State Capacity to Implement
Managed Long-Term Services and Supports:
One State’s Experience

TennCare Overview

- Tennessee’s Medicaid Agency
- Tennessee’s Medicaid Program
  - Managed care demonstration implemented in 1994
  - Operates under the authority of an 1115 waiver
  - Uses managed care to cover persons otherwise not eligible for Medicaid
  - *Entire* Medicaid population (1.2 million) is in managed care
  - Medical, behavioral and (since 2010) LTSS administered by two NCQA accredited “At-Risk” Managed Care Organizations (MCOs) located in each region of the state (*mandatory* enrollment in managed care)
  - Statewide back-up plan (TennCare Select) manages care for certain special populations (e.g., children receiving SSI, children in State custody, persons enrolled in MR waiver programs) via an ASO (i.e., modified risk) arrangement
  - Prescription drugs administered by a statewide Pharmacy Benefits Manager
  - Dental Services for children under 21 administered by a statewide Dental Benefits Manager
  - MLTSS program is called “CHOICES”
Overview

- Integrates TennCare nursing facility (NF) services and HCBS for the elderly and adults with physical disabilities into the existing managed care delivery system (roughly $1 billion); ICF/IID and ID waiver services remain carved out
- Amended contracts with existing MCOs selected via competitive bid process
- Blended capitation payment for all physical, behavioral and LTC services; risk adjusted for non-LTC rate component based on health plan risk assessment scores and for LTC component based on mix by setting
- MCOs at full risk for all services, including NF (not time-limited)
- Enrollment target for HCBS supports controlled growth while developing sufficient community infrastructure to provide care (persons transitioning from a NF and certain persons at risk of NF placement are exempt)
- Cost and utilization managed via individual benefit limits, levels of care (LOC), and individual cost neutrality cap (for those who meet NF LOC)
- Comprehensive person-centered care coordination provided by MCOs
- Consumer direction using an employer authority model

Key Aspects of State Capacity

- State Medicaid Agency role and responsibilities
- Detailed program design and contract requirements, including aligned financial incentives and enforcement mechanisms
- Comprehensive readiness review strategy
- Ongoing monitoring and quality oversight
State Medicaid Agency

- Organized around the delivery of managed care
  - Managed Care Operations
  - Provider Networks/Services
  - Quality Oversight
  - LTSS (Audit & Compliance, Quality & Administration)
  - "integrated" into the SMA
  - Member Services
  - Finance and Budget (Health Care Informatics)

- Contractors include actuary, EQRO, fiscal employer agent for consumer direction, legal consulting services, member services call center, advocacy/outreach call center, medical appeals vendor, MMIS vendor, SPOE, TPL vendor, member satisfaction survey

- Partners/stakeholders include contractors, MCOs, providers/organizations, members/advocacy groups, legislators, and taxpayers

- Integrially involved in day-to-day program management and oversight/monitoring

Detailed program design and contract requirements

- Developed in consultation with partners/stakeholders
- Reviewed and amended at least every 6 months
- Aligned financial incentives and enforcement mechanisms, including CAPs, liquidated damages, and capitation payment withholds


- Contracting considerations for members
  - Freedom of choice
  - Continuity of care
  - Care coordination (model, processes, timelines, tools and staffing)
  - Consumer direction
  - Education/outreach

- Contracting considerations for providers
  - AWQP?
  - Authorizations
  - Reimbursement
  - Prompt pay
  - Training and technical assistance
**Comprehensive Readiness Review Strategy**

- Review of key desk deliverables
- Onsite review of critical processes and operating functions
  -- Care coordination
  -- Service authorization
  -- Training
  -- Care coordinator ride-alongs
  -- Demonstration of critical MCO systems – case management, tracking, service authorizations, claims
- Systems testing – end-to-end testing of eligibility, enrollment and encounters
- Other verification and validation activities
  -- Key milestone deliverables: provider networks and service authorizations

**Ongoing Monitoring and Quality Oversight**

- Uniform measures of system performance
- Detailed reporting requirements
- Ongoing audit and monitoring processes
  -- Site inspections and inspections of work performed
- Measures to immediately detect and resolve problems, including gaps in care – Electronic Visit Verification
- Independent review (EQRO, TDCI)
- Key focus on member perceptions of quality
  -- QOL/Member satisfaction survey
  -- Consumer advisory groups
- Advocacy for members across MLTSS system
Baseline Data Plan

- **Objective #1: Expand access to HCBS**
  - # NF versus HCBS participants
- **Objective #2: Rebalance LTSS spending**
  - Total NF versus HCBS expenditures
- **Objective #3: Provide cost-effective HCBS as an alternative to institutional care**
  - Average per person NF versus HCBS expenditures
- **Objective #4: Delay or prevent the need for institutional placement**
  - Average length of stay in HCBS
  - Percent of new LTSS members admitted to NFs
- **Objective #5: Facilitate transition from NF to HCBS**
  - Average length of stay in NF
  - # NF-to-community transitions

Takeaways and Advice to other States

- There is no perfect program/delivery system and no perfect way to assess State capacity to implement MLTSS
- Assessments of State capacity must be tailored to each State/program based on the State’s experience, program design and the maturity of the program/managed care system
- There are best practice approaches to learn from one another and core capacities that are applicable across-the-board
- Be careful not to confuse the success of the model with the success of the implementation
- Continuous improvement applies to all aspects of the program, including oversight