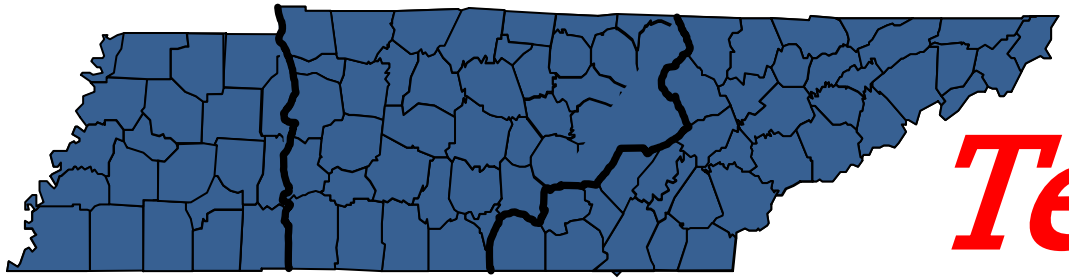
Division of Health Care Finance & Administration

AGING IN AMERICA

How Tennessee is Planning to Support an Aging Population

November 11, 2015
The Reforming States Group



Tennessee

- Managed care demonstration implemented in 1994
- Operates under the authority of an 1115 waiver
- *Entire* Medicaid population (1.4 million) in managed care
  - 68,650 aged 65 and older
- 3 at-risk NCQA accredited MCOs (statewide in 2015)
- Physical/behavioral health integrated beginning in 2007
- Long Term Services and Supports (LTSS) for seniors and adults w/ physical disabilities in 2010
- MLTSS program is called *"CHOICES"*
- ICF/IID and 1915(c) HCBS waivers for individuals with intellectual disabilities carved out; populations carved in
- New proposed MLTSS program component for I/DD for 2016: *Employment and Community First CHOICES*

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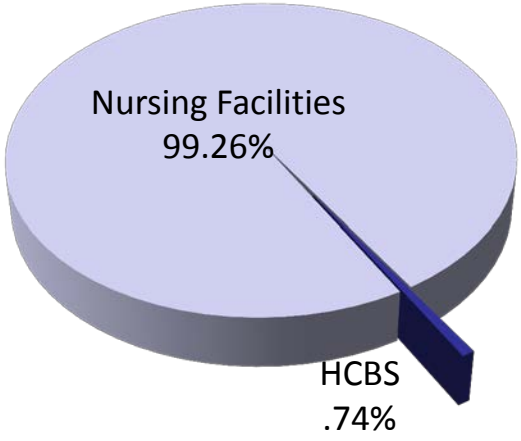
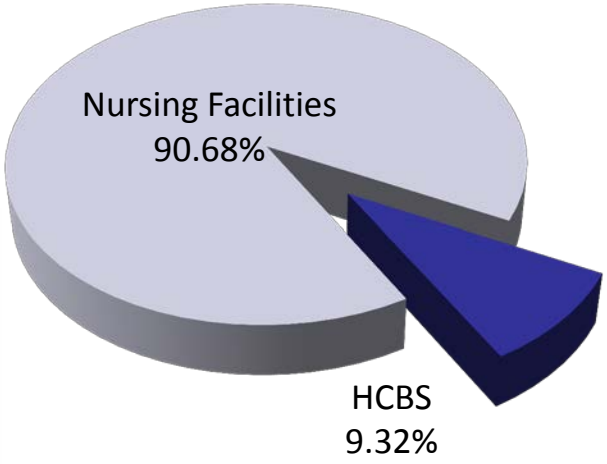
The LTSS System in Tennessee *before...*

TennCare CHOICES in Long-Term Services and Supports

- **Fragmented**—carved out of managed care program
- **Limited options and choices**
- **Heavily institutional**; dependent on new $ to expand HCBS



FY 1999
< 1% HCBS



FY 2009
~ 10% HCBS

Restructuring the LTSS System: Key Objectives

- **Reorganize** – Decrease fragmentation and improve coordination of care.
- **Refocus** – Increase options for those who need LTSS and their families, expanding access to HCBS so that more people can receive care in their homes and communities.
- **Rebalance** – Serve more people using existing LTSS funds, creating a more sustainable system.

CHOICES Program Design

- Extensive stakeholder engagement
- Comprehensive LTSS system reform legislation:
  The Long-Term Care Community Choices Act of 2008
- Integrated 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)
- 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 service mix by setting (NF versus HCBS)
- 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)

CHOICES Program Design

- Cost and utilization managed via individual benefit limits, levels of care (LOC), and individual cost neutrality cap
- MCOs provide comprehensive person-centered care coordination, including social support needs (social determinants)
  - Strengthened requirements and investments in health plan and provider capacity for person-centered planning and support delivery, employment and community integration
- Nursing facility diversion and transition programs, including Money Follows the Person Rebalancing Demonstration
- Electronic Visit Verification system provides fiscal accountability, immediate notification/resolution of potential gaps in care
  - New technology engages paid caregivers as part of care team (ongoing status updates) and gathers point-of-service member satisfaction data)
- Consumer direction using an employer authority model allows individuals to hire family and friends to provide HCBS

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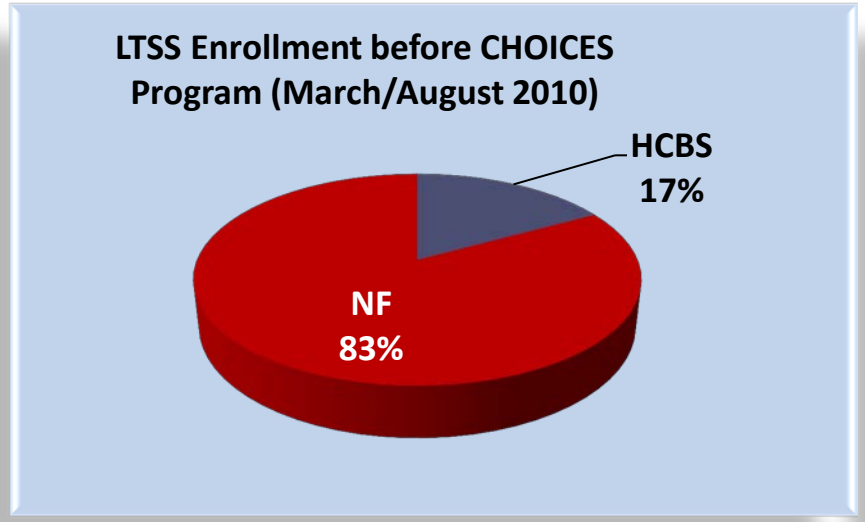
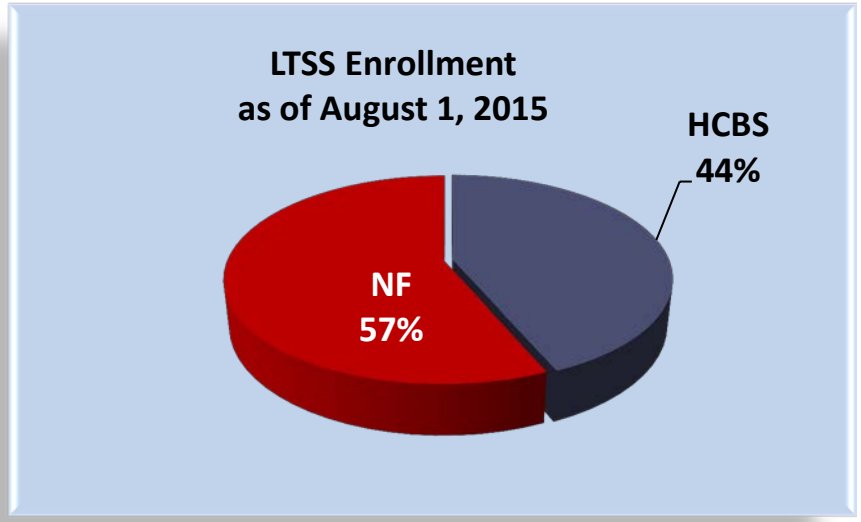
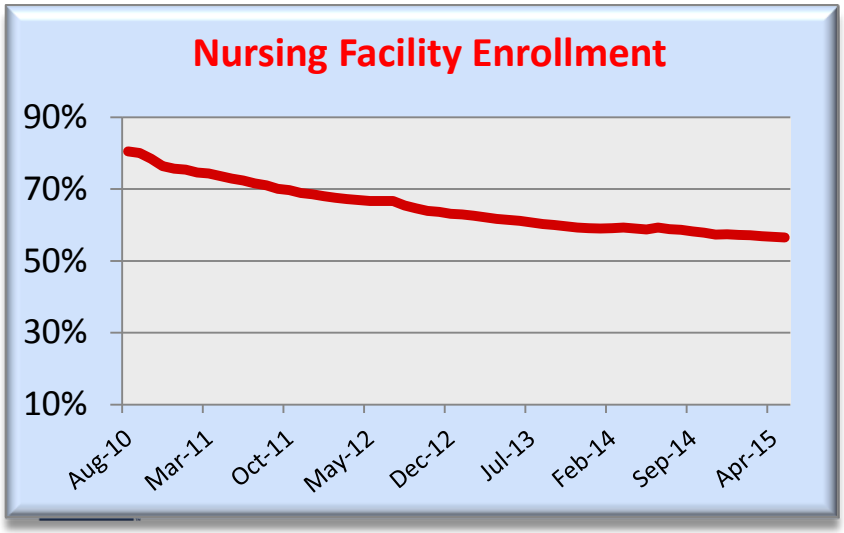
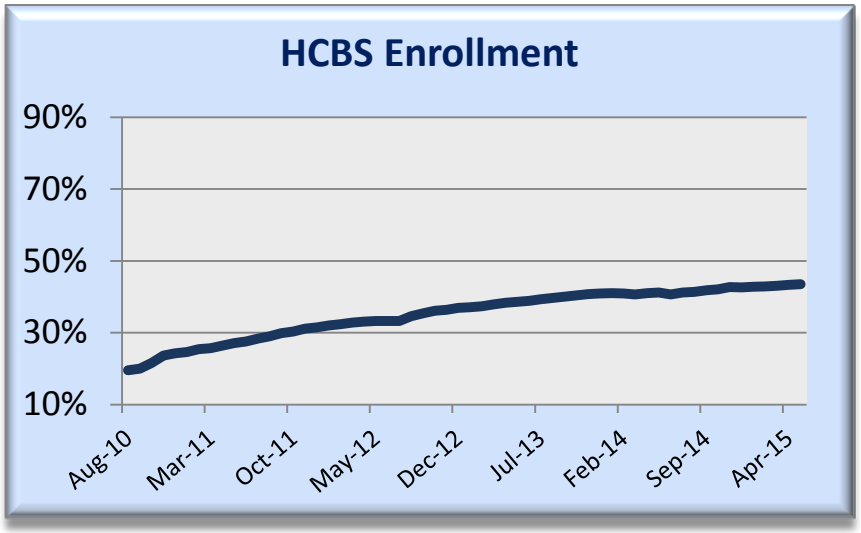
Re-balancing LTSS Enrollment through the CHOICES Program

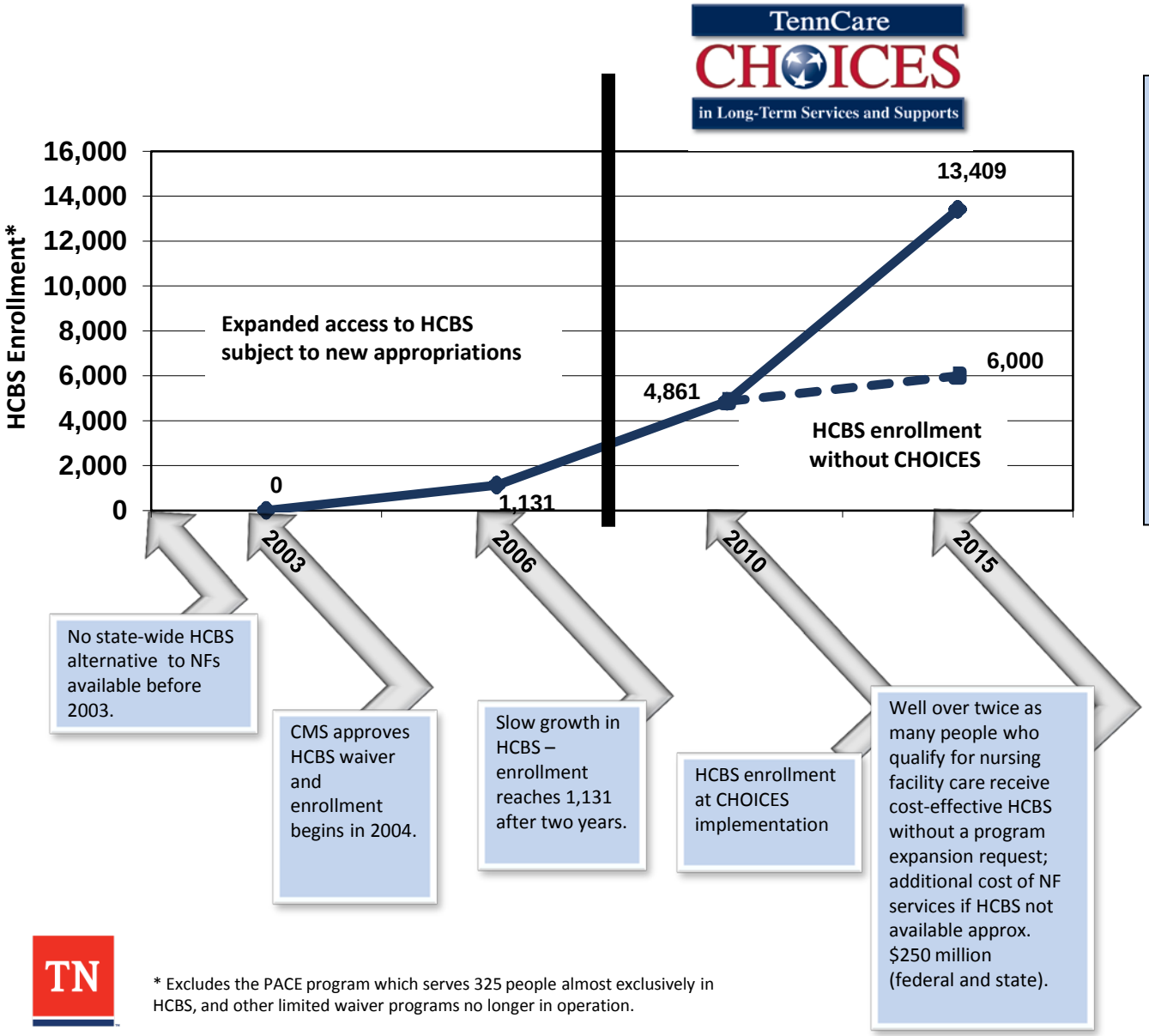








Access to HCBS before and after



- **Global budget approach:**
  - Limited LTC funding spent based on needs and preferences of those who need care
  - More cost-effective HCBS serves more people with existing LTC funds
  - Critical as population ages and demand for LTC increases

HCBS waiting list eliminated in CHOICES

* Excludes the PACE program which serves 325 people almost exclusively in HCBS, and other limited waiver programs no longer in operation.

CHOICES Outcomes

- Number of persons receiving HCBS in CHOICES increased by nearly 170% since the program began (from 4,861 to 13,032, as of 11/1/15)
- Number of persons receiving NF services in CHOICES has declined by nearly 6,000 people (from 23,076 to 17,248, as of 11/1/15)
- Percentage of people coming into LTSS in a NF declined from 81.34% in the year immediately preceding CHOICES implementation to 47.93% as of 6/30/14, with more than 50% of people choosing HCBS upon enrollment in CHOICES for each of the past two years reported in the CHOICES baseline data
- Average length of stay in a NF has declined from 285 days to 250 days

CHOICES Outcomes

- More than 2,500 individuals transitioned from NFs to HCBS as of 6/30/14, an average of 646 individuals per year, compared to 129 people in the baseline year immediately preceding CHOICES
- More than 10% of CHOICES members (1,475) receiving HCBS actively participating in Consumer Direction for some or all services; more than 300 additional persons in referral process
  - Consumer direction options not available for this population prior to CHOICES implementation
  - Ability to self-direct health care tasks
- MCOs consistently monitoring and address potential gaps in care—for example, during the 12 month period beginning October 1, 2014 through September 30, 2015:
  - More than 95% of all scheduled in-home care visits were completed, except for reasons initiated by the member.
  - More than 99.5% of home care visits provided were on time, except for reasons initiated by the member.

Family Caregivers in CHOICES

- **Critical importance recognized in initial MCO contract**
  - *"Long-term care services identified through care coordination and provided by the CONTRACTOR shall build upon and not supplant a member's existing support system, including but not limited to informal supports provided by family and other caregivers…"*
  - Requirement to assess: *"the member's natural supports, including care being provided by family members and/or other caregivers…and whether there is any anticipated change in the member's need for such care or services or the availability of such care or services from the current caregiver…"*
  - As part of ongoing care coordination: *"Maintain appropriate on-going communication with community and natural supports to monitor and support their ongoing participation in the member's care;"*
  - Recognize as a significant change of circumstances requiring re-assessment and updates to the plan of care: *a "[c]hange of residence or primary caregiver or loss of essential social supports;"*

Family Caregivers in CHOICES

- **Expanding the paradigm**
  - Family Caregivers *as critical part of* needs assessment/care planning
    - Source of information/natural support
  - Family Caregivers *as a critical focus* of care needs assessment/care planning

Family Caregivers in CHOICES

- **Assess the needs of family caregivers, including:**

(1) an overall assessment of the family member(s) and/or caregiver(s) providing services to the member to determine the willingness and ability of the family member(s) or caregiver(s) to contribute effectively to the needs of the member, including employment status and schedule, and other care-giving responsibilities

(2) an assessment of the caregiver's own health and well-being, including medical, behavioral, or physical limitations as it relates to the caregiver's ability to support the member

(3) an assessment of the caregiver's level of stress related to care-giving responsibilities and any feelings of being overwhelmed

(4) identification of the caregiver's needs for training in knowledge and skills in assisting the person needing care

(5) identification of any service and support needs to be better prepared for their care-giving role

Family Caregivers in CHOICES

- **Family caregiver assessment:**
  - Typically performed as part of the face-to-face assessment
    - at least once every 365 days as part of the annual review
    - upon a significant change in circumstances; and
    - as the care coordinator deems necessary
- **Caregiver Assessments result in:**
  - A plan to address the needs of each caregiver to maintain the health and well-being of each caregiver and sustain their ability to provide care to the member
  - Include as part of the plan of care
    - *"Caregiver training or supports identified through the caregiver assessment that are needed to support and sustain the caregiver's ability to provide care for the member"*

Next Steps: Supporting Family Caregivers in Employment and Community First CHOICES

- Prioritize for enrollment individuals with aging caregivers
- Specific (and unique) benefit package for individuals with I/DD living with family caregivers tailored to the needs of individuals and their family caregivers, based on input from family caregivers across the state, including:
  - Respite
  - Supportive Home Care (SHC)
  - Family Caregiver Stipend in lieu of SHC
  - Community Support Development, Organization and Navigation (includes Family-to-Family Support and Assistance)
  - Family Caregiver Education and Training
  - Conservatorship/Alternatives to Conservatorship Counseling and Assistance
  - Health Insurance Counseling/Forms Assistance

Quality Improvement in Long-Term Services and Supports

A Value-Based Purchasing Initiative for NFs and HCBS

Phase 1 (Bridge)

Quarterly adjustments to per diem rates largely focused on QI *activities* (i.e., process measures)

Phase 2 (Full Model)

Prospective per diem based on quality *performance* compared against benchmarks

Quality improvements is evaluated from the member's perspective using a point system and rewarded as a *retroactive rate adjustment*:

Satisfaction 35 points

Member	(15)
Family	(10)
Staff	(10)

Culture Change/Quality of Life
30 Points

Respectful treatment	(10)
Member choice	(10)
Member/family input	(5)
Meaningful activities	

Bonus Points: QI initiatives

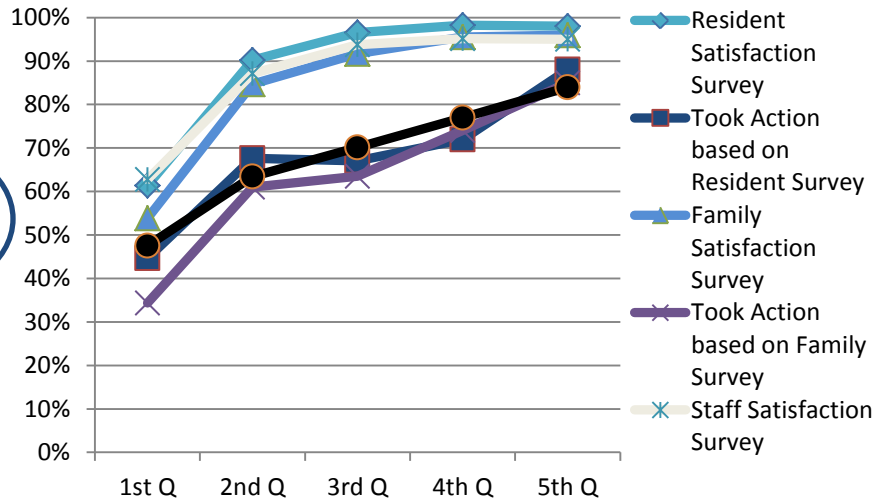
Staffing/Staff Competency
25 Points

RN hours per day	(5)
CNA hours per day	(5)
Staff Retention	(5)
Consistent Staff Assignment	(5)
Staff Training	(5)

Clinical Performance
10 Points

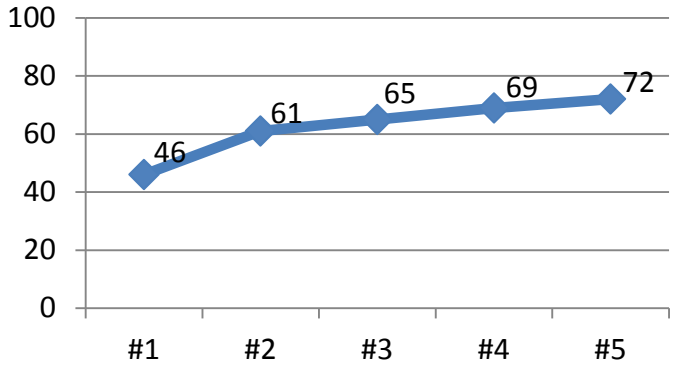
Antipsychotic Medication	(5)
Urinary Tract Infection	(5)

Significant improvement in conducting satisfaction surveys and taking actions to improve satisfaction

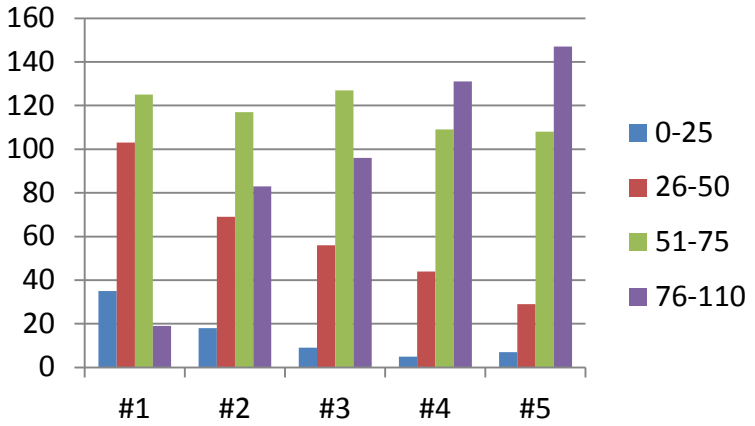


QuILTSS Early Results

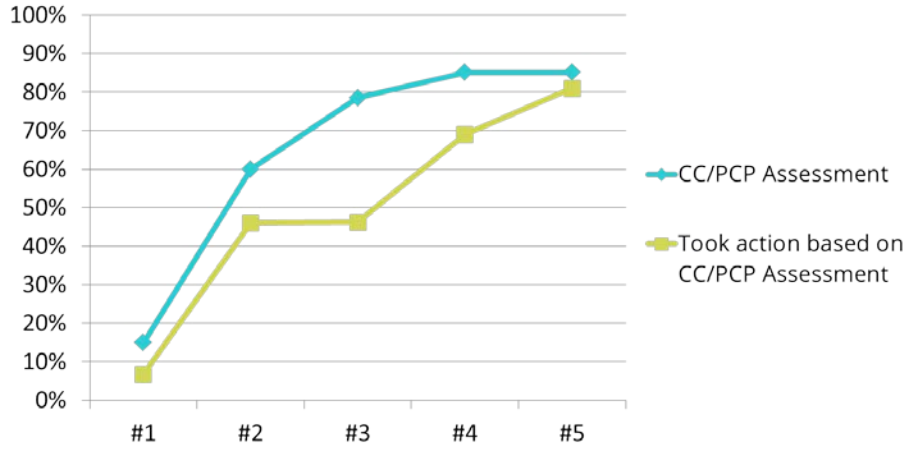
Total quality scores continue to improve (average total scores for all submitting NFs)



Number of NFs with higher quality scores continues to increase; number of NFs with lower quality scores declining



Significantly more NF engaging in Culture Change/ Person Centered Planning assessment and improvement



LTSS Workforce Development

Invest in the development of a comprehensive competency based workforce development program and credentialing registry for individuals paid to deliver LTSS[1]

Better for Workforce

- Opportunity to both learn and earn by acquiring **shorter term credentials** with clear labor market value
- Credentials are portable **across service settings**
- Earn college credit toward certificate and/or degree program—**education path** for direct support professionals
- Build competencies to access more advanced jobs and higher wages—**career path** for direct support professionals

Better for Beneficiaries & Providers

- Supports recruitment/retention of competent staff
- Promotes delivery of high quality person-centered services
- Registry for matching by individuals, families, providers based on needs/interests of person needing support
- Agencies employing better trained and qualified staff will be **appropriately compensated** for the higher quality of care experienced by individuals they serve

[1] for deployment through secondary, vo-tech, trade schools, community colleges, and 4-year institutions, offering portable, stackable credentials and college credit toward certificate and/or degree program

Improve Coordination for Dual Eligible Members

- **Fragmentation:**
  - Dual eligible members confused and frustrated by complex dual systems, with different provider networks, benefit structures, etc.
  - MCOs have limited visibility into the services Medicare providers deliver to dual eligible members; hampers ability to:
    - coordinate care/identify and address gaps in care
    - engage in effective management of chronic conditions
    - engage in discharge planning
- **Limited Medicare HCBS choices/options; heavy reliance on institutional benefits**
  - Medicare benefit/payment structure encourages use of highest cost services and increases Medicaid institutional expenditures

Improve Coordination for Dual Eligible Members

- Require all TennCare MCOs to have a companion Dual Eligible Special Needs Plan (D-SNP)
- Support and encourage member enrollment into an aligned MCO for Medicare and Medicaid benefits
  - As of 11/1/15, 64% of dual eligible members enrolled in a D-SNP are aligned in the same plan for their Medicare and Medicaid benefits. The number of dual eligible members in an aligned D-SNP has increased from 23,271 in December 2013 to 34,627—a 49% increase.
- Educate members about the benefits of aligned enrollment
- Support MCOs in "seamless conversion" of Medicaid-eligible members attaining Medicare eligibility
- Leverage MIPPA (Medicare Improvements for Patients and Providers Act) Agreements with D-SNPs to strengthen care coordination requirements and require/facilitate data exchange necessary to support improved coordination

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THANK YOU

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