# Creating a Cabinet Level Agency for Addressing the Needs of Tennessee's Elderly Population

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## I. Introduction

Tennessee Senate Bill 1171, introduced by Senator Lowe Finney and passed on June 18, 2009, called for a joint legislative committee to study the creation of a Department of Aging and Adult Services (Committee Studying Creation of a Department of Aging and Adult Services (the Legislative Committee)). The Committee was to report its findings in early February although, to date, no report has been issued.

Alicia Smith & Associates (ASA) was contacted by staff in the Office of the Governor and asked to provide assistance to the staff by bringing our perspective to the issues and providing recommendations to the Executive Branch that would incorporate both the firm's knowledge of Tennessee and its work with elderly issues in other states. The firm was tasked with digging into the issues and offering suggestions that could serve as a companion piece and additional resource to help inform the discussion and provide perspective to the ideas put forth by the Legislative Committee.

Coming into the project, ASA understood that a primary concern of both the Legislative and Executive Branches is the growing number of elderly in Tennessee and the fact that services for the elderly are now provided by or through some 23 State agencies which offer more than 100 programs although the majority of the services are provided by the Departments of Human Services and Health (DHS and DOH respectively), the Bureau of TennCare (TennCare) and the Tennessee Commission on Aging and Disability (TCAD). A key question is whether the lack of a single point of entry to services is best developed by the creation of a new Department that would combine all or most of the policy, budget, and service delivery systems targeting the elderly.

## II. Primary Issues Identified by Stakeholders

During the course of our work, the ASA team met with key stakeholders from the General Assembly, State government agencies, Area Agencies on Aging and Disability (AAADs), and advocates. (A complete list is attached at Attachment A.) During these meetings, we asked that the interviewees share their perspectives on the nature of the issues/problems with the system of care for the elderly in Tennessee and their perspectives on various solutions, including the creation of a new Cabinet level Department devoted exclusively to issues affecting the elderly.

While a number of discrete issues were raised by stakeholders during our meetings (See Attachment B for a complete list), three overarching issues emerged from our discussions. They are:

- System Wide Planning for a Growing Elderly Population;
- The Lack of a Single Point of Entry to Services; and
- System Fragmentation.

## A. System Wide Planning for a Growing Elderly Population

In 2008, Tennessee's elderly population (60 years of age and older) was estimated at 1,155,990, representing approximately 19% of the State population.[1] By 2025, Tennessee's elderly population is projected to increase to more than 20% of the State's total population.[2]

The OAA requires that any state receiving OAA funding to provide services to the elderly establish a "state unit on aging" to administer the funds. A "state unit on aging" is defined as an entity within state government empowered by the Governor to be responsible for administering, managing, designing and advocating for benefits, programs and services for the elderly and their families. TCAD is designated as Tennessee's state unit on aging.

The Administration on Aging (AOA) provides an annual allocation of OAA funds to states based primarily on the number of persons 60 years of age and older in the state. TCAD receives this funding and in turn, in accordance with OAA requirements, allocates OAA funds to regional planning and service areas, specifically through contracts with the Development Districts and/or Human Resource Agencies based on an approved funding formula. Development Districts and/or Human Resource Agencies (HRAs) transfer funds to local AAADs. Nevertheless, TCAD is responsible for monitoring the quality of care provided to the elderly population which consists of annual inspections of AAADs.

The perception among most stakeholders is that while strategic planning and policy development are within TCAD's authority, its ability to adequately perform this function is hampered by the fact that it is not a Cabinet level agency and therefore does not receive the same attention afforded to Cabinet level agencies. The stakeholders felt strongly that the entity responsible for overseeing service delivery for the elderly needs to have greater visibility within State government and greater accountability for elderly health outcomes and quality of care.

## B. Lack of a Single Point of Entry (SPOE)

Several stakeholders noted that there is no one entity in the State that serves as the single point of entry (SPOE) to inform the elderly of all available programs across the State and to assist in gaining access to these available resources.

In September 2009, the State introduced a web-based eligibility tool, *FindHelpTN* (www.findhelptn.org), which is designed to help all Tennesseans find State and federal programs they might be qualified to receive. Through a serious of questions, the tool guides the user in identifying available resources such as food stamps, the Women, Infants and Children's (WIC) program, Medicaid, Low-Income Energy Assistance Program, CoverRX, etc.

[1] 2008 U.S. Census Bureau estimates
[2] U.S. Census Bureau, Population Paper Listing #47

and his/her potential eligibility for each. The tool provides a telephone number and a link to a website address for each of the available programs. However, it does not take the next step and assist a user in completing applications for the programs for which he/she is potentially eligible. Nor does it focus exclusively on the needs of and services for the elderly.

To the extent there is an entity that serves as the SPOE for the elderly in Tennessee, that entity is the AAADs. However, the assistance provided by the AAADs is primarily limited to OAA programs, Medicaid and non-Medicaid long-term care services and does not cover the full spectrum of available State resources.

## C. System Fragmentation

While almost everyone we talked to identified fragmentation in the system as an issue, most could not specifically articulate how that fragmentation impacted the delivery of care to the elderly. However, a few concrete examples of fragmentation emerged from our discussions. Most of the examples are results of the lack of a SPOE and/or the lack of a cohesive and coordinated policy or implementation of elderly policy among the different agencies with responsibility.

A few stakeholders noted that responsibility for performing various functions of the service delivery system for the elderly are spread among multiple, independent agencies. For example, TennCare conducts functional eligibility assessments to determine a person's qualifications for Medicaid long-term care services (nursing home care and home and community-based services), usually within less than a week. On the other hand, DHS, through its ninety-five county offices, determines financial eligibility for persons seeking Medicaid services, which can generally take anywhere from 30-45 days to complete. Therefore, while an individual could conceivably be determined by TennCare to fulfill all requirements for receipt of long-term care services, he/she would not be able to receive these services until DHS completes its financial eligibility assessment. Both entities acknowledge that while communication is better than in the past, there is still room for improvement, and that these communication difficulties can ultimately affect the people they are trying to serve. Unfortunately, in the short term this eligibility time lag will not be solved by CHOICES implementation. DHS and the TennCare Bureau have entered into discussions to begin the process of addressing the lag time presented between financial eligibility determination and functional eligibility determination.

Still other stakeholders noted that multiple agencies perform similar functions for different components of the elderly population with little to no coordination. For example, TCAD is primarily responsible for overseeing service delivery for elderly persons (60 years of age and older) participating in Older Americans Act (OAA) programs and for the State funded Options for Community Living program for non-Medicaid eligible persons 18 years of age

and older. In contrast, TennCare administers long-term care programs for Medicaid eligible elderly 65 years of age and older. Having different entities involved in making eligibility determinations, each with a different eligibility threshold, creates barriers and confusion for the elderly and stakeholders trying to understand and navigate the system of care.

In some instances, administration of like services also falls to multiple agencies, depending on the funding source. Building on the previous example, the Options program, administered by TCAD and designed to serve the non-Medicaid population, offers a subset of the long-term care services (homemaker, personal care and home-delivered meals) provided by TennCare to Medicaid eligible elderly. TCAD is also responsible for administration of the OAA funded home-delivered meal and personal care programs. Finally, DHS administers a homemaker services program for non-Medicaid eligible elderly that is funded through the federal Social Services Block Grant Program. Once again, this lack of clarity and potential service duplication is confusing for those elderly and stakeholders trying to understand how the system of care operates and where to access the system for needed assistance.

Still other stakeholders pointed to the multiple levels in the system between the funding source and the direct providers of services. For example, TCAD has no direct line of responsibility over the providers of services to the elderly. As the examples illustrate, eligibility, policy setting, service delivery and oversight differs among and between the agencies. In some cases these differences are driven by federal laws attached to the different funding streams. Nonetheless, the resulting discrepancies lead to the perception that the system is badly fragmented.

Attachment C provides additional information describing the Tennessee service delivery system for the elderly and underscores the multiple agencies and programs involved in operating the system of care and the extent to which fragmentation exist in the system.

## III. State Models

During the course of our work, we were asked to look at other states and how they organize the planning, policy development, budgeting, implementation and monitoring of services provided to the elderly. There is no state that we found that has an agency that comprehensively addresses all of the programs that service the elderly although there are clearly states that have gathered the majority of the traditional human service functions in one organization. Interestingly, however, it is not necessarily the states with department level agencies for the elderly that are cited as model examples of program design and delivery of services to seniors.

To the extent that organizational structure is driven by federal law, the two largest sources of federal money for services to support the elderly come either from the

OAA or through the Medicaid program. While the OAA requires that each state establish a unit on aging through which OAA funds flow, it does not mandate at what level within state government a state unit on aging should reside. States have the discretion to establish the specific title/name of their state unit on aging and the organizational placement within state government. Only 16 states (32%) have a state unit of aging that operates at the Cabinet level (see Table 1).

In a like manner, Medicaid law requires that each state establish a "single state agency" to be accountable to the federal government for the use of Medicaid funds and to assure that funds are spent only on eligible individuals and Medicaid mandatory or optional services.

Other than these two specific requirements, states are free to establish their own organizational structures and have the freedom to address organizational issues in order to best meet the needs of their state and the people being served. What follows is a brief look at the states most frequently mentioned as models.

**Oregon**

During our interviews, Oregon was frequently cited as a model although it was not always clear whether folks were referring to the organizational structure and placement of elderly issues or to the State's focus on spending for home and community based services over institutional care.

In 2008, Oregon's elderly population (60 years of age and older) was reported at 715,847, approximately 19% of the total population (comparable to Tennessee).[3] Oregon's service delivery system for the elderly emphasizes providing long-term care to persons in home and community-based settings over institutional placement. Oregon has one of the oldest 1915(c) home and community-based services waivers for the elderly and disabled. Oregon's 1915(c) home and community-based services waiver program for the elderly and disabled has been in operation since 1991 and currently serves nearly 30,000 persons[4] with long-term care expenditures in FY 2008 of $296,344,011.[5] In FY 2007, approximately 68% of the State's total Medicaid long-term care expenditures ($658,088,113) were for home health and personal care services in comparison to 30.2% ($292,314,675) for nursing facility care.

Oregon's state unit on aging is the Seniors and People with Disabilities Division, within the Department of Human Services. It is this entity that is responsible for Medicaid functional and financial determinations as well as licensing and regulation of long-term care facilities (nursing facilities, assistance living facilities and adult care homes).

Through the *OregonHelps* website (www.oregonhelps.org), seniors receive assistance with determining eligibility for 33 programs and resources. The

[3] 2008 U.S. Census Bureau estimates
[4] CMS data
[5] Thomson Reuters, November 30, 2009

Governor's Commission on Senior Services, a 21 member commission whose chair is appointed by the Governor, provides assistance in long range planning for the elderly in the State.

**Washington**

We also looked at Washington, which is often cited for its long-term care delivery system for the elderly. In 2008, Washington's elderly population was reported at 1,127,229. Washington was one of the first states to receive federal approval for a 1915(c) home and community-based services waiver for the elderly and disabled in 1981. The State now has four home and community-based services waivers for the elderly and disabled that provide services to more than 30,000[6] Medicaid eligible persons. In FY 2007, approximately 60.7% ($1,144,774,306) of total Medicaid long-term care expenditures went towards home health and personal care services in comparison to 31.5% ($594,863,214) in nursing facility expenditures.

Washington's state unit on aging is the Aging and Disability Services Administration, within the Department of Social and Health Services. The Aging and Disability Services Administration oversees services for the aged, physically disabled and persons with developmental disabilities and administers the OAA programs. The agency also conducts both financial and functional eligibility for Medicaid long-term care and is responsible for licensing nursing facilities, adult family homes and boarding homes.

Washington has a SPOE system for all publicly-funded services. State employees at local offices throughout the State offer information and application assistance. A person can apply for cash assistance, food assistance, medical assistance, long-term care assistance (both home and community-based services and residential care) and alcohol and drug treatment through the SPOE.

**Florida**

Florida has the second largest population of elderly persons in the country at 4,200,667 next to California. In comparison to Oregon and Washington, Florida's service delivery system for the elderly has more institutional care available than home and community-based services. Florida has three 1915(c) home and community-based services waivers for the elderly and disabled but serves only a little over 18,000[7] in the combined programs. Approximately 56.6% of Florida's Medicaid long-term care expenditures in FY 2007 were for nursing facility care ($2,341,742,675) in comparison to 35.5% ($1,470,676,127) for home health and personal care services.

Florida's state unit on aging is the Department of Elder Affairs (DOEA). DOEA administers adult protective services and conducts Medicaid functional assessments. However, Medicaid financial eligibility assessments are conducted by the Department of Children and Families and licensing and inspections of long-

[6] CMS data
[7] CMS data

term care facilities (nursing homes, assisted living facilities and adult family care homes) falls under the jurisdiction of the Agency for Health Care Administration, the state Medicaid agency.

Thus, while Florida has ostensibly built a Cabinet level agency for elderly affairs, significant functions that impact service design and delivery are vested in other state agencies.

(See Attachment D for information on other state models and Table 2 for state statics and sources.)

## IV. Recommendations

After five days of interviews and intensive review of the myriad of written materials presented to us by the various stakeholders and based on our fairly extensive knowledge of Tennessee's current delivery system, we have formulated some thoughts that we hope will be helpful to the Executive and Legislative Branches as they assess the various options for addressing the issues raised in this report.

1. **In the short term, the State should consider restructuring TCAD, using its Board as advisory and elevating the Executive Director position to a Cabinet level Secretary. TCAD (or a renamed version) would continue to distribute OAA funds, contract directly with the AAADs, and monitor the service delivery system for both OAA funds and, as will soon be the case, for Medicaid's CHOICES program via contract.**

Given the current financial situation of the State, now does not appear to be the time to create a brand new agency. Regardless of whether the agency created is skeletal or is designed to combine multiple functions and programs there will be a real cost outlay to the State. However, using the positions, dollars, and physical infrastructure already in place for TCAD, the State could elevate the agency to department status and make the Executive Director position a Cabinet level appointment. TCAD would maintain its current responsibilities for the allocation of OAA funds and the monitoring of services provided under the OAA. It would also maintain and augment its mandate to identify and provide advance planning for the future needs of the State's growing elderly population.

Taking this approach would immediately elevate the planning, policy development and budgeting functions to Cabinet level and give the kind of visibility to elderly issues that most stakeholders feel the system currently lacks and needs. However, in order to make this first step work, we further recommend that:

- A thorough management review be conducted of the existing organization and a further organizational sharpening of its roles and responsibilities. The anticipated results of such a review will lead to a

revised organizational structure, changes to some job descriptions and a need for staff training.

- The current practice through which TCAD contracts with the Development Districts and/or HRAs who, in turn, contract with the AAADs who then contract with providers of OAA services be revised. TCAD should contract directly with the AAADs and hold these agencies accountable for the proper expenditure of funds and the quality of the services being provided. The current structure puts too many layers between the allocation of funds and the responsibility for monitoring the system.
- Consider the creation of an informal advisory board that has both "users" of senior services and representatives from key State agencies like DHS and TennCare to enhance communication and coordination of services.

We do not recommend that TCAD resume responsibility for the long-term care services that they were providing under the State's now expiring Medicaid 1915(c) Elderly and Disabled waiver. The CHOICES program is going "live" in the Middle Region of Tennessee on March 1, 2010, with the other Regions to shortly follow. This program must be given a chance to achieve stability and to be evaluated.

Through a contractual relationship, TennCare will look to TCAD to assist in monitoring the overall quality of delivered services in the CHOICES program. However, the administrative accountability for this function is vested within TennCare. Therefore, the contract that TennCare has with TCAD to monitor the overall quality of the CHOICES program should become a priority for the new agency and it (the new agency) should be held accountable to TennCare to produce accurate data so that the program can be evaluated by all stakeholders.

**2. Consider contracting with a single, statewide vendor to operate a single point of entry to all services provided throughout the State.**

Unless and until all elderly functions are located in a single agency, we suggest that the State consider contracting with a vendor to operate a statewide call center and to establish (perhaps co-located with the AAADs) statewide walk-in centers that will serve as a single point of entry to the services provided by the different agencies. The State may be able to build on the *FindHelpTN* design and expand to include a centralized call center co-located with a AAAD.

The concept would be that a "neutral" entity have access to information about the myriad of programs offered throughout the State including eligibility, services, local access, phone numbers etc. for the programs. This could potentially be done by the AAADs but it would require augmentation in their staff, updating of their equipment, and significant training. In the end, it might be less expensive for the State to procure this service and "wrap around" the existing service delivery system.

A comprehensive SPOE approach could consist of the following functions: 1) provide information about all available services and resources; 2) assess eligibility for available programs and services; and 3) facilitate filling out applications (applying for) all programs; 4) transfer callers to other resources, preferably using a warm transfer; and 5) build an infrastructure to track applications, monitor the status of applications and generate system reports to all relevant agencies.

### 3. As time and resources permit, move additional functions into the restructured TCAD agency.

If, in the longer term, the State decides to move additional functions, programs and staff into a restructured TCAD, careful thought needs to be given to determine the appropriate functions and programs that should be vested in a new department and the implications for moving functions and programs from existing State agencies. As presented to the Legislative Committee, there are more than 100 programs in the State to assist the elderly population spread across some 23 State agencies. Starting with a smaller, more streamlined agency and building upon this structure over time will afford the State the opportunity to ensure that appropriate interagency planning and coordination occurs in making difficult decisions regarding the comprehensive functions of the new agency.

# Attachment A:
# Stakeholders Interviewed

We met with several key players in order to gain a better understanding of the current Tennessee service delivery system for the elderly and the system issues. Meetings were conducted during two on-site visits to the State that occurred on November 12-13, 2009 and December 7-8, 2009. The following is the list of those persons we met with during our on-site visits.

**Governor's Office Staff**
John Morgan – Deputy Governor
Tam Gordon – Special Assistant to the Governor for Projects
David Braam – Legislative Liaison
Seth Stanger – Assistant to the Governor for Projects and TCAD member

**Bureau of TennCare**
Darin Gordon – Director
Patti Killingsworth – Chief of Long-Term Care

**Department of Finance and Administration**
Dave Goetz – Commissioner

**Department of Human Services**
Virginia Lodge – Commissioner
Danielle Barnes – EEO/ADA Director and Assistant General Counsel
Marcia Garner – Director Medicaid/TennCare Policy
Vickie Lawson – Program Director for Adult Protective Services

**Tennessee Commission on Aging and Disability**
John Arriola – Chair
Mike Hann – Executive Director
Jerry Blasingame – State Long-Term Care Ombudsman
Perry Register – Fiscal Services Supervisor

**Tennessee Legislators**
Senator Lowe Finney – Chair, Committee Studying Creation of a Department of Aging and Adult Services
Representative Steve McDaniel – Member, Committee Studying Creation of a Department of Aging and Adult Services
Senator Diane Black – Member, Committee Studying Creation of a Department of Aging and Adult Services

**Area Agency on Aging and Disability**
Ernestine Bowers – Director, Greater Nashville Regional Council

**AARP of Tennessee**
Patrick Willard – Advocacy Director

Also while on-site on December 7, 2009, we attended meetings of the Committee Studying Creation of a Department of Aging and Adult Services and the Long-Term Oversight Committee.

# Attachment B:
# Service Delivery System Issues Identified by Stakeholders

The following is a compilation of the problems with the current Tennessee delivery system for the elderly population as identified by stakeholders during our meetings. It is important to note that not everyone we spoke with unanimously identified all issues listed below as problems with the current system. Yet, consistently, everyone indicated that there were one or more problems with the current system that need to be addressed in order to maximize the care and services provided to aging Tennesseans.

- There is inadequate and ineffective communication between key players: TennCare and TCAD; AAADs and DHS; TCAD and DHS; and TCAD and AAADs. While there has been some improvement in communications between DHS and TennCare, the relationship is still problematic.

- DHS does not receive all of the necessary paperwork and information from AAADs in order to make eligibility determinations in a timely manner.

- There needs to be a true single point of entry into the system, for both Medicaid and non-Medicaid recipients.

- TCAD does not provide appropriate oversight of AAADs including:
  - Appropriate/adequate training;
  - Appropriate/timely development and dissemination of policies; and
  - Appropriate/adequate monitoring of the performance of AAADs.

- TCAD needs strong leadership with extensive experience in providing and developing services for the elderly and long-range planning.

- The TCAD commission is a voluntary body that meets four times a year. This is not an effective way to lead the efforts of TCAD.

- There is duplication of service delivery – for example – home maker services funded through DHS for and homemaker services funded through OAA. There is no coordination of the two benefits.

- There is no accountability on the part of TCAD for oversight, training and monitoring of the AAADs and services delivered.

- TCAD does not expend all allocated OAA funding in order to maximize service delivery.

- There is no centralized or streamlined Medicaid financial eligibility process. DHS eligibility determinations are made by 95 different county offices.

- There needs to better collaboration between (DHS and TennCare) on eligibility determinations.

- There needs to better coordination on timelines for functional and financial eligibility processes.

- TCAD is required to contract with Development Districts or Human Resource Areas (East TN) and not AAADs.

- There currently is not a statewide ombudsman program as required by OAA. Instead, there are 9 fragmented programs across the State. Local ombudsman officers are employed by provider agencies that contract with the local AAAD.

- TennCare annual contract process with TCAD does not allow for long-term planning and policy development.

- TCAD has no vision or organized strategy for future planning and service delivery.

- Medicaid eligibility applications are up by 45% and food stamps up by nearly 20%, therefore creating a strain on already limited resources.

# Attachment C:
# Tennessee Service Delivery System for Elderly Population

Tennessee's current service delivery system for the elderly population is a multilayered construct involving multiple independent entities, each with different responsibilities and performing different functions. Four entities have primary responsibility for service delivery and oversight of the delivery of health care services for the State's elderly population: 1) Bureau of TennCare, 2) Tennessee Commission on Aging and Disability, 3) Department of Human Services and 4) Department of Health. Interdependencies exist between several of these entities which warrants the need for collaboration and effective communication. These entities strive to work together to provide a comprehensive system of care for the elderly in Tennessee.

The following is a brief description of the relevant programs for the elderly administered by each of the four entities, the functions performed by each and the extent to which the entities are expected to coordinate.

## 1. Bureau of TennCare

The Bureau of TennCare (TennCare), located within the Department of Finance and Administration, is the designated State Medicaid Agency and in this role oversees service delivery and provider reimbursement for all Medicaid funded programs.

***Medicaid Programs***

Through the TennCare program, Medicaid eligible elderly persons receive access to all physical and behavioral health services via a managed care organization (MCO) that is responsible for addressing the member's health care needs.

In terms of long-term institutional care, TennCare pays for the cost of nursing home care for qualified Medicaid recipients. TennCare also pays for long-term care services provided in the community in lieu of institutional care. Effective, March 1, 2010, community-based long-term care services will be provided to eligible elderly persons through the new CHOICES in Long-Term Care program (see discussion below). Prior to this time, home and community-based long-term care services are provided on a fee-for-service basis through the Statewide Elderly and Disabled Home and Community-Based Services Waiver program (Statewide Waiver program).

TennCare also funds the Program of All–Inclusive Care for the Elderly (PACE) in Hamilton County, which is operated by Alexian Brothers. The PACE program uses a multidisciplinary team approach to providing services in a central location to persons 55 years of age and older in need of long-term care assistance. The services provided through the PACE program include: physician and nursing services, social work, physical therapy, occupational therapy, recreational therapy

and social activities, nutrition counseling, personal care, spiritual care, transportation and escort and meals.

### *Eligibility for Medicaid Long-Term Care*

TennCare conducts functional eligibility assessments to determine a person's qualifications for long-term care services.

### *Coordination, Oversight and Monitoring*

TennCare provides training to and is responsible for monitoring and oversight of MCOs and providers regarding their roles in administering Medicaid programs and service delivery.

TennCare requires periodic reporting by MCOs regarding quality of services, service utilization and member access to providers and services.

## *CHOICES in Long-Term Care Program*

### Program Description

The newest component of the Tennessee delivery system for the elderly, TennCare CHOICES in Long-Term Care (CHOICES) goes into effect March 1, 2010. CHOICES will broaden the scope of services offered by the current MCOs participating in TennCare to include a range of alternatives for elderly and disabled persons who need long-term care. CHOICES implementation will occur on a phased in basis, starting with the Middle Region on March 1, 2010, followed by simultaneous implementation in the East and West Regions later in the year. Once CHOICES in implemented in a Region, the Statewide Waiver program will cease to operate in that Region. All of the services provided in the Statewide Waiver program will be folded into CHOICES, excluding case management. Instead of case management, MCOs will perform comprehensive care coordination for all persons enrolled in CHOICES. Persons enrolled in the Statewide Waiver program will transition to the CHOICES program.

A design feature of CHOICES is the creation of a Single Point of Entry (SPOE) for all potentially eligible Medicaid recipients seeking long-term care services. The SPOE is intended to facilitate access to the system and needed services by providing one entry into the system for information regarding available services and resources and program application. AAADs will assume this SPOE function which will also entail submitting eligibility packages and needed documents to TennCare and the Department of Human Services.

### Coordination, Oversight and Monitoring

Since CHOICES is a new program TennCare will need to monitor more rigorously, at least at the outset, to ensure successful program implementation and outcomes. TennCare will require MCOs to submit periodic reports demonstrating adherence to program requirements and timeframes.

TCAD will assume the responsibility of monitoring the AAADs in fulfilling their SPOE functions and will report results to TennCare.

Coordination and frequent communication between entities will be essential: TennCare and DHS; DHS and AAADs; TCAD and AAADs; AAADs and MCOs; TennCare and TCAD; and AAADs and TennCare.

## 2. Tennessee Commission on Aging and Disability and Area Agencies on Aging and Disability

The Tennessee Commission on Aging and Disability (TCAD) is the State agency responsible for overseeing service delivery for the elderly (both Medicaid and non-Medicaid persons).

### *Older Americans Act (OAA) Programs*

The majority of funding for the programs administered by TCAD are Older Americans Act (OAA) funds. The Administration on Aging (AOA) provides an annual allocation of OAA funds to states based primarily on the number of persons 60 years of age and over in the state. TCAD receives this funding and in turn, in accordance with OAA requirements, allocates OAA funds to regional planning and service areas, specifically through contracts with the Development Districts and/or Human Resource Agencies, based on an approved funding formula. Development Districts and/or Human Resource Agencies transfer funds to local Area Agencies on Aging and Disabilities (AAADs). If a AAAD does not spend a minimum of 92% of allocated funds during the contract year, the remaining 8% is taken back by TCAD and redistributed to other AAADs with identified need.

Services provided through OAA funds include: information and assistance, family caregiver support, nutrition, long-term care ombudsman, legal assistance, guardianship, state health insurance assistance, and senior centers and senior community service employment.

AAADs do not directly provide services. Instead, they contract with local providers who provide the direct care to qualified needy elderly in the region.

### *Other Programs*

TCAD administers the Options for Community Living program (Options). Options is a State funded program that provides to persons age 18 years of age or older with disabilities services and who do not meet Medicaid eligibility requirements home and community-based services. Similar to OAA funding, funding for Options is funneled through TCAD to the AAADs. The Options program provides the following services: homemaker, personal care, case management, home delivered meals and information and assistance.

### *Coordination, Oversight and Monitoring*

TCAD is responsible for training AAADs and monitoring the quality of care provided to the elderly population. In this role, TCAD conducts an annual inspection of AAADs to evaluate their performance.

TennCare provides training to and is responsible for oversight of TCAD, AAADs and providers regarding their roles in administering Medicaid programs and service delivery.

Regular and frequent communication occurs between AAADs, DHS and TennCare regarding eligibility determinations and, as necessary, DHS and TennCare train AAADs on program requirements.

## 3. Department of Human Services

***Programs***
DHS administers several programs for Medicaid and non-Medicaid eligible elderly persons. The services provided through these programs include: adult protective services, homemaker, adult day care and weatherization. These programs are funded through a combination of State funding and federal block grant programs.

***Eligibility for Medicaid Services***
DHS determines the financial eligibility for persons seeking Medicaid services. This function is performed at the local level by 95 DHS county offices.

***Coordination, Oversight and Monitoring***
For persons seeking long-term care services through Medicaid, both institutional and community-based care, the TennCare process for functional eligibility and the DOH process for financial eligibility must be coordinated and both completed in a timely manner.

TennCare communicates with DHS regarding program changes (and provides any necessary training) in order to determine the impact on financial eligibility processes, requirements and timeframes. TennCare and DHS work together to ensure that any program requirements are appropriately reflected in eligibility standards and processes.

Likewise, DHS communicates with TennCare regarding any changes to eligibility processes. DHS also provides training to TennCare staff regarding new requirements.

## 4. Department of Health

The Department of Health (DOH) is the State agency responsible for licensing, regulating and inspecting all long-term facilities, including nursing homes, assisted living facilities and adult care homes.

***Coordination, Oversight and Monitoring***
DOH communicates with TennCare regarding issues identified during inspections, outcomes of inspections and licensure issues regarding specific facilities. TennCare notifies DOH of any noted issues regarding the health and welfare of Medicaid recipients in licensed facilities.

# Attachment D:
# Additional State Models for Elderly Services

**Minnesota**

- State unit on aging is the Board on Aging within the Department of Human Services.
- The Department of Human Services is responsible for licensing and regulating long-term care facilities and conducting Medicaid financial and functional assessments
- Centralized toll-free line for persons to access all AAAs and to obtain information and assistance
- 71% of elderly receive services through managed care organizations
- Higher Medicaid long-term care expenditures in FY 2007 ($1,719,905,875) for home health and personal care services than Florida, Oregon, Washington, Wisconsin or Tennessee

**Wisconsin**

- State unit on aging is the Bureau of Aging and Disability Resources within the Department of Health Services
- The Department of Health Services is responsible for licensing and regulation of long-term care facilities and conducting financial eligibility determinations
- Functional assessments are conducted by Aging and Disability Resource Centers (ADRCs) or local Community Options Agencies
- ADRCs serve as the single entry point for elderly (60 years of age and older) and people with disabilities and their families to get information and advice about a wide range of resources available to them in their local communities

# Table 1: State Units on Aging

| Department | |
|---|---|
| Alabama | New Mexico |
| California | Ohio |
| Florida | Pennsylvania |
| Illinois | Rhode Island |
| Iowa | Texas |
| Kansas | Vermont |
| Kentucky | Virginia |
| Maryland | |
| Nebraska | |
| **Commission** | |
| Idaho | |
| Tennessee | |
| **Office** | |
| Hawaii | Montana |
| Louisiana | New York |
| Maine | South Dakota |
| Massachusetts | Washington |
| Michigan | |
| **Division** | |
| Alaska | Nevada |
| Arkansas | New Jersey |
| Arizona | North Carolina |
| Colorado | North Dakota |
| Delaware | Oklahoma |
| Georgia | Oregon |
| Indiana | Utah |
| Missouri | Wyoming |
| **Bureau** | |
| Connecticut | West Virginia |
| New Hampshire | Wisconsin |
| South Carolina | |
| **Board** | |
| Minnesota | |
| **Council** | |
| Mississippi | |

**Source:** National Association of State Units on Aging

## Table 2: State Statistics

| | Elderly Population (60+) | Nursing Facility Medicaid Expenditures (FY 2007) | % of Total | Home Health and Personal Care Medicaid Expenditures (FY 2007) | % of Total | Total Long-Term Care Medicaid Expenditures (FY 2007) |
|---|---|---|---|---|---|---|
| **State** | | | | | | |
| | | | | | | |
| Florida | 4,200,667 | $2,341,742,675 | 56.6% | $1,470,676,127 | 35.5% | $4,139,883,463 |
| | | | | | | |
| Minnesota | 902,284 | $835,030,547 | 29.9% | $1,719,905,875 | 61.7% | $2,788,267,301 |
| | | | | | | |
| Oregon | 715,847 | $292,314,675 | 30.2% | $658,088,113 | 68% | $967,880,979 |
| | | | | | | |
| Tennessee | 1,155,990 | $1,182,636,387 | 58.2% | $604,140,424 | 29.7% | $2,033,223,813 |
| | | | | | | |
| Washington | 1,127,229 | $594,863,214 | 31.5% | $1,144,774,306 | 60.7% | $1,886,265,755 |
| | | | | | | |
| Wisconsin | 1,031,904 | $988,643,257 | 46.7% | $949,298,189 | 44.8% | $2,119,267,252 |

**Sources:** U.S. Census Bureau 2008 Estimates
Kaiser State Health Facts

**Notes:** All expenditures include state and federal expenditures.
Total long-term care expenditures include expenditures for ICF-MR and Mental Health facilities.