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January 17, 2008

Earle J. Schwarz
THE OFFICES OF EARLE J. SCHWARZ
2157 Madison Avenue, Suite 201
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Re: *United States v. Tennessee (Arlington)*, U.S. Dist. Ct. No. 92-2062D/P
People First of Tennessee v. Clover Bottom Dev. Ctr., U.S. Dist. Ct. No.
3:95-1227

Dear Earle:

In your letter dated January 2, 2008, you raised concerns regarding four separate policy decisions implemented by DMRS within the last few months. You demanded that the State voluntarily roll back each of these changes. If the State fails to do so, you indicated that People First intends to file a Motion for Emergency Relief in both cases seeking temporary and permanent injunctive relief. This letter will address each of your concerns.

First, you have questioned the use of a “new protocol for administering the ICAP” and requested that the State cease using it. In order to put People First’s request in context, it is necessary to understand the purpose of the ICAP. After CMS placed the State’s Home and Community Based Waiver on moratorium, the State began to work with CMS on the steps necessary to have the moratorium lifted. One of the action steps included in the DMRS Blueprint, which was developed by the State in conjunction with CMS for the purpose of lifting the moratorium, was the implementation of a standardized tool for uniform assessment of needs. Consequently, the State began to study the different standardized assessment tools available and used by other states. The ICAP was chosen as being the best option for the State and implementation first began in 2004. In mid-2006, DMRS became concerned regarding the trends that were occurring with the completion of the ICAPS. (The ICAP is designed to be administered every two years.) The ICAP scores were going down indicating a sharp increase in levels of need (at the same time DMRS expected levels of needs to have stabilized or decreased). DMRS began to review the procedures being used to administer the ICAP to assure that ICAPs were being administered in an appropriate and consistent manner. This review process included discussions with other states using the ICAP and discussions with the developers of the ICAP. Consequently, DMRS implemented some changes to assure “best practices” in the use of the ICAP. As a result of these steps, ICAP scores have risen. But, this has not, as you alleged, resulted in the reduction of services in over 25% of the cases. Services have not and are not being changed based solely on an ICAP score. On the contrary, the ICAP is only one of the

methods used for determining rates for an individual. It continues to be the expectation that the person's needs are specifically outlined and justified in the ISP. Furthermore, if any request for services is denied or delayed, the individual has an opportunity to appeal as provided in state and federal regulations. Accordingly, the State cannot agree to cease implementation of the protocols for administering the ICAP, those protocols having been specifically adopted to assure that the ICAP is administered appropriately and consistently.

Second, you have questioned the requirement to access direct care nursing services to class members first through TennCare prior to seeking such services through the HCBS waiver. Under federal law, Home or Community-Based services are defined as services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver. 42 C.F.R. §440.180. As you are aware, nursing services are available under the State's Medicaid plan (TennCare) as well as under the HCBS waivers. Due to a concern about duplication or overlap between TennCare and the HCBS waivers for nursing services, the State began to transition some individuals from nursing services provided through the statewide HCBS waiver to nursing services provided through TennCare. There were some problems that arose after the State began this transition process. Based on these problems, the State has ceased any further transitions from waiver nursing services to TennCare nursing services. Furthermore, for individuals who previously transitioned, they will have the option, upon request, to transition back to waiver nursing services. The only exception will be for individuals who are age 21 or younger. As children age 21 or younger have access to nursing services as medically necessary under the EPSDT program and nursing services during school hours through local school systems, they will continue to receive nursing services through TennCare. We trust that this addresses your concern.

Third, you have questioned recent rate reductions implemented by the State. As you noted, DMRS originally announced a retroactive reduction to the payments under the statewide HCBS waiver. On December 26, 2007, Steve Norris issued a memorandum reversing that decision. This memorandum noted that refunds would be paid within two weeks. In fact, refunds were immediately processed and paid to providers within five days. At the same time, DMRS provided notice of a prospective reduction in payments under the statewide HCBS waiver. (No reductions in payments have been imposed for the Arlington waiver.) The rate reductions have become necessary due to rising costs associated with the statewide HCBS and limited State resources. Prior to implementing this prospective reduction, DMRS met with providers to discuss the reasons for the rate reduction and alternatives to assist with reductions of costs. DMRS is continuing to work with providers to lower the costs associated with the statewide HCBS. If these efforts are successful, the rate reduction will be reduced in future months. DMRS is hopeful that these efforts, along with other efforts being made by DMRS to control costs associated with this waiver, will be successful. Any reductions in rates, however, should not result in a denial of any services. Therefore, the State is not willing to voluntarily cease implementation of the rate reductions.

Fourth, you have questioned the policy of reviewing all existing ISPs and cost plans. DMRS is conducting a review to assure that all existing plans are providing only services that are medically necessary or reasonably expected to reduce harm or loss of functions. The purpose of these reviews is twofold: (1) to determine whether authorized services have actually been provided consistent with the amount of service units billed to the State; and (2) to

determine whether the authorized services in an individual's plan are medically necessary for protection from harm and for increasing functional independence and are being provided in an amount, frequency and duration necessary to meet the outcomes and needs of the service recipient. We believe that these reviews are consistent with the State's obligation to assure that adequate and appropriate services are being provided. Moreover, if any services are denied based on these reviews, the service recipient receives adequate notice and an opportunity to be heard. Accordingly, the State is not willing to voluntarily cease implementation of this process, particularly as it is designed to assure that adequate and appropriate services are actually being provided.

We do not agree that these policy directives have placed class members at risk of substantial harm. If you have any specific information that leads you to believe that specific class members have suffered or will suffer substantial harm, please provide us with the identity of these individuals and the basis for your concern at your earliest convenience. Please feel free to contact me if you have any questions.

Sincerely,

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