Trust but Verify: Tennessee's Approach to Ensuring Accurate Functional Status Data in its Medicaid Managed Long-Term Services and Supports Program

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IN BRIEF

States with Medicaid managed long-term services and supports (MLTSS) programs can use information on enrollees' functional status — such as the ability to perform various activities of daily living (ADLs) — to determine the need for services and supports and potentially to adjust the capitation rates paid to managed care plans. To do this, states need information that is complete, objective, accurate, and timely. The state of Tennessee has a robust approach to collecting and validating functional assessment data that can help other states to advance strategies for MLTSS program rate setting. This brief — supported through the West Health Policy Center — describes how TennCare, Tennessee's Medicaid agency, collects and validates data on enrollees' functional status.

For states with Medicaid managed long-term services and supports (MLTSS) programs, information on enrollees' functional status — such as the ability to perform various activities of daily living (ADLs) — may help predict the risks and costs associated with certain aspects of their care. States are increasingly considering payment approaches for their MLTSS program that adjust the capitation rates paid to managed care plans based on an individual's functional status; however, this requires functional assessment data that are complete, objective, accurate, and timely. It is not enough to collect data; it is also important to validate and audit it.

Functional assessment data can be somewhat subjective, depending on the skills, training, organizational affiliation, and personal biases of the person performing the assessment. Assessments also require the reviewer's judgement regarding an individual's functional capacity, and these judgments can vary across reviewers and over time. In addition, conflicts of interest can arise when an organization both conducts the functional assessment and provides the LTSS identified as needed through that assessment. All of these factors make data validation an important task for states.

Tennessee's Medicaid agency, called TennCare, has a robust approach to collecting and validating functional assessment data that can serve as an example to states that are building the infrastructure required to advance rate-setting strategies for MLTSS programs. This brief — supported through the West Health Policy Center — describes how TennCare assesses enrollees' eligibility for LTSS benefits through its CHOICES MLTSS program based on functional status and level of care. It describes the internal and external processes used to validate level of care determinations. The brief also presents TennCare's approach to identifying and addressing level of care determinations that have the greatest cost implications, then concludes with a discussion of planned changes to the validation process.[1]

Assessing Level of Care Needs

TennCare determines eligibility for CHOICES using a single, state-specific screening tool, the pre-admission evaluation (PAE), which measures level of care needs based on the individual's:[2]

- Need for assistance on four ADLs (i.e., transfer, mobility, eating, and toileting);

- Deficits in four ADL-related functions (i.e., expressive and receptive communication, orientation, behaviors, and self-administration of medications); and

- Need for certain skilled and/or rehabilitative services (e.g., tube feeding, wound care, occupational or physical therapy and even ventilator care).

The PAE is electronic and is submitted via a secure, web-based operating system that is also customized for paperless workflow processing. The PAE does not currently link to TennCare's Medicaid Management Information System (MMIS), but the state plans to release a fully integrated version next year.

To score an individual's level of care needs, certified assessors in TennCare assign a weighted value to the responses for each ADL, ADL-related function, or skilled or rehabilitative need on the PAE. Weights vary based on the amount of assistance that would be required for a person with that type and level of ADL functioning or related deficiency. For example, the need for ventilator services is weighted more heavily than the need for injections or intravenous fluid administration. Moreover, an individual who is totally dependent on caregivers for transfer and mobility would receive a higher weighted score than an individual who only has expressive or receptive communication needs.

The sum of the weighted responses determines an individual's acuity score. Individuals who score at least nine out of a possible 26 points qualify for a nursing home level of care, which entitles them to receive services either in a nursing facility or community setting.[3] Individuals who score less than nine but have at least one significant ADL need or related deficiency qualify as "at risk" for nursing facility placement, which entitles them to receive a more limited package of home- and community-based services (HCBS), along with medically necessary home health and other Medicaid benefits. If a person who is determined to be "at risk" has needs that cannot safely be met in the community with the services available, the individual who completes the PAE can request a safety determination. TennCare nurses reviewing PAE applications use clinical judgement to determine whether to approve nursing facility level of care based on safety concerns.

> **TennCare CHOICES: Eligibility and Covered Services**
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> Since 2010, TennCare has provided Medicaid MLTSS to seniors and adults with physical disabilities through its CHOICES program. The state contracts with three managed care plans to cover medical, behavioral health, and LTSS under a single capitated payment for CHOICES enrollees who need a nursing facility level of care. Individuals must meet this level of care to qualify for the full package of CHOICES benefits. Those who are determined "at-risk" for nursing facility placement can receive a more limited package of home- and community-based services. As of March 2016, CHOICES enrolled more than 30,000 individuals.

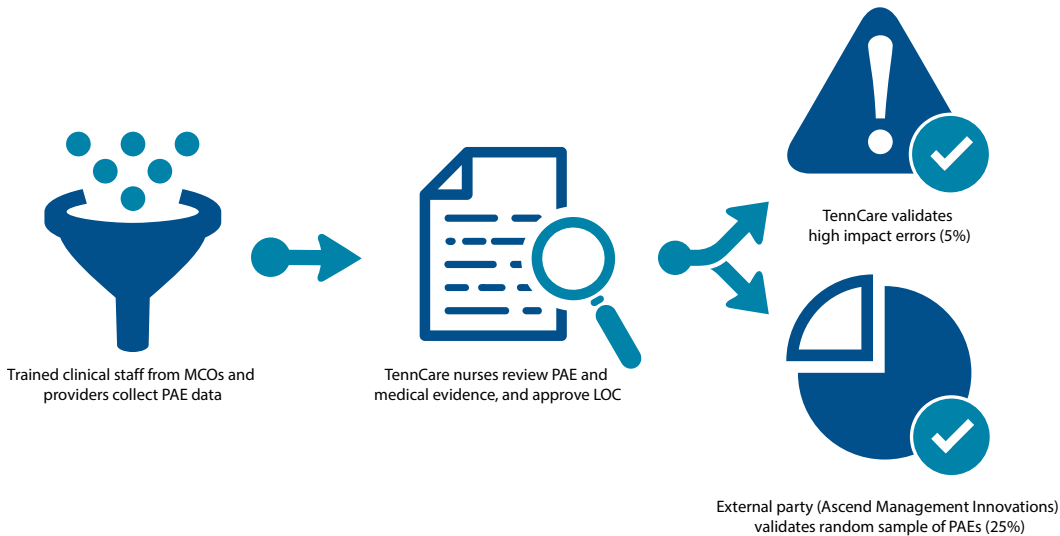## Ensuring Accuracy of Functional Assessment Data

PAEs are completed by clinical staff (i.e., physicians, physician assistants, nurse practitioners, registered nurses, licensed practical nurses, or licensed social workers) from hospitals, nursing homes, Program of All-Inclusive Care for the Elderly (PACE) organizations, managed care plans, or Area Agencies on Aging and Disability. (Exhibit 1 illustrates the data collection and validation process.) Individuals who complete PAEs must be certified by TennCare as meeting certain requirements, which vary by service setting. For PAEs requesting nursing facility services, certified assessors must have completed an online training about LTSS programs and the PAE application process. For PAEs requesting HCBS, certified assessors must have completed an in-person training and passed an annual exam measuring their understanding of HCBS requirements. Individuals are assigned to the appropriate assessors, based on their request. The additional in-person training and annual exam are designed to ensure the accuracy of the medical

evidence that assessors may develop to supplement the medical record for HCBS applicants. Individuals other than the certified assessors may complete and submit the PAE on the assessor's behalf; however, certified assessors are responsible for ensuring the accuracy of the information submitted.

Exhibit 1: TennCare CHOICES' Process for Collecting and Validating Functional Assessment Data

Trained clinical staff from MCOs and providers collect PAE data

TennCare nurses review PAE and medical evidence, and approve LOC

TennCare validates high impact errors (5%)

External party (Ascend Management Innovations) validates random sample of PAEs (25%)

PAEs must be accompanied by medical evidence that documents the reported deficits. This documentation is reviewed by TennCare as part of the level of care determination process. Because medical records may be more difficult to obtain in the community and may not adequately document functional deficits, certified assessors who are completing PAEs for HCBS can document functional needs through observation, narrative descriptions or explanations from applicants, and collateral interviews with caregivers or family members. This documentation supplements other medical records that may also be submitted such as: hospital notes; therapy notes; documentation from doctor visits; ADL flow sheets; or encounter notes from nurses, therapists, or physicians.

TennCare requires all level of care assessments to be certified for accuracy. When submitting an application to the state, certified assessors must attest that the information is accurate and acknowledge that submitting false information is an act of fraud that could result in criminal penalties. Applications for nursing facility placement must also include a physician's certification.

TennCare also provides technical assistance to assessors to improve the accuracy of level of care submissions. Based on its review of PAEs for trends and specific areas of concern and common themes received through the technical help desk call center, the state routinely conducts webinars and issues training newsletters to provide targeted guidance to submitting entities. It communicates trends in discrepancies between levels of care requested in PAEs and those approved by TennCare (i.e., "PAE submission error rates") to entities that are having difficulties submitting applications that accurately reflect the person's needs or providing sufficient documentation to support assessed needs. It also provides targeted training and technical assistance where needed, and monitors subsequent submissions to ensure improvements over time.

Approving Level of Care Determinations

The TennCare LTSS division employs seven registered nurses to review the functional assessments against medical evidence submitted with all PAE applications and approve determinations. The nurses each review approximately 19 PAEs per day within eight business days of receipt. A review takes between 20 to 25 minutes to complete, allowing TennCare to review about 2,500 applications per month and 30,000 applications per year. Though TennCare acknowledges the significant cost of these review activities, the state considers it a good investment relative to the potential cost of approving services for which applicants do not qualify.

If an individual appeals his or her medical eligibility determination, TennCare uses an independent, third party contractor (currently Ascend Management Innovations, LLC) to review the appeal. The contractor performs new, in-person assessments, gathers additional medical evidence as needed, and makes an independent recommendation on level of care. TennCare reports that the third party review plays an "important and objective" role in the eligibility process.

Validating Level of Care Determinations

TennCare considers it an error when there is a discrepancy between the total score submitted on the PAE and the score approved by TennCare, as supported by medical evidence. Applications that initially request a nursing facility level of care (that is, a PAE score of nine or above) but are approved as "at risk" (that is, the PAE score is below nine) are considered "high impact errors" because they have the greatest potential to result in overpayment to the plans, since monthly capitation rates vary based on level of need. About 20 percent of applications each month (over 500 applications) result in high impact errors. TennCare focuses its monitoring efforts on high impact errors and reviews trends by submitting entity name and type. On average, TennCare finds that 23 percent of applications submitted by Area Agencies on Aging and Disability, 22 percent submitted by nursing facilities, and 11 percent submitted by managed care plans result in high impact errors.

As a further check on the accuracy of state level-of-care determinations, TennCare also conducts both external and internal reviews of PAEs. For external validation, Ascend Management Innovations reviews a random sample of PAEs and verifies the level of care by conducting an in-person assessment, reviewing records, gathering additional medical evidence, and making an independent determination. It reviewed 50 percent of approved HCBS applications during the first six months of CHOICES, and it is currently reviewing 25 percent of all HCBS applications.

For internal validation, TennCare relies on independent nurse reviewers who are separate from those who approve nursing facility level of care determinations. The internal validation nurses review five percent of all PAEs and focus on those that have the greatest financial implications for the state if the determination was incorrect. This includes applications in which:

- The scores submitted on the PAE and approved by TennCare could lead to different level of care determinations (i.e., PAEs that have a submitted score of nine or above and an approved score somewhere between seven and 11).

- A nursing facility level of care is requested because a person's need cannot be safely met in the community with the array of services available for an "at risk" level of care (i.e., the PAE score is less than nine but additional clinical information is provided). TennCare reviews all approvals based on safety information and 50 percent of denials.

- New staff completed the assessment or determination, or a significant change to the program or its policies recently occurred.

TennCare also reviews PAE redeterminations. Managed care plans review level of care eligibility annually or when a significant change in functional status occurs, and TennCare uses nurses in a separate care

coordination monitoring unit to conduct chart reviews for these determinations. Chart reviews consist of a complete review of medical evidence, plans of care, and an assessment of whether level of care determinations were accurate.

Defining Managed Care Plan and Provider Responsibilities Regarding Level of Care

TennCare defines plan and provider responsibilities regarding level of care determinations in its contracts. Specifically, when managed care plans conduct level of care determinations, they are responsible for ensuring that the determinations are accurate and complete, satisfy all of the state's technical requirements, and accurately reflect the member's current medical and functional status. They are also required to note in their PAEs any discrepancies between information gathered from the member, his or her representative, the care coordinator's direct observations, and medical records. Managed care plans must include similar contractual requirements in their nursing facility provider agreements.

Managed care plan contracts also specify the monetary sanctions that TennCare may apply if a plan submits inaccurate information on a PAE. TennCare has the option to sanction managed care plans $2,000 for each inaccurate assessment; the amount doubles if a contractor does not comply with caseload and staffing requirements. TennCare reports that these sanctions have prompted assessors to institute internal mechanisms to ensure the accuracy of their applications. As a result, the number of sanctions issued fell from 62 in 2014 to 10 in 2015.[4]

Future Changes to the Collection and Validation Process

Though TennCare does not yet incorporate functional assessment data into its approach for setting capitation rates paid to CHOICES contractors, the state recognizes the value of collecting complete and timely information on level of care, and validating that information to ensure its accuracy. TennCare plans to make several improvements to its approach to collecting and validating functional assessment data to move toward using that data for rate setting. The state requires managed care plans to conduct level of care reassessments at least annually, or when there is a significant change in circumstances; however, managed care plans are only required to report assessment information when level of care changes. Moreover, data are not updated regularly for all members, and the state only reviews and validates a subset of the reassessments that are made. In the future, TennCare plans to collect reassessment data for all members on an annual basis. It also plans to develop a process to review and validate reassessment data, which could involve reviewing a sample of applications and their accompanying medical information.

Conclusion

For its CHOICES MLTSS program, TennCare has developed a robust approach to collecting, approving, and validating functional assessment data. Because data are collected by the same entities that will be providing LTSS, the state has developed several processes to ensure that the data is sound. Individuals conducting the functional assessments must meet professional standards and participate in training on their role as assessors. Two separate groups of TennCare nurse reviewers approve assessments submitted by clinical professionals and audit approvals that pose the biggest threat to CHOICES and its members. In addition, an external organization conducts a full, independent review of random sample of assessments. The state further ensures the accuracy of functional assessment data by describing managed care plan and provider responsibilities in its contracts, and maintaining the ability to sanction contractors that do not comply with these requirements. While TennCare does not yet use functional assessment data as part of the MLTSS rate-setting process, the state plans to move in this direction with the knowledge that the data it collects is as accurate and complete as possible.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS RATE SETTING RESOURCES

This brief is a product of CHCS' *Medicaid Managed Long-Term Services and Supports Rate-Setting Initiative*, which is made possible by the West Health Policy Center to help states and other stakeholders advance rate-setting methods for MLTSS programs. Other resources on www.chcs.org, include:

- *Building Managed Long-Term Services and Supports Risk-Adjustment Models: State Experiences Using Functional Data*

- *Considerations for a National Risk-Adjustment Model for Medicaid Managed Long-Term Services and Supports Programs*

- *Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations*

- *Engaging Managed Care Plans in Rate Setting for Medicaid Managed Long-Term Services and Supports Programs*

- *Look Before You Leap: Risk Adjustment for Managed Care Plans Covering Long-Term Services and Supports*

- *Population Diversity in Medicaid Managed Long-Term Services and Supports Programs: Implications for Risk Adjustment and Rate Setting*

- *Strategies to Mitigate Risk in Medicaid Managed Long-Term Services and Supports Programs*

ENDNOTES

[1] The information in this brief is based on discussions with TennCare staff participating in the *Medicaid Managed Long Term Services and Supports (MLTSS) Rate-Setting Initiative*, supported by the West Health Policy Center.

[2] The PAE manual is available for review at https://tn.gov/assets/entities/tenncare/attachments/PAEManual.pdf.

[3] People who meet a nursing facility level of care can receive HCBS up to the applicable average annual cost of nursing facility placement.

[4] The number of sanctions for 2015 covers actions through November 17, 2015.