderate changes in patterns of utilization over time, with more people able to receive cost-effective care at home because the per-person cost of home and community-based care is less than institutional care.

(f) Implementation.

The Amendment will be phased in by region of the state over a projected twelve month period. There are three regions of the state. Our plan is to implement the CHOICES program in the

Middle Tennessee Region on July 1, 2009; the East Tennessee Region on January 1, 2010; and the West Tennessee Region by June 1, 2010. As each region is phased in, the state will (1) incorporate LTC benefits into the TennCare benefit package provided through the MCOs in that region; (2) cease operation of the 1915(c) waiver in that region; and (3) adjust the level-of-care criteria for nursing facility admission in the region. The state requests a time-limited waiver of comparability in order to ensure an orderly transition. In the event that the state must establish an enrollment cap and create a waiting list for HCBS services before all regions are fully transitioned, the state will ensure that a sufficient number of slots are reserved in the later-transitioning regions for current 1915(c) enrollees, with slots beyond current 1915(c) enrollment allocated equitably among the regions until the transition is complete.

3. Data analysis that identifies the specific "with waiver" impact of the proposed Amendment in the current budget neutrality expenditure cap and SCHIP allotment, if applicable.

Long-term care (LTC) expenditures, comprised of institutional and HCBS waiver services, are not included in Tennessee's 1115 waiver budget neutrality calculation. The inclusion of LTC services will require a change in the current method of establishing budget neutrality. The current method of budget neutrality compares the costs of expenditures of the Medicaid population absent the waiver to the costs of providing services under TennCare (including the additional costs of the expansion population.) In the example of TennCare, the state is able to provide coverage to limited additional populations in a budget neutral fashion due to the use of a managed care model. The baseline PMPM will require adjustment in order to reflect the expenditures for long-term care services. Under the CHOICES program, the state believes the actual expenditures after the Amendment will demonstrate that offering more choices in a managed care environment will lead to a less expensive program, with more reliance on affordable methods of home care. The state will work with CMS to determine the amount of the adjustment to baseline PMPMs.

The current Amendment does not bring in additional populations, nor does it expand long-term care services to the existing demonstration populations (i.e., Standard Spend Down). There is a new demonstration population, but rather than expanding eligibility it mimics the population that is and could be covered under the state's Section 1915(c) waiver pursuant to 42 C.F.R. § 435.217. While the Amendment does add LTC benefits to the TennCare benefit package, with the exception of an expanded array of cost-effective residential alternatives to institutional care, they are benefits that the state currently provides fee-for-service under its State plan or existing Section 1915(c) waiver.

4. A description of how the evaluation's design shall be modified to incorporate the Amendment provisions, if applicable.

Evaluation of overall budget neutrality will continue to be addressed through Objective 1. We will add a minimum of three performance measures, two for Objective 2 and one for Objective 4. We expect that the performance measures for Objective 2 will address increased numbers of persons receiving HCBS, including those who meet the specified level of institutional care and those "at risk" of meeting such level of care, and the changing balance in the allocation of funds between institutional care and home and community-based services. We expect that the performance measure for Objective 4 will deal with patient satisfaction and the state's efforts to

gather specific input regarding customer perceptions of quality, making use of one or more surveys that are specific to LTC recipients and services.

Since the proposed new program will not begin until July 2009, we would like to take some time to develop these measures, in particular the consumer surveys. We want to obtain the input of our stakeholders, as well as the new legislative Oversight Committee for the TennCare CHOICES in Long-Term Care program. We will propose the specific measures to be added to our Evaluation Plan by April 1, 2009.

5. An updated SCHIP allotment neutrality worksheet, if applicable.

This requirement is not applicable to Amendment #7, since Amendment #7 only addresses services for adults.