

**TENNESSEE COMPREHENSIVE PLAN
FOR
THE DELIVERY OF LONG-TERM CARE SERVICES
TO
ELDERLY AND DISABLED PERSONS**

MARCH 15, 1999

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SUBMITTED BY:

THE TENNESSEE LONG-TERM CARE SERVICES PLANNING COUNCIL

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Executive Summary

Tennessee's 100th General Assembly enacted legislation signed by Governor Don Sundquist in 1998 that established a Long-Term Care Planning Council and Advisory Council. The Planning Council was comprised of the commissioners of the departments of Health, Finance & Administration, and Human Services and the executive director of the Commission on Aging. The Advisory Council was comprised of sixteen members, fourteen appointed by the governor and one each appointed by the Speaker of the Senate and the Speaker of the House. The councils were charged with developing a comprehensive long-term care plan for the state that would guide the future funding, coordination and delivery of long-term care services for Tennesseans regardless of age, disability or economic status.

The councils maximized the time allotted by reviewing the work accomplished by four previous groups that had examined the issue. In each instance, the facts noted that services other than nursing homes were very limited for individuals who are not able to function totally independently. While each of the earlier groups noted a lack of service variety and a growing elderly population, none of the groups defined a plan of action. The councils also reviewed current rules and regulations, funding sources, and programs for the elderly and physically disabled currently available in Tennessee.

According to national demographic estimates from the General Accounting Office, approximately 12 million disabled persons across the United States need some type of long-term care assistance. The needs range from occasional household assistance to round-the-clock nursing. If those numbers are applied to Tennessee's population as forecasted by the Department of Sociology at the University of Tennessee, approximately 7,191 children under the age of 18, 95,870 working age adults, and 136,515 elderly persons living in Tennessee fall into this broad category. This category is all-inclusive and broader than just the elderly and physically disabled population for which this Plan has been requested so we can anticipate that the numbers for that specific population would be substantially lower. Persons needing long-term care services reside predominately in the community and receive their primary care from family and friends. Some of those needing assistance will need only occasional support while a smaller number will require substantial assistance.

Tennessee's elderly population alone has grown from 12.5% of the total population in 1996 to 13.6% of the population today, and forecasts indicate that by the year 2030, those over 65 will constitute 20% of the state's population. Life expectancy is increasing as well. According to a recent report, "the combined effects of an aging population and extended life expectancy guarantee a substantial increase in the number of people who will require daily support over the next several decades." [Susan M. Allen and Vincent Mor, "Unmet Need in the Community," p. 135.]

Long-term care as envisioned in the Plan involves the provision of personal care, health care, social services, and other services for an indefinite time period to elderly and physically disabled persons. In Tennessee, medical services, such as home health and nursing home care are more readily available than other community alternatives. Accessing long-term care services can be difficult and confusing. One contributing factor to the confusion is that there is not enough awareness at the local level of sources of information, referral, and education about service availability.

Another problem in accessing formal long-term care services is the lack of availability of service providers in some areas of the state. While medical and rehabilitation resources are readily available in cities, a dozen rural counties lack even general hospitals. Sophisticated day care services, continuing care communities, and assisted living facilities are similarly urban.

Home and community-based services currently available include those that are provided as medically necessary by TennCare managed care organizations and behavioral health organizations and those provided through TennCare 1915 (c) HCBS waivers and through the new 1915 (c) Program for All-Inclusive Care for the Elderly. The TennCare 1915(c) waiver programs have the capacity to serve approximately 650 individuals. In addition, there are services funded by the Older Americans Act provided to approximately 20,000 Tennesseans through the Commission on Aging, and several thousand more people are served through the Department of Human Services and funded primarily by federal dollars with some state dollars included. Some of these programs currently have waiting lists of persons wanting to participate who need services.

Like the groups established earlier, the Councils concluded that there is a need for additional home and community-based services for the elderly and physically disabled. They also felt that it would be extremely important to try to develop a seamless system for people to access in communities all across the state. All of the programs that are targeted for the elderly and physically disabled should be coordinated in a way that takes maximum advantage of federal financial participation and that coordinates services in a manner that provides the most help with the fewest complications to accessing services.

Another universal problem that needs to be addressed is providing adequate information to the public about the need for long-term care services, how to access those services, and the responsibility individuals have in preparing to meet those needs.

The Planning Council has recommended a tiered approach in developing the overall Plan for Long-Term Care Services. First, as directed in the legislation, they have prepared an HCBS Waiver proposal to submit to HCFA for approval. This would provide additional services statewide to approximately 2,500 – 3,000 Tennesseans who would be Medicaid-eligible and who would otherwise be served in a nursing home. The State plans to submit the waiver application to HCFA in April, 1999, with a target implementation date of July 1, 1999. If approved, Tennessee could get federal matching funds for money appropriated by the State. Services in the waiver program include case management, homemaker services, personal care services, minor home modifications which facilitate mobility or enhance safety, specialized medical equipment and supplies (not covered in the Medicaid State plan), personal emergency response systems, assisted care living services (excluding room and board), home delivered meals, nursing services (not covered in the Medicaid State plan) and transportation (not covered in the Medicaid State plan).

In addition, the Planning Council has recommended expanding the services that are available through the Commission on Aging so that individuals who may not meet criteria for Waiver services can be served, also. This funding should allow approximately 3,000 more individuals to receive services, bringing the total of new persons to be served to 5,500 – 6,000. When these numbers are added to the capacity to serve through the current TennCare waivers, approximately 6,650 Tennesseans can be served in home and community-based settings.

The Councils identified several additional potential components to the Long-Term Care Services Plan that will require additional time to complete. The education of the public is instrumental to the State of Tennessee being properly prepared to meet the needs of an aging population and to better providing assistance to persons with physical disabilities. A two-pronged approach toward possible programs has been outlined; one serving Medicaid-eligible individuals and one serving those who would not meet criteria for Medicaid eligibility. Enacting some of the programs would require changes from the federal as well as state level, but they are still worthy of consideration.

The Planning Council has identified several principles for the Long-Term Care services Plan. The Plan should include: 1) broad-based education and dissemination of information; 2) services in home and community-based settings to those most financially and medically needy; 3) well-coordinated programs; 4) simplified access to services; and 5) ways of encouraging individuals to take responsibility for themselves and their future.

The components that have been delineated are:

- 1) developing and implementing a statewide HCBS Waiver;
- 2) developing strategies for extending HCBS services to people who do not meet Medicaid eligibility criteria;
- 3) exploring other service options for individuals who need long-term care services;
- 4) enhancing and simplifying consumer and caregiver access to long-term care services for the elderly and physically disabled;
- 5) developing additional information and education initiatives to promote and explain long-term care and additional health-related services;
- 6) pursuing a long-term care insurance partnership program; and
- 7) exploring ways to promote long-term care insurance programs with public and private employers.

The Plan recommends a five-year moratorium on legislative or regulatory changes to current long-term care laws and regulations beyond those required to implement the plan, and it endorses background check requirements for people providing long term care services. The moratorium would provide a stable period of time for the Plan to take affect. Changes in the current environment could impact the cost of services or the number of people eligible for services. This will allow time, also, to properly assess the impact of the program toward meeting the needs of elderly and physically disabled Tennesseans.

The Planning Council and Advisory Council recognize that the entire Plan cannot be implemented immediately. They further realize that funding constraints and additional administrative infrastructure development may necessitate an incremental approach. Also, they note that it may take some time for the development and expansion of providers to have services readily available in all areas of the state. Therefore, the Councils believe they should continue to meet to complete the development of all components of the Plan and to monitor the implementation of the programs that have been recommended if the funding is ultimately approved by the governor and the legislature.

INTRODUCTION

Tennessee's 100th General Assembly passed legislation that was signed by Governor Sundquist in 1998 requiring the development of a comprehensive long-term care services plan (Plan) for elderly and physically disabled Tennesseans. Public Chapter 1093 (Attachment 1) recognizes that Tennessee's existing system of long-term care is a patchwork of services and sets out fourteen guiding principles to apply in formulating the Plan. The Plan must include a general overview of the components of a coordinated system of services for the elderly and physically disabled, and it, also, must include a waiver proposal for Home and Community Based Services that is to be submitted to the Health Care Financing Agency (HCFA) for approval.

The legislation created the Long-Term Care Services Planning Council, comprised of the Commissioners of Health, Human Services and Finance and Administration, as well as the executive director of the Tennessee Commission on Aging. The Commissioner of Health chairs the four-member planning council.

The legislation also created a sixteen-member Long-Term Care Services Advisory Council to work in conjunction with the planning council in developing the long-term care services plan for Tennessee. Representation on the advisory council is specified in legislation, with the Governor appointing fourteen members and the Speaker of each House having an appointment. A list of members of both councils is provided in Attachment 2.

The new law also addresses the responsibilities of each of the councils. The following outlines these charges:

Purpose Of Long-Term Care Services Planning Council

To formulate a comprehensive Long-Term Care Services Plan to guide future funding, coordination and delivery of long-term care services in the state of Tennessee. Given this charge, the chair has proposed continuing the meetings of the councils in order to get their advice and counsel on the implementation of the proposed Home and Community Based Services waiver and to continue the full development of the overall Plan.

Responsibilities Of Long-Term Care Services Advisory Council

1. To assist in the formulation of a comprehensive and detailed plan to guide the future funding, coordination and delivery of long-term care services in Tennessee, including establishment of specific standards of care.
2. To review a Long-Term Care Services Plan for the State of Tennessee to be submitted by January 1, 1999, to the General Assembly and to forward with the plan any recommendations adopted by the Advisory Council with a majority vote of members.
3. To review subsequent changes to the Long-Term Care Services Plan.
4. To review all proposed regulations which may affect the Long-Term Care Services Plan for Tennessee.

Previous Studies on Long-Term Care in Tennessee

Several studies have been done in recent years on the changing demographics of the state population and what the impact of those changes will be on Tennesseans and on state government. There have been two different studies commissioned by resolution of the General Assembly, another study completed by the State Comptroller's Office and a review by an ad hoc committee established by a former commissioner of finance and administration. Below are the highlights of those studies, and the executive summaries, where available, of their reports are found in Attachment 3.

Long-Term Care Committee Established by Commissioner Bob Corker – May, 1996

Former Commissioner of Finance and Administration Bob Corker established a committee to look at the issue of long term care in the TennCare program and examine ways to control its growth. The committee was formed to explore the problem of long term care program growth and to make suggestions/recommendations. Meetings were held from December, 1995 through March, 1996. A report was submitted to Commissioner Corker in May, 1996.

The committee was unable to reach a consensus on the issues. However, there were suggestions made by individual committee members, TennCare staff, and staff of the Comptroller's office. Those suggestions are listed below:

- Reduce expenditures to Level I and Level II nursing facilities. Accomplish this by changing the payment to Level I and Level II nursing facilities to an amount representing the 65th percentile of allowable operating costs plus the 50th percentile of allowable capital-related costs; apply the inflation factor only to operating costs; include return on equity in capital costs. Also, change the inflation factor to allow a flat percentage for all providers; place reasonable limits on management fees and home office costs claimed in cost reports.
- Impose a global budget for Level I nursing facilities and for Level II nursing facilities. Future efforts could include reductions in the percentage of growth, or even negative growth, with specified monies targeted to expansion of home and community-based type projects.
- Change the payment to ICF/MR facilities to an amount representing the 65th percentile of allowable operating costs plus the 50th percentile of allowable capital-related costs.
- Implement an estate recovery process to recover the costs of all Medicaid expenditures from the estates of deceased Medicaid clients who were at least 65 years old when they were eligible for Medicaid. Also implement a hardship waiver process for estate recovery.
- Request a waiver from HCFA to implement a Program for All-inclusive Care for the Elderly (PACE).
- Expand HCBS waivers as an offset to the long-term budget in the following areas: expand the current ADAPT waiver for the elderly and disabled to other counties; expand the current HCBS waivers to include adult daycare; expand the current Shelby County waiver for elderly and disabled to other counties; ear-mark an increasing portion of the long-term care budget each year for expansion of HCBS programs with corresponding reductions in long term institutional care.
- Require nursing homes to include Social Security numbers of individuals on their waiting lists so that an unduplicated count could be achieved.
- Improve coordination of Medicare/Medicaid funding.
- Include long-term care in the TennCare waiver to allow demonstration of a cost-effective alternative using a single MCO and a supplemental cap payment for qualified individuals. Begin by implementing a single site.
- Implement independent assessment/concurrent reviews to verify that nursing home patients continue to meet the Medicaid requirements for Level I or Level II care.
- Change the reimbursement methodology for Level II facilities to a prospective basis.

SJR 58 Committee Report – January, 1997

SJR 58 called for the Departments of Health and Finance and Administration to jointly study the feasibility of increasing the utilization of home and community-based services as viable alternatives to nursing home care in the TennCare program. Wayne Ray, Ph.D, Professor of Preventive Medicine at Vanderbilt University, served as a consultant for the process and drafted the initial version of the report. The process began in August, 1995 and was sent to the committee in October, 1996. The report was submitted to the General Assembly in January, 1997.

The report makes the following observations in summary:

- It is feasible to increase utilization of home and community-based services in TennCare.
- Analysis of patient needs and of costs is complex.
- Comparative analysis of national and regional studies does not provide evidence from statistically valid, controlled studies that home and community-based programs increase quality of care.
- Comparative analysis of national and regional studies suggests these approaches are unlikely to save substantial sums of money.
- Given the large number of unknowns in all of these factors, it could be prudent to test any policy changes before implementing them statewide.
- Possible strategies include the following:
 - Support additional projects or studies in Home and Community-Based Services.
 - Put aside studies and projects and get started on ways to make it become cost-effective.
 - Increase restrictions of access.
 - Status quo.

Comptroller's Office Report, Long-Term Care of Tennessee's Elderly – October, 1997

This report was submitted to the General Assembly in October, 1997. It was intended to provide an understanding of the issues involved in the long-term care of Tennessee's elderly. The report reached the following conclusions:

- Much of the long-term care population is elderly. The elderly population in Tennessee and nation-wide is increasing, and will soon increase dramatically.
- Tennessee has no comprehensive long-term care plan. The state should develop a plan now.
- There are various options available for funding a long-term care plan.
- There are numerous types of long-term care services to consider in developing a long-term care plan. Each has benefits as well as detriments.
- Home and community based services (HCBS) alone are not a panacea.
- Certain states, specifically Wisconsin, Oregon, and Washington, have effectively included home and community based services in their long-term care plans.
- Home and community based services have been successful in several states. However, there are many other approaches taken by states that have also been successful in managing the cost of long-term care.
- Tennessee must develop a comprehensive and focused plan for the long-term care of its elderly.
- The state must gather more information before a plan can be developed.

SJR 222 Study Committee - February, 1998

The SJR 222 Long-Term Care Study Committee was created to study methods for increasing the availability and utilization of home and community-based care for the elderly and disabled in Tennessee. The committee heard testimony about the need for more home and community-based services and reviewed programs from other states that provide such services. The committee's final recommendations were as follows:

- The state must develop a comprehensive long-term care plan that provides for a continuum of care for all who need it.
- The state needs to develop more options that reflect preferences for Home and Community-Based Services (HCBS) and allow easy access to those services. The state needs a delivery system that provides consumer choice of providers in the community and offers the option for consumers to manage their own services.
- State programs should support caregivers who are willing to delay placing their family member in an institution as long as possible, with a system of home and community-based services that is accessible, affordable, and available.
- The state must consider getting a waiver from the Health Care Financing Administration (HCFA) to spend a percentage of the federal Medicaid money on home and community-based services. The state should consider integrating its Medicare and Medicaid money into a single program. Any transition of funding should be gradual to allow alternative services to be developed and nursing homes to adjust. The state should allocate a portion of the Medicaid money to home and community-based services and allow it to grow over time or look to allocate a certain rate of growth.
- The state should develop a system based on a social model rather than a medical model.
- The state should utilize the aging network already in place and develop a single point-of-entry/care management system. Organizations responsible for assessment and case management functions should not be engaged in the actual provision of services to avoid conflicts of interest. The single point-of-entry would be responsible for information and assistance, outreach, counseling, assessment and case management.
- The state needs to use its money cost-effectively to provide the most appropriate services for the most people. Tennessee must approach the issue of developing a plan based on whether a person's needs could be met in a less costly setting with better or equivalent care.
- The Commission on Aging could expand their homemaker services, home-delivered meals, public guardianships (conservatorships), and respite care services if the requested funds were made available.
- The state needs to develop a sliding pay scale for long-term care services.
- The state should look at what other states have done to help develop a long-term care plan.
- Tennessee needs to develop a person-centered delivery system that tailors services to the needs of individuals rather than the setting of care. The dollars should follow the person and not an institution.
- The state needs to encourage consumer and family involvement in the development of an individual's plan of care, choices of services and providers, and quality assurance. Families must help out as much as possible.
- Tennessee must improve the coordination of long-term care services at the state and local levels and promote the programs that exist but are not well advertised.
- The state should consider funds from the state general fund as well as from Medicaid and the Older Americans Act. Funding from the general fund might include cost-sharing provisions/sliding scale fees.
- Any long-term care plan developed should utilize nursing home criteria (Pre-Admission Evaluation) for HCBS eligibility and follow stringent standards. To qualify for HCBS in Tennessee the following Activities in Daily Living (ADLs) should be considered and enrollees should need assistance with two of the following:

- Requires assistance in bathing
- Requires assistance in dressing
- Requires assistance in using the bathroom or has difficulty with bowel or bladder control
- Requires assistance in transferring (moving from point to point with the residence)
- Requires assistance in eating

DEMOGRAPHIC OVERVIEW OF PERSONS NEEDING LONG-TERM CARE SERVICES

Long-Term Care Defined

Rosalie Kane defines long-term care (LTC) as "an individualized blend of health, personal care and social services for persons whose functional impairments dictate that they receive assistance with tasks of everyday living. LTC can be received in residential settings such as nursing homes, but persons living in their own homes receive more often. It may be provided by paid long term care workers, but the bulk of it is provided on a voluntary basis by family and friends." Long-term care involves helping people with the activities of daily living - bathing, eating, dressing, and using the bathroom. It may also include assistance with housekeeping, shopping, and money management. Long-term care takes place in a variety of settings - the home, community facilities, day care facilities and nursing homes. Nursing homes may serve as community day care sites and often provide rehabilitation services. [Rosalie A. Kane, "Ethical and Legal Issues in Long-Term Care: Food for Futuristic Thought," *The Journal of Long-Term Care Administration*, Fall 1993, p. 66]; [Walter N. Leutz, John A. Capitman, Margaret MacAdam, and Ruby Abrahams, Care for Frail Elders: Developing Community Solutions, p. 21].

Population Characteristics

Two separate descriptive studies provide assistance in identifying characteristics of the population needing long-term care services. The first study, prepared by the United States General Accounting Office, titled Long-Term Care: Diverse, Growing Population Includes Millions of Americans of All Ages, November 1994, estimates the prevalence of current long-term care need and reports on the future prevalence of need. The second study focuses on a single community and describes the diversity of needs among different groups. Specifically, this study funded by the Robert Wood Johnson Foundation, focuses on chronically ill people in Springfield, Massachusetts. [GAO, Long-Term Care: Diverse, Growing Population Includes Millions of Americans of All Ages, A Report to Congressional Requesters, November 1994, pp. 1-2] [Susan M. Allen and Vincent Mor, "The Unmet Need in the Community: The Springfield Study," a Reprint from To Improve Health and Health Care, 1997]

The General Accounting Office study describes the population needing long-term care as the following: "The long-term care population today includes more than 12 million people who say they need assistance with everyday activities as a result of chronic conditions such as heart disease, mental retardation, or acquired immunodeficiency syndrome (AIDS). Contrary to popular perception, millions of these people are not elderly. About five million are working-age adults and about half a million are children under age 18." The study shows that their needs range from around-the-clock nursing to occasional household assistance. Five million one hundred thousand of these people are so disabled that they need assistance with basic self care activities such as eating and going to the bathroom. Approximately half of this severely disabled group, 2.4 million persons, lives in institutions such as nursing homes. Two million seven hundred thousand, however, live at home and in community settings. Of all the disabled, four-fifths live in the community. While the program envisioned in the Plan is only for elderly and physically disabled individuals, the general needs described in the GAO report are applicable to them; however, those two groups are only a subset of the overall national numbers identified in the GAO report. [GAO, Long-Term Care, p.2]

The 12 million disabled persons needing assistance represent slightly more than 4.6% of the total national population. Of this disabled population, 3% are children, 40% working age adults, and 57% elderly persons. Tennessee demographics approximate national averages. Applied to the projected population rates in Tennessee, data from this national study suggest that the disabled population in Tennessee includes approximately 7,191 children under age 18. Working age disabled people number approximately 95,870 persons. Following these estimates, there are approximately 136,615 elderly persons in Tennessee over 65 years of age needing long-term care

services. However, these percentages reflect a broader population than just those who are elderly and physically disabled; therefore, we can logically presume that the numbers for those two specific populations would be smaller.

Among both the elderly and non-elderly, arthritis and heart disease are the two most common causes for long-term care needs. Alzheimer's disease and its related disorders are another major underlying cause for the need for long-term care. No reliable information is available showing the exact number of persons afflicted by Alzheimer's disease and related disorders in Tennessee. Alzheimer's is not a reportable disease in Tennessee and no research has been conducted on the prevalence of the disease in the state. Reliable estimates based on national data indicate that Alzheimer's disease is a major health concern for the elderly of Tennessee. The GAO estimates that 5.7% of the population over age 65 have some degree of Alzheimer's disease. Moderate or severe Alzheimer's disease is found in 3.3% of this population. Based on these estimates, 42,068 Tennesseans over 65 years of age have Alzheimer's disease, and of these, 24,355 people would have moderate or severe Alzheimer's. There is general agreement that the incidence of the disease increases with age, and the GAO estimates that 58% of the people with Alzheimer's are between the ages of 75 and 89. These estimates are projected from prevalence rates from 18 different studies, and the individual studies have produced estimates of the percentage of elderly with any type of Alzheimer's varying from 2 percent to 12 percent. **[GAO, Alzheimer's Disease: Estimates of Prevalence in the United States, A Report to the Secretary of Health and Human Services, January, 1998, p. 6]**

Their own families care for most of these persons. Minimal services are available to assist persons with Alzheimer's disease and their caregivers. Most of the medical, health, and social service resources to assist this population are concentrated in the metropolitan areas and have been developed, maintained, and supported through local initiative.

Long-term care needs of varying intensity cut across all age groups. The general population of Tennessee, according to 1999 estimates, is 5,403,690 persons. A breakdown by age group is provided below. **[Population estimates for the State of Tennessee, prepared by the Department of Sociology, University of Tennessee]**

Age	Total Population
0 to 4	360,835
5 to 9	370,005
10 to 14	358,139
15 to 19	353,939
20 to 24	345,613
25 to 29	353,451
30 to 34	362,401
35 to 39	395,296
40 to 44	399,073
45 to 49	365,392
50 to 54	329,739
55 to 59	265,454
60 to 64	302,859
65 to 69	235,720
70 to 74	173,711
75 to 79	138,862
80 to 84	95,635
85 +	94,100
Total	5,403,690

Of this population, 13.6% or 738,028 are over 65 years of age and 3.5% or 189,735 are over age 80. The 1990 Census for Tennessee documents the number of persons reporting that they need assistance with personal care. Of the population living in community settings between the ages of 16 and 64, 3.5% report needing assistance in caring for themselves and 9.6% report mobility problems. Approximately 13.8% of the population 65 years of age and older report difficulty with self-care. Of this older age group, 39.9% report having mobility limitations. [1990 Census of Population and Housing, Summary Social, Economic, and Housing Characteristics. Table seven.]

The disabled population is very diverse. "There is increasing recognition that the medical model of diagnosis, treatment, and cure that has dominated the structure of our health care system is a poor fit with the needs of people for whom cure is not a possibility but who may lead a full life with their disability. A different model of care and support is needed when the goal is not preventing death but instead managing life with a disabling condition. People with disabilities may also have social, emotional, and rehabilitative needs, and these vary widely among individuals." [Susan M. Allen, Vincent Mor, "Unmet Need in the Community," p.134.]

Long-term care needs differ among elderly, working age adults, and children, according to the expectations and everyday activities typical for each life stage. "Severely disabled children frequently need services to support their families in continuing the care they already provide as well as assistance with learning basic life skills and attending school. In contrast, non-elderly adults more often require services to help them establish their own households or regain lost skills. They may want assistance to enable them to work and participate in related activities. Elderly people, who often no longer work, may instead need long-term care services that let them maintain their independence and stay in their own homes and communities despite a decline in their abilities." [GAO, Long-Term Care, pp. 12-13.]

Analysis of Long-Term Care Needs Based on Activities of Daily Living

The need for long-term care or the risk for needing these services is often described in terms of performance of the activities of daily living (ADL) and the instrumental activities of daily living (IADL). Activities of daily living are the basic activities of bathing, bed/chair transferring, dressing, using the bathroom, eating, and walking. Nationally, difficulties with walking and bathing are the most frequently encountered deficits, with 8.9% and 7.7%, respectively, of the elderly having these difficulties. Bed/chair transferring and dressing are next most common and using the bathroom and eating difficulties are the least frequent. Instrumental activities include using the telephone, handling money, shopping, getting about the community, preparing meals, and doing light housework. Getting about the community (13%) and shopping (11.5%) were those tasks with which more people had difficulty. Using the telephone (4.4%) and handling money (6.3%) were less frequently seen as problems. [J. Leon and T. Lair, Functional Status of the Noninstitutionalized Elderly: Estimates of ADL and IADL Difficulties. National Medical Expenditure Survey, Research Finding 4, Agency for Health Care Policy and Research, 1990, pp. 6-7.]

Estimates of ADL/IADL Difficulties, Ages 65+

	One ADL/IADL Difficulty	One ADL Difficulty	Number of ADL difficulties		
			1	2 or 3	4 or more
			% DISTRIBUTION WITH DIFFICULTY		
TOTAL AGE & ALL	19.5	11.4	5.2	3.8	2.4
65 to 69	9.9	5.9	2.4	2.1	1.3
70 to 74	13.2	7.9	3.4	3.0	1.5
75 to 79	19.9	11.5	6.2	3.3	2.0
80 to 84	34.1	18.6	8.0	7.5	3.2
85+	56.8	34.5	15.6	9.7	9.2

[J. Leon and T. Lair, Functional Status of the Noninstitutionalized Elderly: Estimates of ADL and IADL Difficulties. National Medical Expenditure Survey, Research Finding 4, Agency for Health Care Policy and Research, 1990, p. 9.]

Estimates of IADL Difficulties, Ages 65+

	One IADL Difficulty	Number of IADL difficulties		
		1	2 or 3	4 or more
		% DISTRIBUTION WITH DIFFICULTY		
TOTAL AGE & ALL	17.5	5.0	5.7	6.8
65 to 69	8.4	2.7	2.4	3.4
70 to 74	11.6	3.5	3.9	4.2
75 to 79	17.3	5.7	5.8	5.9
80 to 84	31.4	10.0	10.8	10.6
85+	54.4	10.4	17.3	26.7

[J. Leon and T. Lair, Functional Status of the Noninstitutionalized Elderly: Estimates of ADL and IADL Difficulties. National Medical Expenditure Survey, Research Finding 4, Agency for Health Care Policy and Research, 1990, p. 11.]

Summary

This demographic overview points out the likely size of the population needing assistance with long-term care. The population includes infants, working age individuals, and older persons. Persons needing long-term care services reside predominately in the community and receive their primary care from family and friends. Some of those needing assistance will need only occasional support while a smaller proportion of them will require substantial assistance.

Rates of disability increase with age and, with the general aging of the American population, the number of disabled persons is increasing. In Tennessee, persons over 65 years of age are estimated to number 13.6% of the population, up from 12.5% in 1996. When all baby boomers have achieved the ranks of senior citizens in 2030, those over 65 will constitute 20% of the total American population. Projected life expectancy for a 65-year-old in 2030 is 17 years for a man and 21.8 years for a woman. This is a considerable gain over the 15.7 years for a man and 20.3 years for a woman estimated for the year 2000. Susan Allen and Vincent Mor summarize the debate concerning the impact of the increased life expectancy: "Scientists disagree about the implications of increasingly longer life spans. Some are convinced that longer survival allows time for the onset of other illness or conditions, resulting in higher levels of disability among tomorrow's elderly population than among today's. Another theory is that continued medical advances and improved health practices delay disease to advanced ages. Thus, the average American will experience a "compression of morbidity," in which disability is confined to the several years before death. Regardless of which theory turns out to be correct in the end, the combined effects of population aging and extended life expectancy guarantee a substantial increase in the number of people who will require daily support over the next several decades." [Susan M. Allen and Vincent Mor, "Unmet Need in the Community," p. 135.]

CURRENT TENNESSEE LONG-TERM CARE SERVICES

Overview

Long-term Care (LTC) as envisioned in the Plan involves the provision of personal care, health care, social services, and other services for an indefinite time period to elderly and physically disabled persons. In Tennessee, medical services, such as home health and nursing home care are more readily available than other community alternatives. Accessing long-term care services can be difficult and confusing. One contributing factor is that there is not enough awareness at the local level of sources of information, referral, and education about service availability.

Common services offered in LTC programs include assistance with activities of daily living (i.e. bathing, dressing, using the bathroom, eating), assistance with instrumental activities of daily living (i.e. house cleaning and shopping), skilled nursing and rehabilitative care. Providers include nursing facilities, hospitals, home health agencies, adult day care centers, hospices, assisted living facilities, foster homes, continuing care communities, and community agencies.

For those who need services for a limited time period, convalescent care is available. Convalescent care typically follows an acute hospitalization and provides rehabilitation services, home health care, and other support services aimed at assisting patients to regain those functions necessary to return to former living arrangements. Reimbursement may be provided by publicly funded programs such as Medicare or TennCare or by private insurance. Many Tennessee hospitals, especially in metropolitan areas have developed convalescent care centers as a direct result of mandated discharge planning.

With the exception of convalescent care, LTC programs are generally more custodial than rehabilitative. Often, families provide LTC services with limited support and assistance. Formal service networks furnish less than 15% of community LTC services. Informal support networks (e.g. family and friends) meet the majority of LTC needs, including transportation, shopping, household maintenance, personal care, coordination, and monitoring.

One of the problems in accessing formal LTC services is the lack of availability of service providers in some areas of the state. While medical and rehabilitation resources are readily available in cities, a dozen rural counties lack even general hospitals. Sophisticated day care services, continuing care communities, and assisted living facilities are similarly urban.

Formal service providers or volunteers may provide other LTC services such as home-delivered meals, respite, sitter service, chore, home repair, homemaker, and personal care. The Older Americans Act (42 USC 3001) programs which are administered through the Tennessee Commission on Aging and its designated Area Agencies on Aging assist more than 20,000 Tennesseans with such services. In addition, some funding for support services comes through the Department of Human Services Social Service and Community Service Block Grants. TennCare also funds a limited amount of community services through two relatively modest 1915 (c) waivers and through the new Program for All-Inclusive Care for the Elderly (PACE), another type of 1915 (c) waiver.

Current TennCare Services

Nationally, the Medicaid program remains the main source for public health care related services, especially for the elderly and disabled populations. This program is utilized by state administrations because each dollar spent is matched with federal financial participation of at least 50%. Therefore, this lowers the financial impact on states' general funds. In Tennessee, TennCare is the state Medicaid program, and state dollars are currently matched with federal dollars on a 63:37 ratio, approximately. In other words, when the state appropriates \$37, the federal financial participation is \$63. Current services available through TennCare's Managed Care Organizations and Behavioral Health Organizations are detailed in Attachment 4.

The primary focus of the TennCare and TennCare Partners programs is to meet the acute care medical and behavioral needs and the short-term rehabilitative needs of TennCare enrollees. Services are provided when they are determined to be medically necessary. The exception to a short-term focus is service to enrollees who are seriously and persistently mentally ill. This group of enrollees is provided their long-term behavioral health needs through the Partners program. The long-term care needs, however, of the elderly and physically disabled are not addressed through the TennCare program.

TennCare-reimbursed long-term care options currently include nursing facility care statewide. The 1999 budget for nursing facility care is \$705,642,000. There are also limited home and community based waiver services for the elderly and physically disabled available in four Tennessee counties. The 1999 budget for these waivers is \$5,856,543.

TennCare reimbursed nursing facility care is available to individuals meeting medical and financial criteria. Participating nursing facilities may receive reimbursement at a Level 1 or Level 2 rate, depending on the health care needs of the resident. It is important to note that the proposed 1915 (c) waiver must demonstrate to HCFA that the average per capita cost for home and community based waiver services do not exceed the average per capita cost for Level 1 nursing facilities in order to receive federal reimbursement.

Tennessee currently operates three 1915(c) home and community based services (HCBS) waiver programs for the elderly and disabled. One Home and Community Based Waiver for the Elderly and Disabled has the capacity to serve 400 elderly and physically disabled residents of Shelby County. Services available in this waiver include case management, personal care, homemaker, home delivered meals, personal emergency response systems, and minor home modifications. Another Home and Community Based Services Waiver for the Elderly and Disabled has the capacity of serving a total of 150 elderly and physically disabled residents of Davidson, Hamilton, and Knox counties (50 slots are available in each of the three counties). Services available in this waiver include case management, personal care, home delivered meals, personal emergency response systems, and minor home modifications. Some of these waivers currently have a list of people who are waiting to participate and who need services. None of these waivers provide services to individuals in alternative residential settings. The PACE program that is described below provides for a full continuum of care, and the proposed HCBS waiver will allow services to be provided to individuals living in assisted living facilities.

Additionally, a Medicare/Medicaid dual capitation Program of All-Inclusive Care for the Elderly (PACE) is under development in Hamilton County. The Bureau of TennCare has recently received approval from the Health Care Financing Administration (HCFA) to begin the PACE project. This will provide another alternative to institutional care in this county for approximately 120 enrollees at the current site.

Description of Services for the Elderly and Disabled and Their Funding Sources

LTC services vary in definition, depending on a number of factors, including payment source and service provider. The following list of services is intended to provide a general description of individual services currently available in Tennessee. The services listed may not be available in all areas of the state. Commission on Aging staff collected information related to the availability of non-TennCare services. The data collected may not accurately reflect service availability in some areas since some agencies did not respond to the Commission's request for information.

Case Management

Case management has been a standard element in the provision of long-term care. Case management involves arranging, coordinating, and monitoring the effectiveness of long-term care services, including developing, reviewing and updating the plan of care. Fewer than 3,000 total

people in all programs statewide receive comprehensive case management. Case management is most effective when caseloads are manageable, in-home services are available in the community, and there is a good system of coordination with hospital and medical service.

Currently, case management services are available through the Area Agencies on Aging. Also, the Department of Human Services, Division of Adult Protective Services, provides case management to those who need protective services due to abuse or neglect (funding provided by Social Services Block Grant and TennCare). Medicare programs offer case management services through home health agencies and Medicare managed care plans. TennCare Managed Care Organizations (MCO) provide case management services to enrollees with intensive health care needs. Additionally, TennCare HCBS waivers for the elderly and disabled provide case management services.

Adult Day Care/Adult Day Health

Adult Day Care can provide a variety of services, including respite care, social activities, health education, personal care, meals, and monitoring. Many Adult Day Care Centers are operated as social models, providing activities, congregate meals, caregiver respite, and supervision in a safe environment.

Adult Day Health is typically a more medically oriented model, providing both health and social services. Adult Day Health is usually available four or more hours daily on a regular scheduled basis in an adult day care facility, within local nursing homes, or in other community settings. Services provided include those available in adult day care centers and additional services such as medical monitoring, medication administration, and more extensive assistance with activities of daily living (i.e. mobility, using the bathroom and incontinence care, eating).

Adult Day Care is currently not available in all areas of the state. Adult day care programs exist in 38 counties. A total of 40 centers across the state have the capacity to provide services to approximately 700 individuals. Licensure regulations for Adult Day Care are currently being developed by the Department of Human Services (DHS). DHS probably will begin statewide implementation of the Adult Day Care licensure program in the spring of 1999. Licensure will be required for programs serving ten or more clients. Most existing programs are heavily concentrated in urban areas and are based on a social model. They are generally not equipped to provide nursing services and are usually open for limited hours during the day.

There is currently no Medicare or TennCare funding for Adult Day Care; therefore, 95% of adult day care services are privately paid. Some not-for-profit providers cover adult day care services through a sliding scale reimbursement system subsidized by the Social Services Block Grant (SSBG) or various private pay sources. In 1997, 1509 adults received adult day care services supported by SSBG funds in the amount of \$564,850 (not inclusive of local match dollars). There are two adult day care sites in Tennessee that provide services to veterans through a contract with the Veteran's Administration.

Adult Day Health is even more limited in availability than Adult Day Care. The review of services indicates that of the 40 existing day programs, only eight currently are able to provide Adult Day Health or have the capacity to easily arrange for the provision of Adult Day Health services.

Chore Services

Chore services provide assistance to persons who have difficulty with heavy housework (i.e. washing walls and windows, scrubbing floors, cleaning attics and basements to remove fire and health hazards) and/or yard work (i.e. mowing lawns, raking leaves, shoveling snow from sidewalks). These services are funded through the Older Americans Act, local government, and other local support. During Fiscal Year 1997-98, the Commission on Aging and its designated Area Agencies on Aging could track chore services only in 9 counties with 105 people served. Volunteers provide services in other localities.

Conservatorship/Guardianship

The Public Guardianship for the Elderly Program (T.C.A. 34-7-102), operated by the Commission on Aging, assists persons 60 years of age and over who are unable to manage their own affairs and who have no family member, friend, bank or corporation willing and able to act on their behalf. This program is available statewide with offices located in the nine Area Agencies on Aging. Through this program, approximately 420 persons were provided services during the last year, including conservatorship of person and or property, durable power of attorney for health care, and durable power of attorney for finances. A conservator may provide assistance with health care and financial decisions and may arrange services to provide a safe, protective environment in the least restrictive setting. As an attorney in fact, the district public conservator may pay bills for the client and make health care decisions when the person is no longer capable of doing so.

The Department of Human Services, Division of Adult Protective Services (APS) serves as the surrogate decision maker for individuals in need of protective services when the courts have determined that the individual lacks the capacity to make decisions related to health and safety. APS does not act as the surrogate decision-maker for financial or property related matters. In 1997, an estimated 173 individuals received these services through APS (funding provided by Social Services Block Grant and TennCare).

Private nonprofit and proprietary organizations also may provide additional guardianship/conservatorship services.

Home-Delivered Meals

Home delivered meal programs typically provide one nutritionally balanced meal per day to elderly and disabled individuals who may have difficulty with meal preparation.

The home-delivered meals program (Meals on Wheels) is the largest long-term care program operated by the Commission on Aging. The program is available in all 95 counties in Tennessee. Volunteers are an essential component of the home-delivered meals program. Churches and other volunteer organizations deliver the majority of meals to the homes of elderly participants. The Older Americans Act funds are used to purchase food and provide staff for the preparation of meals and the coordination of delivery services. Approximately 16,000 persons were assisted with home-delivered meals last year. Older Americans Act funds also provide food and staff to operate congregate meal sites throughout the state.

The home-delivered meals program has a waiting list of 2,183 persons. Lack of funding, lack of adequate numbers of volunteers, and lack of adequate transportation for volunteers prevent the provision of home delivered meals to many individuals who could benefit from this service.

Home delivered meals also are provided through TennCare Home and Community Based Waivers for the Elderly and Disabled.

Homemaker Services

Homemakers provide assistance to persons who have functional limitations that prevent them from performing household tasks. In some situations, homemakers provide limited personal care services, as well. Examples of homemaker services include such activities as meal preparation and menu planning, shopping, financial management, and performing light housework. The demand for homemaker services in Tennessee greatly exceeds the availability of the service.

The homemaker services program operated by DHS provided homemaker services to approximately 19,480 individuals in 1997. DHS homemaker services are funded through a combination of state dollars (\$500,000) and federal Social Services Block Grant monies (\$2,981,871). Homemaker programs are found in 82 counties; however, at the end of 1997 there were 3,438 individuals on the waiting list for homemaker services.

Homemaker services are available through the TennCare HCBS Waiver for the Elderly and Disabled in Shelby County.

Home Health Care

Tennessee has historically relied heavily on home health for the provision of community based LTC. Home health agencies provide skilled nursing and rehabilitative care as well as personal care. Home health services are available statewide. In 1996, 287 home health agencies served 172,637 patients of all ages, almost seventy-five percent of whom were elderly. [Report 6, Joint Annual Report for Home Health Agencies, FY 1995-1996, Office of Health Statistics and Information, Department of Health.]

Medicare is a major funding source for home health care in Tennessee. In 1997, Medicare funded 91.3% of home health care in Tennessee, serving 104,755 persons. TennCare Managed Care Organizations are responsible for providing home health services, as medically necessary, to homebound individuals. TennCare Managed Care Organizations reimbursed 2.9% of home health services in 1997, and private pay reimbursement was utilized for the remaining 3.4% of home health services. [Report 2, Joint Annual Report for Home Health Agencies, FY 1996-1997, Office of Health Statistics and Information, Department of Health.]

Personal Care

Personal Care staff provides assistance with activities of daily living including eating, dressing, bathing, using the bathroom, and mobility. Personal care is often identified as one of the most desirable LTC services.

Primarily home health agencies and residential facilities, such as assisted care living facilities, residential homes for the aged, and nursing facilities provide personal care. Adult day care or adult day health centers, or other community service agencies also can provide personal care. As a discrete service separate from home health, personal care is available in 19 counties.

Public funding for personal care services in the home is minimal. Tennessee has not elected to cover personal care as a state plan optional service in the TennCare program. While some funds are available through the three HCBS Waivers for the Elderly and Disabled for personal care services in the home and community setting, public funds for this purpose have been limited. Without supplementary resources, many of the elderly and disabled frequently do not have sufficient financial resources to purchase personal care services. For Medicare recipients, personal care is provided only if there is a skilled nursing or rehabilitative need. If skilled care is not required, personal care is considered custodial and is not covered by Medicare.

Personal care is available in nursing facilities, residential homes for the aged and assisted living facilities. However, there is no state or federal funding for residential options with the exception of TennCare funding for nursing facility care for eligible individuals. One must be eligible for TennCare and must meet the medical pre-admission evaluation (PAE) criteria to qualify for TennCare reimbursement.

Respite Care

Respite care is provided on a temporary, short-term basis when an individual's usual caregiver needs relief from care-giving responsibilities or becomes unable to provide care due to illness or other unforeseeable circumstances. Respite services may be provided in the home or in other community settings.

Brief respite may be provided in a designated senior center. Brief respite allows the caregiver an opportunity to complete essential tasks outside of the home such as shopping or keeping medical appointments. Respite for longer periods might be provided within a licensed nursing home or other approved facility in the community, allowing time for vacations and other relief options.

Respite service is available in 59 counties. In-home respite is often provided by unlicensed attendants, some who are volunteers. Assistance in locating and coordinating respite services is often available from the Alzheimer's Association and from counseling agencies.

Minimal funding is available for respite care. Respite services are usually privately paid, which prohibits access to many individuals in need of respite services. However, respite often is available to caregivers when someone is in the home providing home health or personal care or homemaker services.

Assisted Transportation

Assisted transportation can encompass a variety of services, ranging from escort to social events to emergency ambulance transportation.

Both TennCare and Medicare reimburse emergency and non-emergency ambulance transportation. Non-emergency transportation to medical services and appointments is a TennCare covered benefit and is provided by the TennCare Managed Care Organizations.

Local Human Resource Agencies are major providers of transportation services. Funding for these transportation services is provided by a variety of sources, including the Older Americans Act. Transportation may be provided to medical appointments, congregate meal sites, or other activities (i.e. shopping) and social functions. Priority is given to individuals who need transportation to medical appointments and meal sites. Wheel chair accessible transportation is available and assistance is provided with getting on and off the van. Formal assisted transportation services are available in 25 counties.

Assistive Technology/Personal Emergency Response Systems/Home Modifications

Assistive technology refers to adaptive aids, controls, or appliances which enhance an individual's ability to perform activities of daily living; to perceive, control, or communicate with the environment; or to access the community. Assistive technology products may be purchased commercially or customized to meet the needs of the individual.

Assistive technology devices may be relatively simple and inexpensive or complex and costly. Inexpensive devices may include such things as phone amplifiers, hand held magnifiers, grabbers or reachers, large digit phones, or clocks and watches with voice capabilities. More costly and complex devices may include augmentative communication aides (to assist persons with hearing, speech, or vision impairments) or adaptive equipment such as environmental control units and devices (i.e. patient lifts/mobility devices, vehicle lifts/adaptations, hygiene aids/devices, units to turn on lights, appliances, or adjust thermostats).

Assistive technology services include evaluation of client need and assistance with the selection, design, fit, customization, adaptation, and repair of products or devices. The services also include instruction in the use and care of assistive devices.

Home modifications may include grab bars and ramps, widening of doors, specialized electrical/plumbing systems to accommodate medical equipment, or modification to bathroom facilities.

A Personal Emergency Response System is an electronic device that enables individuals who would otherwise require extensive supervision and assistance to stay alone safely for portions of the day. Such systems provide a means to secure assistance in emergency situations.

Assistive technology services are available statewide. Presently, there are four nonprofit Technology Assistance Centers (established as part of the Federal Technology Act) for people with disabilities. The STAR center in Jackson serves west Tennessee. Middle Tennessee Access Center in Nashville serves middle Tennessee. The East Tennessee Technology Access Center

in Knoxville serves east Tennessee and Signal Center in Chattanooga serves Hamilton County. Other providers include hospital rehabilitation centers and freestanding centers.

Home modifications, including ramp construction, are done on a small scale by a number of agencies. Home modification is heavily dependent upon volunteer effort, both in terms of supplies and manpower. According to the Commission on Aging, there are long waiting lists for home modifications.

TennCare Managed Care Organizations are responsible for medically necessary durable medical equipment, prosthetics and orthotics, and medically necessary assistive technology such as augmentation communication devices for children.

The TennCare HCBS waivers for the elderly and disabled cover modifications for homes and Personal Emergency Response Systems.

Residential Options

Persons who have activities of daily living deficits may not have sufficient family or community resources to be able to live alone safely. Although there may be a strong desire to remain in the home, safety concerns may prompt the elderly and disabled to seek care in a setting which offers both housing and supportive services, such as a nursing facility, an assisted care living facility, or a residential home for the aged. All three of these options are available statewide; however, reimbursement from public funds is limited, with the exception of TennCare reimbursed nursing facility care.

The Tennessee Department of Health licenses and regulates nursing facilities, assisted care living facilities, and residential homes for the aged. Supportive housing with less than four residents is not licensed and is, therefore, difficult to inventory. In rural areas, these types of residences may fill a housing gap where other solutions are unlikely.

Medicare reimburses for skilled nursing facility services up to 100 days per year. TennCare provides additional reimbursement for Level 2 (skilled) care for those who meet medical and financial criteria and who are not Medicare eligible or who have exhausted Medicare benefits.

Level 1 nursing facility care (formerly called ICF care) is reimbursed through TennCare for those who meet medical and financial criteria

Tennessee currently has two license categories for residential options outside of institutional nursing facilities. In April 1996, the Tennessee legislature passed Public Chapter 818 that added a new license category - Assisted-Care Living Facilities (ACLF). Rules and regulations were promulgated and became effective in April of 1998. Also, the legislature enacted Public Chapter 869 during the second session of the 100th General Assembly. This legislation addressed issues relative to revising definitions concerning residents and licensure of certain homes for the aged.

ACLFs provide services to primarily aged ambulatory persons who require domiciliary care and who may require non-medical living assistance services. They also may provide medical services such as medication procedures and administration of medications that are typically self-administered, emergency response services and home care organization services as prescribed by a physician's order and as allowed by law. All other services may be provided to a resident of an assisted care living facility, but only by a licensed home care organization. Such services include part-time or intermittent nursing care; physical, occupational and speech therapy; medical social services; medical supplies (other than drugs and biological); and durable medical equipment that a licensed home care organization is authorized to provide to homebound persons. They are not authorized to provide home health aides, however. A resident of an ACLF may receive certain skilled services for a period not to exceed 21 days or for a longer period if, within such 21 day period, the department is notified of same and does not object. The facility also may operate a secured unit for persons in all but the latter stages of Alzheimer's Disease and Related Disorders.

Residential Homes for the Aged accept primarily aged residents who are ambulatory and who require permanent domiciliary care. Residents receive assistance with personal services and may receive professional medical or nursing observation and/or care on a short-term basis for a temporary illness, injury, or disability, as long as such care can be safely and appropriately given in that setting and is provided by licensed professionals. Licensed nursing personnel may be employed for medication administration and other services if the facility desires. New rules have been promulgated for the Homes for the Aged category but are not yet approved.

The Residential Homes for the Aged Quality Enabling Program is currently operating in 18 counties in Tennessee and is available only for support services provided in licensed residential homes for the aged (RHAs). The program is currently funded at \$525,000. Thirty-nine facilities currently participate in the program, allowing Quality Enabling Funds to be utilized by approximately 160 residents.

The rate paid to participating facilities is \$13 per day less patient income. By law, eligible residents are required to have a total income which does not exceed \$600 per month and whose income is limited to payments made under the Social Security Act.

Participating RHAs are required to provide enhanced services to residents and to produce receipts/documentation of the cost for those services. The most common enhanced services provided by participating RHAs are:

- Transportation services to physicians' offices, social gatherings, religious services
- Additional activities, such as theater passes, cable television, magazine subscriptions
- Residents' environment, such as purchasing/repairing personal furniture and appliances
- Residents' self-esteem, such as purchasing new clothing, shoes, cosmetic/grooming aids
- Residents' health, such as physician/pharmacy reimbursements, provision of special diets
- Residents' care and protection, such as hiring additional staff/sitters, upgrading security systems.

The Department of Health and Department of Mental Health and Mental Retardation have studied this program to look into possibilities for statewide expansion. Expansion will be discussed later in this Plan. The report by the Department of Health on the Quality Enabling Program is provided in Attachment 5.

Volunteer Services

Volunteers, particularly at the state funded senior centers, assist in the provision of appropriate services such as making daily telephone calls, shopping assistance, visiting, and chore services.

Overview of the Medicare Program and Associated Long-Term Care Services

The Federal Medicare program is the largest source of funds for public health care services provided to the elderly and disabled other than the State's TennCare program. There are two programs under Medicare, the Federally funded Part A program and the beneficiary premium funded Part B program. Part A benefits include the following:

Covered Services	Beneficiary Pays*
Hospital Stays: Semiprivate room, meals, general nursing and other hospital services and supplies (but not private duty nursing, a television or telephone in the room, or a private room unless medically necessary).	For each benefit period, beneficiary pays: • A total of \$764 for a hospital stay of 1-60 days. • \$191 per day for days 61-90 of a hospital stay. • \$382 per day for days 91-150 of a hospital stay.** • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies.	For each benefit period, beneficiary pays: • Nothing for the first 20 days. • Up to \$95.50 per day for days 21-100. • All costs beyond the 100th day in the benefit period.
Home Health Care: Intermittent skilled nursing care, physical therapy, speech/language pathology services, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	Beneficiary pays: • Nothing for Home Health Care services. • 20% of approved amount for durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers).
Hospice Care***: Pain and symptom relief and supportive services for the management of a terminal illness. Home care is provided. Also covers necessary inpatient care and a variety of services otherwise not covered by Medicare.	Beneficiary pays: • Limited costs for outpatient drugs and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest).
Blood: From a hospital or skilled nursing facility during a covered stay.	Beneficiary pays: • For the first 3 pints.

* 1999 Part A & B premium, coinsurance, and deductible amounts will be available before January 1, 1999.

** Beneficiary has 60 reserve days that may only be used once. For each reserve day, Medicare pays all covered costs except for a daily coinsurance (\$382 in 1998).

*** Beneficiary must meet certain conditions in order for Medicare to cover these services.

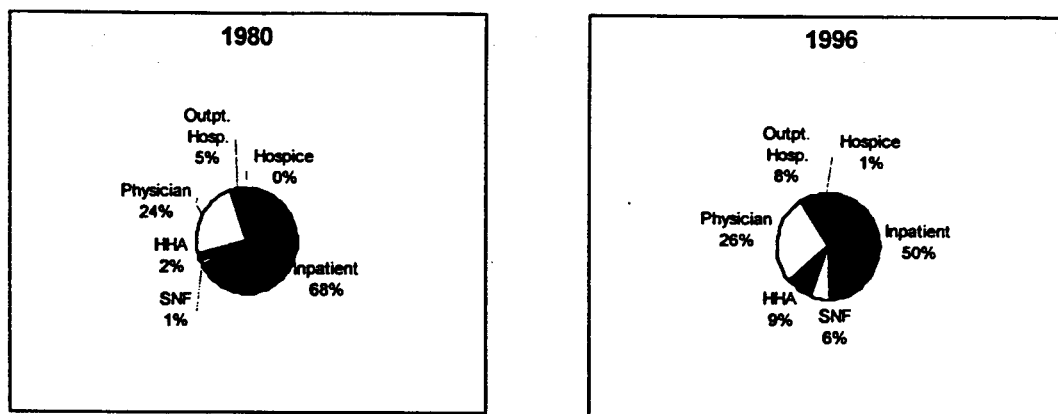
Part B services include the following:

Covered Services	Beneficiary Pays*
Medical Expenses: Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment (DME).	Beneficiary pays: • \$100 deductible (pay once per year). • 20% of approved amount after the deductible, except in the outpatient setting. • 50% for most outpatient mental health. • 20% of first \$1,500 for all physical therapy services and 20% of first \$1,500 for all occupational therapy services, and all charges thereafter. (Hospital outpatient therapy services do not count towards limit.)
Clinical Laboratory Service: Blood tests, urinalysis, and more.	Beneficiary pays: • Nothing for services.
Home Health Care: (If insured does not have Part A.) Intermittent skilled care, home health aide services, DME and supplies, and other services.	Beneficiary pays: • Nothing for services. • 20% of approved amount for DME.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.	Beneficiary pays: • No less than 20% of the Medicare payment amount (after the deductible).
Blood: As an outpatient, or as part of a Part B covered service.	Beneficiary pays: • For the first 3 pints plus 20% of approved amount for additional pints (after the deductible).

* 1999 Part A & B premium, coinsurance, and deductible amounts will be available before January 1, 1999.

Note: Actual amounts person must pay for coinsurance are higher if the doctor does not accept assignment.

Growth of the Medicare program has been tremendous mainly in the post-acute service area. The following pie charts show the percentage of Medicare payments to different provider types for the nation as a whole in 1980 compared to 1996. Note that the inpatient services percentage has declined from 68% of the total payments in 1980 down to 50% in 1996.



HCFA/Office of Actuary, 1997

It should be noted that the rate of Medicare program growth of around 7% percent is generally considered to be unsustainable. Even with the latest changes to reduce Medicare growth through the Balanced Budget Amendment of 1997, HCFA estimates that the Medicare Hospital Insurance (HI) Trust Fund will become insolvent in the near future. At the end of 1997, for the third year in a row, the Medicare (HI) Trust Fund fell from the prior year's end limit. Assets in the Medicare HI Trust Fund fell 7.5% below 1996. (HCFA / Office of Actuary, 1998)

Changes targeted to reduce growth of the Medicare program may have a higher impact on beneficiaries in the State of Tennessee than in most other states. As an example, because beneficiaries in Tennessee utilize the home health benefit at a significantly higher rate than other states, recent reductions in Medicare services most likely will impact Tennessee more than other states. The following chart shows the utilization of the Medicare home health benefit in the sample of states compared in another section of this report.

Medicare Home Health Data 1995

State	1995 Total Medicare HHA Payments (in thousands)	1995 Average Payment Per Visit	Average Payment Per Person
AL	459,796	47	5,675
AR	172,533	48	3,870
GA	525,269	52	5,567
KY	211,117	53	3,595
NC	325,635	60	3,358
OR	91,237	82	3,116
SC	189,420	57	3,939
TN	730,412	57	6,886
WA	137,800	79	3,055

HCFA Office of Actuary, 1998

This example shows that the utilization of Medicare Home Health Services has been significant when compared to other publicly funded long-term care spending areas, especially in Tennessee. Tennessee spent \$205 million more than Georgia, the next closest state in expenditures, although some states have a significantly larger population.

COMPARISON OF LONG-TERM CARE SERVICES PROVIDED BY SELECTED STATES

Introduction

Health care expenditures are steadily rising in the United States of America, especially pertaining to the publicly funded programs of Medicare and Medicaid. The United States Congress attempted to slow this growth by the passage of the Balanced Budget Amendment of 1997 (BBA). The BBA most likely will slow the rate of public health care expenditure growth over the next few years. However, the Health Care Financing Administration (HCFA) still estimates that in the year 2007, \$2.1 trillion will be spent on health care related services whereas, in 1996, \$1.0 trillion was spent.

Seven states within the Southeastern part of the United States (Alabama, Arkansas, Georgia, Kentucky, North Carolina, South Carolina, and Tennessee) were selected for comparison. They represent similar populations, economic patterns, per capita incomes, and geographic proximity. In addition, Oregon and Washington were selected because of their extensive use of HCBS services and widespread attention.

Demographics of States Compared

The states selected within the southeast have somewhat similar demographic characteristics. The chart below (based on 1996 information) shows the range of total population, percentage of the population over 65 years old, and per capita income. The percentage of the over 65 population ranges from 10.0% - 14.5% and personal per capita income ranges from \$15,995.00 to \$19,249.00. (Both Oregon and Washington have higher per capita incomes than the southeastern states surveyed.)

State	1996 Total Population Estimate	1996 Population Over 65	1996 Personal Income Per Capita
AL	4,545,000	13.0%	17,129.00
AR	2,483,800	14.5%	15,995.00
GA	7,200,900	10.0%	19,249.00
KY	3,860,200	12.6%	16,889.00
NC	7,195,700	12.5%	18,670.00
OR	3,140,600	13.6%	19,437.00
SC	3,673,300	12.0%	16,861.00
TN	5,256,100	12.5%	18,439.00
WA	5,430,900	11.6%	21,774.00

US Census Bureau: State Profiles 1998

Nursing Facility Data

The primary service provided to the elderly by Medicaid programs is nursing facility care. The following charts show comparisons in general nursing facility (NF) care for the sample. These charts show that Tennessee's nursing home population does not appear to be significantly different than the sample of southeastern states.

Nursing Facility Beds per 1,000 Elderly 1996

As can be seen in the chart below, Arkansas is the only state in sample exceeding Tennessee in the amount of beds per 1,000 elderly population. The national average is 57 beds per 1,000 for the population 65-84 years of age and 454 beds for ages 85 and older.

State	NF Beds per pop. Ages 65 – 84	NF Beds per pop. Ages 85+
AL	47	454
AR	86	659
GA	58	502
KY	54	431
NC	47	419
OR	36	272
SC	40	381
TN	63	512
WA	49	386

HCFA-OSCAR data for current surveys as of 1/31/97 and US Bureau of Census, 1997 Statistical Abstract.

Percentage of Nursing Facility Residents by Payer Source 1997

According to the information below, Tennessee's nursing homes are not significantly different from the sample in the types of patients in nursing facility care by payer source. The average Medicaid mix of patients for the nation as a whole is 67.6%.

State	Medicare	Medicaid	Other
AL	9.8%	71.5%	18.6%
AR	7.4%	74.4%	18.2%
GA	8.1%	77.3%	14.6%
KY	10.2%	75.0%	14.8%
NC	11.0%	74.0%	15.0%
OR	7.9%	60.3%	31.8%
SC	11.8%	70.7%	17.5%
TN	10.2%	73.3%	16.6%
WA	10.1%	63.9%	25.9%

HCFA-OSCAR Form 672, current surveys as of 3/1/98

State Nursing Home Expenditures

1996

Nursing facility care can be the largest single line item in a Medicaid budget. The national average percentage of Nursing Facility care to total Medicaid expenditures is 20.3%. Tennessee's percentage, 20.0%, is just slightly less than that of the national average.

State	Total Medicaid Expenditures	Total Medicaid Nursing Facility Expenditures	Percent of NF Payments to Total Medicaid Expenditures
AL	2,036,656,600	446,192,600	21.9%
AR	1,242,555,000	295,433,700	23.8%
GA	3,560,561,500	645,137,500	18.1%
KY	2,087,296,800	404,987,500	19.4%
NC	4,088,863,500	744,176,300	18.2%
OR	1,490,979,900	164,869,100	11.1%
SC	2,013,832,100	273,131,200	13.6%
TN	3,137,642,200	627,649,800	20.0%
WA	3,050,970,400	522,173,100	17.1%

Medicaid Statistics: Program and Financial Statistics, 1996

Note: Some of these statistics may have a variance due to how a program is financed. For example, some states may have a provider tax that passes through a provider. This "pass through" may show as an expenditure, depending on how a state reports the tax.

Nursing Facility Patient Assistance with Activities of Daily Living and Occupancy Rates - 1996

The chart below shows the average assistance required by number of activities of daily living. Activities of daily living are areas of bathing, transferring, dressing, eating, and toilet use. The national average number of ADL's with which patients in nursing facilities require assistance is 3.87. Tennessee's average number, 3.89, is almost precisely in line with the national average. In addition, the chart also shows the average occupancy for nursing facilities in the sample. The average national occupancy rate is 86%. Tennessee's average occupancy rate is slightly higher at 87.0%.

State	1996 NF Residents' Average ADL's	1996 Average NF Occupancy Rate
AL	3.71	92.0%
AR	3.62	74.0%
GA	3.66	91.0%
KY	4.18	86.0%
NC	3.85	92.0%
OR	3.85	80.0%
SC	4.03	85.0%
TN	3.89	87.0%
WA	3.86	82.0%

HCFA-OSCAR Form 672, current surveys as of 3/1/98

Average Daily Direct Nursing Care Hours by position 1997

The chart below shows the average amount of hours by direct care nursing staff per patient day reported by nursing facilities. The national average for Certified Nursing Assistants was 2.3 hours. Direct care hours per patient day by Licensed Practical Nurses was .7 hours and for Registered Nurses it was .5 hours.

State	Certified Nursing Assistant	Licensed Practical Nurse	Registered Nurse
AL	2.7	1.1	0.3
AR	2.2	0.8	0.1
GA	2.3	0.9	0.2
KY	2.5	1.0	0.3
NC	2.6	0.8	0.4
OR	2.4	0.4	0.6
SC	2.6	1.0	0.3
TN	2.2	0.9	0.2
WA	2.8	0.6	0.7

HCFA-OSCAR Form 672, current surveys as of 3/1/98

Older Americans Act Services

The Older Americans Act provides funding to each state for the following: supportive, nutrition, in-home, and elder rights services for older persons in each state. In Tennessee, these services are primarily granted through the Tennessee Commission on Aging and provided through the Area Agencies on Aging and their local network of providers. These services include but are not limited to:

Personal Care	Homemaker
Adult Day Care	Case Management
Assisted Transportation	Legal Assistance
Information and Assistance	Outreach
Health Promotion	Recreation
Chore	Public Education
Nutrition	Ombudsman
Minor Home Repair	

However, since these funds are very limited in each state, other sources of revenue, such as Medicaid funding, are very important. The chart on the next page compares the sample of states and the programs offered. Other programs that are not included may exist in a state on a regional level. For example, a state may have a small demonstration program funded that does not have a significant impact on the state infrastructure of services to the elderly and, therefore, it is not included on this list.

Home and Community Based Services

Home and Community Based services to the elderly are primarily provided by state administrations through their Medicaid programs. However, a number of states have home and community based services funded with state-only dollars. These programs often target the non-Medicaid populations and/or those that do not meet the functional "at risk" definition needed to receive 1915 (c) HCBS waiver services. When Medicaid funding is used, only two options exist for state administrations. Those choices are to either place HCBS services under the Medicaid state plan, making it an option for every Medicaid enrollee to be eligible, or to place those services under a Medicaid waiver. The second main funding source for HCBS services usually comes from the Older Americans Act, which is administered by each State Unit on Aging. The chart on the next page compares, state by state, which services are offered.

Comparison of Services

Service	Alabama	Arkansas	Georgia	Kentucky	North Carolina	Oregon	South Carolina	Tennessee	Washington
Older Americans Act									
Meals									
Home Delivered	X	X	X	X	X	X	X	X	X
Congregate	X	X	X	X	X	X	X	X	X
Access Services	X	X	X	X	X	X	X	X	X
In-Home Services	X	X	X	X	X	X	X	X	X
Community Svcs.	X	X	X	X	X	X	X	X	X
Senior Centers	X	X	X	X	X	X	X	X	X
Legal Assistance	X	X	X	X	X	X	X	X	X
Ombudsman	X	X	X	X	X	X	X	X	X
Personal Asst.*		X							
Medicaid									
Home and Community Based Waiver									
1915(c) Waiver**	X		X	X	X	X	X	X	X
Case Mgmt.	X			X	X	X	X	X	X
Homemaker/Chore	X	X	X	X	X	X	X	X	X
Companion Svcs.						X	X		X
Nursing Aide Care			X		X	X		X	X
Home Del. Meals	X	X			X	X	X	X	X
Minor Home Mod.			X	X	X	X	X	X	X
Med. Supplies					X				
Adult Day Care		X	X			X			X
Adult Day Health	X	X		X	X	X	X		
Adult Foster Care		X				X			
Residential Care						X			X
Assisted Living						X			
Board and Care			X						
Respite									
Non-institutional				X	X		X		
Institutional	X	X			X				
PERS		X	X		X				
Other Medicaid Programs									
Assisted Living					X*				X
2176 Waiver		X**							

* Provision included in Medicaid State Plan.

** Arkansas does not have a 1915(c) waiver, but does have a 2176 waiver.

Medicaid Waivers

As stated earlier, state administrations use Medicaid as the primary source of funding for long term care because of the federal financial participation. A few states also have obtained 1115 research and demonstration waivers (i.e., Arizona and Minnesota) and at least one state (Texas) has received a combination 1915 (c) and 1915 (b) waiver to implement a LTC managed care program for the elderly and disabled populations. However, in the fee for service program, because of program restrictions and state lack of power to control growth, states have pursued implementing 1915 (c) waivers. These waivers allow states to provide greater flexibility in the services offered and to control the number of enrollees allowed to enter the program to restrain growth. Below is a chart that compares the total expenditures under each state's waiver authority.

1915 (c) Waiver Expenditures 1997

State	Enrollees (Unduplicated)	HCBS Per Capita Cost	HCBS Program Cost*
AL	6,455	5,000.00	32,275,700.00
AR	7,681	2,621.00	20,129,200.00
GA	12,810	3,313.00	42,433,100.00
KY**	11,500	2,514.00	28,911,000.00
NC	8,700	12,963.00	112,774,600.00
OR	7,372	5,703.00	42,044,100.00
SC	8,754	4,526.00	39,616,800.00
TN***	400	8,386.00	3,354,500.00
WA**	17,013	7,346.00	124,977,500.00

Reported on individual state 372 reports. Figures do not reflect state Medicaid Plan costs

* Does not include acute care costs.

** Figures reported by National Association of State Medical Directors

*** Does not include ADAPT waiver costs. In year surveyed program was just being implemented.

Common Medicaid Waiver Services - Comparative Data 1997

Case Management

State	Enrollees	Amount
AL	6,430	5,850,700
AR		
GA		
KY	N/A	N/A
NC	8,504	8,220,800.00
OR		
SC	8,754	4,723,500.00
TN	399	492,600.00
WA	N/A	N/A

Reported on individual state 372 reports.

Note: No number denotes that the service is not offered.

**Personal Care / Homemaker / Chore Services
1997**

State	Enrollees	Amount
AL	5,321	14,908,600.00
AR	1,527	1,381,600.00
GA	9,306	22,550,100.00
KY	N/A	N/A
NC	4,517	46,503,000.00
OR	6,405	26,664,000.00
SC	7,885	27,142,600.00
TN	78	89,640.00
WA	N/A	N/A

Reported on individual state 372 reports.

Note: No number denotes that the service is not offered.

**Nurse Aide Services
1997**

State	Enrollees	Amount
AL	2,356	4,766,700.00
AR		
GA	2,388	2,829,100.00
KY	N/A	N/A
NC	4,967	55,648,100.00
OR		
SC	1,370	693,800.00
TN	400	2,438,000.00
WA	N/A	N/A

Reported on individual state 372 reports.

Note: No number denotes that the service is not offered.

**Home Delivered Meals
1997**

State	Enrollees	Amount
AL		
AR	4,315	3,209,200.00
GA	1,168	919,000.00
KY	N/A	N/A
NC	261	96,000.00
OR	530	252,500.00
SC		
TN	260	314,600.00
WA	N/A	N/A

Reported on individual state 372 reports.

Note: No number denotes that the service is not offered.

**Personal Emergency Response System (PERS)
1997**

State	Enrollees	Amount
AL		
AR	5,172	1,286,500.00
GA	5,622	1,226,900.00
KY	N/A	N/A
NC	3,092	575,100.00
OR		
SC		
TN		
WA	N/A	N/A

Reported on individual state 372 reports.

Note: No number denotes that the service is not offered.

**Adult Day Care
1997**

State	Enrollees	Amount
AL		
AR	163	535,700.00
GA		
KY	N/A	N/A
NC		
OR	24	53,500.00
SC		
TN		
WA	N/A	N/A

Reported on individual state 372 reports.

Note: No number denotes that the service is not offered.

**Adult Day Health Care
1997**

State	Enrollees	Amount
AL	189	322,317.00
AR	54	173,300.00
GA	504	2,003,500.00
KY	N/A	N/A
NC	148	429,200.00
OR		
SC	1,529	6,053,900.00
TN		
WA	N/A	N/A

Reported on individual state 372 reports.

Note: No number denotes that the service is not offered.

Respite Care (Non-institutional)
1997

State	Enrollees	Amount
AL*	2,229	6,427,500.00
AR	2,029	3,538,600.00
GA	2,129	4,419,600.00
KY	N/A	N/A
NC	106	92,800.00
OR		
SC	1,370	693,800.00
TN		
WA	N/A	N/A

*Includes skilled and unskilled providers.
Reported on individual state 372 reports.

Respite Care (Institutional)
1997

State	Enrollees	Amount
AL		
AR		
GA		
KY	N/A	N/A
NC	7	4,400.00
OR		
SC		
TN		
WA	N/A	N/A

Reported on individual state 372 reports.

Note: No number denotes that the service is not offered.

Adult Foster Care
1997

Adult foster care homes are private residences that provide care to several (usually less than 5) residents. They offer room and board and personal care from a caregiver in the home 24 hours per day. The southeastern states are not especially representative of the rest of the nation in the provision of adult foster care. Many states, in addition to Oregon, cover alternative residential settings such as adult foster care.

State	Enrollees	Amount
AL		
AR	1	6000.00
GA		
KY	N/A	N/A
NC		
OR	1,843	10,348,800.00
SC		
TN		
WA	N/A	N/A

Reported on individual state 372 reports.

Note: No number denotes that the service is not offered.

Residential Care Facilities/Assisted Living Facilities/Specialized Living Facilities - 1997

Oregon is the only state surveyed that provides Residential Care Facilities/Assisted Living Facilities/Specialized Living Facilities as a service in their home and community based waiver. (Other states listed in the chart on page 30 offer this service through their state Medicaid plan or other Medicaid programs). These facilities accommodate a larger number of residents. They offer assistance with full dining room services, housekeeping, and call services for help when needed. In addition, assistance with physical care needs and medication monitoring are often included.

State (Oregon)	Enrollees	Amount
Residential Care Facility	348	1,474,400.00
Assisted Living Facility	106	1,028,500.00
Specialized Living Facility	196	2,190,600.00

Reported on individual state 372 reports.

The "Consumer-Directed" Method of Providing Long-Term Care Services

The Robert Wood Johnson Foundation has been the driving force behind establishing a new method of providing health care services to meet long-term care needs. This method, known as "consumer-directed," has been modeled after programs used primarily by the developmentally disabled population where it is known as "self-determination". This type of program gives enrollees tremendous choice and control over how services are to be delivered on an individual level. In its more limited form, "consumer-directed" means that consumers are asked their preferences in terms of what and how services should be provided. In its more expansive form, the consumer could be given a voucher or cash payment, allowing the consumer to use the dollars to purchase whatever services they desire. Enrollees are usually given an annual spending cap. Within this cap, individuals can decide how the allowed funds are to be spent. Individuals can choose from traditional and/or non-traditional providers. "Non-traditional" providers could include individuals such as neighbors and friends of the person receiving services.

Robert Wood Johnson and DHHS are currently supporting several "Cash and Counseling" Demonstrations in Arkansas, New York, New Jersey and Florida. These demonstrations, which were initiated in 1996, are intended to target the elderly as well as younger disabled consumers. They are to test the effects of "cashing out" Medicaid-funded personal assistance services by allowing a treatment group to receive a monthly cash payment in an amount roughly equal to the cash value of the services they would have received under the traditional HCBS program. The cash allowances are paid directly to the disabled or elderly persons, enabling them to select and purchase services they feel would best meet their needs. The counseling component includes various supportive services to help the consumer manage cash allowances, including information on hiring, training, supervising and paying personal assistants. DHHS had to grant waivers to these states for the projects to be implemented since, for example, Medicaid law does not allow direct cash payments to be made to enrollees.

Most states apply for a Medicaid waiver such as a 1915(c) Home and Community-based Services waiver or an 1115 Demonstration waiver in order to receive federal matching financial participation. Since the program allows use of non-traditional providers who may not have expertise in maintaining accounting documents and detailed records of services provided, financial issues with this method can result. One solution that has been used to address this issue involves creating fiscal intermediaries (FI) to administer finances for individual enrollees. FI's assume responsibility for making payments to those providing reimbursable services and make sure federal tax regulations are adhered to, thus lowering the potential for fraud. The FI's act solely as a "check writing" service and not as a manager to control services. A description of existing models in several other states is provided in Attachment 6.

The following are two historical methods states have used to receive federal financial participation through Medicaid:

- 1) to designate this service as an option in the state Medicaid program, making personal care services available to eligible Medicaid enrollees, or
- 2) to attempt to obtain HCFA approval for a 1915(c) waiver or 1115 waiver.

If a state designates this program as an option within its state Medicaid plan, then no controls can be placed on the program to control program growth. All eligible beneficiaries are able to obtain the service. In FY 1994, thirty-three states chose to cover personal care services as a Medicaid State Plan service. States often design the service requirements so that a consumer is afforded greater choice. This includes allowing: 1) personal care attendants to be "independent providers" rather than requiring them to be employees of certified home health agencies; 2) consumers to hire or fire their own attendants; and/or 3) consumers/family members to sign time sheets and/or paychecks.

The second option involves pursuing HCFA approval for a Medicaid waiver. However, HCFA has communicated that, at this time, no additional demonstration project waivers like the "cash and counseling" are being granted except for current projects already in place and applications that have already been submitted. Therefore, if HCFA remains resistant to granting additional waivers in this area, funding for the program currently would have to come from state appropriations or other sources.

However, Tennessee could pursue a "Consumer-Directed" project as a service that would be funded with only state dollars. This would give the state a comparison basis to determine whether a program of this nature should be pursued. A number of states have state-funded programs targeting the elderly and/or disabled population that provide cash payments to consumers who need community support services (i.e., Colorado's Home Care Allowance program).

INDIVIDUAL PREFERENCES IN THE PROVISION OF LONG-TERM CARE SERVICES

A recent survey, commissioned by the Tennessee Commission on Aging and carried out by the Social Science Research Institute of the University of Tennessee, documents trends in the preferences for long-term care choices by Tennesseans over the age of 18. Over one third (35%) would prefer to receive care in their own homes from family and friends. Almost two fifths (39%) would prefer home care provided by an agency. Fifteen percent would have the care provided in a board and care home or in an assisted living apartment. Five percent would have care provided in a nursing home. The study summarizes: "Should long-term care be needed, about three-fourths of our respondents prefer some sort of in-home care for themselves or members of their family. Of those willing to consider care outside the home, assisted living is preferred to nursing homes by a three to one margin. [Social Science Research Institute, University of Tennessee, Knoxville, "Long-Term Care and Caregiving in Tennessee", November, 1998, p.7.]

The public sees long-term care as a family issue and expects long-term care to be addressed with a mixture of resources: individual, family, private market, and community. "According to our results an overwhelming majority of Tennesseans —86%—are supportive of a long-term caregiving program under the aegis of state government. This support cuts across racial, income, educational, gender and geographical lines; there is simply no group that drops below the 75% level of support for such a program. The support may be firm as well, despite the fact that the respondents were reacting to a hypothetical program. Specifically, almost seven-out-of ten indicated that they would support higher taxes for a long-term care program." This program should not be limited to those with low incomes; the idea of cost sharing is attractive. In Tennessee, medically related services and nursing home care are more readily available than community alternatives. No system of LTC services, no effective single entry to a range of options, and little professional counseling are presently available—even for families with sufficient means. In rural areas basic resources often are insufficient to meet demonstrable need. Even in urban localities with more extensive programs, services are often insufficient. In spite of limited services and the complex system, coordinating mechanisms are absent or largely informal. Families provide most care needed by disabled persons and frail elderly with little advice and assistance. The recent research on long-term care in Tennessee indicates a noteworthy gap: "The need for one particular program, likely to be relatively inexpensive is clearly indicated by our results. A central clearinghouse for information concerning long-term care of all types, which is well publicized and easily accessible, should be established. This would not be especially costly, and would help alleviate the confusion many apparently experience when they search for information." By strengthening the ability of the family to continue caring for their members, inappropriate loss of community living status may be avoided. [Social Science Research Institute, Long Term Care and Caregiving in Tennessee, p.14]; [Social Science Research Institute, Long Term Care and Caregiving in Tennessee, p.15]

GENERAL CONCLUSIONS REGARDING LONG-TERM CARE SERVICE NEEDS

In evaluating long-term care programs and services in Tennessee, members of the Long-Term Care Services Planning Council and Long-Term Care Services Advisory Council have concluded that significant gaps exist in the availability and funding of home and community based long-term care services for the elderly and disabled.

While home health and nursing facility services are generally available, financial considerations often prohibit access to services. Other services such as adult day care, adult day health, personal care/homemaker, respite care, or residential care may not be sufficiently available in all areas of the state. When available, these services may not be affordable for many individuals.

While TennCare is a major funding source for those who qualify, the services funded by TennCare focus on medical rather than social need. Current TennCare HCBS waivers for the elderly and disabled are available only in four counties and provide a limited service package. To more adequately meet the long-term care needs of the elderly and disabled in Tennessee, a statewide HCBS waiver with an expanded service package is needed. In addition, there is a need for creative options for those who do not meet TennCare medical and/or financial criteria. The governor and the General Assembly will need to address the policy question of the appropriate level of state financial participation for these optional programs.

PRIMARY COMPONENTS OF THE LONG-TERM CARE SERVICES PLAN

Based on extensive evaluation and consideration of demographic and financial data, comparative data from other states, information on available programs and services, and survey results on individual preferences for long-term care services, the following have been identified as essential components of the comprehensive Long-Term Care Services Plan for the state of Tennessee.

1. DEVELOP AND IMPLEMENT STATEWIDE HCBS MEDICAID WAIVER
2. DEVELOP STRATEGIES FOR EXTENDING HCBS SERVICES TO PERSONS NOT MEETING MEDICAID ELIGIBILITY CRITERIA
3. EXPLORE OTHER SERVICE OPTIONS FOR PERSONS NEEDING LONG-TERM CARE SERVICES
4. ENHANCE AND SIMPLIFY CONSUMER AND CAREGIVER ACCESS TO LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED
5. DEVELOP ADDITIONAL INFORMATIONAL AND EDUCATIONAL INITIATIVES TO PROMOTE AND EXPLAIN LONG-TERM CARE AND HEALTH RELATED SERVICES
6. PURSUE LONG-TERM CARE INSURANCE PARTNERSHIP
7. EXPLORE WAYS TO PROMOTE LONG-TERM CARE INSURANCE PROGRAMS WITH PUBLIC AND PRIVATE EMPLOYERS

Each of these program components should be pursued with the thought of developing an integrated network of services designed to meet the State's long range goals for the long-term care delivery system. Every effort should be made to prevent program fragmentation. Steps should be taken to ensure program integration and coordination, beginning with those services currently available. Consideration must be given to the appropriate interface for the current and proposed long-term care programs (PACE, HCBS waivers, state-funded, OAA funded) and, also, to the best method of coordinating physical health and behavioral health delivery systems.

Strategies for implementing each Plan component are described in detail in the following sections.

Component 1

DEVELOP AND IMPLEMENT STATEWIDE HCBS MEDICAID WAIVER

STATEWIDE HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY AND DISABLED

Background

Public chapter 1093 requires the development of a comprehensive long-term care services plan, part of which is specified to be a statewide home and community based services waiver to serve as an alternative to nursing facility care for the elderly and disabled.

In evaluating Tennessee's existing long-term care services, a number of health care and social needs were identified among the elderly and disabled. However, limitations in state funding may prevent the immediate initiation of all needed programs. In accordance with public chapter 1093, a draft of a statewide Home and Community Based Services (HCBS) 1915(c) Waiver for the Elderly and Disabled has been prepared. This waiver would provide home and community based services to individuals meeting nursing home admission and Medicaid criteria throughout the state and would provide a needed alternative to institutionalization for the frail and financially needy elderly and disabled.

Federal regulations governing 1915 (c) waivers require that states seeking federal financial participation provide certain assurances to the Health Care Financing Administration (HCFA). One of the requirements for 1915 (c) waivers is that the average per capita expenditures under the waiver not exceed the average per capita expenditures for nursing facility care. If waiver costs exceed nursing home costs, federal financial participation is not guaranteed for the amount in excess of the nursing facility cap. This requirement ensures that waivers serve as a cost-effective alternative to institutional nursing facility care.

Another requirement for 1915 (c) waivers is that participants meet the same admission criteria utilized for admission to the Medicaid reimbursed nursing facility program. Additionally, the staff making medical eligibility determinations for the waiver program must have education and training comparable to that of the staff making determinations for the nursing facility program.

While HCFA requires that all HCBS applicants meet nursing facility eligibility criteria, there is no specific requirement that HCBS waiver enrollees receive a package of services equivalent to nursing facility care. Such enrollees may receive an alternative package of services designed to meet their health care needs in a less restrictive home and community based environment. The state must, however, provide assurances to HCFA that necessary safeguards exist to protect the health and safety of waiver enrollees.

The intent is to submit the finalized waiver application to HCFA in April 1999. The targeted date for implementation of the statewide waiver is July 1, 1999. However, federal regulations allow HCFA a ninety-day review period, which may be extended indefinitely. Implementation of the waiver cannot occur without final HCFA approval if the state is to receive federal financial participation. For initial Waiver applications, HCFA grants approval for a period of three years. A renewal of the waiver would be required at the end of this three-year period. If approval is granted for waiver renewal, federal financial participation is available for a five-year period.

TennCare will contract with the Tennessee Department of Health to serve as the Administrative Lead Agency that would oversee the project. Potential enrollees would receive information about the waiver program and assistance in applying from the Area Agencies on Aging, the Minority Applicant Pool System staff, and the Independent Living Centers as well as regional and county health departments. The specific number of enrollees to be served and the amount of state funds

available for the waiver are undetermined at this time. These determinations will be finalized when the budget for FY 2000 receives final approval.

The waiver draft is included as Attachment 7. A summary of waiver services and eligibility criteria, and a discussion of financial considerations in implementing the statewide waiver follows.

Services

Waiver services include the following:

- 1) **Case Management** - a standardized process of screening potential applicants to determine if they meet the requirements for enrollment in the Waiver; of assessing an Enrollee's medical, functional, and social needs; of developing, implementing, monitoring, and updating a goal-oriented Individual Care Plan, including a Safety Plan, that is based on the Enrollee's needs; of arranging and coordinating the provision of Waiver Services and other services regardless of payment source; of evaluating and reevaluating the Enrollee's level of care; and of monitoring the provision of services to assure that Waiver Services and other services are being provided to meet the Enrollee's needs.
- 2) **Homemaker Services** - services consisting of general household activities and chores (e.g., sweeping, mopping, dusting, making the bed, washing dishes, personal laundry, ironing, mending, and meal preparation and/or education about the preparation of nutritious appetizing meals; assistance with maintenance of a safe environment) and errands essential to the Enrollee's care (e.g., grocery shopping, having prescriptions filled) provided by a trained homemaker when the enrollee is unable to perform such activities and when the individual regularly responsible for these activities is temporarily unable to perform such activities for the Enrollee or for purposes of providing temporary respite for the regular caregiver. This service can provide temporary respite for the caregiver while the homemaker provides services to the individual.
- 3) **Personal Care Services** - services provided to assist the Enrollee with activities of daily living, household tasks, and other activities that enable the Enrollee to remain in the home, as an alternative to Nursing Facility care, including the following:
 - a. Assistance with activities of daily living (e.g., bathing, grooming, personal hygiene, using the bathroom, eating, dressing, ambulation);
 - b. Assistance with routine household tasks (e.g., meal preparation; laundry essential to the comfort and cleanliness of the Enrollee; and cleaning essential to the health and welfare of the Enrollee);
 - c. Performance of errands essential to the Enrollee's care (e.g., grocery shopping, having prescriptions filled, serving as an escort to medical appointments);
 - d. Assistance with maintenance of a safe environment;
 - e. Providing temporary respite for the regular caregiver. This service can provide temporary respite for the caregiver while the personal care provider renders personal care services to the individual.
- 4) **Minor Home Modifications** - the provision and installation of certain home mobility aides (e.g., ramps, rails, non-skid surfacing, grab bars, and other devices

and minor home modifications which facilitate mobility) and modifications to the home environment to enhance safety. Excluded are those adaptations or improvements to the home which are of general utility and which are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

- 5) **Specialized Medical Equipment and Supplies and Assistive Technology** – provision of specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

Assistive technology services include evaluation of client need and assistance with the selection, design, fit, customization, adaptation, and repair of products or devices. The services also include instruction in the use and care of assistive devices.

- 6) **Personal Emergency Response Systems (PERS)** - PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's telephone and programmed to signal a response center once a "help" button is activated. Trained professionals, as specified in Appendix B-2 of the HCBS Waiver application, staff the response center. PERS services are limited to those individuals who are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

- 7) **Assisted-Care Living Services (excluding room and board)** - a package of services that shall include personal care services, homemaker/chore services, therapeutic social and recreational services, personal laundry services, periodic nursing evaluations, and medication administration provided to individuals who reside in a licensed Assisted-Care Living Facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs and to provide supervision, safety, and security. Assistance with activities of daily living shall include, at a minimum, assistance with transfer, mobility, eating, using the bathroom, and bathroom hygiene (including incontinence care), dressing, grooming, and bathing.

Other individuals or agencies also may furnish care directly, or under arrangement with the Assisted-Care Living Facility, but the care provided by these other entities shall supplement that provided by the Assisted-Care Living Facility and shall not supplant it.

An individual who receives Assisted-Care Living Services shall not be eligible to receive any other Waiver services except Case Management, Specialized Medical Equipment and Supplies and Assistive Technology, and Nursing Services.

- 8) **Home Delivered Meals** - nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the Enrollee's home. Special diets shall be provided in accordance with the Individual Plan of Care when ordered by the Enrollee's physician.
- 9) **Nursing Services** - physician-ordered nursing services provided (one on one) to an Enrollee by a registered nurse or a licensed practical nurse that is licensed in Tennessee. Excluded are nursing services provided in a hospital, nursing facility, Intermediate Care Facility for the Mentally Retarded, or other inpatient facility. Nursing Services shall not include nursing services that would otherwise be covered through the State Plan or by a TennCare Managed Care Organization.
- 10) **Transportation** - Services offered in order to enable individuals served in the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Eligibility

Individuals wishing to enroll in the HCBS Waiver must meet the following requirements:

- 1) Be a resident of the State of Tennessee;
- 2) Meet the financial requirements to receive Medicaid as determined by the Department of Human Services;
- 3) Meet TennCare PreAdmissionEvaluation (PAE) medical criteria for level 1 nursing facility care;
- 4) Have an adequate support system to assure the health and safety of the individual while receiving services in a home and community based setting (i.e. caretaker with personal emergency response system or assisted care living facility staff)

Financial Considerations

HCFA requires that states applying for 1915 (c) waivers prepare financial documentation for their proposed waiver, including the number of persons to be served, the services to be provided, the unit cost of each service, the average usage of each service, and the projected costs of providing waiver services as compared to the cost of providing nursing facility services. The financial portion of the waiver application is located in Appendix G of the HCBS Waiver proposal. Appendix G has not been completed in the statewide waiver draft, since certain data elements, such as the number of individuals to be served, the average service usage, and the amount of state funds to be allotted to the waiver have not been specified yet.

Component 2

DEVELOP STRATEGIES FOR EXTENDING HCBS SERVICES TO PERSONS NOT MEETING MEDICAID ELIGIBILITY CRITERIA

Tennessee's concept for serving disabled and elderly persons with long-term care needs should include a long-range planning mechanism for creating a system which will serve the demonstrated needs of all Tennesseans regardless of age, disability or economic status. The proposed program of home and community based long-term care services in the Medicaid State Plan will be limited to those individuals who meet Medicaid medical necessity (PAE) and financial eligibility standards. Also, funds may be provided to the Commission on Aging for providing meals on wheels and homemaker services to additional individuals who may not meet the HCBS criteria. The governor and general assembly will have to determine public policy on how much public funding should be provided for the two programs, especially considering the Commission on Aging program will be providing services to persons who do not meet Medicaid financial criteria.

This plan will provide for initial screening of all persons capture data on services needed and services obtained, assess unmet needs and can characterize the level of financial status of those persons who are not currently served. It is generally assumed that the number of persons currently served by current PAE and Medicaid financial criteria will be similar to those served in the Waiver or by the Commission on the level of support from other programs. The aging process will be used to age each client and chart unmet needs. Planning services will be provided for individuals who do not meet the current medical criteria but who do need assistance. The plan will continue, also, to expand the availability of services.

quiring long-term care services and will

From this data, planning efforts can be needed, the medical condition and the or HCBS Waiver services. While it is ing for initial intake who will not meet eed the number who are successfully many of these clients will receive some data system can track the disposition of ide developing additional ways to access criteria or for individuals who do not meet living in the community. Efforts should e Waiver to additional eligible individuals.

The long-range planning effort should c

the following strategies:

- Execute and document a complete inventory of public-funded health and long-term care services now being provided to disabled and elderly adult Tennesseans, by county, including funding source, delivering agency, clients served, and unit cost.
- Chart and match eligibility criteria for all short-term and long-term care services provided, regardless of funding source.
- Coordinate duplicative services that are funded through more than one state department.
- Improve efforts to identify dual-eligible clients to maximize efforts to ensure that Medicare pays for home health and long-term care services whenever possible.
- Study data on the extent that HCBS Waiver services meet the needs of the eligible population.

Social services for elderly individuals which are funded under the Older Americans Act are not based on means-tested eligibility criteria although, because of limitations in funding availability, services are targeted to those frail and vulnerable population segments which include low-income, low-income minority, socially-needy and rural individuals. The long-range planning effort should investigate methods for adjusting definitions for these categories so that only those elderly individuals who fail to meet Medicaid financial need criteria, but whose income might be considered "low income" are targeted with Older Americans Act services. This re-focus must be accomplished methodically and over a sufficient period of time so that otherwise eligible elderly individuals are not excluded from receiving needed program services. This effort should work in concert with the HCBS waiver program so that persons who meet financial and PAE criteria who are not served through the waiver would remain eligible for services through the Older Americans Act. Also, coordination needs to occur so that individuals who meet financial criteria but who do not meet medical criteria for the Waiver can find ways to access services in order to stay in the community setting.

Beyond Older Americans Act services, the long-range planning effort should examine adjusting eligibility criteria for other funding sources such as Social Services Block Grant and state-funded programs so that the programs are coordinated in a manner that takes maximum advantage of the dollars available.

As the HCBS infrastructure matures and is fully extended statewide to meet the demonstrated needs of the PAE-eligible population, the long-range planning effort should address strategies for serving disabled and aged individuals who meet only one of the two sets of criteria, medical or financial. Joint efforts should be explored with public, private and not-for-profit providers to offer HCBS services using a sliding-fee, ability to pay method. This should be approached with providers as an incentive to expand and improve service delivery areas and as an opportunity to increase their markets. One of the ancillary benefits of the HCBS Waiver program and the expansion of Commission on Aging programs, is that providers will be available in more areas than they are currently. Therefore, individuals who have the ability to pay will be able to access services.

Component 3

EXPLORE OTHER SERVICE OPTIONS FOR PERSONS NEEDING LONG-TERM CARE SERVICES

Potential Options for Medicaid Eligible Population

- 1) Replicate the Medicare/Medicaid dual capitation long-term care program known as the Program of All-inclusive Care for the Elderly (PACE) in other urban sites throughout Tennessee. This would require HCFA approval to receive federal financial participation.
- 2) Establish another waiver program if HCFA approval could be gained, or a state-funded program, that would be a consumer-directed pilot program that would provide funding for a single service - attendant care - to disabled Tennesseans. The disabled individual would receive a monthly payment to purchase attendant care. The enrollee would be given counseling and training on employing, supervising and evaluating personal care attendants.
- 3) Establish another waiver program, or a state-funded one, for a consumer-directed pilot program that would provide funding for personal care and/or other home and community based service alternatives to elderly and physically disabled Tennesseans. The individual would receive a monthly capitation payment that could be used to purchase personal care or other home and community based service alternatives.
- 4) Establish another waiver demonstration program that incorporates funding for acute physical and behavioral care with funding for long-term care services into a single capitation rate and that provides a single source of responsibility for service provision. This could be accomplished through a pilot project combining funding for long-term care services with funding for a portion of the population covered by a single health maintenance organization (HMO) in a specific geographic region. HCFA approval could be sought for a demonstration project that would allow the program to include both Medicaid and Medicare funding for those who would be involved that would be eligible for both programs. The HMO would manage the total care of the enrollees. This project would have the potential of aligning the incentives appropriately to provide the best in managed care while serving individuals in the least restrictive and most cost-effective setting.
- 5) Establish a Social Health Maintenance Organization (SHMO) demonstration project. This project model would be based on a single capitated organizational structure that would integrate acute and long-term care benefits by utilizing funds from Medicare, Medicaid, and co-payments and premiums. This would be accomplished by combining benefits traditionally offered by Medicaid risk HMOs, the FFS Medicare program, and home and community based services. Under an SHMO, enrollees receive traditional services such as physician care, hospitalization, preventive programs, prescription drugs, and hearing and vision services. In addition, they are eligible for up to \$1,000 per month of home care benefits such as personal care, adult day care, respite care, personal response systems, and support and training for family caregivers. A coordinated case management system authorizes long-term care services based on disability criteria.

Potential Options for Persons Not Meeting Medical and/or Financial Medicaid HCBS Waiver Criteria

- 1) Expand programs offered through the Commission on Aging.
- 2) Replicate any of the programs for the Medicaid-eligible population for those not meeting either financial or medical eligibility with funding provided from state-only, other public, or private sources. These new programs would have to exclude current programs that are partially funded with federal dollars.
- 2) Establish a state-funded (or one funded by other public or private sources) adult day care program, based on a social model, which would provide adult day care services to elderly and physically disabled Tennesseans who do not meet either financial or medical criteria for participation in the waiver program. The individual would be required to have an income-based sliding scale co-payment. Participation could be contained for individuals within certain income levels, such as those with incomes less than 200% of the federal poverty level.
- 3) Establish a medical model state-funded one funded by other (or public or private sources) adult day health program. The program would provide adult day health services to Tennesseans who do not meet either financial or medical criteria for participation in the waiver program but who have a need for this type of program. The individual would be required to have an income-based sliding scale co-payment. Participation could be contained for individuals within certain income levels, such as those with incomes less than 200% of the federal poverty level.
- 5) Expand the state-funded Residential Homes for the Aged Quality Enabling Program to all counties in Tennessee.
- 6) Add personal care services as a benefit under the TennCare program. As a Medicaid state plan option, personal care services may include providing assistance with an individual's activities of daily living. The services must be authorized by a physician and provided by a qualified individual who is not a legally responsible relative.

Any of the above options need to be reviewed by policy makers in light of an overall system of services for the elderly and physically disabled. Priorities should be established that begin with those in greatest need of public assistance – those who are financially and medically eligible for HCBS waiver services. From that point, assistance should be considered for individuals who meet the criteria in one area but not both. In additional planning, the process should include others who are in need of support if they are to remain safely in a community-based setting. Various pilot programs could be implemented to see which seem to work the best; however, all approaches should be taken with a comprehensive view in mind. Once a complete needs assessment has been done, additional program options can be selected that best meet the identified needs. The governor and the general assembly will have to set the public policy parameters for state-funded assistance for any of the programs mentioned for consideration.

Component 4

ENHANCE AND SIMPLIFY CONSUMER AND CAREGIVER ACCESS TO LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED

Background

A readily available source of information regarding the available services for the elderly and disabled is an important component of a comprehensive long-term care plan. Older persons, as well as their families, friends or other caregivers need information concerning the types of long-term care services that are available and how they may be accessed.

There is presently no "single point of entry" where the elderly and disabled can obtain information about all long term care services available in Tennessee and gain assistance in accessing needed services. For this reason, public chapter 1093 requires that the comprehensive long-term care plan include the development of a single point of entry.

In developing Tennessee's comprehensive long-term care plan, it was determined that the local health department would serve as the single point of entry for eligibility determination for HCBS waiver programs. In addition, the state intends to initiate an approach in collaboration with the Commission on Aging in ensuring maximum access to long-term care services. Using this approach, the Area Agencies on Aging with expertise in dealing with elderly and disabled populations will be utilized to provide information and referral services to those seeking information about long-term care. MAPS staff and staff at the Independent Living Centers also will be available to provide information and referral services to people who they regularly serve.

Involving these agencies at the local level will ensure access to long-term care services in each county of the state. Local health departments have the availability of licensed staff to assist in completing PreAdmission Evaluations needed for application for TennCare reimbursed waiver services. Local health department staffs have a history of providing case management and patient advocacy services. Department of Human Services has the necessary expertise in determining financial eligibility. DHS will work to outstation eligibility counselors in county health departments on a scheduled rotation so that access for potential enrollees will be easier.

The Tennessee Aging Network has developed, over the past 25 years, a social services delivery infrastructure which is uniquely capable of serving as an initial access point for statewide HCBS services. The Commission on Aging is currently increasing its capacity to support a coordinated, statewide elderly Information, Referral and Assistance system. Already in progress is the completion of a statewide, comprehensive computer database of services and service agencies. Intake to this system could expand from only community-based access to the possibility of statewide intake from a single telephone number.

Process

Individuals in the community seeking long term care services for the elderly and disabled will be able to obtain information about the available services and receive assistance in accessing needed services at either the local health department or Area Agency on Aging. Individuals who initially present to the Area Agency on Aging will be referred to the local health department if evaluation and determination of eligibility for TennCare funded programs is needed. Area Agency on Aging staff may assist the individual to ensure that appropriate documentation is collected and available when the individual is referred to the local health department for medical and financial eligibility determination. Health department licensed nurses will complete the PreAdmissionEvaluation (PAE) assessment and obtain any additional documentation needed. The PAE will then be submitted to TennCare for review. The TennCare Division of Long-Term Care will make determination as to whether an applicant meets TennCare medical criteria for nursing facility or waiver services. DHS staff will be available at local health department offices to collect financial documentation and make financial eligibility determinations.

For those individuals already residing in nursing facilities or awaiting nursing facility placement following hospital discharge, the PAE application will continue to be completed by nursing facility or hospital staff and submitted to the TennCare Division of Long-Term Care for medical criteria determination.

All appeals related to the denial of PAEs will be submitted to the Bureau of TennCare, Division of Long-Term Care. Individuals who appeal will have the right to an administrative hearing if TennCare upholds the initial denial.

The Area Agency on Aging shall serve, also, as an information and referral resource for long-term care services that are not TennCare reimbursed. For those who are determined not to meet medical criteria, referral may be made to the Area Agency on Aging to arrange other services in the community.

The Aging Network Information, Referral and Assistance System for older persons and their caregivers will serve as the central point for interaction with consumers, caregivers and advocates to answer inquiries, screen for non-TennCare service options and refer to appropriate parties for eligibility determination or immediate assistance. This consumer access point will provide accurate information about long-term care services as well as other services needed by older persons and their caregivers. The system is comprised of the Commission on Aging, the regional Area Agencies on Aging, the county-based Senior Citizen Centers and various other information, referral and assistance provider agencies.

- A copy of the data gathered by the Information, Referral and Assistance provider during the screening process will be provided to the local health department for determining medical necessity and to the county Department of Human Services for use in beginning the financial eligibility determination process. DHS will have staff available in local health departments on a scheduled basis to be more accessible to potential enrollees. Staff from the local health department and the Department of Human Services will contact the applicant to schedule an appointment for assessment and eligibility determination.
- For those determined to be medically or financially ineligible for TennCare funded services, the Area Agency on Aging Information, Referral and Assistance agency will:
 - conduct a more in-depth assessment of the person's needs;
 - identify appropriate community services to meet those needs, including eligibility requirements;
 - identify providers, including government agencies, private non-profit agencies, and for-profit agencies;
 - provide information on "How to Select a Provider," and
 - offer tracking and follow-up to assure the client has received services.

The Aging Information, Referral and Assistance System database will be available to HCBS waiver case managers to assist in the assessment and care planning for waiver enrollees.

The Area Agencies on Aging will operate the Home Care Ombudsman Program supervised by the Commission on Aging, Office of the State Long-Term Care Ombudsman. The Home Care Ombudsman will investigate consumer/family member complaints regarding the quality of care and assist in the resolution of problems between the consumer/family and case manager and/or service provider. A report of each complaint, including documentation about how the complaint was resolved, will be submitted to the Bureau of TennCare, Division of Long Term Care.

If the complaint includes allegations of abuse, neglect and/or exploitation of a vulnerable adult, a report will be made to the Department of Human Services - Adult Protective Services Intake number at 1-888-APS-TENN (277-8366).

Component 5

DEVELOP ADDITIONAL INFORMATIONAL AND EDUCATIONAL INITIATIVES TO PROMOTE AND EXPLAIN LONG-TERM CARE AND HEALTH RELATED SERVICES

The development of informational and educational initiatives is an important component of the comprehensive plan to provide for the long-term care needs of the elderly and the disabled populations. It is important that the development of any educational initiatives, campaigns or materials take into consideration the needs of the older population without de-emphasizing outreach to the disabled community. Currently, a number of agencies and associations have education and promotion initiatives geared towards populations likely to request information on long-term care. The development of educational materials and initiatives should incorporate the knowledge and resources of each stakeholder to ensure that consistent, accurate information is provided regarding long-term care in Tennessee.

Potential Initiatives and Programs

The focus of educational campaigns of the future must incorporate the knowledge and activities of all agencies involved in the development, maintenance and coordination of long-term care services and administration. It is important to recognize that currently there are a number of access points for individuals seeking information on long-term care options. With the development of this Long-Term Care Services Plan, it is essential that coordination and dissemination of consistent information occur.

Although many agencies are currently engaged in education and promotion activities, misinformation exists regarding long-term care, especially with respect to recent changes in Federal law. Because of the uniqueness of the potential population that will access long-term care services, promotions should be geared towards intervention, prevention, and detection of needs before services are required. The limited eligibility of the state program will bar many individuals access to state-sponsored services. Thus, an educational campaign should promote personal responsibility in planning for one's long-term care needs.

Health Promotion and Wellness

The development of health promotions specifically designed to recognize lifecycles could enhance the effectiveness of such programs. Childhood, adolescence, young adulthood, adulthood and late adulthood each require individualized programs that emphasize the uniqueness of each stage within the lifecycle.

Many current Department of Health programs and activities already emphasize health and wellness. Current activities such as those listed below form core health promotion services for the targeted population around which others can be expanded in the future:

- Health promotion activities in senior citizens centers and community groups for the elderly, stressing the importance of continued mammograms, PAP smears, and monitoring of blood pressure among other preventative measures
- Attending health fairs to educate and stress the importance of fitness and wellness aimed at elderly and disabled populations
- Hosting special days for specific health screenings, such as blood pressure checks

- Organizing training sessions for Activities Coordinators in senior centers and skilled nursing facilities on various fitness and wellness activities to improve physical well-being
- Promoting and administering flu shots geared specifically towards elderly and disabled populations
- Conducting a statewide, multigenerational effort to decrease the incidence of osteoporosis through the Tennessee Osteoporosis Prevention, Treatment and Education Program, part of the Health Promotion/Disease Control Section
- Performing tuberculosis skin tests at nursing homes

Area Agencies on Aging also fund a variety of health promotion and disease prevention activities provided through 140 senior centers and other community agencies using Older Americans Act and state funds. The most common activities include health risk assessment, physical fitness and exercise programs, health education, home safety and a variety of health screening activities. Active leisure activities like swimming, dancing and team sports that are sponsored by centers also contribute to a healthy lifestyle.

In addition to serving meals, nutrition programs for the elderly also provide nutrition and health education and nutrition screening to all program participants. Nutrition screening utilizes a ten-item checklist developed by the (National) Nutrition Screening Initiative that can alert participants to malnutrition warning signs. Screening is followed by education, nutrition counseling, or referral to appropriate social services or medical professionals for intervention to correct the problems associated with nutrition risk. Finding assistance with oral health problems and nutrition counseling for persons needing these services has been problematic.

The Nutrition Screening Initiative recommends that screening take place at a variety of locations including physicians' offices and nursing homes. A high percentage of nutrition participants were found to be at high nutrition risk and this group is thought to be better nourished generally than elderly who do not attend such programs. Clearly there is still room for improvement.

Although exercise and good nutrition are extremely important in maintaining good health and physical functioning, there are other factors that are important, especially to older persons. Vision and hearing deteriorate with aging. This not only affects quality of life in general but poor vision and hearing, also, are risk factors for injuries such as falls. The high cost of eyeglasses and hearing aides and the lack of resources for funding of these items contribute to dependency. Reduction in tobacco use and identification and treatment of persons with hypertension, also, should receive additional attention in any future plan for disability prevention and intervention.

Other health issues commonly considered important in the care of older persons are minimizing polypharmacy, detecting incontinence, and discussing advance directives. Since the physician is key to these and most prevention strategies, medical education might be helpful in improving patient adoption of health practices that help them to live longer, more active lives.

Insurance Education and Promotion of Personal Responsibility

The Tennessee Commission on Aging operates a Health Insurance Information, Counseling and Assistance Program (ICA) through contract to the Tennessee Association of Legal Services (TALS) and the Department of Commerce and Insurance (DCI). ICA counseling activities are provided to any Medicare beneficiary through the statewide network of 22 legal services offices using social workers, paralegals, attorneys and some volunteers. The Insurance Assistance Office for the Elderly (DCI) operates a statewide toll-free telephone number for initial contact and referral to local provider agencies on Medicare and related health insurance matters.

The initial consumer focus for health insurance information resides with the Insurance Assistance Office for the Elderly. This office has provided support to senior citizens since 1988 in

understanding, evaluating and comparing insurance products available to them. The Assistance Office maintains a statewide toll-free telephone number for consumers to obtain basic information and for referral to local legal services offices for direct assistance.

Consumer education and individual counseling under this program will assist consumers and caregivers in making informed decisions about their health and long-term care insurance, in knowing their rights and in accessing their benefits. In addition to individual and group informational presentations, this program provides individual counseling by trained counselors and, where appropriate, legal assistance to resolve problems with particular insurance carriers or in obtaining rights or benefits under insurance plans.

State units on aging, area agencies on aging and senior citizen centers in other states have been successful in developing partnerships with various segments of the business and industrial community to work with employees planning for retirement as they consider various health planning choices. Discussions should take place among several agencies of state government to develop a "healthy retirement program" concept to offer to corporations and businesses.

This program also should include a coordinated state government effort at offering a "multigenerational retirement planning" educational program which will inform adult children of aging parents about resources for services for elderly and disabled persons including information on the HCBS waiver program and other HCBS options. Central to this type of educational program should be an emphasis on reinforcing the importance of individual responsibility to ensure one's own physical well-being to the greatest extent possible.

Community Information And Education Network Activities Supporting HCBS Benefits Programs

The Tennessee Commission on Aging (TCA) will coordinate a statewide effort to strengthen aging network provider agency staff skills and procedures for providing accurate and complete information on all available home and community based long-term care options.

All component agencies comprising the statewide elderly Information, Referral and Assistance System will use a statewide comprehensive computer database of services and service provider agencies that will be maintained with current information by the TCA. This system is comprised of the Commission on Aging, the (9) regional Area Agencies on Aging, the (140) county-based Senior Citizen Centers and various other information, referral and assistance provider agencies. All information posted to this system will be available for retrieval by any case manager serving an HCBS Waiver client.

All Information, Assistance and Referral program staff and other senior center personnel, including volunteers, will attend initial and periodic training sessions that will be conducted in their local areas. The training will include instructions for applying standard I & R taxonomy and proper interviewing techniques to assess clients' needs and to make referrals.

The TCA developed a state-specific computer-based public benefits screening software program through a benefits outreach grant, "Benefits Education for Senior Tennesseans (B.E.S.T.)." This stand-alone computer application will run on IBM-type personal computers and has been distributed widely to Tennessee social services agencies that serve families and might also come in contact with elderly clients. The software currently uses a ten-question input to screen for the five services most utilized by seniors (QMB, SLMB, SSI, TennCare (Medicaid) and food stamps. The program produces a referral report, based on the client's zip code, detailing the proper local contact and application procedure for eligible services. The software will be modified to include eligibility indicators for the LTC/HCBS program.

Additionally, participation in training events will be offered to volunteers in ombudsman, legal assistance, health insurance counseling, senior center, information and assistance and public

guardian programs to prepare them to further educate consumers in various community settings on LTC/HCBS options.

Other organizations that have outreach capabilities and who normally see older and disabled clients and/or families will be encouraged and trained to provide strategies and tools for expanded public education and outreach efforts on LTC/HCBS choices.

Other Activities

Other potential promotional and educational activities include the following:

- Design a comprehensive Long-Term Care Informational Booklet, similar to model used by Medicare. This booklet would provide: overview of long-term care; definition of terms; services offered; steps towards accessing system; county by county listing of services offered and service providers (including phone number and addresses); self-screening guide/checklist to evaluate needs; chart of statewide toll-free numbers for more information
- Develop internet access for the information outlined for the LTC Information Booklet
- Expand coordination with school systems to promote prevention, fitness and wellness at younger ages, stressing the importance of regular exercise and nutritional diets

Component 6

PURSUE LONG-TERM CARE INSURANCE PARTNERSHIP

PARTNERSHIPS FOR LONG-TERM CARE

Partnerships for Long-Term Care are public/private alliances between state governments and insurance companies to create long-term care insurance programs. The Partnerships offer long-term care insurance policies that contain unique features, which must be approved by state insurance departments. These policies may allow many elderly and disabled individuals to afford their own long-term care without the need for impoverishment and dependency on Medicaid.

Partnerships for Long-Term Care provide an alternative to spending down or transferring assets by developing a partnership between Medicaid and private long-term care insurers. The states participating in Partnership programs work with private insurance companies to create insurance policies that provide quality, affordable, and coordinated long-term care coverage. Once the private insurance benefits have been exhausted, special Medicaid eligibility rules are applied if additional coverage is necessary. **["Overview". University of Maryland - Center on Aging Partnership for Long-Term Care. 12 December 1998**
<<http://www.inform.umd.edu/EdRes/Colleges/HLHP/AGING/PLTC/overview.html>>.]

There are currently two Partnership models among the various active programs: Dollar for Dollar and Total Assets. In Dollar for Dollar programs (used in California, Connecticut and Indiana) every dollar paid out by an insurer through a certified policy will reduce the insured person's resources counted toward Medicaid eligibility; while in the Total Assets Model (used in New York) the Medicaid eligibility process will not consider assets at the time the policies' benefits are exhausted. Once an individual is enrolled in Medicaid, both models require that their income be devoted to the cost of care. **["Background". University of Maryland - Center on Aging Partnership for Long-Term Care. 12 December 1998**
<<http://www.inform.umd.edu/EdRes/Colleges/HLHP/AGING/PLTC/overview.html>>.]

While many states have reviewed replication of the Partnership program, a few of the states have ceased efforts at implementation due to the impact of the Omnibus Reconciliation Act of 1993 (OBRA '93). Among the areas that are restricted by OBRA '93 is the asset protection component of a partnership program. Under OBRA '93, asset protection is only in effect while the insured is still living (Sec 1917(b) paragraph 1 subparagraph C). After the insured dies, states must recover what Medicaid spent from the estate, including protected assets. State plans had to be approved by the Department of Health and Human Services prior to May 14, 1993 in order to be exempt from OBRA's restrictions. **["OBRA 1993 Provisions Pertaining to The Partnership For Long-Term Care". University of Maryland - Center on Aging Partnership for Long-Term Care. 12 December 1998**
<<http://www.inform.umd.edu/EdRes/Colleges/HLHP/AGING/PLTC/overview.html>>.]

In order to implement an effective Partnership program, Tennessee will need to actively pursue program development in the following areas:

- Participation incentives – In order to provide asset protection, the State will work with its Congressional delegation and urge that the sections pertaining to the partnership program in OBRA '93 be modified to allow States flexibility in developing partnerships to entice consumers to purchase long-term care insurance policies.
- Development of provider networks – Begin discussions with the Department of Commerce & Insurance and various insurance providers on what can be done to facilitate the development of adequate provider networks that can meet the long-term care insurance needs of all Tennesseans.

- **Product development - Work with interested departments, providers and consumers in determining the elements of an appropriate long-term care insurance policy.**
- **Education of target population – Provide assistance to insurance providers in jointly developing a coordinated educational campaign to raise Tennesseans awareness of the need and the benefits of long-term care insurance coverage.**

Component 7

EXPLORE WAYS TO PROMOTE LONG-TERM CARE INSURANCE PROGRAMS WITH PUBLIC AND PRIVATE EMPLOYERS

LONG-TERM CARE INSURANCE

Overview

The primary incentive for individuals to purchase long-term care insurance is to protect their own assets rather than simply assuring sufficient income for appropriate care later in life. However, more individuals and families are now beginning to consider this as only one of several long-term health care strategies available to them.

If the purpose of long-term care insurance is to help people protect their assets against the high cost of long-term care, this kind of insurance is not necessary for those persons with limited assets who may be or may become eligible for Medicaid assistance to pay for needed long-term care.

The average annual premiums for basic LTC policies in 1992 were slightly less than \$500 annually for persons 50 years of age; about \$1,000 annually for persons 65 years old; and almost \$4,000 a year for persons 79 years old. ["Private Long-Term Care Insurance," AARP Public Policy Institute Fact Sheet, 1994.]

Efforts in the private sector to finance long-term care reflect the view that home and community-based care does not substitute for institutional care, but should be considered an add-on cost. [An] analysis of long-term care insurance premiums revealed that insurers charged premiums that were on average one-third higher for policies that covered both home and community-based care and nursing facility care than for policies that only covered nursing facility care (Lewin-VHI). However, because of the newness of the market, home and community-based care premiums are based on data other than actual claims. ["Home and Community-Based Care as an Alternative to Nursing Home Care," Wayne H. Ray, Ph.D, Vanderbilt University, October 1996.]

Private long-term care insurance, [could be] seen as a means of helping reduce the catastrophic financial risk for people needing long-term care and some of the financing burden that falls to public programs. It is a relatively new form of insurance with a growing market. Nevertheless, after ten years, very small proportions of elderly or near-elderly have coverage. For example, in 1995, private long-term care insurance covered less than 1 percent of total long-term care expenditures. Consumers' reluctance to purchase long-term care insurance is attributed to their limited knowledge about the risk of needing long-term care and the limitations on Medicare and Medicaid long-term care coverage, as well as concerns about the affordability of policies. ["Long-Term Care: Baby Boom Generation Presents Financing Challenges," William J. Scanlon, Director Health Financing and Systems Issues, U.S. General Accounting Office, March 1998.]

To encourage Americans to plan for their own long-term care needs and to ensure that long-term care insurance has great value for the future, the Balanced Budget Act of 1997 (BBA) created tax incentives, effective January 1, 1997, for purchasers of long-term care policies that meet the following qualifications:

- ♦ Benefits paid from a LTC policy will only be taxable income when benefit payments received are more than \$180/day and exceed the actual cost of care.
- ♦ A portion of the long-term care insurance premium based on the age of the policyholder can count as a medical expense for tax deduction purposes.
- ♦ The allowable percentage of LTC insurance premiums will be treated like health insurance for the self-employed tax deduction.

- ◆ Employers receive a tax deduction for any portion of the long-term care insurance premiums paid for employees.
- ◆ Premium contributions made by employers will not be taxable income to employees.
- ◆ A LTC insurance premium is an acceptable medical expense under the new Medical Savings Account (MSA) option of Medicare+Choice.
- ◆ Unreimbursed costs for qualified LTC services that are purchased count toward the itemized medical deduction for federal income tax for any dependent (e.g., the cost of unreimbursed qualified long-term care and cost of the premium paid for a dependent parent can be counted as an itemized federal income tax deduction).

More than 5 million persons are currently covered by long-term care insurance plans. Over 1,200 employers already offer group long-term care coverage as part of the employee benefits package, and almost 50% contribute to the employee's cost of the premium. A 1996 survey conducted by John Hancock Insurance Co. with the National Council on Aging reported that 7 out of 10 employees would like their employer to offer long-term care insurance benefits. Although 20 percent of Fortune 500 employers offer long-term care insurance, only 10 percent of all employers currently offer long-term care coverage. Another 27 percent of employers report they are considering offering this incentive within the next three years.

The greatest support for offering long-term care insurance coverage to employees seems to come from small employers. More than half of the companies offering long-term care plans in 1995 had less than 500 employees and almost half had 100 or fewer employees. A growing number of insurance companies are offering their individual long-term care insurance product to small employers, sometimes for even less than five employees. While full medical underwriting applies, the company usually provides a payroll deduction discount. Some plans can extend coverage to spouses, parents, in-laws, and even to grandparents. Group coverage generally allows for guaranteed issue, and in many cases the coverage is portable when the employee changes jobs. [**“Long-Term Care Planning Guide: the consumer resource for long-term care financing,”** Phyllis R. Shelton, 1998.]

Recent Tennessee Legislation Regarding Long-Term Care Insurance

The Tennessee General Assembly has enacted Public Chapter 883 [Acts of 1998] authorizing the State Insurance Committee to study the feasibility of offering long-term care insurance as a benefit to active and retired state employees. According to the legislation (Attachment 8), a long-term care benefits program may be established at the discretion of the Insurance Committee. The committee is authorized to determine the benefits package, funding method, administrative procedures, eligibility provisions and rules relating to the program.

Component 8

OTHER LONG-TERM CARE SERVICES PLAN CONSIDERATIONS

Consider Priority of Need in Allocating HCBS Waiver Services

The Adult Protection Act states that the legislative intent for the protection of the Adult Protective Services client requires the cooperation of many agencies [see 71-6-101 (b)(1), 71-6-113 (a) and (b)]. The Department of Human Services suggests that the comprehensive Long-Term Care Services Plan and any waiver services developed for Tennessee incorporate this provision. Currently when Adult Protective Services (APS) clients are referred for nursing home care, it is the informal policy of TennCare to consider the APS client to be in a "dangerous situation" and the application is given priority in the PAE processing. Georgia and Kansas also give priority to Adult Protective Services clients in accessing waiver services. Georgia includes in their policy manual a written policy of letting Adult Protective Services referrals take precedence over clients on the waiting list for waiver services and Kansas also considers the risk of abuse/neglect/exploitation as a factor in determining eligibility.

Consider Establishing Criteria for Assessing Comparable Health Risk Severity in Persons Eligible for Long-Term Care Services

Home and Community Based Care Standards on eligibility criteria for programs and benefits should insure that individuals with comparable long-term care needs have equitable access to publicly-supported benefits, regardless of the type of disability. For this reason, there is a need to establish eligibility criteria that incorporates a comparable severity assessment for those accessing long-term care services. If incorporated into the eligibility process, using the level of risk (high, intermediate, and low) imposed by comparable long-term care needs and their impact on the health and safety of the applicant provides an opportunity for equitable comparisons. This would be especially helpful when the demand for services by the potential client population exceeds the number of services/slots that funding can support, resulting in potential legal challenges of access decisions.

Examples of client situations when risk is a critical factor in their long-term care needs include:

- The client at risk of abuse or neglect in combination with their long-term care needs. This population is in far greater need of services, since those they depend upon for care may be abusive, or they may have no caregiver and live in great danger due to their functional and health needs.
- For clients with an amputation, sensory/communication impairments and spinal cord injuries, the duration of the injury is critical to client risk: recent onset needs versus long-term disability needs.
- There is an elevated level of risk to a client when their degree of cognitive impairment is considered to overlay their performance of functional skills.

States vary in the way they currently factor in the component of risk into their eligibility criteria. For some, relative risk is informally factored through the professional judgment of eligibility determination staff; other states include specific risks as weighted factors within their long-term care services assessment process.

Consider Development of Long-Term Care Client Database

One of the greatest challenges in developing a Long-Term Care Services Plan for Tennessee is the limited amount of reliable data currently available on what services are needed, where services are needed (geographically), and the level and amount of service intervention required. It is difficult to develop programs addressing the long-term care needs of Tennesseans and prepare accurate budgetary and cost estimates without having more comprehensive information about the potential population to be served. It will also be difficult to assess the effectiveness of Tennessee's Long-Term Care Plan in providing alternatives to institutionalization without having additional data beyond what is currently available.

For this reason, development of a long-term care client database is recommended. Data required to assess the population needing long-term care services could be collected as part of the initial screening process. The screening should include an evaluation of each person's functional abilities and determination of the level and type of services needed, based on his or her particular situation. In addition to initial screening, efforts should be made to follow-up on all clients after they have been referred to appropriate services. Information obtained during initial screenings and follow-up would be entered into a client database that could be used for the following purposes:

- To more accurately identify the target population.
- To track the impact of the program on persons who are accepted, persons referred to other services, and persons for whom no service is currently available.
- To document service needs of other population groups that would justify applying for additional medical waiver categories.
- To determine if persons who do not qualify subsequently deteriorate and are institutionalized a few months later.
- To determine which eligibility criteria are the most accurate predictors of the need for institutionalization.
- To determine which functional factors are the highest predictors of subsequent need for nursing home placement.
- To determine if the assessment process is accurately predicting the need for the level of service.
- To determine which home and community based services are the most effective in preventing and delaying nursing home placement.
- To plan for services needed by qualifying individuals.
- To identify service infrastructure gaps.
- To determine how many applicants are cognitively impaired and to what level of severity.
- To more accurately project the cost of long-term care services for potential waiver recipients so that services to waiver beneficiaries do not exceed institutional costs.
- To address waiting list issues.

RULES AND REGULATIONS RELATING TO THE LONG TERM CARE SERVICES PLAN

In accordance with section 6(a) of Public Chapter 1093, which authorized development of a plan for the delivery of long-term care services, the Commissioner of Health was authorized to promulgate rules and regulations to effectuate the purpose of the act.

Rules, including some that are in the final stages of promulgation, already exist for the Medicaid Home and Community-Based Services waivers for the elderly and disabled. Implementation of a statewide Medicaid Home and Community-Based Services waiver for the elderly and disabled would require minor revisions to these rules, primarily to include the addition of any new services, to expand the HCFA-approved geographic service area, and to specify the Administrative Lead Agency. Additional requirements not addressed in these rules could be incorporated into the contracts between TennCare and the Administrative Lead Agency and between the Administrative Lead Agency and the service providers.

Rules are being developed currently by the Tennessee Department of Human Services for the licensure of Adult Day Care Facilities. It is not anticipated at the present time that additional licensure rules would be required in order to implement a statewide Medicaid Home and Community-Based Services waiver for the elderly and disabled.

Moratorium on Legislative or Regulatory Changes to Current Long-Term Care Facility, Service and Eligibility Requirements

In developing components of the Long-Term Care Services Plan for the Elderly and Disabled, including the statewide Home and Community-Based Services Waiver, the following current state and/or federal requirements were taken into consideration:

- Licensure requirements for long-term care facilities and service organizations;
- State and federal standards and definitions for long-term care services; and
- State and federal eligibility requirements for individuals in need of long term care services.

In order to move forward successfully with a comprehensive plan for long-term care services, the Long-Term Care Services Planning Council strongly recommends that the state legislature and state agencies make no substantive changes to current law or regulations beyond those required to implement the Plan itself over the next five (5) years.

Such a moratorium would provide the time needed to collect and analyze historical data on utilization of home and community-based services once the waiver has been implemented. Also, it would allow time to accurately analyze the impact on general long-term care needs that the waiver services may have. As part of developing the HCBS waiver proposal, cost projections and need projections were examined as carefully as possible. Changes in either statutes or regulations could cause the proposed statewide HCBS waiver to be funded inappropriately or to serve fewer people than anticipated. Changes also could cause the cost under the waiver to increase above the ability of the state to pay.

BACKGROUND CHECK COMMITTEE REPORT
to the
Long Term Care Services Planning Council
Long Term Care Services Advisory Council

Issue: Should the State of Tennessee require providers of long term care services to conduct background checks of paid and volunteer staff.

Discussion: Long-term care providers serve the most frail and vulnerable Tennesseans. Elder abuse experts are predicting that home care recipients will represent a growing proportion of abuse victims. The U.S. Department of Health and Human Services Inspector General issued a report in September 1998 recommending that:

"the Health Care Financing Administration and the Administration on Aging work with the states to improve the safety of long term care residents and to strengthen safeguards against the employment of abusive workers by elder care facilities."

The Tennessee Code Annotated contains three citations regarding background checks for persons working with specific population groups:

TCA 37-1-414 permits religious, charitable, scientific, educational, athletic or youth service institutions or organizations to require persons applying to work with children as a volunteer or as a paid employee to agree to the release of all investigative records to verify criminal violation information contained in the application, supply fingerprint samples, and/or submit to a criminal history check.

TCA 71-3-533 permits a child welfare agency to require all persons applying to work with children in any capacity (paid or volunteer) to agree to the release of all investigative records, supply fingerprint samples, and/or submit to a criminal history check.

TCA 33-1-209 requires the Department of Mental Health and Mental Retardation to conduct background checks on any employee or volunteer whose job functions include direct contact or direct responsibility for persons with mental illness or developmental disabilities. All applicants must agree to the release of all investigative records, supply fingerprint samples for a criminal history check through both the TBI and FBI.

Each citation requires the agency requesting the background check to pay the cost of conducting the check. According to the Developmental Disabilities Council staff, the cost to the Department of Mental Health and Mental Retardation is \$45 per background check.

Proponents of background checks say that agencies serving vulnerable populations must do everything possible to prevent victimization of vulnerable individuals. Opponents of background checks contend the process is slow, often provides incomplete or inadequate information and can be costly.

The State of Illinois requires state criminal background checks for direct care employees of community living, long term care, life care, home health agency, community residential alternative, nurse agency, respite care, hospice, mental health, community integrated living, and hospital providers. The state has conducted approximately 21,000 criminal checks and found 5 percent had disqualifying crimes.

Due to Tennessee's unique geography, 43 percent of the state's counties share a border with at least one other state. The likelihood for a significant portion of potential paid or volunteer staff to have lived and/or worked in an adjoining state is high.

The Tennessee Department of Health maintains a registry of Certified Nursing Assistants who have been disciplined for abusive behavior in an institutional setting. All adjoining states maintain a similar database. In addition, the Tennessee Department of Health maintains databases on all licensed health professionals. These databases contain information on disciplinary actions taken against a specific individual. The Tennessee databases are publicly available through the telephone and the Internet. Databases in other states are less easy to access.

State	Telephone	Internet	Who Can Access
Alabama	X		NH with code
Arkansas	X		NH with code & SSN
Georgia	X	Spring 1999	Registry sent quarterly to facilities. Anyone can access by telephone to generate a written response.
Kentucky	X		NH, APS, State Ombudsman
Missouri	X		Any licensed facility and in-home operator
Mississippi	X		NH, State Ombudsman
North Carolina	X		Anyone with SSN of Perpetrator; quarterly reports sent to State Ombudsman, LTC Association, Board of Nursing & Home Health Assoc.
Virginia	X		Registry for health professionals: CNAs, LPNs, RNs

The U.S. Department of Health and Human Services Inspector General has recommended the Health Care Financing Administration and the Administration on Aging should consider establishing Federal requirements and criteria for performing criminal background checks. In addition, the Inspector General recommended HCFA consider assisting in the establishment of a national abuse registry and expanding the current state registries to include all workers who have abused or neglected residents or misappropriated their property in facilities receiving Federal reimbursement.

Recommendations

1. The Department of Health, the Department of Human Services and the Commission on Aging should adopt identical background check requirements for individuals, both paid and volunteer, providing direct care for, having direct contact with, or having direct responsibility for a recipient of long term care services.
2. The requirements adopted shall be minimum requirements, with provider agencies having the option to make more intensive background checks.
3. The provider agency is responsible for all costs of conducting background checks. These costs shall be included in the reimbursement rate for long-term care services.
4. All applicants for pay or volunteer employment must list any prior conviction by any local, state, federal or military court of any felony or any other conviction involving sexual crimes,

crimes against a person, and substance abuse and any charge of an attempt to commit sexual crimes, felonious assault, homicide, crimes against the person, substance abuse, unlawful breaking or entering, robbery, burglary, theft, or arson.

5. The provider agency must document in its personnel files:
 - A. The applicant's statement of prior convictions and all allegations of attempts to commit crimes (item 4 above).
 - B. The results of its check of three personal and/or employment references.
 - C. The results of a county criminal history check for each of the last two counties in which the applicant lived or worked.
 - D. The results of the check of Department of Health databases of licensed health professionals including CNAs.
 - E. The results of any other checks conducted by the provider agency.
 - F. Justification/explanation of the decision to employ an individual if the background check identified negative information.

Committee Members:

Jamie Bergmann
Criss Chastain
Ludell Coffey
James Whaley

PUBLIC CHAPTER NO. 1093

SENATE BILL NO. 2411

By Henry, Harper, Haynes, Person, Haun, McNally, Crowe, Ramsey, Leatherwood,
Williams, Miller, Atchley, Cooper, Cohen, Burks, Carter, Clabough, Crutchfield, Davis,
Dixon, Elsea, Ford, Fowler, Gilbert, Graves, Herron, Jordan, Kurita, Kyle, Rochelle,
Springer, Womack,
Mr. Speaker Wilder

Substituted for: House Bill No. 2842

By Arriola, Cooper, Langster, Buck, Pruitt, West, Sherry Jones, Bowers, Newton, Brenda
Turner, Brooks, Haley, Hargett, Brown, McKee, Towns, Miller, West, Fraley, Armstrong, Ford,
Chumney, Odom, Boner, Lewis, Ferguson, Mumpower, McDonald, Fitzhugh, Maddox, Eckles,
Hood, Bone, Mike Walker, Kerr, Ronnie Cole, Curtiss, Pleasant, Patton

AN ACT To amend Tennessee Code Annotated, Title 71, relative to the development of a
comprehensive plan for the delivery of long-term care to the elderly and the disabled and its
relationship to the medical assistance program.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The General Assembly finds that:

(a) Long-term care for the elderly and disabled faces a deepening crisis. The elderly population is increasing and will soon increase dramatically. Across the nation, approximately one (1) in every eight (8) persons was elderly in 1994. By the year 2030, however, one (1) in five (5) will be elderly. Conditions which necessitate long-term care occur most frequently among the elderly, but are increasing among Tennesseans of all ages.

(b) Tennessee's existing system of long-term care is a patchwork of services, with nursing homes being the primary place for long-term care services.

(c) Tennesseans want to live at home and be independent, and Tennessee families want to care for frail loved ones at home, for as long as that is possible.

(d) Public funding for long-term care should afford Tennesseans who are in need a choice of a broad array of home- and community-based services, and should not be limited to institutional care.

(e) Public policy should promote the availability of long-term care services that enhance independence, dignity and privacy; and

(f) Tennessee should develop and implement a comprehensive long-term care system responsive to the needs of all Tennesseans regardless of age, disability or economic status.

(g) Tennessee shall develop a Long-Term Care Services plan, which shall be a comprehensive plan to guide the future funding, coordination and delivery of long-term care services (with the exception of institutional nursing home services) in the state. The plan should include, but not be limited to, the submission by the state of an application for home and community based services (HCBS) waiver, also known as a Section 1915(c) waiver under P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981, to the health care financing Administration (HCFA). The Section 1915(c) waiver shall allow the state to utilize available state funds to draw

down federal Medicaid funds in order to serve low income nursing home eligible individuals, who have been pre-admission evaluation (PAE) approved by the Department of Health, in HCBS settings.

SECTION 2. Tennessee Code Annotated, Section 71-5-107, is amended by adding to clause (a)(21), after the phrase "medical assistance" the phrase "and home- and community-based services to those eligible being served through a HCFA approved waiver".

SECTION 3. Tennessee Code Annotated, Section 71-5-103, is amended by adding to the section the following appropriately designated subsection:

() "Home- and community-based services" means any of the following supportive services and systems, as approved by HCFA, which are provided to older persons and individuals with disabilities to remain independent and avoid inappropriate institutionalization and which help individuals maintain physical, social, and spiritual independence in the least restrictive environment.

- (1) living environments and supportive services (assisted care living facilities, homes for the aged and assistive technology);
- (2) personal care, homemaker and chore services;
- (3) adult day services;
- (4) congregate and home delivered meals;
- (5) home care organizations;
- (6) rehabilitative care;
- (7) assisted transportation or mobility services; and
- (8) support services to caregivers, including hospice and respite care.

SECTION 4. (a) The Commissioner of Health, the Commissioner of Finance and Administration, the Commissioner of Human Services and the Executive Director of the Commission on Aging, shall constitute a Long-Term Care Services Planning Council to formulate the Tennessee Long-Term Care Services Plan which shall be a comprehensive plan to guide the future funding, coordination and delivery of long-term care services in Tennessee. The Commissioner of Health shall serve as chair and convenor of the committee. A plan shall be submitted by the Governor to the members of the General Assembly by January 1, 1999.

(b) There is hereby created a Long-Term Care Services Advisory Council which shall convene not later than July 1, 1998, at the call of the Commissioner of Health and shall be composed of fourteen (14) members appointed by the Governor as follows:

- (1) One (1) representative of the American Association of Retired Persons;
- (2) One (1) representative of the Tennessee Association of Area Agencies on Aging;
- (3) One (1) representative of the Tennessee Association for Home Care;
- (4) One (1) representative of the Tennessee Association of Homes and Services for the Aging;

(5) One (1) representative of the Tennessee Chapters of the Alzheimer's Association;

(6) One (1) representative of the Tennessee Conference on Social Welfare;

(7) One (1) representative of the Tennessee Disability Coalition;

(8) One (1) representative of the Tennessee Health Care Association;

(9) One (1) representative of the nursing home industry;

(10) One (1) representative of business in an unrelated industry;

(11) One (1) other representative at-large representing the general public;

(12) One (1) representative of the Tennessee Association of Homemaker Service Providers;

(13) One (1) representative of the Tennessee Hospital Association who represents a hospital-based nursing home;

(14) One (1) representative appointed by the Speaker of the House;

(15) One (1) representative appointed by the Speaker of the Senate; and

(16) One (1) representative of the American Disabled For Attendant Program Today (ADAPT).

(c) The members of the Long-Term Care Services Advisory Council shall serve without compensation or reimbursement for travel expenses from the state.

(d) Duties and responsibilities of the Long-Term Care Services Advisory Council shall be to:

(1) Assist in the formulation of a comprehensive and detailed plan to guide the future funding, coordination and delivery of long-term care services in Tennessee, including establishment of specific standards of care;

(2) Review a Long-Term Care Services Plan for the State of Tennessee which is to be submitted by January 1, 1999, and forward with that plan to the General Assembly any critique thereof or recommendations which the council may adopt by majority vote of its members;

(3) Review any subsequent changes to the Long-Term Care Services Plan; and

(4) Review all proposed regulations which may affect the Long-Term Care Services Plan for the State of Tennessee.

(e) The plan submitted by the Governor to the General Assembly by January 1, 1999, as well as any recommendations made by the Long-Term Care Services Advisory Council, shall be consistent with the following principles:

(1) Long-term care programs and services should enhance independence, dignity, choice, and individual well-being.

(2) Elderly and disabled Tennesseans will receive the care and services which are most appropriate for their needs and aspirations.

(3) Long-term care services should be provided at the most economical cost and in the least restrictive setting.

(4) Funding for long-term care services should follow the consumer regardless of delivery method utilized, and without regard to whether such services are categorized as medical care.

(5) Appropriate consumer safeguards, including quality of care standards, should be instituted as part of the home- and community-based services system.

(6) Long-term care policy should foster wellness and prevention.

(7) Long-term care policy should be coordinated with TennCare and Medicare acute care services in a rational and financially prudent manner.

(8) State long-term care policy should make maximum use of available public funding, including federal financial assistance.

(9) In any HCBS waiver there should be a single point of entry for case management services in each geographical region where persons in need of long-term care can obtain case management services for the purpose of helping them assess their needs, assisting them in developing a plan of services, and referring them to providers who are qualified to implement the plan of services.

(10) Case managers should not also be service providers for their clients.

(11) Case management should seek to maximize the use of voluntary and existing services.

(12) Long-term care services should be available on the basis of functional need, rather than on the basis of age, diagnosis or other arbitrary criteria unrelated to individual capacity and need.

(13) The Commission on Aging should act as a clearinghouse that collects and analyzes data from the agency in each geographical region. On the basis of such data and analysis, the commission should at least annually, make a report and recommendations to the Long-Term Care Services Advisory Council, the Speakers of each House of the General Assembly and the Governor, regarding the amount and type of long-term care services needed in each geographical region.

(14) The Commissioner of Health, in consultation with the Commissioner of Human Services, the Executive Director of the Commission on Aging, and consumer and advocacy organizations representing the elderly and persons with disabilities, should develop standards of care to ensure quality and protect consumers of home- and community-based services.

SECTION 5. In the 1998-1999 fiscal year any funds appropriated to implement the provisions of this act shall be expended by the Department of Health to enhance services related to home- and community-based care. Any recurring funds appropriated in fiscal year 1999-2000 and any subsequent fiscal year to implement the provisions of this act shall be available for funding home- and community-based services (HCBS) on a statewide basis under any Section 1915(c) waiver which the state may receive and/or any additional waiver programs developed as a part of the Long-Term Care Services Plan.

SECTION 6. (a) The Commissioner of Health is authorized to promulgate rules and regulations to effectuate the purposes of this act. All such rules and regulations shall be promulgated in consultation with the Commissioner of Human Services and Director of the Commission on Aging and the Long-Term Care Services Advisory Council in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

(b) For purposes of oversight, the Department of Health shall report progress on establishing a home- and community-based services system to the appropriate standing and/or oversight committees by February 1 of each year.

SECTION 7. Nothing in this act shall be construed to alter any existing waiver or program of home- and community-based services for the elderly or disabled or for persons with mental retardation or developmental disabilities, or to conflict with any court order relating to services for such individuals. However, it is the intent of the General Assembly to encourage the coordination of home- and community-based services across the entire spectrum of age and diagnosis or type of disability, to the maximum extent possible without altering existing waiver programs or court-ordered services for the elderly or disabled or persons with mental retardation or developmental disabilities.

SECTION 8. This act shall take effect upon becoming law, the public welfare requiring it.

PASSED: May 1, 1998

APPROVED this 19th day of May 1998

Attachment 2

LONG TERM CARE SERVICES PLANNING COUNCIL

Nancy Menke, Chair
Commissioner of Health

Linda Rudolph
Commissioner of Human Services

John Ferguson
Commissioner of F&A

Jim Whaley
Exec. Dir., Commission on Aging

LONG TERM CARE SERVICES ADVISORY COUNCIL

Glenn Barr
Tennessee Disability Coalition
Dyersburg, Tennessee

Jamie Bergmann
Tennessee Conference on Social Welfare Representative
Hixson, Tennessee

Charlotte Burns
CEO Hardin County Hospital
Tennessee Hospital Association
Savannah, Tennessee

Criss Chastain
Executive Director, Southeast Tennessee Alzheimer's Association
Chattanooga, Tennessee

Ludell Coffey
Homemakers Association
Knoxville, Tennessee

Gerald Coggin
National HealthCare Corporation
Murfreesboro, Tennessee

Gerald Crowder
President, ADA Consultants
At-large representing general public
Memphis, Tennessee

Cynthia Finch
Tennessee Association for Home Care Representative
Knoxville, Tennessee

Bob McFalls
Delta Area Agency on Aging
Tennessee Association of Area Agencies on Aging Representative
Memphis, Tennessee

Attachment 2

Doug Pace
Executive Director, Tennessee Association of Homes & Services for the Aging
Nashville, Tennessee

Dawn Russell
ADAPT
Memphis, Tennessee

Ray Stomer
AARP Representative
Kingsport, Tennessee

Ron Taylor
Tennessee Health Care Association
Nashville, Tennessee

Dan Thompson
Tennessee Business Roundtable
Nashville, Tennessee

James Vandiver
Speaker Jimmy Naifeh's appointment
LifeTrust America
Nashville, Tennessee

Bob Wilson
Lt. Gov. John Wilder's appointment
Hamilton County Nursing Home
Chattanooga, Tennessee

TennCare Long-Term Care Recommendations

The Long-Term Care Committee was established with the task of developing recommendations for future policies in the area of long-term care. The Committee was made up of the following members:

Bill Barrick	Roger Blue	Gordon Bonnyman
Gerald Coggin	Diane Coleman	Polly Darnell
Dan Gray	Vicky Gregg	Hop Hopkins
Mike Huggins	Linda Penny	Gayla Sasser

Meetings were held during December, January, February and March to obtain recommendations of committee members. There was no consensus among the members on a recommendations for future operation and containment of the long term care program. However, there were some suggestions offered by individual committee members that appeared to warrant further review. Those suggestions, along with suggestions from the TennCare staff and representatives from the Comptroller's office on ways to better control the long term care program are presented below.

Suggestion #1:

Reduce expenditures to Level I and Level II nursing facilities. This can be accomplished in the following areas:

1. Change the payment to Level I and Level II nursing facilities to an amount representing the 65th percentile of allowable operating costs plus the 50th percentile of allowable capital-related costs; do not apply the inflation factor to capital-related costs; include return on equity in capital costs;
2. Change the inflation factor to allow a flat percentage (such as 3.5%) for all providers. One alternative to a flat percentage could be the actual percentage per individual nursing home subject to a ceiling where inflation above the ceiling would be capped at the ceiling. A second alternative could be to establish a ceiling consistent with available funding and then compress actual individual nursing homes into this ceiling to obtain a proportional amount. Each nursing home would then receive a proportional amount of its actual inflation amount.
3. Place reasonable limits on management fees and home office costs claimed in cost reports. (Rules to do this in ICF/MR facilities are already in process.)

As an alternative to this suggestion, suggestion # 2 could be considered.

Suggestion #2:

This suggestion is presently being implemented pursuant to an agreement with the nursing home industry. However, it could be further strengthened in the future with reductions in the percentage of growth, or even negative growth, with specified monies targeted to expansion of home and community based type projects. See suggestion # 6 for ideas on HCBS expansion.

Impose a global budget for Level I nursing facilities and for Level II nursing facilities. Each global budget would be the lesser of revenue growth, inflation or a fixed percentage such as 5%. The global budget should be based on anticipated utilization. Each nursing home would be given a per diem rate which would be subject to periodic adjustments as necessary to remain within the global budget. Program expenditures would be limited to the aggregate amount of the actual utilization level for each nursing home multiplied by the per diem rate for each nursing home. If utilization rates exceeded the projections, the nursing homes would be paid a lesser amount for each bed day to remain within the global budget. However, if the utilization rate was less than expected, the program would expend less than the global budget.

Suggestion #3:

Change the payment to ICF/MR facilities to an amount representing the 65th percentile of allowable operating costs plus the 50th percentile of allowable capital-related costs.

Suggestion #4:

Implement an estate recovery process to recover the costs of all Medicaid expenditures from the estates of deceased Medicaid clients who were at least 65 years old when they were eligible for Medicaid. Also implement a hardship waiver process for estate recovery. Estate recoveries are required by Federal Medicaid regulations but Tennessee has been lax in enforcing the requirement.

Suggestion #5:

Request a waiver from HCFA to implement a PACE (Program for All-inclusive Care for the Elderly) program. PACE provides total medical and long-term care in the community for the frail elderly. The PACE program offers a comprehensive service package delivered by an integrated, team-managed care system focused on the frail elderly (55 years of age and older) who qualify for nursing home admission and reside in a defined geographic area. Under a capitated rate, PACE programs offer a wide array of acute, post acute and long term care services. The PACE Programs attempt to reduce admission to nursing homes and hospitals because of their emphasis on community-based care, preventive care, and rehabilitation therapy. Participation in PACE will require that a waiver be obtained from HCFA.

Suggestion #6:

Expansion of HCBS waivers as an offset to the long-term budget in the following areas:

1. Expand the current ADAPT waiver for the elderly and disabled to other counties. It is currently operating in Davidson, Hamilton and Knox counties;
2. Expand the HCBS waivers to include adult daycare;
3. Expand the current Shelby County waiver for the elderly and disabled to other counties.
4. Ear-mark an increasing portion of the Long Term Care budget each year for expansion of HCBS programs with corresponding reductions in Long Term Care institutional care.

Suggestion #7:

Require nursing homes to include Social Security numbers of the individuals on their waiting lists. Such a requirement will make it possible to determine how many persons are actually waiting for admission to a nursing home. It is believed that a significant number of persons are on waiting lists at multiple nursing homes to hold a place for future admission to the home or as a means to have options available to select from several nursing homes when admission becomes necessary. Such actions artificially inflate the number of persons seeking admission to nursing homes and complicate efforts to determine the number of nursing home beds needed to meet demand.

Suggestion #8:

Improve coordination of Medicare/Medicaid funding. Presently, there is a significant amount of Medicare funding available for part or all of the services provided in a nursing home. For a Level II facility, Medicare pays most of the charges for 100 days annually, except for applicable Medicare deductibles and coinsurance. In Level I facilities, Medicare can make payment for much of the durable medical equipment, medical supplies, etc. that are used by persons on both Medicare and Medicaid. Improved use of this available funding can help reduce TennCare program costs.

Suggestion #9:

Include long-term care in the TennCare waiver. Modify the 1115 waiver to allow demonstration of a cost effective alternative using a single MCO and a supplemental cap payment for qualified individuals. Initially, implement at a single site, not statewide, in order to demonstrate effectiveness.

Suggestion #10:

Implement independent assessment/concurrent reviews to verify that nursing home patients continue to meet the Medicaid requirements for Level I or Level II care. Rather than setting up a new program to review patients, add this responsibility to the current Health Care Facilities' inspection team. At present, patients' conditions are reviewed thoroughly prior to admission through a Pre-Admission Evaluation (PAE) process but little is done by the State on an on-going basis to determine to that the patient's condition continues to meet the requirements for nursing home confinement.

Suggestion #11:

Change the reimbursement methodology for Level II facilities to a prospective basis. If the global budget recommendation is adopted, this would be advantageous to the State because it would relieve the State from having to perform cost settlement functions and it would allow the State to more closely monitor global budget expenditures. It would be beneficial to the providers because it would reduce the need to reserve a large amount of the global budget funds to address cost settlements that occur 2 - 3 years after services are delivered. If the global budget proposal is not adopted, elimination of the cost settlement process would still be advantageous to the State because of reduced administrative requirements.

5 SUMMARY

1. It is feasible to increase utilization of home- and community-based long term care services in TennCare and Tennessee Medicaid. These services could provide alternatives to institutional solutions for some patients, but it is difficult to tell how many. There are four broad approaches to providing home/community-based services: fee-for-service, case-managed, carve-out, and capitated. Each of these potentially has major implications for cost and quality of care.
2. Analysis of patient needs and costs is complex. There are too many unknown factors as to how new programs would affect quality and costs to assess the effects of such programs from readily available tabulated data such as that provided by the Medicaid reporting systems. Reliable assessments would be provided by statistically valid controlled studies that compare patients in different systems.
3. With regard to patient quality of care, comparative analysis of national and regional studies does not provide evidence from statistically valid, controlled studies that such programs increase quality of care. It is clear that many persons needing long-term care and their families prefer home and community-based services and perhaps this alone is sufficient basis for expanding availability. However, as illustrated by the Oregon experience, such programs have the potential for quality of care problems and will bring the difficult regulatory problem of assuring standards for new (and possibly numerous) types of care providers.
4. With regard to cost, comparative analysis of national and regional studies suggest these approaches are unlikely to save substantial sums of money. Fee-for-service probably would lead to explosive cost increases. Proponents of case-management claim substantial savings, but this is not yet proven by statistically valid studies. Case-management also can take choices from patients and families and put them in the hands of government agencies. Carve-out could keep costs constant, but could reduce quality. Capitation has some promise for modest cost control, does not require government agencies to make choices on specific patient care, and is the only method that provides fiscal incentives for preventing progression of chronic disabilities. A project to add long term care services to the managed care component would allow the development of cost effective alternatives for nursing facility services by the managed care organizations. However, there are unanswered questions vis a vis quality of care and implementing capitation in Tennessee.
5. Given the large number of unknowns in all of these factors, it could be prudent to test any policy changes before implementing them statewide. Robert Wood Johnson intends to fund a new round of state trials of new modes of health care delivery; such a trial could be eligible for this funding. The managed care

organizations participating in the trial could propose new modes of providing care (e.g., delivery of some medical services by non-medical personnel, residential care facilities, etc) and the necessary changes in licensing/certification/inspections could also be tested during the trial. There are two ways in which the trial could be implemented. The first is the usual pilot study/demonstration mode, in which a small scale implementation is conducted with informal evaluation. The primary objective is to identify problems so that they can be resolved before full implementation. Another possibility is to conduct a formal comparative study, which would also have the objective of measuring the effect of the new program on clinical, quality of life, and economic outcomes. This comparative study, although more complex to design, would provide better assurance that the new modes of care saved money without worsening outcomes.

6. POSSIBLE STRATEGIES FOR TENNESSEE

1. Support additional projects or studies in Home and Community Based Services.

Studies conducted, as to date, of Home and Community Based Long-Term Care suggest it may not be cheaper to do Home and Community Based Long-Term Care, but it does support patients preference and an increase in life satisfaction. Policy makers may wish to support additional studies of expanded Community Based Long-Term Care Services based on these two proven outcomes - life satisfaction and consumer preference - even though cost effectiveness has not been tested or proven.

Projects could consist of:

Long-term care services added to managed care component;
Co-sponsorship with long term care organizations utilizing the PACE or On Lok models.

2. Put aside studies and projects and get started on ways to make it become cost-effective.

- Establish budget caps that assure cost-effectiveness even though there is very little research or published information on capitation.
- Bring additional private resources into the long-term care system. This can be done in three ways: encouraging and providing incentives to purchase private long-term care insurance; more strictly enforcing prohibitions against transfer of assets prior to receiving long-term care; and more aggressively recovering money from the estate of decreased Medicaid nursing home residents.
- Utilize case management in the delivery of long-term care services
- If capitation is done, support the use of cost and utilization tracking

software, a mechanism that provides authority not to admit patients who have low likelihood of benefit, and support the contracting of clinicians.

3. Increase restrictions of access.

Currently, Tennessee has strict fiscal and medical eligibility requirements for Medicaid patients entering nursing homes. Increasing restrictions could possibly result in denying impaired patients nursing home placement if the systems is not monitored closely. Restrictions may include:

tightening entry requirements,
decreasing per diem reimbursement,
limiting bed supply.

4. Status quo.

Make no changes in the present system of long term care services and continue to work toward continual incremental improvements. Observe the implementation of the Assisted Living facilities as to the impact on quality of care and cost.

Conclusions and Alternatives

Following are the conclusions and alternatives that Tennessee should consider in order to prepare to meet the demand for long-term elder care:

Tennessee must develop a comprehensive and focused plan for the long-term care of its elderly. A cohesive and focused policy, best administered through one agency, is necessary for Tennessee to meet the demand for elder long-term care. The Department of Health, with input from the Commission on Aging, would be a likely choice. Should the state choose to accept responsibility for the care of its elderly, there would necessarily be costs involved in implementing such a plan. A special committee or commission could be established, either by the executive or legislative branch, to develop a plan. Or the decision could be tasked to a state agency.

The state must gather more information before a plan can be developed. The number of underserved in Tennessee and their needs have not been determined. A demonstration project, based upon a statewide sample of Tennesseans, would be the best way to determine this information.

In developing a long-term care plan, the implementation of some of these alternatives could create administrative costs. Nonetheless, with adequate and informed preparation and planning, state officials will be able to effectively address the impending crisis.

Utilization of home and community based services, with clear objectives and targeted populations of the elderly would be the best way to serve not only people who are receiving little or no care at all, but also some nursing home residents. In addition, it would reduce Medicaid expenditures for institutional care. However, this approach could lead to an initial increase in total long-term care costs, because of an initial rapid growth among elders seeking to use previously unavailable services. Some nursing home patients would be better served by home and community based services. Because home and community based services can be less costly than nursing home care, the state could reduce Medicaid expenditures for institutional care if these services were used as an alternative to nursing home care.

An extensive case mix reimbursement system could more efficiently utilize Medicaid dollars. Paying for only the care that the elder requires would be more cost-efficient than paying a flat rate per person or paying one of two flat rates.

Capping expenditures per service could reduce overall expenditures. Limiting expenditures would likely lead to reduced expenditures, at least in the short-term. Limitation of expenditures also means limiting service. The elderly population could receive lesser services than with a comprehensive, carefully planned system of care.

Tennessee's PAE requirements could include heightened medical and financial eligibility criteria for nursing home admission. This could decrease Medicaid expenditures, but could also limit access to services and care. Further, compared to other states, Tennessee has relatively stringent criteria.

Case management would help assure that elders are matched to the services that best suit their needs. Although several organizations, such as the area agencies on aging and the Tennessee Commission on Aging, provide information on Tennessee services for the elderly, a more proactive approach is necessary to best serve consumers and reduce expenditures.

Consumer-directed care attendant programs could help reduce state costs and liability. By assessing an elder's needs and then disbursing money to allow the elder to purchase the service that he/she needs, costs and liability could be less than if the state provided the services. Allowing elders to select their own caregivers would give them a sense of independence.

Encouragement of long-term care insurance, through legislation, could reduce state expenditures. Use of long-term care insurance could help shift the burden of long-term care from the public sector back to the private sector.

More aggressive estate recovery could also be utilized to reduce state Medicaid expenditures. The state could recover money spent on Medicaid recipients from their estates after death.

The committee on long-term care heard a great deal of testimony over the past three months about the need for more home and community-based services in Tennessee. Although a number of questions remain unanswered, there is no denying the fact that Tennessee has no long-term care plan. Therefore, the study committee makes the following recommendations:

- The state must develop a comprehensive long-term care plan that provides for a continuum of care for all who need it.
- The state needs to develop more options that reflect preferences for Home and Community-Based Services (HCBS) and allow easy access to those services. The state needs a delivery system that provides consumer choice of providers in the community and offers the option for consumers to manage their own services
- State programs should support caregivers who are willing to delay placing their family member in an institution as long as possible, with a system of home and community-based services which is accessible, affordable, and available.
- The state must consider getting a waiver from Health Care Finance Administration (HCFA) to spend a percentage of the federal Medicaid money on home and community-based services. The state should consider integrating its Medicare and Medicaid money into a single program. Any transition of funding should be gradual to allow alternative services to be developed and nursing homes to adjust. The state should allocate a portion

of the Medicaid money to home and community-based services and allow it to grow over time or look to allocate a certain rate of growth.

- The state should develop a system based on a social model rather than a medical model.
- The state should utilize the aging network already in place and develop a single point-of-entry/care management system. Organizations responsible for assessment and case management functions should not be engaged in the actual provision of services to avoid conflicts of interest. The single point-of-entry would be responsible for information and assistance, outreach, counseling, assessment and case management.
- The state needs to use its money cost-effectively to provide the most appropriate services for the most people. Tennessee must approach the issue of developing a plan based on whether a person's needs could be met in a less costly setting with better or equivalent care.
- The Commission on Aging could expand their homemaker services, home-delivered meals, public guardianships (conservatorships), and respite care services if the requested funds were made available.
- The state needs to develop a sliding pay scale for long-term care services.

- The state should look at what other states have done to help develop a long-term care plan (Arkansas & Missouri)
- Tennessee needs to develop a person-centered delivery system that tailors services to the needs of individuals rather than the setting of care. The dollars should follow the person and not an institution.
- The state needs to encourage consumer and family involvement in the development of individual's plans of care, choices of services and providers, and quality assurance. Families must help out as much as possible.
- Tennessee must improve the coordination of long-term care services at the state and local levels and promote the programs that exist but are not well advertised.
- The state should consider funds from the state general fund as well as from Medicaid and the Older Americans Act. Funding from the general fund might include cost-sharing provisions/sliding scale fees.
- The General Assembly should extend this study committee until the state of Tennessee can develop a long-term care plan

• Any long-term care plan developed should utilize nursing home certification (PAE) for HCBS eligibility and follow stringent standards. To qualify for HCBC in Tennessee we should consider the following in Activities of Daily Living (ADL):

- Requires assistance in bathing
- Requires assistance in dressing
- Requires assistance in using toilet
- Requires assistance in transferring (moving from point to point within the residence)
- Has difficulty with bowel or bladder control
- Requires assistance in eating

Candidates for Tennessee's HCBC should require two of the six deficits named above. For nursing home eligibility, Medicaid requires three of the six ADL impairments.

Members of the Study Committee on Long Term Care

SENATE

Senator Ben Atchley

Ben Atchley

Senator David Fowler

Senator Joe Haynes

Senator Douglas Henry

Douglas Henry

Senator Curtis Person, Jr.

Curtis Person, Jr.

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Don Bird

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Gene Caldwell

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Carol Chumney

Representative Steve McDaniel

Steve McDaniel

Representative John Arriola, Chair

John Arriola

MCO and BHO Covered Services

Service	Covered by MCO	Covered by BHO	Comments
Inpatient hospital days	X		As medically necessary. Preadmission approval and concurrent reviews allowed.
Psychiatric inpatient facility services		X	As medically necessary for enrollees under 21 and over 65. For enrollees 21-65 who are not Severely and/or Persistently Mentally Ill (SPMI), limited to 30 days per occasion and 60 days per year.
24-hour psychiatric residential treatment		X	As medically necessary for children under 21 and for adults 21 and older with SPMI.
Psychiatric housing/residential care		X	As medically necessary for children under 21 and for adults 21 and older with SPMI.
Outpatient hospital days	X		As medically necessary.
Physician inpatient services	X		As medically necessary. This shall include acupuncture performed by a physician or a registered nurse as an anesthetic in connection with a surgical procedure.
Physician psychiatric inpatient services		X	As medically necessary.
Physician outpatient services	X		As medically necessary. This shall include acupuncture performed by a physician or a registered nurse as an anesthetic in connection with a surgical procedure.

Service	Covered by MCO	Covered by BHO	Comments
Outpatient mental health services		X	As medically necessary.
Specialized psychiatric outpatient and symptom management services		X	As medically necessary for children under 21 and for adults 21 and older with SPMI.
Inpatient and outpatient substance abuse treatment services		X	As medically necessary for children under 21 and for enrollees 21 and older who are SPMI. For non-SPMI adults 21 and older, limited to 10 days detox; inpatient and outpatient substance abuse benefits for these enrollees have a maximum lifetime limitation of \$30,000.
Specialized psychiatric crisis services		X	As medically necessary.
Lab & X-ray services	X		As medically necessary.
Newborn services	X		As medically necessary including circumcisions performed by a physician.
Hospice care (must be provided by an organization certified pursuant to Medicare Hospice regulations)	X		As medically necessary.

Service	Covered by MCO	Covered by BHO	Comments
Dental services	X		Preventive, diagnostic, and treatment services for enrollees under age 21. Services for enrollees age 21 and older limited to cases of accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance.) Orthodontics limited to individuals under age 21 except when an orthodontic treatment plan is approved prior to the enrollee's attaining 20 ½ years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered by TennCare at birth).
Vision services	X		Preventive, diagnostic and treatment services (including eyeglasses) for enrollees under age 21. The first pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults.
Home health care	X		As medically necessary.
Pharmacy	X		As medically necessary. Non-

Service	Covered by MCO	Covered by BHO	Comments
			covered therapeutic classes as described in TennCare contract. DESI, LTE, IRS drugs excluded.
Psychiatric pharmacy services and pharmacy-related lab services		X	As of July 1, 1998, psychiatric pharmacy services are being provided directly by the State.
Durable medical equipment	X		As medically necessary.
Medical supplies	X		As medically necessary.
Emergency ambulance transportation	X	X	As medically necessary.
Non-emergency ambulance transportation	X	X	As medically necessary.
Non-emergency transportation	X	X	As necessary for enrollees lacking accessible transportation for covered services. The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services, as related to travel distance, should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult.
Transportation to covered mental health and substance abuse services		X	As medically necessary for enrollees lacking accessible transportation. The availability of specialty services, as related to travel

Service	Covered by MCO	Covered by BHO	Comments
			distance, should meet the usual and customary standards for the community. However, in the event the BHO has no contracted provider for specialty services that meets the travel distance or other access requirements, transportation must be provided to an enrollee regardless of whether or not the enrollee has access to transportation. If the enrollee is a child and needs to be accompanied by an adult, transportation must be provided for both the child and the accompanying adult.
Community health services	X		As medically necessary.
Renal dialysis services	X		As medically necessary.
EPSDT services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.	X		Screening, diagnostic, and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care."

Service	Covered by MCO	Covered by BHO	Comments
Mental health case management		X	As medically necessary for children under 21. Must be offered to all persons with an assessment of CRG 1, CRG 2, or TPG 2. As clinically indicated for CRG 3.
Rehabilitation services	X		As medically necessary when determined cost effective by the MCO. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
Psychiatric rehabilitation services		X	As medically necessary for children under 21 and for adults 21 and older with SPMI.
Chiropractic services	X		When determined cost effective by the MCO.
Private duty nursing	X		As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Speech therapy	X		As medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic, or personality disorder. All medically necessary services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described

Service	Covered by MCO	Covered by BHO	Comments
			in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
Sitter services	X		As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. care is needed and neither is available.
Convalescent care	X		Upon receipt of proof that a covered person has incurred medically necessary expenses related to convalescent care, the Plan shall pay for up to and including the 100 th day of confinement during any calendar year for convalescent facility(ies) room, board, and general nursing care, provided: (1) a physician recommends confinement for convalescence; (2) the enrollee is under the continuous care of a physician during the period of confinement; and (3) the confinement is required for other than custodial care.
Donor organ procurement	X		As medically necessary for a covered organ transplant.

**TENNESSEE DEPARTMENT OF HEALTH
AND
BOARD FOR LICENSING HEALTH CARE FACILITIES
HOUSE JOINT RESOLUTION 741 STUDY REPORT
TO THE ONE HUNDRED FIRST GENERAL ASSEMBLY
ON THE OPERATING, ADMINISTERING AND FUNDING OF THE
RESIDENTIAL HOMES FOR AGED QUALITY ENABLING PILOT PROGRAM**

Definitions

Tennessee Code Annotated § 68-11-201(13)(A) defines a "home for the aged" as:

"Home for the aged" means a home represented and held out to the general public as a home which accepts primarily aged persons for relatively permanent, domiciliary care. A home for the aged provides room, board and personal services to one (1) or more nonrelated persons. The word "primarily" was added to the definition in the last legislative session.

Tennessee Code Annotated § 68-11-201(14) currently defines a "home for the aged resident" as:

"Home for the aged resident" means a person who is ambulatory and who requires permanent, domiciliary care but will be transferred to a licensed hospital, a licensed assisted living facility, or a licensed nursing home when health care services are needed which must be provided in such other facilities.

Prior to the 1997-98 legislative session, a home for the aged resident was defined as "any aged person requiring permanent, domiciliary care and who is not ill or physically or mentally unable to care for themselves at the time of admission and who will be transferred to a licensed hospital or licensed nursing home when more technical nursing care is needed than the personnel and facilities can offer in a home for the aged."

History

The Residential Homes for the Aged Quality Enabling Pilot Program began July 1, 1986, by vote of the Tennessee General Assembly under Public Chapter 927 which amended Tennessee Code Annotated § 12-4-320. The bill mandated authority to the Board for Licensing Health Care Facilities to establish a pilot program to reimburse Residential Homes for the Aged (RHA's) nine dollars (\$9.) per day less patient income. The per diem rate was increased in 1993 to thirteen dollars (\$13.) per day less patient income. The intent of the program is to improve the quality of care and services provided to residents of residential homes for the aged and funding for the program must be appropriated annually by the General Assembly. From 1986 to the present, all funding appropriated by the General Assembly for reimbursement through this program has been 100% state moneys without any type of supplement from federal funds.

By law, eligible residents are required to have a total income which does not exceed six hundred (\$600.) dollars per month and whose income is limited to payments made under the Social Security Act. The eligibility requirements for resident qualification are detailed in the Department's regulations. Originally, eligible residents were also required to be 65 years or older. However, the

age requirement was waived by the Board from the beginning of the program in response to public and industry requests until deleted from the statute by the General Assembly in 1993.

The law also originally contained a bed cap rate which limited the total number of resident beds that could receive reimbursement through the program annually. Annual appropriations for the program were calculated by multiplying the bed cap rate by the daily reimbursement rate to determine the amount of funding necessary to fully fund the program. The bed cap rate was also eventually deleted from the statute in the 1993 legislative session.

Three counties, Shelby, Davidson, and Wilson, were originally designated to be qualified for the receipt of reimbursements from the Quality Enabling Program with an initial bed cap of one hundred twenty (120) beds. That year the program was fully funded at \$219,000.

In 1987, White, Haywood, Dyer, and Trousdale Counties were added to the program. The bed cap was increased to 162 with the allocation being increased to continue to fully fund the program at \$296,000.

In 1988, Sequatchie, Grundy, Hardeman, Fayette, Madison, and Knox Counties were added to the program by the General Assembly. The bed cap was increased to 217 and the program was partially funded at \$383,500. And while no licensed RHA's are located in Moore County, it became eligible for the program due to its metropolitan form of government.

In 1989, Bedford and Dekalb Counties were added to the program. The bed cap was not increased and the program was fully funded at \$396,200., both that fiscal year and in 1990.

In 1991, the budget for the program was reduced by approximately 13% due to required departmental budget reductions and the program was funded at \$345,100. This amount was also allocated in 1992 which funded 189 of the 217 allotted beds each year.

In 1993, the General Assembly amended the law to add eligibility for Carroll and Weakley Counties to participate in the program, the bed cap and age limit were eliminated and the funding increased to \$525,100. The program has continued to be funded at this same level of \$525,100. for the past six (6) years. No other counties have been added and only three proposed (3) bills have been introduced since 1993 to add various counties to this program, all of which failed passage. This amount funds a total of 159.85 residents annually.

Currently there are eighteen (18) counties whose licensed residential homes for the aged are designated by law as eligible to participate in the program. The counties are: Shelby, Davidson, Wilson, Dyer, Haywood, Trousdale, White, Grundy, Sequatchie, Hardeman, Fayette, Knox, Madison, Moore, Bedford, Dekalb, Carroll, and Weakley. Out of the eighteen (18) counties, only eleven (11) counties have facilities participating in the program. There are thirty-nine (39) facilities participating in the program for the 1998-99 fiscal year out of the eighty-nine (89) eligible facilities. Sixteen (16) of the thirty-nine (39) facilities participating in the program are located in Shelby County which has the largest number of licensed RHA's in the state. There are no homes for the aged in three (3) of the eligible counties (Moore, Sequatchie and Fayette) and four (4) counties (Bedford, Dekalb, Dyer, and Hardeman) have no facilities participating in the program.

Based upon statewide figures, the total number of licensed RHA's in the state has dropped 9.4% while the total number of licensed beds has increased by 4 beds since the previous year. This decrease in total number of licensed RHA's is likely due to the advent of the licensing of Assisted

Care Living Facilities (ACLF's) and the deeming of licensed and compliant RHA's as meeting fire and life safety standards for conversion to licensed ACLF's. ACLF's are authorized by statute to provide residents a level of medical services above those authorized to be provided in a home for the aged. As T.C.A. § 12-4-320 was not amended to include ACLF's in the Quality Enabling Program, ACLF's are currently not eligible for participation in the Quality Enabling Program and those RHA's that convert to ACLF's automatically become ineligible to participate in this program.

Each year of the program all licensed and eligible RHA's located in the eligible counties are contacted to invite them to participate in the program. Facility eligibility requirements are delineated in the regulations that govern this program (attached as Exhibit A). Facilities which decide to participate are required to submit a facility application, a resident application for each eligible resident, proof of resident eligibility, and subsequently sign a contract. Once all of the information is received, the funds are contracted according to the amount requested, the proof of eligibility provided, and the amount of the facility's previous contract, if any. The entire amount of funding allocated for the program each fiscal year by the General Assembly is contracted out to the grant applicants. Facilities receiving reimbursement from the program are required to submit invoices quarterly on forms provided by the Department certifying the number of days each eligible and participating resident received domiciliary care from the facility.

Program Procedures

1. All RHA's in all eligible counties are invited to participate in QEP. (Usually in early May for the upcoming fiscal year.)
2. Facilities deciding to participate are requested to submit the following:
 - a) Facility application;
 - b) Resident applications;
 - c) Documentation for all eligible residents; and,
 - d) Signed contract.
3. Once all information is returned from facilities that want to participate and verified for eligibility, funds are allocated according to previous contract amount (if any), number of eligible residents applied for, and by applying the percentage of total number of beds that can be funded for the entire year.
4. Allocation for 1998-99: \$525,100.

\$525,100 divided by \$9. (daily rate of \$13./day minus \$4./day personal needs allowance) divided by 365 days equals 159.85. Therefore 159.85 is the maximum number of residents that can be funded for 1998-99.
5. Once the contracts are processed, the facilities submit verification forms and compensation claims quarterly (per regulations) for reimbursement.

Formula Utilized in Allocating Funds Grants

Multiply the daily reimbursement rate times 365 days which equals the cost to fund one (1) resident for a full year.

Multiply the number of facilities with only one (1) eligible resident times the yearly resident cost which thereby equals the cost to fully fund single resident contracts.

Subtract that total from the total appropriation amount which equals the remaining amount to be contracted.

Multiply the total number of residents applied for by all facilities (excluding single resident only facilities) times the yearly resident cost which then equals the cost to fund all applicants for an entire year.

Divide the remaining contract amount by the cost to fund all applicants which provides the percentage of the year residents can be funded.

Then, by applying facility, multiply the number of residents applied for times the yearly resident cost times the percentage of the year which provides the facility's contract amount.

Example:

$\$9.00/\text{day} \times 365 \text{ days} = \$3,285.$

$5 \text{ facilities w/ } 1 \text{ resident} \times \$3,285 = \$16,425.$

\$525,100.	(funding amount)
- 16,425.	(fully funded single residents)
\$508,675.	(remaining contract amount)

$189 \text{ applying residents} \times \$3285. = \$620,865.$

$\$508,675. \div \$620,865. = 81.93\%$

$3 \text{ residents applying in one facility} \times \$3285. = \$9,855. \quad \$9,855 \times .8193 = \$8,074.20$

Round off to \$8,074. (facility's contract amount)

Conclusions/Summary

The Residential Homes for the Aged Quality Enabling Pilot Program was designed to enhance the quality of life for eligible recipients. The Division monitors participating facilities through the annual RHA licensure survey process and through the required submission of a facility self-evaluation form. Participating RHA's are required to detail what enhanced services are being provided to residents and to produce receipts and/or documentation of the cost for those services. Enhancements/services most often cited as being provided by participating RHA's are:

- Transportation services to physicians' offices, social gatherings and religious services, etc.
- Additional activities, i.e., theater passes, cable television, magazine subscriptions, etc.
- Residents' environment, i.e., purchasing/repairing personal furniture, and appliances, etc.
- Residents' self-esteem, i.e., purchasing new clothing, shoes, cosmetic/grooming aids, etc.

- Residents' health, i.e., physician/pharmacy reimbursements, provision of special diets, etc.
- Residents' care and protection, i.e., hiring additional staff/sitters, upgrading security systems, etc.

Mainly, the program enhances the quality of life for those individuals who would otherwise be denied access to placement in any licensed boarding and personal care establishment due to lack of sufficient income. The program enables homes for the aged to admit individuals with limited incomes and thereby provide those individuals with shelter, nutrition, personal care services, protection, and assistance with basic health care needs. By reimbursing the homes for the aged for providing for these residents' essential needs, the participating residents are properly cared for and do not join the ranks of the growing number of homeless and forgotten elderly. Unfortunately, as the pilot program has traditionally been limited in scope both by the county eligibility requirements and the availability of sufficient funding, the number of individuals assisted annually by this program continues to remain extremely limited.

Statewide Expansion

In estimating potential minimum cost to expand the RHA Quality Enabling Program statewide, the following assumptions have been made:

1. The current mandates of the statute would essentially remain unchanged, i.e., daily rate, resident eligibility requirements, personal needs allowance, etc. Naturally, should changes/amendments occur in any of the variables of this program, these estimated figures would be likely to escalate considerably. Statewide expansion would increase the number of counties eligible from the current 18 counties to at least 60 counties. This number would encompass all counties which currently have at least one licensed RHA in that county. Of course, if the current appropriation level of \$525,100 is not increased, the program would still fund only 159.85 residents annually, no matter which counties are eligible to participate. It is impossible to determine the number of SSI recipients that will seek admittance to homes for the aged in any given year in any given county and thereby qualify for the program. However, for projection purposes, assuming that the same percentage of participating eligible residents to total available beds currently experienced would apply if the program was expanded to include all the 60 counties mentioned above, the following projection would result:

$$\text{A. } \frac{194 \text{ current number participating}}{1770 \text{ current available beds}} = 10.96 \text{ or } 11\%$$

$$\text{B. } \begin{array}{l} \text{Therefore, 4,667 total beds available in all 60 counties} \\ \quad \times 11\% \\ \hline 513.37 \text{ projected participants} \end{array}$$

$$\text{C. } \begin{array}{l} \text{Therefore, 513.37 projected participants} \\ \quad \times \$3,285 \text{ cost of one resident for a year at \$9 per day} \\ \hline \$1,686,420.45 \text{ projected cost for residents} \end{array}$$

2. Expansion of this program would require sufficient funding for additional staff to conduct the contracting, monitoring and regulating processes to support the increased number of facilities and residents participating in the program. The program currently operates utilizing 1.5 full-time equivalent (FTE) Central Office staff and .5 FTE staff per each of three Regional Offices for a

total of 3.0 FTE staff. The cost of this existing staff is not charged to the current appropriation of \$525,100 for the Quality Enabling Program. However, if the program is expanded statewide as described above, additional staff will be needed to effectively administer the program.

3. Therefore, the total projected cost of expanding the program on a statewide basis as described above would be:

\$1,686,420	Projected cost for 513.37 residents
<u>\$ +167,100</u>	Projected cost for administration
\$1,853,520	Total projected cost
<u>\$ - 525,100</u>	Less current appropriation
\$1,328,420	Total additional funding needed

Possible Funding Sources

This department would not recommend the redirection of funds from any of its other programs. However, perhaps there are other funds in the State budget which could be redirected to fund the expansion of the Quality Enabling Program. Otherwise, it is assumed that some type of grant, tax or fee would be necessary to provide the needed funding. Possible options for such grants/taxes/fees:

1. Make application for private and/or block grant moneys that are or become available for home and community based services pilot projects, such as, the National Affordable Housing Act of 1990 Section 202 HOME Investment Partnership Program, the Community Development Block Grants through municipalities, the Robert Wood-Johnson Foundation, etc. Utilizing this option would require extensive ongoing research, be subject to applicable grant utilization standards and could not be relied upon to guarantee any or sufficient funding.
2. Amend T.C.A. § 68-11-213(c)(1) to authorize the Department to assess civil monetary penalties up to five thousand dollars (\$5000.) per day against any person or entity found to be operating an unlicensed health care facility required to be licensed under that chapter. Any funds collected, along with any accrued interest, from the issuance of such penalties could be designated to expand the RHA QEP program. (Note, this penalty authorization currently applies only to unlicensed assisted care living facilities found to be in operation.) Utilizing this option could be met with opposition by other health care providers and the amounts collected could vary significantly from year to year.
3. Amend T.C.A. § 68-11-801, et. seq., to authorize the imposition of civil monetary penalties on all deficient licensed provider types and mandate that all funds collected, along with any accrued interest, from the issuance of such penalties be placed in a separate account designated to expand the RHA QEP program. (Note, this penalty authorization currently applies only to licensed nursing homes.) Utilizing this option could be met with opposition by other health care providers and the amounts collected could vary significantly from year to year.
4. Legislate the increase of facility licensure fees and direct that the amount of difference between the current and any new fees be applied to fund the program. Utilizing this option would likely not be met with enthusiasm by such providers but would guarantee a minimal, but possibly sufficient, level of funding to expand the program.

Program Participation Data

Counties Eligible and Participating in 1998 - '99:

•	Carroll	1 of 1	homes participate
•	Davidson	6 of 15	homes participate
•	Grundy	2 of 2	homes participate
•	Haywood	2 of 2	homes participate
•	Knox	1 of 15	homes participate
•	Madison	4 of 5	homes participate
•	Shelby	16 of 29	homes participate
•	Trousdale	3 of 3	homes participate
•	Weakley	2 of 4	homes participate
•	White	1 of 1	homes participate
•	Wilson	1 of 6	homes participate

Counties Eligible and Not Participating:

•	Bedford	2 homes	0 participate
•	Dekalb	1 home	0 participate
•	Dyer	2 homes	0 participate
•	Fayette	0 homes	
•	Hardeman	1 home	0 participate
•	Moore	0 homes	
•	Sequatchie	0 homes	

Number of Licensed Facilities and Beds by Eligible County for 1998-99:

<u>County</u>	<u># Facilities</u>	<u># Beds</u>
• Bedford	2	21
• Carroll	1	26
• Davidson	15	250
• Dekalb	1	12
• Dyer	2	86
• Fayette	0	
• Grundy	2	49
• Hardeman	1	22
• Haywood	2	34
• Knox	15	408
• Madison	5	76
• Moore	0	
• Sequatchie	0	
• Shelby	29	461
• Trousdale	3	47
• Weakley	4	134
• White	1	10

•	Wilson	6	123
•	TOTALS	89	1,759

AMOUNTS CONTRACTED TO COUNTIES

	1986-87	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99
Grant Amt:	219,000.	296,000.	383,500.	396,200.	396,200.	345,100.	345,100.	525,100.	525,100.	525,100.	525,100.	525,100.	525,100.
Bedford	Not Eligible	N/E	N/E	0	0	0	0	0	0	0	0	0	0
Carroll	N/E	N/E	N/E	N/E	N/E	N/E	N/E	3,285.	4,205.	0	4,687.	3,285.	5,382.
Davidson	26,655.	55,005.	78,415.	81,000.	84,985.	79,383.	74,318.	74,331.	54,662.	61,460.	64,300.	73,089.	53,839.
Dekalb	N/E	N/E	N/E	0	0	0	0	0	0	0	0	0	0
Dyer	N/E	0	16,645.	18,470.	20,405.	17,793.	0	0	0	0	0	0	0
Fayette	N/E	N/E	0	0	0	0	0	0	0	0	0	0	0
Grundy	N/E	N/E	38,725.	38,725.	38,725.	24,637.	24,637.	40,622.	44,150.	52,353.	49,220.	59,510.	53,820.
Hardeman	N/E	N/E	0	6,545.	9,275.	6,844.	6,844.	8,426.	6,307.	6,929.	0	0	0
Haywood	N/E	7,930.	7,690.	6,545.	4,260.	8,211.	8,643.	13,517.	9,592.	12,399.	15,004.	16,810.	14,068.
Knox	N/E	N/E	0	7,140.	7,140.	6,843.	0	0	0	0	0	8,115.	10,783.
Madison	N/E	N/E	18,070.	22,325.	19,185.	23,267.	24,918.	27,084.	24,579.	16,953.	26,722.	30,942.	25,407.
Moore	N/E	N/E	0	0	0	0	0	0	0	0	0	0	0
Sequatchie	N/E	N/E	8,645.	4,380.	2,390.	2,737.	2,737.	9,232.	9,592.	3,294.	0	0	0
Shelby	103,075.	140,650.	156,905.	153,850.	144,580.	131,394.	136,571.	248,137.	269,465.	262,791.	258,754.	249,494.	250,857.
Trousdale	N/E	18,075.	24,280.	24,555.	31,050.	23,268.	32,087.	42,119.	48,354.	59,182.	77,346.	59,510.	72,657.
Weakley	N/E	N/E	N/E	N/E	N/E	N/E	N/E	21,952.	32,718.	19,228.	22,036.	24,345.	29,620.
White	N/E	4,325.	16,325.	15,365.	16,875.	6,843.	9,000.	18,920.	6,307.	6,929.	0	0	3,285.
Wilson	5,410.	9,970.	8,515.	7,300.	7,300.	4,106.	0	8,705.	7,490.	10,123.	7,031.	0	5,382.
Totals	135,140. *	237,605. *	374,215. *	386,200. *	386,170. *	335,326. *	319,755. *	516,330. *	517,421. *	511,441. *	525,100. *	525,100. *	525,100.

* Remainder/portion of appropriation funds reverted due to inability/lack of facilities/residents to qualify for reimbursement of entire amount of contract. All appropriated funding is contracted to facilities at the beginning of the fiscal year.

NUMBER OF BEDS PER COUNTY

	1990*	1991	1992	1993	1994	1995	1996	1997	1998
1. Bedford	28	28	27	27	21	21	21	21	21
2. Carroll	N/E	N/E	N/E	26	26	26	26	26	26
3. Davidson	314	390	433	422	347	347	347	347	250
4. DeKalb	15	21	33	33	33	33	50	50	12
5. Dyer	30	80	80	50	50	50	50	50	86
6. Fayette	0	0	0	0	0	0	0	0	0
7. Grundy	49	49	49	49	49	49	49	49	49
8. Hardeman	22	22	22	22	22	22	22	22	22
9. Haywood	30	30	30	30	34	34	34	34	34
10. Knox	108	143	152	202	202	230	414	414	408
11. Madison	114	114	110	110	106	100	96	76	76
12. Moore	0	0	0	0	0	0	0	0	0
13. Sequatchie	10	17	23	23	23	23	0	0	0
14. Shelby	430	567	566	603	603	603	653	697	461
15. Trousdale	37	38	38	38	40	40	40	38	47
16. Weakley	N/E	N/E	N/E	145	134	134	134	134	134
17. White	52	54	54	18	10	10	10	10	10
18. Wilson	71	78	85	85	85	123	123	123	123
Totals	1,310	1,631	1,702	1,883	1,785	1,845	2,069	2,091	1,759

*Data unavailable for 1986-1989

NUMBER OF ELIGIBLE PARTICIPANTS BY COUNTY

	1990	1991	1992	1993	1994	1995	1996	1997	1998
1. Bedford	0	0	0	0	0	0	0	0	0
2. Carroll	N/E	N/E	N/E	N/E	N/E	N/E	2	1	1
3. Davidson	51	60	58	43	28	27	27	27	20
4. DeKalb	0	0	0	0	0	0	0	0	0
5. Dyer	15	18	13	0	0	0	0	0	0
6. Fayette	0	0	0	0	0	0	0	0	0
7. Grundy	25	22	18	19	21	23	21	22	20
8. Hardeman	4	4	5	4	3	3	0	0	0
9. Haywood	5	2	6	5	4	5	6	5	6
10. Knox	5	6	5	0	0	0	0	3	4
11. Madison	20	18	17	14	13	13	9	11	9
12. Moore	0	0	0	0	0	0	0	0	0
13. Sequatchie	4	2	2	2	1	1	0	0	0
14. Shelby	110	87	96	89	127	123	110	92	93
15. Trousdale	22	18	17	17	23	26	33	22	27
16. Weakley	N/E	N/E	N/E	15	15	8	9	9	11
17. White	12	9	9	5	3	3	0	0	1
18. Wilson	4	5	3	0	4	4	3	0	2
Totals	277	251	249	213	240	236	220	192	194

*Data unavailable for 1986-1989

NUMBER OF FACILITIES PER COUNTY

	1990	1991	1992	1993	1994	1995	1996	1997	1998
1. Bedford	2	2	2	2	1	2	2	2	2
2. Carroll	N/E	N/E	N/E	1	1	1	1	1	1
3. Davidson	26	27	27	25	20	15	15	15	15
4. Dekalb	1	1	2	2	2	1	1	1	1
5. Dyer	1	2	2	1	1	2	2	2	2
6. Fayette	0	0	0	0	0	0	0	0	0
7. Grundy	2	2	2	2	2	2	2	2	2
8. Hardeman	1	1	1	1	1	1	1	1	1
9. Haywood	2	2	2	2	2	2	2	2	2
10. Knox	10	12	12	15	14	15	15	15	15
11. Madison	9	9	8	8	6	5	5	5	5
12. Moore	0	0	0	0	0	0	0	0	0
13. Sequatchie	1	2	2	2	2	1	0	0	0
14. Shelby	27	33	31	37	37	29	29	29	29
15. Trousdale	4	4	4	4	3	3	3	3	3
16. Weakley	N/E	N/E	N/E	3	4	4	4	4	4
17. White	3	3	3	2	1	1	1	1	1
18. Wilson	3	5	6	6	7	6	6	6	6
Totals	92	105	104	113	104	90	89	89	89

*Data unavailable for 1986-1989

NUMBER OF FACILITIES PARTICIPATING BY COUNTY

	1990	1991	1992	1993	1994	1995	1996	1997	1998
1. Bedford	0	0	0	0	0	0	0	0	0
2. Carroll	N/E	N/E	N/E	N/E	1	1	1	1	1
3. Davidson	12	12	13	10	6	6	7	7	6
4. DeKalb	0	0	0	0	0	0	0	0	0
5. Dyer	2	2	2	1	0	0	0	0	0
6. Fayette	0	0	0	0	0	0	0	0	0
7. Grundy	2	2	2	2	2	2	2	2	2
8. Hardeman	1	1	1	1	1	1	0	0	0
9. Haywood	1	1	2	2	2	2	2	2	2
10. Knox	1	1	1	0	0	0	0	1	1
11. Madison	4	4	3	3	5	4	4	5	4
12. Moore	0	0	0	0	0	0	0	0	0
13. Sequatchie	2	1	1	1	2	1	0	0	0
14. Shelby	19	18	17	17	20	22	20	17	16
15. Trousdale	5	4	4	4	3	3	3	3	3
16. Weakley	N/E	N/E	N/E	3	4	2	2	2	2
17. White	2	3	1	1	1	1	0	0	1
18. Wilson	1	1	1	0	2	2	1	0	1
Totals	52	50	48	47	49	47	42	40	39

*Data unavailable for 1986-1989

CM/JA

Self-Determination - State Summaries

Arizona

Implementation of self-determination in the state of Arizona is the responsibility of the Arizona Department of Economic Security, Division of Developmental Disabilities (The Division). The Division annually serves 14,000 individuals through six district offices and approximately 40 local community offices. The Division has a \$200 million annual budget including \$60 million in State general funds and \$140 million in Federal Title XIX funds.

The self-determination project is called *This is My Life: Arizona's Response to Consumer Control, Choice and Responsibility*. The project shifts services from a case management model to a system that empowers individuals with developmental disabilities and their families. Because of immense rural areas and large Hispanic and Native American populations additional challenges and opportunities exist in achieving self-determination.

The project joins The Division with the state's Center For Independent Living (CIL). This alliance along with funding from the Robert Wood Johnson Foundation will match 50 trained peer mentors with 72 DD individuals and their families. The peer mentors are DD individuals or family members of DD individuals who are living full, community-integrated lives. *This is My Life* participants are encouraged to become peer mentors themselves hopefully creating a self-perpetuating system.

By shifting routine tasks into the community via the peer mentors The Division decreases average per capita costs. Case managers have the opportunity to become Personal Agents offering customer-service, service options, and system cooperation with consumer budget management choices. A management level position will also be added vested with the authority to remove barriers preventing consumer choice at every level. Any savings will be reallocated to provide services to those presently on waiting lists.

An evaluation will be undertaken at the end of each year in the two-year project. This will provide necessary data to allow the Division justification for legislative and regulatory changes needed for statewide implementation.

Connecticut

The Connecticut Department of Mental Retardation (DMR) is responsible for the Connecticut Self-Determination Systems Change Initiative. The DMR serves 13,904 citizens with mental retardation and their families. The DMR delivery system consists of five regional offices, one training school, and a central office.

Presently 7,000 individuals reside in residential settings and 6,000 individuals live in their own homes or with their families. Those living in residential settings tend to receive more comprehensive service than those living at home or with family. A rapidly expanding waiting list exists for residential and day services. The state recognizes that the traditional service system may not be the most efficient or cost-effective and that additional resources are not likely forthcoming.

The DMR has committed to implementing self-determination through recent pilot programs, studies, and related activities. These activities have surfaced many of the system barriers that will affect a large-scale implementation of self-determination. A grant from the Robert Wood Johnson Foundation (RWJF) is helping move the present service system towards a system based on the principles of self-determination.

The DMR will assist 125 people from all five regions in the efforts to determine their own futures. Fifty people will be assisted in year one of the project and seventy-five people in year two. Some of the individuals are presently using the existing system while others will be new entrants into the new system. The DMR is working to reallocate \$2,500,000 in state funds to support the participants of self-determination in Connecticut. During the grant period the DMR is striving to maximize federal reimbursements through the use of vouchers, direct payments to authorized third parties, and use of fiscal intermediaries.

Florida

At present the state of Florida has re-formed an advisory/oversight team (51% are people with disabilities, the balance are family members and members of the service system) to pursue the concepts of self-determination. They have also begun the creation of presentation and training materials regarding self-determination and supporting self-advocates to do training/presentations to inform the DD/MR population.

They have also involved themselves in applying the model of self-determination in the ICF/DD Transition Process and Institutional Phase-Down. The state also continues researching the opportunities to replicate other states use of self-determination as a foundation for systems change.

Hawaii

The Developmental Disabilities Division of the Hawaii Department of Health (DOH) is responsible for the self-determination project named Owau Ke Alaka `i. A 1995 Hawaiian legislative act mandates that all programs and services administered by the DOH are to be provided in the community. This has helped the system move from a paternalistic system to one that recognizes the decision-making capabilities of individual having DD's.

State agencies worked together to develop the Owau Ke Alaka `i model of self-determination. With grant assistance from the RWJF it is their goal to implement a participant driven system that is cost-effective and offers a higher quality of living for individuals with DD. This model allows the participant to make decisions on a) what supports and services they need, and b) how to allocate funds to obtain these supports and services. The Owau Ke Alaka `i project will also test the question of whether managed care principles are compatible with participant choice.

The project will also use an advanced evaluation system to measure the effectiveness of the program. The measurement system, The Accreditation Council on Services for People with Disabilities' Outcome-Based Performance Measures, will gather information from participants prior to entrance into the program and then at the end of each subsequent year.

Through the funding received from the RWJF the DOH intends to develop a community-controlled managed support organization. The responsibilities of the MSO include obtaining training on essential Lifestyle Principles by providing this and other training for participants, support brokers, and existing and new providers; developing a capitation rate(s) that is/are based on the needs of consumers; assisting existing providers to restructure to meet the needs of consumers and encourage new providers to offer services; identifying both legislative and administrative barriers to the initiative; collecting data to evaluate the effectiveness of Owau Ke Alaka `i.

Iowa

The lead agency for self-determination is the Iowa Department of Human Services, Division of Mental Health and Developmental Disabilities. The project, developed by 11 state and private organizations, intends to assist counties in developing the tools, techniques and the infrastructure to implement individualized services. Presently, Iowa uses managed mental health care for Medicaid recipients via one state contracting managed care organization. The DD service system is primarily funded through the counties. Legislation passed in 1995 requires counties to submit plans on managing the county service system both to DD and mentally ill individuals. The service

system uses combined county, state, and federal funds at the county level. This is new to the counties and in response counties have set up Central Points of Coordination (CPC).

This new model of service delivery uses the concept of Customer Designed Services developed by the Governor's DD Council. Customer Designed Services are defined as: "any services, supports, or goods identified by the individuals with disabilities as necessary for them to pursue their own goals." The DOH understands that coordination is key in the successfulness of this project. Accordingly, the 11 entities involved in the design of the program take on individual responsibilities in guaranteeing the successful implementation of the project. Members of the 11 entities will also combine to create a management team that is responsible for identifying barriers and developing solutions for successful implementation.

There is a total of four project sites for the duration of the test period. Two sites will go on line in the first year with the second two opening during the second year. It is hoped that the lessons learned in the first year will be overcome in replicating the second two facilities in year two. The original two sites contain a mix of rural vs. urban and areas needing a full array of services vs. areas with minimal services.

The state agencies responsible for licensing and accrediting providers have agreed to waive current rules and standards in the pilot areas to allow for actual freedom of choice by the participant in their community. They will still assess the quality of services provided by utilizing outcome-based standards based on customer satisfaction.

The state of Iowa feels that they will serve 25 individuals in the first year growing to another 25 in the second year. The second two sites are expected to follow in a similar start-up and growth pattern.

Kansas

In 1995, the Kansas legislature passed the Developmental Disability Reform Act. The act requires the state to commit to services in the community, provide opportunities for choice to DD individuals, develop an organized network of community services, and the establishment of Community Developmental Disabilities Organizations (CDDO's) to manage the network of community services.

Kansas has essentially placed themselves in the position of implementing a statewide system of self-determination. They are presently in the process of researching the elements needed to create an infrastructure that implements the option for self-determination. The Kansas Self-Determination Project is managed by the Mental Health and Developmental Disabilities Commission which contains an advisory board of stakeholders, mostly consumers.

There are two initial project sites located, one each, in Sedgewick county and Shawnee county. The first six months of the project, beginning on 2/1/97, consisted of developing implementation strategies and training. The second six months involves introducing self-determination to one person at a time in the demonstration areas.

Maryland

The Maryland self-determination initiative will be conducted by the Developmental Disability Association (DDA) and The ARC of Frederick County. The DDA is responsible for providing leadership to allow DD individuals with access to quality supports and services necessary to foster the goals of the individual. The ARC of Frederick County is the largest provider of independent service coordination services in Maryland. The agency does not provide direct service they only coordinate.

The new system developed in Maryland uses support brokers to help DD individuals attain the services they desire. The support brokers intend to maximize natural community supports to

maximize cost savings. The cost savings will then be turned around to provide services to those on waiting lists.

A coalition of state agencies, advocacy groups, and providers was able to develop a set of guiding principles that will be implemented as the DDA creates system changes. The guidelines are based on the principles of Self-Determination and are the basis for any system changes.

A training process is being undertaken to provide: person-centered planning, connecting people with their communities, using community resources, building partnerships, and creative thinking and brainstorming. A technical resource group has been formed to meet these needs.

The new system will simply build upon the old system by utilizing the existing strengths. By doing so, they hope to alleviate the fears of the consumers, families, and providers. By training consumers and users how to control their budgets successfully and guaranteeing the same level of funds for services to provider they are hoping to alleviate the stresses of transition. The support brokers will work with 25 individuals each helping to develop and organize the delivery of their desired services. It is hoped that such a small consumer to broker ratio will allow for quicker system conversion.

Two pilot sites will be implemented for a pilot period of 3 years. One site is a suburb of Baltimore offering an urban environment and the other site consists of three rural counties in western Maryland.

Massachusetts

The Massachusetts Department of Mental Retardation will implement a system of self-determination for one of their five state regions. The project region is the Metro-Boston Region, which serves 1,005,204 citizens of which 4,000 are served with a full array of DMR services. The DMR has set objective for change in three areas.

The DMR has established objectives that support individual outcomes, objectives that support internal systems change, and objectives that support external systems change. The state has allocated a total of \$16,554,200 in state funds to support the two year self-determination project in the Metro-Boston Region. Because 282,462 citizens in the Metro-Boston Region community fall below the federally defined poverty line and approximately 44% belong to minority groups, the DMR is committed to exploring the questions of diversity and poverty related to self-determination.

The DMR will draw their initial participants from those DD individuals already in the community and then a second group that will be entering the community after leaving the Fernald Developmental Center. The DMR is forming "Family Councils" that will control the resources for DD individuals in their community. These councils will aid the families in their community in exercising self-determination by helping develop their plan of resources, location of informal and formal supports, and development of the financial plan. From the 6 councils a steering and information sharing committee will be formed. The committee will problem solve issues that arise by sharing information from their own experiences as well to identify common and individual concerns about the program.

Michigan

The state of Michigan, having been awarded \$397,000 from the RWJF in conjunction with similar state investments, intends to involve 600 persons with DD in self-determination across 3 local project sites. These sites are comprised of 5 County Community Mental Health Services Programs (CMHSPs). The state feels that this is the next step in their service system. For two decades they have worked to achieve one of the lowest levels of institutionalization for individuals with DD. They have done so by creating a network of small community residential group homes, apartments, and family support arrangements.

Present planning is directed to changing Michigan's services and supports requiring each CMHSP to make consumer-managed service options with the intended outcome of providing people with meaningful choices and control of their lives. Michigan has built upon the approach used by the first self-determination site in New Hampshire.

The initiative operates at the state level allowing the sharing of information and joint problem solving between sites. The state intends to introduce other project sites, known as affiliate sites, in addition to the original initiative sites. The three project sites have identified a group of individuals who the state feels will and can most benefit from control over their lives. These individuals/family/friends will have the ability to tailor the services and supports they feel they need and to develop arrangements to receive those services from the providers they choose. It is anticipated that many will pursue non-traditional provider arrangements.

As the three project sites live and learn, they will pass their experiences on to the affiliate sites as they start transitioning over to a self-determined system.

Minnesota

The state of Minnesota has made substantial efforts to allow citizens with DD the ability to enjoy their citizenship to the fullest extent. They are doing this by creating a system based upon the fundamentals of self-determination. The state would like DD individuals to enjoy the pride, power, and satisfaction that comes from being able to determine one's lifestyle.

Members of the DD community met over a time period of 7 months to develop an extensive framework that would guide in the transition to a more self-determined system. The Minnesota Department of Human Services (DHS) also established a stakeholder group that will determine principles to guide county-based demonstrations of self-determination for the DD population.

Approximately 42% of Minnesota's \$3.1 million Medicaid budget is spent on persons with disabilities. Annually the state spends \$600 million for medical, social, and long-term care supports for the DD population. Because 80% of those dollars go towards long-term care supports the state feels that a restructuring of those services is part of any solution they come up with. The concern that has arisen relates to the existing system reliance upon a managed care concept. In restructuring the existing system to include a long-term care model of self-determination, substantial effort must be taken to ensure that services and supports are not restricted.

Minnesota will begin with three sites to test the idea that person-centered planning, individually-controlled budgets, consumer-controlled housing, outcome-based quality assurance, consumer education/support, and consumer/family choice of providers is possible in a restructured system. Also to be tested and designed in the three test sites are the viability of the service infrastructure and the ability to replicate such systems in other areas. The three counties that were selected were deemed the most suitable for such projects and are felt to have the highest potential for success.

The budget for this project is approximated at \$1.8 million combined from state, federal match, and grant monies. The initial project duration period is three years.

New Hampshire

New Hampshire has a Division of Developmental Services which operates through 12 independent area agencies. By giving the area agencies a lot of latitude in developing innovative and locally determined approaches to service and support the state of New Hampshire has helped pioneer the movement to self-determination. Because of the self-determination approach and the success of using the state's HCBS waiver, the state was able to close its only institution for individuals with DD.

A grant from the RWJF enabled the state to initiate a three-year systems change project. The systems change project works with nine of the state's twelve regions to develop and implement regionally specific strategies for organization and financing structures. Ultimately over 300 DD individuals will benefit from this project. The intention is to gradually phase-in a statewide system of self-determination.

The state recognizes that policy development is of key importance. In the transition of control of services, the state wants to guarantee that in the development of new supports they do not increase financial vulnerability, jeopardize access, or increase an individual's exposure to unacceptable levels of risk. The state also will use quantitative and qualitative surveys to evaluate the successfulness of project objectives. The surveys will be conducted during and at the conclusion of the project.

Ohio

It is the goal of the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD) to provide every Ohioan with DD the opportunity to make their own decisions on living, working, and community participation. To meet this need they have positioned a Director in access to all department heads, the Governor, and legislative leaders.

There are seven divisions within the ODMR/DD and all seven had a part in the vision development. Project leaders will also be pulled from these seven divisions to implement the project. Further, there are 88 county boards of mental retardation and developmental disabilities (cb'smrdd) that manage the provision of services in their area. The cb'smrdd are represented by Ohio Association of cb'smrdd (OACBMR/DD) and regulated by the ODMR/DD.

The above organizations along with several interested parties formed a coalition to receive grant money from the RWJF. The grant money is being used to develop policy, funding processes and politics to restructure the MR/DD system.

Seventeen counties volunteered to host one of 4 pilot projects. The other 13 counties who did not receive grant monies to operate a pilot project are being offered incentives to develop a working self-determination project of their own within state guidelines. The four project sites will offer support to 223 DD individuals who choose to participate. The state will also allow 420 DD individuals from the other 13 cb'smrdd's to participate if they desire.

A risk pool will be funded from any cost savings the program realizes. Any savings beyond the risk pool will be spent on placement of DD individuals on waiting lists. It is hoped that by the end of year 3, the project duration period, all regulatory barriers controlled by the ODMR/DD will be removed. Any barriers that cross intergovernmental lines may take longer due to delays in changing state policy or legislation.

Oregon

The Oregon self-determination project involves three statewide organizations: Oregon's Office of Developmental Disabilities Services (ODDS), Oregon Developmental Disabilities Council (ODDC), and the Oregon Technical Assistance Corporation (OTAC). Their project intends to close the Fairview Training Center by the year 2000, limit access to the 24-hour system of congregate care, and reallocate service dollars to a personalized service system controlled by the consumer.

The project site will benefit 60 DD individuals in Multnomah County, which encompasses Portland. The system allows the individual to manage their services and funds through a service broker. The project will cost \$450,000 for 2 ½ years. The state has prepared for the transition to a person-centered program by training 400 individuals in program planning techniques.

By year 2 of the project, future brokerage sites will be identified and selected to implement self-determination. The state intends to use a statewide education campaign to inform consumers

about the system change and opportunity for choice. An evaluation will be taken to identify the successful project practices and system changes, and analyze outcomes for consumers.

Eventually the program will receive future funds of \$14 million when the training center is fully closed. These funds, to be used for family and brokered supports, will allow approximately 1,500 DD individuals and their families to control the services they receive.

Pennsylvania

The state of Pennsylvania originally intended to implement 9 county mental health and mental retardation self-determination projects. They now only intend to initiate 3 county pilot projects that will run for 18 months instead of 3 years. The project coordinators in each county will collaborate to ensure successful implementation of the independent projects.

Each county is expected to develop a system of service delivery, support, brokerage, and customer service that is unique to the individual county. All 3 counties will utilize the service providers in their area independently from the other counties. The result will hopefully be a statewide use of self-determination managed on the county level.

The Office of Mental Retardation will oversee the entire project. They have named the process of implementing a statewide system of self-determination the Office of Mental Retardation Multi-Year Plan.

Texas

The Texas Self-Determination Partnership is a project collaborated on by the Texas Department of Mental Health and Mental Retardation (TXMHMR), the Texas Health and Human Services Commission, the Texas Department of Human Services, and the University Affiliated Program for Developmental Disabilities at the University of Texas. The lead agency as chosen by these organizations is the TXMHMR.

The state is working towards a support system that is shared among agencies, communities, and personal networks. TXMHMR is going to use multiple project sites over a 3 year period. The project will be guided by an Advisory Committee with representatives from advocacy groups, state agencies, community public and private providers, and professional organizations.

The Texas program will involve training to service providers, DD individuals, and family members in the principles and implementation of self-determination. It will also include consultation from national experts on the use and adaptation of person-directed planning. The state is interested in developing new ways to include Medicaid funding into a self-determined system.

Utah

Approximately 3,200 individuals are serviced by the Utah Department of Human Services, Division of Services for People with Disabilities. That includes 2,894 individuals receiving support in their home or community and 302 individuals receiving services from the states only ICF/MR named the Development Center. All community based services are under the authority of the DOH. Supports are delivered via 44 independent service providers contracted with the state through their 4 regional offices.

At the end of the three-year project period the state hopes to have one-third of the Division's consumers exercising self-determination. They would like 35 of the 44 providers and 90 out of 98 support coordinators in each of the four regions to be providing the appropriate consumer services. Five project sites will start the program in the first year with the goal of expanding to 20 sites in year three.

Vermont

The state of Vermont has positioned itself over the last decade to implement self-determination by closing the only DD institution and having all but two 6 bed ICF/MR facilities closed. Over the past

few years they have also worked on developing and implementing a framework that allows consumers to make their own decisions.

Vermont proposes to implement the concepts of self-determination statewide over the course of a 3-year self-determination project. The plan for system redesign is almost complete and the state will use grant money from the RWJF to focus on implementation. The state intends to supply support and information to consumers so they can transition smoothly into their new responsibilities if they choose so.

The state has set out seven objectives to implement self-determination. Objective 1 involves creating environments of support for DD individuals to help assess the nature, duration, and extent of services. Objective 2 requires the promotion of self-determination initiatives when restructuring the delivery system. Objective 3 includes the establishment of a Self-Directed Service Network. This includes a stakeholder group that meets regularly to share information. Objective 4 will facilitate the continued search for and development of alternative support options. Objective 5 should identify and resolve issues relating to technical, structural, administrative and regulatory barriers to implementation. Objective 6 involves the development of a statewide training and technical service assistance system to help educate all players in the system. Objective 7 requires the development of a quantitative and qualitative measuring device to evaluate the project along with an independent review of the project.

Washington

Washington State has a unique test program ready for implementation. Similar to other states uses of multiple sites, Washington will initiate self-determination in two locations. The first is in Spokane County and will focus on the South Central neighborhood of the city of Spokane. The second site is Island County, Washington which encompasses the island of Whidby.

The South Central site has approximately 150 individuals with DD. A Project Advisory Committee sent out letters asking for replies from families interested in participating in a project of self-determination. The committee received over 60 replies from families and individuals showing interest in the program. The DD population in South Central ranges in age from infants to people in their seventies. The Advisory Committee will choose 15 to 25 people or families to participate in the first year. The project hopes to work with all 60 respondents by the end of the three year project period.

The second project located on Whidby Island is unique because it is self-contained, it is a very large island with a small population (30,000), and mostly rural. Three small cities are located roughly twenty miles apart and a large Naval Base is located on the North end of the island. Approximately 200 individuals with DD, mostly under age 7, reside on the island including residents of the Naval Base. The project on Whidby Island desires to assist families in discovering and using all of the supports available to them in the community and make responsible choices with those resources. Their ultimate goal is to educate families to see their children as active participants in any community they live in. The project intends to start with five families over the first year and work with 50 families within three years.

Wisconsin

The State of Wisconsin is using three primary test sites for the development of self-determination. Each site is a countywide program.

In Winnebago County the program has changed from a provider-driven system to a consumer-driven system. It will put support service dollars in direct control of 60 selected consumers. The county case managers are available to help consumers, but they spend more time now implementing services rather than determining people's services. The county has also established a fiscal intermediary/accounting firm to pay the providers selected by the consumer. The county desires to reduce waiting lists, contain costs, and enable DD individuals to lead regular lives.

LaCrosse County is working with Riverfront, Inc. in hiring a project facilitator to develop and begin self-determination for 25 to 30 people. The county would like to offer a wide selection of supports, greater flexibility, and a sense of control.

Dane County has been involved in self-directed services for selected participants with the reward of the RWJF grant. A select number of participants with DD will choose a broker to help choose between 36 residential and vocational providers. The broker will then assist in negotiating rates with the county for services to be paid by a voucher system. The broker is not allowed to be a county case manager, service provider, or family member.

In addition to the 3 existing project sites, there are 15 to 20 other counties involved in developing models of self-determination. It is hoped that they will be able to implement their models as they become mature enough and that funding is made possible.

PUBLIC CHAPTER NO. 883

HOUSE BILL NO. 2423

By Representatives Hargrove, Pleasant, Haley, Miller, West, Davidson, Fitzhugh, Ford, Patton, Langster, John DeBerry, Ulysses Jones, Kent, Ralph Cole, Boyer, Bittle, Sharp, Maddox, Tidwell, Wood, Stulce and Mr. Speaker Naifeh

Substituted for: Senate Bill No. 2404

By Senators Womack, Miller, Williams, McNally

AN ACT to amend Tennessee Code Annotated, Title 8, Chapter 27, Part 2, relative to long-term care benefits for active and retired public employees.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 8, Chapter 27, Part 2, is amended by adding the following as a new, appropriately designated section as follows:

8-27-2____. A long-term care benefits program may be established at the discretion of the committee created in Section 8-27-101. The committee is authorized to determine the benefits package, funding method, administrative procedures, eligibility provisions and rules relating to the program. If such a program is established, the committee shall have all the powers set forth in Section 8-27-201 in administering the program. Payroll deductions shall be available for the payment of premiums from salary paid by the State of Tennessee and from retirement benefits paid by the Tennessee Consolidated Retirement System to members participating in the plan.

SECTION 2. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 3. This act shall take effect upon becoming a law, the public welfare requiring it.

PASSED: April 23, 1998

APPROVED this 6th day of May 1998



Department of Health

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