DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

APR 0 8 2016

Darin Gordon
Director
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to the TennCare II section 1115 of the Social Security Act (the Act) demonstration (Project No. 11-W-00151/4) to ensure that the special terms and conditions (STCs) reflect how the state is currently operating its demonstration based on the February 2, 2016 amendment (Amendments 27 and 28).

We accepted the requested edits submitted in your February 22, 2016 letter and submitted in subsequent communication to your project officer on March 3, 2016. Specifically, we revised the following:

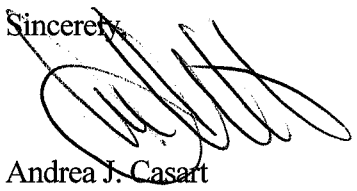
- Citing Tennessee Code Annotated (T.C.A.) for the definition of "intellectual disability" in the Program Description section and in STC 18 to describe who is eligible for the Employment and Community First (ECF) CHOICES Program.
- Ensuring that the terms used for the ECF CHOICES Program in the STC document is consistent with what the state intended, for example, the state's preference to call the Individual Service Plan (ISP) the Person-Centered Support Plan (PCSP) to delineate the ECF CHOICES plan tool from the 1915(c) plan tool.
- Ensuring that the services provided for in STC 28 match the services listed in Attachment G for ECF CHOICES service definitions.
- Correcting typographical errors, including updating paragraph numbers.

The demonstration STC document and Attachment G have been changed to reflect CMS' the requested changes referenced in your letter.

Your project officer, Jessica Woodard, is available to answer any questions or provide technical assistance concerning your 1115 demonstration. Ms. Woodard can be reached at (410) 786-9249 or Jessica.Woodard@cms.hhs.gov.

We look forward to continuing our work with you and your staff on Tennessee's section 1115 demonstration.

Sincerely,



Andrea J. Casart
Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Jackie Glaze, Associate Regional Administrator, CMS Atlanta Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **No. 11-W-00151/4 Title XIX**

TITLE: **TennCare II Medicaid Section 1115 Demonstration**

AWARDEE: **Tennessee Department of Finance and Administration**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or specified as not applicable in the following list, shall apply to all TennCare II populations identified in paragraph 17 *(Eligibility)* of the Special Terms and Conditions.

The TennCare II Demonstration will operate under these waiver authorities and those provisions specified as "not applicable." The waiver authorities and the provisions specified as "not applicable" will continue through June 30, 2016 unless otherwise stated.

The following waivers shall enable Tennessee to implement the TennCare II Medicaid Section 1115 demonstration.

WAIVERS OF TITLE XIX REQUIREMENTS FOR TENNCARE MEDICAID TITLE XIX STATE PLAN GROUPS

1. Statewideness/Uniformity **Section 1902(a)(1)**
42 CFR § 431.50

To the extent necessary to enable the state to provide managed care plans or certain types of managed care plans only in certain geographical areas of the state. Certain managed care plans or certain types of managed care plans (e.g., risk-based plans) are only available in certain areas of the state.

2. Proper and Efficient Administration **Section 1902(a)(4)(A)**
42 CFR § 438.52

To the extent necessary to permit the state to have only one pharmacy benefits manager and one dental benefits manager to provide services in a region of the state or statewide.

3. Proper and Efficient Administration **Section 1902(a)(4)(A)**
42 CFR § 435.831

To the extent necessary to enable Tennessee to use streamlined eligibility procedures that provide for coverage of optional Medically Needy children and pregnant women and the Standard Spend Down demonstration population for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. In accordance with the Code of Federal Regulations, the "budget period" is the period of

time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

4. Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary to enable the state to limit enrollment in CHOICES 2 and 3 to the enrollment target(s) established by the state, as authorized under 32.d. (*Enrollment Targets for TennCare CHOICES*) of the Special Terms and Conditions, and to allow the state to require applicants for long-term services and supports to complete a person-centered assessment and options counseling process.

To the extent necessary to enable the state to limit enrollment in each Employment and Community First (ECF) CHOICES benefit group to the enrollment target established by the state for that group, as authorized under paragraph 33.d. *(Enrollment Targets for ECF CHOICES)* of the STCs.

5. Access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Benefits **Section 1902(a)(10) 42 CFR §§ 440.210 and 440.220**

To the extent necessary to enable the state to permit managed care contractors to limit coverage of FQHC and RHC services, so long as access to care is assured from other providers.

6. Amount, Duration, and Scope of Services **Section 1902(a)(10)(B) 42 CFR 440 Subpart B**

To the extent necessary to enable the state to offer a reduced benefit package, a different benefit package, or cost-effective alternative benefit packages to different populations under the demonstration (except for individuals specified in Section 1902(l)(4) of the Act), to the extent authorized under Section V of the Special Terms and Conditions.

7. Comparability and Amount Duration and Scope **Sections 1902(a)(17) and 1902(a)(10)(B)**

Should the state change the level of care criteria for admission to nursing facilities, to the extent necessary to enable the state to determine whether an individual has a continuing need for nursing facility services, PACE services, or home and community-based services for the elderly and disabled, based on the criteria in use when the individual first was determined to need the service.

To the extent necessary to allow the state to offer the applicable ECF CHOICES benefits package to an individual with intellectual or developmental disabilities (I/DD) enrolled in that benefit group.

8. Freedom of Choice **Section 1902(a)(23)(A) 42 CFR § 431.51**

To enable the state to restrict freedom of choice of provider, through the use of mandatory enrollment in managed care plans or TennCare Select for the receipt of TennCare II, TennCare CHOICES and ECF CHOICES covered services, including for individuals

specified at Section 1932(a)(2) of the Social Security Act (the Act). No waiver of freedom of choice is authorized for family planning providers.

9. Retroactive Eligibility **Section 1902(a)(34)**
42 CFR § 435.914

To enable the state not to extend eligibility prior to the date that an application for assistance is made. This waiver authority will expire at the end of the extension period of the demonstration, June 30, 2016, unless otherwise approved based on the requirements of paragraph 8 *(Extension of the Demonstration)* of the STCs.

10. Payment for Outpatient Drugs **Section 1902(a)(54)**
42 CFR §§ 440.120,
447.331-447.334,
and 456 Subpart K

To the extent necessary to enable the state to establish a drug formulary that does not comply with the requirements of Section 1927(d)(4) of the Act.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **No. 11-W-00151/4 Title XIX**

TITLE: **TennCare II Medicaid Section 1115 Demonstration**

AWARDEE: **Tennessee Department of Finance and Administration**

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under Section 1903, shall, for the period of this demonstration extension, be regarded as expenditures under the state's Medicaid title XIX state plan.

The expenditure authorities listed below promote the objectives of title XIX in the following ways:

- Expenditure authorities 1, 2, and 10 promote the objectives of title XIX by increasing efficiency and quality of care through initiatives to transform service delivery networks.
- Expenditure authorities 2, 3, 6, 7, 8, 9, 11, 15, and 16 promote the objectives of title XIX by increasing overall coverage of low-income individuals in the state.
- Expenditure authorities 3, 9, 10, 11, 12, 13, 14, 15, and 16 promote the objectives of title XIX by improving health outcomes for Medicaid and other low-income populations in the state.
- Expenditure authorities 4, 5, and 6 promote the objectives of title XIX by increasing access to, stabilizing, and strengthening providers and provider networks available to serve Medicaid and low-income populations in the state.

The following expenditure authorities shall enable Tennessee to implement the Medicaid Section 1115 demonstration (TennCare II)

1. Expenditures Related to MCO Enrollment and Disenrollment.
Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the Act specified below. Tennessee managed care plans will be required to meet all requirements of Section 1903(m) except the following:

- Section 1903(m)(2)(A)(vi) of the Act, Federal regulations at 42 CFR § 438.56, to the extent that the rules in Section 1932(a)(4) are inconsistent with the enrollment and disenrollment rules contained in paragraph 40 *(Plan Enrollment and Disenrollment)* of the demonstration's Special Terms and Conditions (STCs), such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without

cause within 45 days of enrollment in an MCO. After 45 days, enrollees may disenroll from an MCO with cause at any time.

2. Expenditures Related to Expansion of Existing Eligibility Groups.
To enable Tennessee to use streamlined eligibility procedures and include eligibility standards and requirements that differ from those required by law.

a. Expenditures for Medical Assistance furnished to state plan optional Medically Needy children and pregnant women for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. The "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

b. Expenditures for Medical Assistance furnished to mandatory state plan Transitional Medical Assistance beneficiaries, who are eligible in accordance with section 1931(c)(1) of the Act, for the remainder of a 12-month eligibility period after the 4-month period specified in the statute.

3. Expenditures for Expanded Benefits and Coverage of Cost-Effective Alternative Services.

a. Expenditures for TennCare Medicaid and TennCare Standard child enrollees for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*. and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

b. Expenditures for TennCare Medicaid and TennCare Standard adult enrollees for optional services not covered under Tennessee's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*., paragraph 28 *(TennCare Benefits)*, and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

4. Expenditures for Pool Payments.
Expenditures for Graduate Medical Education, Essential Access Hospital, Critical Access Hospital, Meharry Medical College, Unreimbursed Public Hospital Costs for Certified Public Expenditures, Unreimbursed Hospital Cost, and Public Hospital Supplemental Payment pool payments to the extent specified in paragraph 56.d. through h. and j. through l. *(Extent of Federal Financial Participation for the Demonstration)* of the demonstration's STCs.

5. Indirect Payment of Graduate Medical Education.
Expenditures, up to $50 million in total computable expenditures for each demonstration year, for payments to universities that operate graduate physician medical education

programs, which are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics.

6. Payments for Non-Risk Contractor.
Payments to the TennCare Select prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor more than what Medical Assistance would have paid fee-for-service under the state plan in accordance with the upper limits at 42 CFR § 447.362.

7. Expenditures Related to Eligibility Expansion.
Expenditures to provide Medical Assistance coverage to the following demonstration populations that are not covered under the Medicaid state plan and are enrolled in TennCare Standard:

a. **Medically Eligible Demonstration Population Children, Not CHIP Eligible.** Uninsured children under age 19 who lose eligibility in TennCare Medicaid, have been determined to be "medically eligible" (uninsurable), have family income at or above 200 percent of the Federal poverty level (FPL), and do not meet the definition of an optional targeted low-income child.

b. **Adult Demonstration Population Eligibles-Standard Spend Down (SSD):** Non-pregnant, non-postpartum adults aged 21 or older who have been determined to meet criteria patterned after the state plan Medically Needy requirements (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category* of the STCs), comprising:
- Aged, blind, or disabled individuals; or
- Caretaker relatives.

8. CHIP-Related Medicaid Expansion Demonstration Population Children.
Expenditures to provide Medical Assistance coverage to uninsured children who lose eligibility under TennCare, who meet the definition of optional targeted low-income child, and who have family income up to 200 percent of the FPL.

9. The CHOICES 217-Like HCBS Group.
Expenditures for TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with Section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under TennCare CHOICES were provided under an HCBS waiver granted to the state under Section 1915(c) of the Act, as of the initial approval date of the TennCare CHOICES component of this demonstration. This includes the application of the spousal impoverishment eligibility rules. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the STCs;

b. Home and community-based waiver-like services as specified in Table 2b, subject to the definitions in Attachment D of the STCs, net of beneficiary regular and

spousal impoverishment post-eligibility responsibility for the cost of care, and with post-eligibility treatment of income for individuals receiving short-term nursing facility care calculated as if they were receiving HCBS in the community.

10. Employment and Community First (ECF) CHOICES 217-Like HCBS Group.
Expenditures for ECF CHOICES enrollees with intellectual or developmental disabilities (I/DD) who would be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) and 42 CFR § 435.217, if the services they received under ECF CHOICES were provided under a Section 1915(c) waiver. This includes application of the post-eligibility and spousal impoverishment rules. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the TennCare II STCs; and

b. ECF CHOICES services as authorized under paragraph 28.i. and Attachment G.

11. CHOICES HCBS Services for SSI-Eligibles.
Expenditures for the provision of home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs that are not described in Section 1905(a) of the Act and not otherwise available under the approved state plan but could be provided under the authority of Section 1915(c) waivers, that are furnished to TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities with income at 100 percent of the Supplemental Security Income/Federal Benefit Rate and resources at or below $2,000 who either:

a. Meet the nursing facility institutional level of care; or

b. Do not meet the nursing facility institutional level of care but who, in the absence of TennCare CHOICES services, are "at risk" of institutionalization.

12. ECF CHOICES Services for SSI Eligibles
Expenditures for the provision of home and community-based waiver-like services, as specified under paragraph 28.i. and Attachment G, that are not described in Section 1905(a) and not otherwise available under the approved state plan, but could be provided under Section 1915(c), that are furnished to ECF CHOICES enrollees with I/DD with income up through 100 percent of the SSI/FBR and resources at or below $2,000 who either:

a. Meet the nursing facility (NF) level of care (LOC) and need specialized services for I/DD, or pursuant only to paragraph 33.c.i. of the STCs, are granted an exception by the State based on transition from the Statewide or Comprehensive Aggregate Cap Waiver into CHOICES Group 6; or

b. Do not meet the NF LOC but who, and in the absence of ECF CHOICES services, are "at risk" of institutionalization.

13. The CHOICES At Risk Demonstration Group.

Elderly adults and adults age 21 and older with physical disabilities who have not been otherwise determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services are "at risk" of institutionalization. The CHOICES At Risk Demonstration Group is open to new enrollment until June 30, 2015. Persons enrolled in the CHOICES At Risk Demonstration Group as of June 30, 2015 may continue to qualify in the group as long as they continue to meet nursing facility financial eligibility standards and the nursing facility level of care criteria in place on June 30, 2012, and remain continuously eligible and enrolled in the CHOICES At Risk Demonstration Group.

Expenditures allowable under this demonstration for these individuals are for the following benefits:

a. Services as presented in Table 2a of the STCs.

b. Home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs, net of beneficiary post-eligibility responsibility for the cost of care (including application of spousal impoverishment rules), as set forth in the STCs.

14. Continuing Receipt of Nursing Facility Care.

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

15. Continuing Receipt of Home and Community-Based Services.

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

16. Continuing Receipt of Program of All-Inclusive Care for the Elderly (PACE) Services.

Expenditures for PACE-enrolled individuals, who upon redetermination do not meet the current nursing facility level of care criteria, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the PACE Carryover Group.

17. LTC Partnership.

Expenditures for individuals in CHOICES 2 to participate in the Long Term Care Partnership Program.

18. Demonstration Benefits for Presumptively Eligible Pregnant and Postpartum Women.

Expenditures to provide demonstration benefits to presumptively eligible pregnant and postpartum women who have incomes up to 195 percent of the FPL. Demonstration benefits, for purposes of this expenditure authority, shall mean benefits covered by the TennCare program that are provided to presumptively eligible pregnant and postpartum women on a non-ambulatory basis.

19. Interim ECF CHOICES At-Risk Demonstration Group.

Individuals with I/DD who are not otherwise eligible for Medicaid or TennCare who are receiving ECF CHOICES services; meet the financial eligibility standards for the ECF CHOICES 217-Like Group; meet the nursing facility level of care in place on June 30, 2012 but not the nursing facility level of care in place on July 1, 2012; and in the absence of the services offered through ECF CHOICES are "at risk" of institutionalization. Enrollment in this group will stop upon implementation of Phase 2 of ECF CHOICES. However, individuals enrolled in the Interim ECF CHOICES At-Risk Demonstration Group prior to implementation of Phase 2 may continue to be eligible through the interim group as long as they continue to meet the eligibility requirements and remain continuously enrolled in the interim group. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the TennCare II STCs;

b. ECF CHOICES services as authorized under paragraph 28.i and Attachment G.

The following expenditure authorities are authorized upon implementation of "Phase 2" of ECF CHOICES:

20. ECF CHOICES At-Risk Demonstration Group

Beginning with Phase 2 of ECF CHOICES, individuals with I/DD who are not otherwise eligible for Medicaid or TennCare who are receiving ECF CHOICES services; meet the resource limit for the ECF CHOICES 217-Like Group; have income at or below 150 percent of the FPL; meet the NF LOC criteria in place on June 30, 2012 but not the criteria in place on July 1, 2012; and in the absence of ECF CHOICES are "at risk" of institutionalization. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the TennCare II STCs;

b. ECF CHOICES services as authorized under paragraph 28.i and Attachment G.

21. ECF CHOICES Working Disabled Demonstration Group

Beginning with Phase 2 of the ECF CHOICES, working age individuals with I/DD who are not otherwise eligible for Medicaid or TennCare who are receiving ECF CHOICES services; meet the NF LOC criteria in place on June 30, 2012, and in the absence of ECF

CHOICES are "at risk" of institutionalization, or meet the current NF LOC criteria; but for their earned income would be eligible for SSI; and have family income at or below 250 percent of the FPL. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the TennCare II STCs;

b. ECF CHOICES services as authorized under paragraph 28.i and Attachment G.

REQUIREMENTS NOT APPLICABLE TO TENNCARE STANDARD TITLE XIX DEMONSTRATION ELIGIBLE GROUPS

All Title XIX requirements that are waived for the TennCare Medicaid Groups are also not applicable to the TennCare Standard Title XIX Demonstration Eligible Groups. In addition, the following is not applicable to the Title XIX Demonstration Eligible Groups.

Cost Sharing	**Section 1902(a)(14) and Section 1916** **42 CFR §§ 447.51 – 447.56**

To enable the state to charge cost sharing beyond applicable Medicaid limits to TennCare Standard demonstration populations, with cost-sharing subject to a quarterly aggregate cap of 5 percent of family income for children.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: **11-W-00151/4 (Title XIX)**

TITLE: **TennCare II**

AWARDEE: **Tennessee Department of Finance and Administration**

DEMONSTRATION EXTENSION PERIOD: **July 1, 2013 through June 30, 2016**

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CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **Title XIX No. 11-W-00151/4**

TITLE: **TennCare II Medicaid Section 1115 Demonstration**

AWARDEE: **Tennessee Department of Finance and Administration**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Tennessee's TennCare II Section 1115(f) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to this agreement are the Tennessee Department of Finance and Administration, Bureau of TennCare ("state") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the demonstration project. The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the approval letter's date, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This demonstration extension is approved through June 30, 2016.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits; CHOICES and Employment and Community First (ECF) CHOICES Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality for the Demonstration; Evaluation of the Demonstration; TennCare Eligibility Redetermination and Disenrollment and Rights; Appeals Process for Changes in Benefits; Enrollment in Standard Spend Down; and the Schedule of State Deliverables During the Demonstration Extension.

II. PROGRAM DESCRIPTION AND OBJECTIVES

TennCare II is a continuation of the state's demonstration, funded through titles XIX and XXI of the Social Security Act (the Act). TennCare began as an 1115(a) demonstration project in January 1994. A 3-year extension was approved for 1999-2001, and a 1-year extension was approved early in 2002. A new TennCare II 1115(a) demonstration was approved by CMS on May 30, 2002, and initiated on July 1, 2002, for a 5-year period. On October 5, 2007, an extension was granted under Section 1115(a) through June 30, 2010, with revised waiver and expenditure authorities and STCs. (Note: Temporary extensions under the existing TennCare II STCs were granted for the July 1 through October 5, 2007 period, in order to provide additional time to conclude discussions on a longer extension.) The most recent extension, granted in December 2009 under the authority of Section 1115(e) of the Act, was in effect from July 1, 2010 through June 30, 2013. The current extension is granted under the authority of Section 1115(f) of the Act and is in effect from July 1, 2013 through June 30, 2016.

As of October 2012, the TennCare II program had 1.213 million enrollees, about half of whom were children. All mandatory and optional populations eligible under Tennessee's state plan are enrolled in TennCare II, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only").

There are three components to the TennCare II demonstration program. **TennCare Medicaid** is the component that serves enrollees who are Medicaid-eligible under Tennessee's title XIX state plan. **TennCare Standard** is the component that serves title XIX Medicaid enrollees who are eligible only through the demonstration's expenditure authorities**.** Title XXI Medicaid expansion children are also served under TennCare Standard, with a more extensive benefits package and a different service delivery system than the children served under the title XXI stand-alone Children's Health Insurance Program (CHIP). Both TennCare Medicaid and TennCare Standard deliver all Medicaid services, except for services specified at paragraphs 28 *(TennCare Benefits)* and 30 *(Medicaid Benefits Carved Out of TennCare II Demonstration)* as excluded from the TennCare benefits package for specified populations.

The **CHOICES** Program utilizes the existing for-risk, Medicaid managed care organizations to provide eligible individuals with nursing facility services or home and community based services. With the implementation of the CHOICES program in 2010, home and community based services and nursing facility services were added to the existing TennCare II benefit package of primary, acute, and behavioral health services for qualifying state plan and demonstration eligible individuals. This provides participating individuals with an integrated package of acute and long-term services and supports, through a managed care delivery system.

Employment and Community First (ECF) CHOICES is the newest component of the CHOICES program. ECF CHOICES utilizes Medicaid managed care to provide home and community-based long-term services and supports for individuals with intellectual or developmental disabilities. To be eligible to participate in ECF CHOICES, a person must meet the definition of intellectual disability located at T.C.A. § 33-1-101(16), or the definition of developmental disability located at T.C.A. § 33-1-101(11). Eligibility for ECF CHOICES will proceed in two phases. Phase 1 will commence upon implementation of ECF CHOICES and assurance of plan readiness. Phase 2 will begin 60 days after the State notifies CMS that its eligibility systems are ready to begin processing

eligibility for the ECF CHOICES At-Risk Demonstration Group and the ECF CHOICES Working Disabled Demonstration Group. Benefits are the same in both phases.

The goals of TennCare are the following:

- Use a managed care approach to provide services to Medicaid state plan and demonstration enrollees at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.
- Assure appropriate access to care for enrollees.
- Provide quality care to enrollees.
- Assure enrollees' satisfaction with services.
- Improve health care for program enrollees.
- Assure that participating health plans maintain stability and viability, while meeting all contract and program requirements.
- Provide appropriate, and cost-effective home and community based services that will improve the quality of life for persons who qualify for nursing facility care, as well as for persons who do not qualify for nursing facility care but who are "at risk" of institutional placement and that will help to rebalance long-term services and supports expenditures.
- Provide appropriate, cost-effective home and community-based services to individuals with I/DD who meet the nursing facility level of care and need specialized services for I/DD, or are at risk of meeting the nursing facility level of care, to help promote and support integrated competitive employment and integrated community living that will result in improved employment, health and quality of life outcomes.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with Section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the

demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 *(Amendment Process)* below.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following

a. An explanation of the public process used by the state, consistent with the requirements of paragraph 15 *(Public Notice and Consultation with Interested Parties)*, to reach a decision regarding the requested amendment;

b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

Changes to TennCare II benefits described in the state plan shall be made by state plan amendment. Changes to TennCare II benefits not described in the state plan shall be made by amendment to the demonstration. Changes in benefits shall be implemented in accordance with the process set forth in Section XIII of these STCs.

Additions or Changes to CHOICES or ECF CHOICES Benefits. All requests for changes in coverage of CHOICES or ECF CHOICES benefits are subject to CMS approval. Changes in benefits defined in Attachment D or Attachment G must be submitted to CMS for approval at least 60 days in advance of the state's desired implementation date. Requests for services that are not defined in Attachment D or Attachment G must be submitted by the state to CMS as a request to amend the demonstration.

The state must send a courtesy copy of all Medicaid state plan amendment requests to the Project Officer. This requirement is in addition to the submissions that the state must make as part of the usual state plan amendment process, and is not meant to substitute for or supplant that process in any way.

8. Extension of the Demonstration.

a. Should the state intend to request an extension of the demonstration, the state must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9 *(Demonstration Phase-Out).*

b. Compliance with Transparency Requirements 42 CFR § 431.412. Effective April 27, 2012, as part of demonstration extension requests the state must provide documentation of compliance with the transparency requirements of 42 CFR § 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15 *(Public Notice and Consultation with Interested Parties).*

9. Demonstration Phase-Out. The state may suspend or terminate this demonstration in whole, or in part, only consistent with the following requirements:

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of the phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §§ 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §§ 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR § 431.230. In addition, the state must conduct administrative renewals for all affected

beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010 State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **Post Award Forum**. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this paragraph. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 46 *(Quarterly Progress Reports)* associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 47 *(Annual Report).*

11. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice and Consultation with Interested Parties.** The state must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6 *(Changes Subject to the Amendment Process)*, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR § 431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 CFR § 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR § 447.205 for changes in statewide methods and standards for setting payment rates.

16. **FFP.** No Federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

17. Eligibility. Tennessee includes in the TennCare II demonstration all of the mandatory and optional populations eligible under the Tennessee Medicaid state plan, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only"). Also included in TennCare II are several title XIX demonstration-only eligible populations and one title XXI Medicaid Expansion demonstration population. Medicaid state plan-eligible individuals are served in the component of the program called TennCare Medicaid. Other demonstration-only eligible populations are served in the component called TennCare Standard.

The mandatory and optional Medicaid state plan populations described below derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the demonstration to generate savings for covering the Expansion populations, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.

The title XXI Medicaid Expansion demonstration population is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as otherwise listed as not applicable.

Under the TennCare II demonstration, Tennessee is not required to extend eligibility for medical assistance prior to the date that an application for assistance is made; however, the state may provide retroactive coverage for up to 3 months for class members in *Daniels, et al. v. Tenn. Dept. of Health and Env't., et al.*, (1) who have been terminated from TennCare on or before March 31, 2010, for failure to respond to a Request for Information and Expiration Notice in accordance with the process approved in the Federal court order dated January 8, 2009; (2) who subsequently complete a Request for Information within 60 days of termination; and (3) who are determined to have been eligible at the time of termination. The state must notify the Project Officer by letter if it intends to extend retroactive eligibility to Daniels class members as described above.

Any changes to eligibility must be submitted to CMS as an amendment request, subject to the process set forth in paragraphs 6 (*Changes Subject to the Amendment Process)* and 7 *(Amendment Process)* of these STCs.

The criteria for TennCare eligibility groups are as follows (Table 1a).

Table 1a
TennCare Eligibility Groups

Note: This table does not change the state plan requirements.

Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
Title XIX State Plan Mandatory Groups – TennCare Medicaid		
1931 recipients including: • Children younger than 18/19 • Caretaker relatives • Pregnant women with no other eligible children (coverage for third trimester)	Income up to 185% of Consolidated Standard of Need; resources $2000	1, 2, 5, 6, 8, 9, 10
Transitional Medical Assistance – Medicaid Extension for families who lose TANF benefits due to: • income from employment or work hours or loss of "income disregard" • increased child or spousal support collections	6 initial months + 6 months continued coverage 4 months continued coverage *and expenditure authority for 8 additional months*	1, 2, 5, 6, 8, 9, 10
Individuals who are ineligible for AFDC benefits solely due to requirements that are prohibited under Medicaid, including AFDC time limits	Income up to and including 185% of Consolidated Standard of Need; resources $2000	1, 2, 5, 6, 8, 9, 10
Poverty level pregnant & postpartum women	Income up to and including 185% FPL; no resource test	1, 2, 5, 8, 9, 10
Poverty level newborns under age 1	Income up to and including 185% FPL; no resource test	1, 2, 5, 8, 9, 10
Poverty level children 1-5	Income up to and including 133% FPL; no resource test	1, 2, 5, 8, 9, 10

Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
Poverty level children 6-18	Income up to and including 100% FPL; no resource test	1, 2, 5, 8, 9, 10
Deemed categorically eligible newborns: born to & living with a woman who was eligible and received Medicaid on the date of the child's birth	Eligible for 1 year as long as mother is eligible or would be if pregnant	1, 2, 5, 8, 10
Pregnant woman who would otherwise lose eligibility because of an increase in income remains eligible through the postpartum period		1, 2, 5, 8, 9, 10
Woman who was eligible while pregnant continues eligibility through the postpartum period		1, 2, 5, 8, 9, 10
Title IV-E eligible children in adoption subsidy or foster care	AFDC income standard	1, 2, 5, 6, 8, 9, 10
SSI cash recipients: aged, blind or disabled (may or may not be receiving CHOICES or ECF CHOICES benefits)		1, 2, 4, 5, 6, 7, 8, 9, 10,
Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87		1, 2, 5, 6, 8, 9, 10
"DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits.		1, 2, 5, 6, 8, 9, 10
SSI cash ineligible for reasons prohibited by Title XIX.		1, 2, 5, 6, 8, 9, 10
"Pickle" SSA Beneficiaries who lost SSI cash benefits due to cost of living adjustment (COLA) increase in Title II OASDI benefits		1, 2, 5, 6, 8, 9, 10

Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
"DWB" Disabled widow/widower who lost SSI or state supplement due to early receipt of OASDI benefits.		1, 2, 5, 6, 8, 9, 10
Title XIX State Plan Optional Groups – TennCare Medicaid		
Presumptively eligible pregnant & postpartum women who receive Medicaid state plan benefits and demonstration benefits, including non-ambulatory care.	Income up to 195% FPL; no resource test	1, 2, 5, 8, 9, 10
Children under 21 who meet AFDC income & resource criteria—children in state custody, foster care, subsidized adoptions, institutionalized	Income up to 185% of Consolidated Standard of Need; resources $2000	1, 2, 5, 6, 8, 9, 10
Persons who would be eligible for AFDC or SSI cash assistance except for their institutional status		1, 2, 4, 5, 6, 7, 8, 9, 10
Special income level group: individuals who are in a medical institution at least 30 consecutive days with income that does not exceed 300% of SSI income standard under 1902(a)(10)(ii)(V) of the Act.	Income no more than 300% of SSI rate; resources $2000	1, 2, 4, 5, 6, 7, 8, 9, 10
Categorically needy individuals under the state plan who are receiving home and community based services in accordance with 42 CFR § 435.217. (This group consists solely of enrollees in the ID waivers.)		1, 2, 5, 6, 8, 9, 10
Non-IV-E children with special medical needs who receive a state adoption subsidy payment		1, 2, 5, 6, 8, 9, 10

Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
Women under 65 who need treatment for breast or cervical cancer, and are not otherwise eligible for Medicaid. State utilizes presumptive eligibility for this population.		1, 2, 5, 6, 8, 9, 10
Medically needy children under 21 *(expenditure authority for 12-month coverage based on 1-month budget period)*	Medically needy spend-down level ($241 for 1, etc.)	1, 2, 3, 5, 6, 8, 9, 10
Medically needy pregnant or postpartum women *(expenditure authority for 12-month coverage based on 1-month budget period)*	Medically needy spend-down level ($241 for 1, etc.)	1, 2, 3, 5, 6, 8, 9, 10
Title XIX Demonstration Eligible Groups– Carryover		
CHOICES 1 and 2 Carryover Group: Individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria.	Income no more than 300% SSI/FBR; resources $2,000	1, 2, 4, 5, 6, 7, 8, 9, 10
PACE Carryover Group: Individuals who were enrolled in a PACE program as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria.	As required under the state plan.	
Title XIX Demonstration Eligible Groups – TennCare Standard		

Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
Medically Eligible Children: uninsured children under 19 who have been determined to be "medically eligible" (uninsurable) (category is currently closed to new enrollment except for Medicaid rollovers *[*as defined in paragraph 20, *Rollover Definition]* who are not otherwise eligible for TennCare. See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*.	Income 200% FPL or higher without limit; no resource test	1, 2, 5, 6, 8, 9, 10 and cost sharing "not applicable"
Standard Spend Down (SSD): non-pregnant/postpartum adults 21 or older who have been determined to meet criteria patterned after the medically needy requirements *(enrollment target: 100,000)* • aged, blind, or disabled • caretaker relatives CMS approved an amendment to add this expansion population in Nov. 2006. (Expenditure authority for 12-month coverage based on 1-month budget period.) Effective January 1, 2016, this category is closed. See paragraph 21.a. *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*.	Medically needy spend-down level ($241 for 1, etc.); resources $2000	1, 2,, 3, 5, 6, 8, 9, 10 and cost sharing "not applicable"
Title XIX Demonstration Eligible Groups – CHOICES and ECF CHOICES		

Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
CHOICES 217-Like HCBS Group: Aged and / or disabled categorically needy adults who meet the CHOICES NF level of care requirement, are receiving home and community based services and who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236, and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915 (c) waiver. This group is subject to the enrollment target for CHOICES 2 in paragraph 32.d *(Enrollment Targets for TennCare CHOICES).*	Income no more than 300% SSI/FBR; resources $2,000	1, 2, 4, 5, 6, 7, 8, 9, 10
CHOICES At Risk Demonstration Group: Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of the TennCare Interim Choices 3 services, are "at risk" of institutionalization. The CHOICES At Risk Demonstration Group is open to enrollment starting July 1, 2012, and closed to new enrollment on June 30, 2015.	Income no more than 300% SSI/FBR; resources $2,000	1,2,4,5,6,7,8,9,10

Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
ECF CHOICES 217-Like HCBS Group: Individuals with I/DD who would be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) and 42 CFR § 435.217, if the services they received under ECF CHOICES were provided under a Section 1915(c) waiver. This group is subject to the enrollment targets for ECF CHOICES in paragraph 33.d. *(Enrollment Targets for ECF CHOICES).*	Income no more than 300% SSI/FBR; resources $2,000	1,2,4,5,6,7,8,9,10
ECF CHOICES At-Risk Demonstration Group Upon implementation of Phase 2 of ECF CHOICES, individuals with I/DD who are not otherwise eligible for Medicaid or TennCare who: are receiving ECF CHOICES services; meet the NF LOC criteria in place on June 30, 2012 but not the criteria in place on July 1, 2012; and in the absence of ECF CHOICES are "at risk" of institutionalization. This group is subject to the enrollment targets for ECF CHOICES in paragraph 33.d. *(Enrollment Targets for ECF CHOICES).*	Income no more than 150% FPL; resources $2,000	1,2,4,5,6,7,8,9,10

Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
ECF CHOICES Working Disabled Group Upon implementation of Phase 2 of ECF CHOICES, working age adults with I/DD who are not otherwise eligible for Medicaid or TennCare who: are receiving ECF CHOICES services; meet the NF LOC criteria in place on June 30, 2012, and in the absence of ECF CHOICES are "at risk" of institutionalization, or meet the current NF LOC criteria and need specialized services for I/DD; have family income no more than 250% of the FPL and but for their earned income would be eligible for SSI. This group is subject to the enrollment targets for ECF CHOICES in paragraph 33.d. *(Enrollment Targets for ECF CHOICES).*	Income no more than 250% FPL; resources $2,000	1,2,4,5,6,7,8,9,10

Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
Interim ECF CHOICES At Risk Demonstration Group: Individuals with I/DD who are not otherwise eligible for Medicaid or TennCare who: meet the financial eligibility requirements for the ECF CHOICES 217-Like group; meet the nursing facility level of care in place on June 30, 2012 but not the nursing facility level of care in place on July 1, 2012; and in the absence of the services offered through ECF CHOICES are "at risk" of institutionalization. New enrollment in this group will close upon implementation of Phase 2 of ECF CHOICES. However, individuals enrolled in the Interim ECF CHOICES At-Risk Demonstration Group prior to implementation of Phase 2 of ECF CHOICES may continue to be eligible through the interim group as long as they continue to meet the eligibility requirements and remain continuously enrolled in the interim group. This group is subject to the enrollment targets for ECF CHOICES in paragraph 33.d. *(Enrollment Targets for ECF CHOICES).*	Income no more than 300% SSI/FBR; resources $2,000	1,2,4,5,6,7,8,9,10
Title XXI Medicaid Expansion Demonstration Eligible Group – TennCare Standard		

Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
Optional Targeted Low-Income Children: uninsured children under 19 who: • have lost Medicaid eligibility under the approved Medicaid state plan and who do not have access to insurance or • were uninsured and enrolled in this category in the original TennCare demonstration as of 12/31/01, even if they had access to insurance, and have been continuously enrolled in this category since 12/31/01 See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed.*	Income up to 200% FPL	1, 2, 5, 6, 8, 9, 10, and cost sharing "not applicable"

18. TennCare CHOICES and ECF CHOICES Eligibility Groups.

a. CHOICES

As further set forth in paragraph 32 *(Operations of the TennCare CHOICES Program)*, eligibility for enrollment in TennCare CHOICES depends on (a) the individual's TennCare Eligibility Group, (b) the nursing facility (NF) (or "At Risk," as applicable) level-of-care (LOC) criteria as established by the state, and (c) the type of long-term services and supports (LTSS) to be provided.

There are three principal eligibility groups for TennCare CHOICES. CHOICES 1 is for individuals receiving NF services. CHOICES 2 is for individuals who meet the NF LOC that are receiving HCBS as an alternative to NF care. CHOICES 3 is for individuals who do not meet the NF LOC, but are at risk of NF placement and are receiving HCBS to delay or prevent NF placement.

Effective July 1, 2012, the state elected to change the level of care that is medically necessary for admission to a NF. CHOICES 3 serves SSI eligibles enrolled after the implementation of the LOC change who do not meet the new LOC standard but who are "at risk" of institutionalization. Individuals in CHOICES 1 and CHOICES 2 who continue to meet the standard in place at the time of the individual's enrollment will continue to qualify for those services.

Between July 1, 2012, and December 31, 2013, the state opened Interim CHOICES 3 to serve SSI eligibles and other adults who meet the LOC standard and financial eligibility requirements in place prior to the change, allowing the state to abide by the "Maintenance of Effort" (MOE) requirements as specified by the Affordable Care Act, Section 2001. The Interim CHOICES 3 group has since been extended through June 30, 2015.

Table 1b summarizes the CHOICES Eligibility Groups and addresses how a change in LOC criteria is taken into account in determining eligibility for each group.

Table 1b
TennCare + CHOICES Eligibility Groups

Note: This table does not change the state plan requirements. CHOICES 1, CHOICES 2, CHOICES 3, and Interim CHOICES 3 are defined in paragraph 32 *(Operations of the TennCare CHOICES Program)*. The CHOICES 1 and 2 Carryover Group and the PACE Carryover Group are defined in Table 1a of paragraph 17 *(Eligibility)*. With respect to benefits, cost-sharing, and similar issues, persons in the CHOICES 1 Carryover Group are treated as though they were in CHOICES 1; persons in the CHOICES 2 Carryover Group are treated as though they were in CHOICES 2; and persons in the PACE Carryover Group are treated as though they were in PACE.

CHOICES Groups	Description	TennCare Medicaid	TennCare Standard
CHOICES 1	• Nursing facility residents who meet the NF LOC in place at the time of enrollment*	Yes	Yes, CHOICES 1 and 2 Carryover Group
CHOICES 2	• Meet NF LOC in place at the time of HCBS • Receive HCBS as alternative to NF care • Age 65+ or 21+ and disabled	Yes, SSI only	Yes, CHOICES 217-Like HCBS Group and CHOICES 1 and 2 Carryover Group
CHOICES 3	• "At risk" for institutionalization (as defined in Attachment D) • Age 65+ or age 21+ and disabled	Yes, SSI only	No
INTERIM CHOICES 3 (open to enrollment	• Same as CHOICES 3, but not limited to SSI recipients • Must meet nursing facility financial eligibility criteria	Yes, SSI only	Yes, At Risk Demonstration Group

CHOICES Groups	Description	TennCare Medicaid	TennCare Standard
starting July 1, 2012 and closed to new enrollment on June 30, 2015)			

***** The state may grant an exception for persons in the community seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

b. ECF CHOICES

i. TennCare eligibility groups for ECF CHOICES will be implemented in two phases. In Phase 1, a person may qualify to enroll in ECF CHOICES services in one of the following TennCare eligibility groups: SSI recipients; the ECF CHOICES 217-Like Group; and the Interim ECF CHOICES At- Risk Group. In Phase 2, a person may also qualify to enroll in ECF CHOICES in the ECF CHOICES At-Risk Group and the ECF CHOICES Working Disabled Group. Upon implementation of Phase 2, new enrollment will close for the Interim ECF CHOICES At-Risk Demonstration Group; however, individuals enrolled through that group prior to implementation of Phase 2 may continue to be eligible in the interim group as long as they continue to meet the eligibility requirements and remain continuously enrolled in the interim group. The State will provide CMS with at least 60 days' notice in advance of implementing Phase 2 of ECF CHOICES.

ii. As further set forth in paragraph 33 *(Operations of Employment and Community First (ECF) CHOICES)*, eligibility for enrollment in ECF CHOICES depends on (a) the individual's TennCare eligibility group or, for individuals not otherwise eligible, meeting the applicable financial eligibility criteria for ECF CHOICES Title XIX Demonstration Eligible Groups set forth in Table 1a; (b) the individual's age; (c) the NF LOC (or "At Risk", as applicable) criteria as established by the state, except as provided pursuant only to paragraph 33.c.i. of the STCs; (d) the type of long-term services and supports (LTSS) to be provided, and (e) the individual's I/DD status. In order to be considered to be an individual with I/DD, a person must meet the definition of intellectual disability located at T.C.A. § 33-1-101(16), or the definition of developmental disability located at T.C.A. § 33-1-101(11). ECF CHOICES is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with I/DD. There are four target populations for ECF CHOICES: (1) children under age 21 with I/DD living at home with family and who meet the NF LOC; (2) children under age 21 with

I/DD living at home with family and who, in the absence of HCBS, are "at risk of NF placement"; (3) adults age 21 and older with I/DD who meet the NF LOC and need specialized services for I/DD (except as provided pursuant only to paragraph 33.c.i. of the STCs); and (4) adults age 21 and older with I/DD who, in the absence of HCBS, are "at risk of NF placement". Table 1c summarizes the ECF CHOICES Target Populations:

Table 1c
TennCare + ECF CHOICES Target Populations

Target Population Descriptions	TennCare Medicaid	TennCare Demo Standard
Children under age 21 with I/DD living at home with family and who meet the NF LOC	SSI	ECF 217-Like (Phase 1 and Phase 2) ECF Working Disabled (upon implementation of Phase 2)
Children under age 21 with I/DD living at home with family and who, in the absence of HCBS, are "at risk of NF placement"	SSI	ECF At-Risk (upon implementation of Phase 2) ECF Working Disabled (upon implementation of Phase 2) Interim ECF At-Risk (Open to new enrollment only during Phase 1)
Adults age 21 and older with I/DD who meet the NF LOC and need specialized services for I/DD (except as provided pursuant only to paragraph 33.c.i. of the STCs)	SSI	ECF 217-Like (Phase 1 and Phase 2) ECF Working Disabled (upon implementation of Phase 2)
Adults age 21 and older with I/DD who, in the absence of HCBS, are "at risk of NF placement"	SSI	ECF At-Risk (upon implementation of Phase 2) ECF Working Disabled (upon implementation of Phase 2) Interim ECF At-risk (Open to new enrollment only during Phase 1)

19. Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed. The state has closed enrollment into the following demonstration categories, except for "rollovers" (as defined in paragraph 20, *Rollover Definition*). Therefore, children are only eligible for a non-state plan demonstration population as a "rollover." If children lose Medicaid state plan eligibility, they may qualify for one of these demonstration-only groups rather than for the stand-alone title XXI CHIP program.

- Title XIX Medically Eligible Children: Individuals who are under age 19, are uninsured, have income that is 200 percent of the FPL or higher without limit, are not otherwise eligible for TennCare, and meet the state-defined criteria of "medically eligible" as having medical conditions that make them uninsurable. (There is no income or resource limit for this group.)

- Title XXI Medicaid Expansion Children: Individuals under age 19 who are uninsured, have family income less than 200 percent of the FPL, and meet the definition of an optional targeted low-income child. (There is no resource limit for this group.)

Individuals under age 19 who lose eligibility for a Medicaid category may roll over into a TennCare Standard category if they meet the criteria for the category.

20. Rollover Definition. For the purpose of this demonstration, a "rollover" eligible is an individual who qualifies for continued coverage through a TennCare Standard demonstration category upon losing Medicaid eligibility under any category included in Tennessee's title XIX state plan.

21. Adult Non-State Plan Demonstration Population Categories.

a. **Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category.** The SSD eligibility category is open to non-pregnant/postpartum adults ages 21 or older who are Caretaker Relatives or Aged, Blind, or Disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the state plan. The SSD demonstration eligibility group has an enrollment cap of 105,000, with a target enrollment of 100,000. The state shall establish eligibility and enroll individuals into the SSD group in accordance with the process set forth in Section XIII of these STCs. Effective January 1, 2016, this category is closed. Persons enrolled in the category as of that date will remain in the program until they complete the redetermination process. If they are found through the redetermination process to be eligible in another TennCare category, they will be moved to that category when they complete the redetermination process. If they are not found eligible for another category, they will be disenrolled.

b. **CHOICES 217-Like HCBS Group**. This group consists of persons aged 65 and older or persons aged 21+ and who are disabled who: (1) meet the CHOICES NF level of care requirement; (2) are receiving home and community-based services; and (3) would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal Regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915(c) waiver. Paragraph 18 *(TennCare CHOICES Eligibility Groups)* and paragraph 32.b. *(Eligibility for TennCare CHOICES Benefits)* describe how the NF LOC requirements shall be determined for individuals in this group. The state retains the discretion to apply an enrollment target as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES).*

c. CHOICES **At Risk Demonstration Group.** As of July 1, 2012, this group consists of elderly adults and adults age 21 and older with physical disabilities who (1) meet nursing facility financial eligibility; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization.

d. **CHOICES 1 and 2 Carryover Group.** This group consists of individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who no longer qualify for CHOICES enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in CHOICES 1 or CHOICES 2 if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, (2) meet all the eligibility requirements for a CHOICES program; and (3) remain continuously enrolled in CHOICES 1 and/or 2, as specified below:

i. Persons enrolled in CHOICES 1 can continue in CHOICES 1 or transition to CHOICES 2, and persons enrolled in CHOICES 2 can continue in CHOICES 2; and

ii. The state may grant an exception to i. for persons in CHOICES 2 seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

e. **PACE Carryover Group.** This group consists of individuals who were enrolled in PACE as of June 30, 2012, but who no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in PACE if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the

time they were enrolled, and (2) meet all other eligibility requirements for PACE in the Medicaid state plan. PACE remains under the Medicaid state plan.

f. **ECF CHOICES 217-Like HCBS Group**. This group consists of individuals of all ages with I/DD who would be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) and 42 CFR § 435.217, if the services they received under ECF CHOICES were provided under a Section 1915(c) waiver.

g. **Interim ECF CHOICES At-Risk Group**. This group consists of individuals of all ages with I/DD who are not otherwise eligible for Medicaid or TennCare who: are receiving ECF CHOICES services; meet the financial eligibility standards for the ECF CHOICES 217-Like Group; meet the nursing facility level of care in place on June 30, 2012 but not the nursing facility level of care in place on July 1, 2012; in the absence of the services offered through ECF CHOICES are "at risk" of institutionalization; and are enrolled in the group prior to implementation of Phase 2 of ECF CHOICES. The Interim ECF CHOICES At-Risk Group will close for new enrollment once the ECF CHOICES At-Risk Group and the ECF CHOICES Working Disabled Group are implemented. Individuals enrolled in the Interim ECF CHOICES At-Risk Demonstration Group prior to implementation of the ECF CHOICES At-Risk Group and the ECF CHOICES Working Disabled Group may continue to be eligible through the interim group as long as they continue to meet the eligibility requirements and remain continuously enrolled in the interim group.

h. The following two demonstration groups will be added in Phase 2 of ECF CHOICES:

i. **ECF CHOICES At-Risk Group**. This group consists of individuals with I/DD who are not otherwise eligible for Medicaid or TennCare who: are receiving ECF CHOICES services; meet the resource limit for the ECF CHOICES 217-Like Group; have income at or below 150% of the FPL; meet the NF LOC criteria in place on June 30, 2012 but not the criteria in place on July 1, 2012; and in the absence of ECF CHOICES are "at risk" of institutionalization.

ii. **ECF CHOICES Working Disabled Group**. This group consists of working age adults with I/DD who are not otherwise eligible for Medicaid or TennCare who: are receiving ECF CHOICES services; meet the NF LOC criteria in place on June 30, 2012, and in the absence of ECF CHOICES are "at risk" of institutionalization, or meet the current NF LOC criteria and need specialized services for I/DD; but for their earned income would be eligible for SSI; and have family income at or below 250% of the FPL.

22. Medically Needy Eligibility Period. Financial eligibility for state plan medically needy pregnant women and children and for Standard Spend Down adults is based on a 1-month budget period described in the state plan. Those determined eligible remain eligible for up to 1 year from the effective date of eligibility.

23. Quality Review of Eligibility. At least annually, the state shall submit a plan for a Medicaid Eligibility Quality Control (MEQC) pilot project to the CMS Regional Office for approval. When each pilot is complete, the state shall send a report to the CMS Regional Office for approval, and shall submit a plan for the next pilot project. The MEQC pilots must be conducted in accordance with Federal law, regulations, and policy.

24. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.

a. Except as specified in paragraph 24.b. below, in determining eligibility for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in Section 1924 of the Act and 42 CFR § 435.725 of the Federal regulations.

b. For an individual in CHOICES 2 or CHOICES 3 who is admitted for short-term nursing facility care (as defined in Attachment D), in order to ensure that the individual can maintain a community residence for transition back to the community, the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. After 90 days, or as soon as it appears that the inpatient stay will not be short-term, whichever comes first, the person will be transitioned to CHOICES 1 and the institutional post-eligibility calculation shall apply.

25. Eligibility/Post-Eligibility Treatment of Income and Resources for the CHOICES 217-Like HCBS Group, the CHOICES At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, the ECF CHOICES 217-Like HCBS Group, the ECF CHOICES At-Risk Group, the ECF CHOICES Working Disabled Group, the Interim ECF CHOICES At-Risk Group and the PACE Carryover Group. For individuals receiving 1915(c) like services in CHOICES 217-Like HCBS Group, the CHOICES At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, the ECF CHOICES 217-Like HCBS Group, the ECF CHOICES At-Risk Group, the ECF CHOICES Working Disabled Group, the Interim ECF CHOICES At-Risk Group or the PACE Carryover Group, the state must use institutional eligibility and post-eligibility rules for individuals who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a Section 1915(c) waiver.

26. Post-Eligibility and Patient Liability for the CHOICES 217-Like HCBS Group, the CHOICES At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, The ECF CHOICES 217-Like HCBS Group, the ECF CHOICES At-Risk Group, the ECF CHOICES Working Disabled Group, the Interim ECF CHOICES At-Risk Group and the PACE Carryover Group. The state assures that, for individuals receiving 1915(c) like services, under the post-eligibility process, the state must have a method to

carve out / identify the cost of the 1915(c) like services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of the 1915(c) like services.

27. **Non-Payment of Patient Liability.** A provider (including an MCO) may decline to continue to provide services to an individual who fails to pay his or her patient liability. If an enrollee who has failed to pay patient liability is unable to find another provider or MCO who is willing to provide LTSS, then the individual may be disenrolled from the CHOICES or ECF CHOICES program. If the beneficiary's eligibility for TennCare is dependent on the receipt of long-term institutional care or HCBS through TennCare CHOICES or ECF CHOICES, such individual may be disenrolled from TennCare if he or she is no longer able to receive such services, unless he/she qualifies in another Medicaid category. The consequences for failing to pay patient liability must be clearly explained to members upon enrollment in CHOICES or ECF CHOICES. Nothing herein shall prejudice any individual from fully exercising his or her rights to reapply for Medicaid coverage.

V. BENEFITS

28. TennCare Benefits. With the implementation of the CHOICES program, TennCare covers physical, behavioral, and long-term care benefits provided through managed care delivery systems.

a. All mandatory and optional Medicaid state plan eligible adults aged 21 or older, are enrolled in TennCare Medicaid, and receive all services covered under Tennessee's state plan according to the limitations specified in the state plan, including the services identified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration)* as appropriate. Additional TennCare benefits are provided as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives).*

b. Members of the CHOICES 217-Like HCBS Group, the CHOICES At Risk Demonstration Group or the CHOICES 1 and 2 Carryover Group, the ECF CHOICES 217-Like HCBS Group, the ECF CHOICES At-Risk Group, the ECF CHOICES Working Disabled Group and the Interim ECF CHOICES At-Risk Group, all of which are demonstration-only groups, are enrolled in TennCare Standard, but receive all benefits described in a. above. In addition, individuals in the CHOICES 217-Like HCBS Group are members of CHOICES 2 and members of the CHOICES At Risk Demonstration Group are members of Interim CHOICES 3.

c. Demonstration-only eligible adults who are members of the Standard Spend Down population (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*) are enrolled in TennCare Standard and receive all state plan services, plus additional TennCare benefits as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)* as appropriate, except that they do not have access to the services discussed in Table 2b or Table 3. Medicare Parts A and B premiums and Medicare co-payments and deductibles are covered in accordance with paragraphs 30.b. and c.

d. All mandatory and optional Medicaid state plan eligible children younger than 21 years old enrolled in TennCare Medicaid receive all state plan and EPSDT covered services.

e. The demonstration-only eligible children enrolled in TennCare Standard receive the same benefits as the state plan eligible children enrolled in TennCare Medicaid, except as specified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration).*

f. The Medicaid state plan mandatory and optional eligibility categories for poverty level pregnant or postpartum women receive all TennCare Medicaid benefits, because the state considers that all of these services are pregnancy-related services.

g. The following table (Table 2a) lists benefits for TennCare Medicaid and TennCare Standard adults aged 21 and older that are different from those identified in the state plan. All benefits are limited by medical necessity as defined by the state. "State Plan Coverage for Adults" is provided for informational purposes only, and does not supersede the approved Medicaid state plan. CMS will issue an updated version of Table 2a in the event that future SPAs cause the Medicaid state plan to be in conflict with what appears in Table 2a.

Table 2a
TennCare Medicaid and TennCare Standard Benefits for Adults Aged 21 and Older That Are Different Than State Plan Covered Services and Limitations

Service	TennCare Medicaid and TennCare Standard Coverage for Adults	State Plan Coverage for Adults
Diagnostic services not included in other service categories	Covered as medically necessary.	Not covered.
Home health	Covered as medically necessary, and in accordance with the definitions and limitations included in Attachment B.	Coverage limited to 60 visits per enrollee per state fiscal year.
Hospice care	Covered as medically necessary.	Coverage limited to 210 days per enrollee per state fiscal year.
Inpatient and outpatient substance abuse services	Covered as medically necessary	Not covered.
Inpatient hospital services	Covered as medically necessary.	Coverage limited to 43 days for heart transplants, 67 days for liver transplants, and 40 days for bone marrow transplants, per enrollee, per state fiscal year.
Lab and X-ray services	Covered as medically necessary.	Coverage limited to 30 occasions per enrollee per state fiscal year.
Medicare premiums and cost-sharing	Covered for state plan eligibles, SSD enrollees, members of the CHOICES 217-Like HCBS Group, members of the	Covered for Medicare beneficiaries who are dually eligible for Medicaid according to their

Service	TennCare Medicaid and TennCare Standard Coverage for Adults	State Plan Coverage for Adults
	CHOICES At Risk Demonstration Group, members of the ECF CHOICES 217-Like HCBS Group, members of the ECF CHOICES At-Risk Group, members of the ECF CHOICES Working Disabled Group, and members of the Interim ECF CHOICES At-Risk Group, in accordance with paragraphs 30.b. and c.	classification under the state plan (QMB, SLMB, Other Medicaid/Medicare Duals, etc.)
Mental health case management services	Covered as medically necessary.	Coverage limited to Targeted Case Management for persons who are Severely and/or Persistently Mentally Ill.
Occupational therapy	Covered as medically necessary.	Not covered.
Organ and tissue transplants	Covered as medically necessary, except that experimental or investigational transplants are not covered.	Coverage limited to renal, heart, liver, corneal, and bone marrow transplants.
Outpatient hospital services	Covered as medically necessary.	Coverage limited to 30 visits per enrollee per fiscal year.
Outpatient rehabilitation services	Covered as medically necessary.	Coverage limited to mental health services provided by Community Mental Health Agencies.
Pharmacy services	• Not covered for dually eligible adults. • Covered for non-dual state plan eligibles in accordance with the state plan. • Covered for non-dual SSD eligibles and non-dual CHOICES At Risk Demonstration Group members, non-dual ECF CHOICES At-Risk Group members, non-dual Interim ECF CHOICES At-Risk Group members, and non-dual ECF CHOICES Working Disabled Group members who do not meet	Coverage as specified in state plan.

Service	TennCare Medicaid and TennCare Standard Coverage for Adults	State Plan Coverage for Adults
	the current NF LOC, but are at risk of institutionalization, with the co-payments specified in Table 6 of paragraph 35.b. *(Co-Pays on Pharmacy).* • Covered for non-dual CHOICES 217-Like HCBS Group enrollees, CHOICES 1 and 2 Carryover Group enrollees, ECF CHOICES 217-Like HCBS Group members, ECF CHOICES Working Disabled Group members who meet the current NF LOC, and PACE Carryover enrollees in accordance with the state plan for Medicaid enrollees.	
Physical therapy services	Covered as medically necessary.	Not covered.
Physicians' services (including medical and surgical services furnished by a dentist)	Outpatient services: Covered as medically necessary. Inpatient services: Covered as medically necessary.	Outpatient services: Coverage limited to 24 outpatient office visits per year, which includes 2 office visits for podiatrists and 4 office visits for optometrists. Inpatient services: Coverage limited to 20 visits per enrollee per state fiscal year for services other than heart, liver, and bone marrow transplants, which are limited to 43, 67, and 40 days, respectively.
Preventive services	Covered as medically necessary.	Not covered.

Service	TennCare Medicaid and TennCare Standard Coverage for Adults	State Plan Coverage for Adults
Private duty nursing services	Covered when medically necessary to support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Definitions and limitations applicable to this service are contained in Attachment C.	Not covered.
Psychiatric residential treatment services (outside of an IMD)	Covered as medically necessary.	Not covered.
Screening services	Covered as medically necessary.	Not covered.
Speech, hearing, and language services	Covered as medically necessary.	Not covered.
Vision services	Covered for the first pair of cataract glasses following cataract surgery.	Not covered.

h. The following table (Table 2b) lists HCBS benefits for TennCare Medicaid enrollees and CHOICES demonstration eligibles who are enrolled in the designated CHOICES groups (specified in paragraph 32.a., *Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition, the following rules apply to the CHOICES benefit.

i. The cost of medical assistance provided to an eligible participant in CHOICES 2 is limited to the amount calculated in the individual cost-neutrality test used in Section 1915(c) waivers as set forth in Section 1915(c)(4)(A). The state may delegate implementation of the cost neutrality test to the MCOs.

ii. For purposes of determining capitation rates, the cost of room and board, as defined in Attachment D, is not included in non-institutional care costs.

iii. For persons in CHOICES 3 or Interim CHOICES 3, in addition to the service limits stated in Table 2b, the total cost of the HCBS identified in

Table 2b shall not exceed $15,000 per calendar year, excluding the cost of minor home modifications (as described in Attachment D and Table 2b).

iv. Definitions for CHOICES benefits are provided in Attachment D of these STCs.

Table 2b
Benefits for Persons Enrolled in the CHOICES Program

Benefit (Definitions provided in Attachment D)	**CHOICES 1**	**CHOICES 2**	**CHOICES 3***
Nursing facility care	X	Short-term only	Short-term only
Community-based residential alternatives		X	X**
Personal care visits (up to 2 visits per day)		X	X
Attendant care (up to 1080 hours per calendar year); up to 1400 hours per calendar year ONLY when Homemaker services are needed in addition to hands-on care		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to $900 per calendar year)		X	X
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)		X	X
Pest control (up to 9 units per calendar year)		X	X

*Subject to the limitations in 28.h.iii.

** CBRAs available to individuals in Group 3 include only Assisted Care Living Facility services and Community Living Supports (CLS) and Community Living Supports – Family Model (CLS-FM) that can be provided within the limitations set forth in 28.h.iii, when the cost of such services will not exceed the cost of CHOICES HCBS that would otherwise be needed by the member to 1) safely transition from a nursing facility to the community; or 2) continue being safely served in the community and to delay or prevent nursing facility placement. Consistent with the CMS final rule defining person-centered planning and HCBS setting requirements, TennCare requires that persons receiving HCBS choose the setting in which services will be delivered.

i. The following tables (Tables 2c and 2d) list the HCBS benefits (and limits on those benefits) for TennCare Medicaid enrollees and demonstration eligibles who are enrolled in the ECF CHOICES benefit groups (specified in paragraph 33.a., *Determination of ECF CHOICES Benefits by Designation into an ECF CHOICES Group*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition, the following rules apply to the ECF CHOICES benefits.

i. For purposes of determining capitation rates, the cost of room and board, as defined in Attachment G, is not included in non-institutional care costs.

ii. Definitions for ECF CHOICES benefits are provided in Attachment G of these STCs.

iii. In addition to the benefits specified below and defined in Attachment G, a person enrolled in ECF CHOICES may receive short-term nursing facility care as defined in Attachment D, without being required to disenroll from their ECF CHOICES group until such time that it is determined that transition back to HCBS in ECF CHOICES will not occur within 90 days from admission.

iv. ECF CHOICES benefits will be subject to an annual per member expenditure cap. Specifically:

(A) Individuals receiving Essential Family Supports benefits will be subject to a $15,000 cap (on benefits), not counting the cost of minor home modifications (as described in Attachment D and Table 2b);

(B) Individuals receiving Essential Supports for Employment and Independent Living benefits will be subject to a $30,000 cap on benefits. The State may grant an exception for emergency needs up to $6,000 in additional services per year, but shall not permit expenditures to exceed a hard cap of $36,000 per year; and

(C) Individuals receiving Comprehensive Supports for Employment and Community Living benefits will be subject to an annual expenditure cap as follows:

i. Individuals with low-to-moderate need as determined by the State, in accordance with the published criteria, will be subject to a $45,000 expenditure cap.

ii. Individuals with high need as determined by the State, in accordance with the published criteria, will be subject to a $60,000 expenditure cap.

iii. The State may grant an exception as follows: For individuals with developmental disabilities (DD) and exceptional medical/behavioral needs as determined by the State in accordance with published criteria, up to the average cost of NF plus specialized services that would be needed for persons with such needs determined appropriate for NF placement; or for individuals with intellectual disabilities (ID) and exceptional medical/behavioral needs as determined by the State in accordance with published criteria, up to the average cost of private ICF/IDD services.

Table 2c
Benefit Groups for Persons Enrolled in the ECF CHOICES Program

	Benefit Groups		
	Essential Family Supports	**Essential Supports for Employment and Independent Living**	**Comprehensive Supports for Employment and Community Living**
Target population	Children under age 21 with I/DD living at home with family and who meet NF LOC Children under age 21 with I/DD living at home with family and who, in the absence of HCBS, are "At risk of NF placement" If they are living at home with family caregivers, adults age 21 and older with I/DD who meet or are "At risk of NF placement" may also elect to be in this benefit group	Adults age 21 and older with I/DD who do not meet NF LOC, but who, in the absence of HCBS are "At Risk of NF placement"	Adults age 21 and older with I/DD who meet NF LOC and need specialized services for I/DD

Table 2d
Benefits and Benefit Limits in ECF CHOICES Benefits Groups

Benefit (Definitions provided in Attachment G)	**Essential Family Supports**	**Essential Supports for Employment and Independent Living**	**Comprehensive Supports for Employment and Community Living**
Respite (up to 30 days per calendar year **or** up to 216 hours per calendar year only for persons living with unpaid family caregivers)	X	X	X
Supportive home care (SHC)	X		
Family caregiver stipend in lieu of SHC (up to $500 per month for children under age 18; up to $1,000 per month for adults age 18 and older)	X		
Community integration support services (subject to limitations specified in Attachment G)	X	X	X
Community transportation	X	X	X
Independent living skills training (subject to limitations specified in Attachment G)	X	X	X
Assistive technology, adaptive equipment and supplies (up to $5,000 per calendar year)	X	X	X
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)	X	X	X
Community support development, organization and navigation	X		
Family caregiver education and training (up to $500 per calendar year)	X		
Family-to-family support	X		
Conservatorship and alternatives to conservatorship counseling and assistance (up to $500 per lifetime)	X	X	X
Health insurance counseling/forms assistance (up to 15 hours per calendar year)	X		
Personal assistance (up to 215 hours per month)		X	X
Community living supports (CLS)		X	X
Community living supports—family model (CLS-FM)		X	X
Individual education and training (up to $500 per calendar year)		X	X
Peer-to-peer person-centered planning, self-direction, employment and community support and navigation (up to $1,500 per lifetime)		X	X
Specialized consultation and training (up to $5,000 per calendar year[1])		X	X
Adult dental services (up to $5,000 per calendar year; up to $7,500 across three consecutive calendar years)	**X**[2]	X	X

[1] For adults in the Comprehensive Supports for Employment and Community Living benefit group determined to have exceptional medical and/or behavioral support needs, specialized consultation services are limited to $10,000 per person per calendar year.
[2] Limited to adults age 21 and older.

Benefit (Definitions provided in Attachment G)	**Essential Family Supports**	**Essential Supports for Employment and Independent Living**	**Comprehensive Supports for Employment and Community Living**
Employment services/supports (subject to limitations specified in Attachment G)	**X**	X	X
− Supported employment—individual employment support − Exploration − Benefits counseling − Discovery − Situational observation and assessment − Job development plan or self-employment plan − Job development or self-employment start up − Job coaching for individualized, integrated employment or self-employment − Co-worker supports − Career advancement	**X**	X	X
− Supported employment—small group supports	**X**	X	X
− Integrated employment path services	**X**	X	X

29. Cost-Effective Alternatives. TennCare MCOs and TennCare Select may provide services not listed in, or exceeding the individual service limits in, the Medicaid state plan or paragraph 28 *(TennCare Benefits)* of these STCs as allowed under their contracts with the TennCare program. Provision of these services is at the sole discretion of the MCO and TennCare Select. Capitation for the MCOs must be certified as actuarially sound (in accord with 42 CFR § 438.6), and comply with the Federal managed care regulations at 42 CFR §§ 438 et seq. TennCare Select must demonstrate to the state that a service not listed as covered in the Medicaid state plan or in paragraph 28 *(TennCare Benefits)* is a cost-effective alternative, in order for the state to reimburse TennCare Select for the service. The state must demonstrate to CMS annually as part of the annual report described in paragraph 47 (*Annual Report*) that utilization of these services by the MCOs and TennCare Select is cost-effective and is reimbursed in compliance with the Federal managed care regulations at 42 CFR §§ 438 et seq. Under the CHOICES and ECF CHOICES programs, cost-effective alternatives may include a Transition Allowance, as defined in Attachment D.

30. Medicaid Benefits Carved Out of the TennCare II Demonstration.

a. **"Base" Medicaid State plan services.** Base services are services carved out of TennCare II, and are provided, in accordance with the provisions of the Medicaid

state plan, only to the mandatory and optional state plan eligibles and members of the PACE Carryover Group (in the case of PACE services only). The other TennCare II demonstration-only populations, which are eligible through the demonstration's expenditure authorities and enrolled in TennCare Standard, are not eligible for any of the services listed in Table 3. Expenditures for these "Base" services are not demonstration expenditures (see paragraph 52.a., *Tracking Expenditures*), are not included in the demonstration's budget neutrality, and should, therefore, be reported on the "Base" reporting schedules of the Form CMS-64 reports (or in the case of 1915(c) waiver services, the appropriate 1915(c) waiver schedule). Some carved out services were carved in as of the initial implementation of CHOICES (i.e., March 1, 2010), however, as indicated in Table 3, and must from that point forward be reported as TennCare II demonstration expenditures.

Table 3
Base Services

Services Carved Out of TennCare II	
Nursing facility services	Services moved from the base to the demonstration as of March 1, 2010 (in Middle Tennessee) and August 1, 2010 (in East and West Tennessee)
Services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID)	Base
State Plan targeted case management services	Base
Program of All Inclusive Care for the Elderly (PACE)	Base
Services covered by the home and community-based services waiver for individuals with intellectual disabilities under 1915(c) of the Social Security Act. Upon implementation of ECF CHOICES, enrollment in this waiver is closed except as specified in the approved Comprehensive Aggregate Cap (CAC) Waiver application (CMS Control #0357).*	Base
Services covered through the state's agreement under Title V of the Social Security Act	Base

*This includes persons identified by the state as a former member of the certified class in the United States vs. State of Tennessee, et. al. (Arlington Developmental Center), a current

member of the certified class in the United States vs. the State of Tennessee, et. al. (Clover Bottom or Greene Valley) or the Harold Jordan Center following a stay of at least 90 days.

b. **Medicare Parts A and B Buy-In Premiums.** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, the CHOICES At Risk Demonstration Group, the ECF CHOICES 217-Like HCBS Group, the Interim ECF CHOICES At-Risk Group, and upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES Working Disabled Group and ECF CHOICES At- Risk Group; the Standard Spend Down group, the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare Buy-In premiums are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles as permitted in Section 1902(a)(10)(E) of the Act and 42 CFR § 431.625,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals),

(C) Dually eligible members of the CHOICES At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the ECF CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals),

(E) Dually eligible members of the Interim ECF CHOICES At-Risk Demonstration Group and, upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES At-Risk Demonstration Group and ECF CHOICES Working Disabled Group (QMBs/SLMBs and Demo Duals),

(F) Dually eligible members of the Standard Spend Down group (QMBs/SLMBs and Demo Duals), and

(G) Dually eligible members of the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group (QMBs, SLMBs, and Demo Duals).

ii. Medicare premiums paid on behalf of Demo Duals are demonstration expenditures, and must be reported on an appropriate Form CMS-64.9 or 9p Waiver, as described in paragraph 52.e. *(Use of Forms).*

iii. Medicare premium payments for other beneficiaries are excluded from TennCare II and must be reported as "Base" Medicaid expenditures on the CMS-64 reports.

iv. Records in CMS's Master Billing Record for Demo Duals and all buy-in transactions for Demo Duals must be identified using a specific Buy-In Eligibility Code (BIEC) value as agreed upon between the state and the Project Officer.

c. **Medicare Co-payments and Deductibles (i.e., Medicare crossover claims).** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, CHOICES At Risk Demonstration Group, CHOICES 1 and 2 Carryover Group, the ECF CHOICES 217-Like HCBS Group; the Interim ECF CHOICES At-Risk Demonstration Group; upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES Working Disabled Group and the ECF CHOICES At-Risk Demonstration Group; the PACE Carryover Group or the Standard Spend Down group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare crossover claims are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs, and Demo Duals),

(C) Dually eligible members of the CHOICES At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the ECF CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals),

(E) Dually eligible members of the Interim ECF CHOICES At-Risk Demonstration Group and, upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES At-Risk Demonstration Group and the ECF CHOICES Working Disabled Group (QMBs/SLMBs and Demo Duals).

(F) Dually eligible members of the CHOICES 1 and 2 Carryover Group and PACE Carryover Group, and

(G) Standard Spend Down enrollees (QMBs/SLMBs and Demo Duals).

The SSD population, the CHOICES 217-Like HCBS Group, the CHOICES At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, the ECF CHOICES 217-Like HCBS Group; the Interim ECF CHOICES At-Risk Demonstration Group; upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES Working Disabled Group and the ECF CHOICES At-Risk Demonstration Group; and the PACE Carryover Group

are the only demonstration populations for whom the state pays Medicare cost-sharing.

ii. For TennCare Medicaid enrollees, members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals), members of the CHOICES At Risk Demonstration Group (QMBs, SLMBs, and Demo Duals), members of the CHOICES 1 and 2 Carryover Group; members of the ECF CHOICES 217-Like HCBS Group; members of the Interim ECF CHOICES At-Risk Demonstration Group; and upon implementation of Phase 2 of ECF CHOICES, members of the ECF CHOICES Working Disabled Group and the ECF CHOICES At-Risk Demonstration Group (QMBs, SLMBs, and Demo Duals); and the PACE Carryover Group (QMBs/SLMBs and Demo Duals), these expenditures are not demonstration expenditures and are not included in the budget neutrality calculations, so report these as "Base" Medicaid expenditures on the CMS-64 reports.

iii. For dually eligible SSD enrollees (QMBs/SLMBs and Demo Duals), these expenditures are included as demonstration expenditures that are subject to budget neutrality, so report these demonstration expenditures as "EG6E Expan Adult" on the CMS-64 reports. Medicare cost-sharing for SSD dual eligibles is covered in the same manner as Medicare cost-sharing would be covered for Medically Needy aged, blind, or disabled individuals and caretaker relatives, had these groups been included in the Medicaid state plan.

31. Additional Provisions Related to Institutions for Mental Diseases (IMDs). Expenditures for services rendered to TennCare II enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.

VI. CHOICES AND ECF CHOICES ENROLLMENT

32. Operations of the TennCare CHOICES Program.

a. **Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group.** The CHOICES Program provides long-term services and supports (LTSS) as identified in Table 2b to four groups of people, as defined below:

i. **CHOICES 1.** This group consists of persons who are receiving Medicaid-reimbursed care in a nursing facility (NF).

ii. **CHOICES 2.** Persons age 65 and older and adults age 21 and older with physical disabilities who meet the NF level of care (LOC), who qualify either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to NF care. The demonstration population includes persons who could have been eligible under 42 CFR § 435.217 had the state continued its 1915(c) HCBS waiver for persons who are elderly and/or physically disabled.

iii. **CHOICES 3.** Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles, who do not meet the NF LOC, but who, in the absence of HCBS, are "at risk" for institutionalization, as defined by the state.

iv. **Interim CHOICES 3.** Elderly adults and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of the CHOICES At Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. This group will close to new enrollment on June 30, 2015.

b. **Eligibility for TennCare CHOICES Benefits.** Individuals can be eligible for one of the four TennCare CHOICES groups defined in a. above depending upon their medical and / or functional needs, their TennCare eligibility group, and the ability of the state to provide them with safe, appropriate, and cost-effective LTSS.

i. Medical and / or functional needs are assessed according to LOC criteria published by the state in state rules.

(A) There will be one set of LOC criteria for NF care, which will be used in assessing eligibility for CHOICES 1 and CHOICES 2.

(B) On July 1, 2012, the state opened enrollment in CHOICES 3, which is subject to a separate set of criteria to determine the "At-Risk" population.

(C) For the purposes of redetermining whether a recipient of NF services (CHOICES 1) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial LOC determination for that individual at the time of enrollment into CHOICES 1.

(D) For the purposes of determining whether a recipient of HCBS for elderly and disabled (CHOICES 2) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial level of care determination for that individual at the time of HCBS enrollment, or for persons transitioning from a NF, at the time of enrollment into CHOICES 1.

(E) For purposes of enrollment into CHOICES 1, the state may grant an exception for persons in the community who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely be met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of initial enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

ii. Financial eligibility:

(A) Financial eligibility for CHOICES 1 is established according to the Medicaid state plan.

(B) In order to be financially eligible for CHOICES 2, an individual must be eligible for TennCare as an SSI recipient or meet the criteria for the CHOICES 217-Like HCBS Group, individuals who qualify under institutional income and resource rules, and who are receiving home and community-based services and would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.726, and 435.236 of the Federal regulations and Section 1924 of the Act, if the home and community based services were provided under a 1915(c) waiver.

(C) In order to be financially eligible for CHOICES 3, an individual must be eligible for TennCare as an SSI recipient.

(D) In order to be financially eligible for Interim CHOICES 3, an individual must be eligible for TennCare as an SSI recipient or as a member of the CHOICES At Risk Demonstration Group. Members of the CHOICES At Risk Demonstration Group must meet institutional income and resource criteria.

iii. The state's ability to provide applicants with appropriate home and community based services is determined by the availability of slots under an established enrollment target (see paragraph 32.d., *Enrollment Targets for TennCare CHOICES*) and, for persons in CHOICES 2, the determination by the MCO that the individual can be served appropriately at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i), and for persons in CHOICES 3 and Interim CHOICES 3, the determination by the MCO that the cost of HCBS will not exceed the limit in paragraph 28.h.iii. There is no enrollment target for Interim CHOICES 3.

c. **Enrollment in TennCare CHOICES.** The effective date of enrollment in TennCare CHOICES must be established by the state based on a determination that an applicant is eligible for and must begin receiving LTSS. Enrollment procedures differ depending upon whether or not the person is already enrolled in TennCare Medicaid.

i. **Persons Not Already Enrolled in TennCare.** Persons not already enrolled in TennCare who wish to enroll in TennCare CHOICES must enroll through the State's Single Point of Entry (SPOE). The SPOE must provide counseling and assistance in evaluating LTSS options, screening and intake for LTSS programs offered by the state (TennCare CHOICES as well as other programs), assistance in evaluating the individual's functional LOC for LTSS, and facilitation of Medicaid eligibility determination by the state.

(A) Individuals who are determined to be both medically and financially eligible for NF placement will always be allowed to receive TennCare CHOICES services in a NF as members of CHOICES 1, if they choose.

(B) Those individuals who meet the criteria for CHOICES 2 subject to the limitations set out in these STCs, will be allowed to choose HCBS as an alternative to NF placement if the determination is made that the individual can be served appropriately in CHOICES 2 at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i).

ii. **Persons Already Enrolled in TennCare.**

(A) **Nursing Facility Residents.** MCOs will conduct an assessment of NF residents who wish to move to HCBS to determine if they can be served appropriately in the community at a cost that does not exceed the cost neutrality test set forth in Section 1915(c)(4)(A), as individually applied. Even if an enrollment target has been reached for CHOICES 2, an MCO may transition persons from CHOICES 1 to CHOICES 2 in accord with subparagraph 32.d.iii.(C) *(Transition from CHOICES 1 to CHOICES 2).*

(B) TennCare enrollees who are not already participating in CHOICES may request enrollment in CHOICES through their MCOs, or they may be identified through other mechanisms that would trigger an assessment of their need for LTSS by the MCO. The MCO will provide counseling and assistance in evaluating LTSS options, and assistance in evaluating the individual's functional LOC eligibility for LTSS. The functional LOC determination for LTSS will be made by the Bureau of TennCare, using criteria published in state rules. Once individuals have established LOC and financial eligibility for LTSS, they can be enrolled in CHOICES in accordance with paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*).

d. **Enrollment Targets for TennCare CHOICES.** The state may establish enrollment targets for CHOICES 2 and CHOICES 3. (There will be no enrollment target for CHOICES 1 or Interim CHOICES 3.) The purpose of the targets is to permit the CHOICES program to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available state and Federal resources. Information on CHOICES Groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Progress Report as set forth in paragraphs 46 *(Quarterly Progress Reports),* 50 *(Enrollment Reporting)* and Attachment A.

i. The state may establish an enrollment target for CHOICES 2, consistent with the upper and lower limits shown in the table below; with the actual target number to be published in state rules. The state may adjust the target as appropriate from time to time upon notification to CMS at least 30 days prior to the desired effective date of the change. Except as set forth in paragraph 32.d.iii., an increase in the enrollment target above the upper limit appropriate to the DY or a decrease below the lower limit will require an approved waiver amendment prior to implementation.

Table 4
Enrollment Targets for Demonstration Years 12 Through 14

Demonstration Year	Lower Limit	Upper Limit
DY 12	12,000	16,000
DY 13	13,500	17,500
DY 14	15,000	18,500

ii. The state may also establish an enrollment target for CHOICES 3, if this group is established after a change in the level of care criteria. At a minimum, this target will be set at 10% of the enrollment target for CHOICES 2. There will be no enrollment target for Interim CHOICES 3.

iii. If the enrollment target established by the state for CHOICES 2 or CHOICES 3 is reached or exceeded, the state shall not enroll additional persons in CHOICES 2 or CHOICES 3, except as indicated below. The state may also establish a waiting list for CHOICES, subject to the following:

(A) **Reserve Capacity.** The state may reserve slots in CHOICES 2 for individuals being discharged from a NF and for individuals being discharged from an acute care setting who are in imminent risk of being placed in a nursing facility setting absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved must be included as an attachment to the Annual Report (see paragraph 47). The state may establish additional criteria or modify procedures for allocating reserve slots upon 30 day advance written notification to CMS; the operational procedure documents included as attachments to subsequent Annual Reports must reflect any such changes. In each Quarterly Progress Report, the state must provide an accounting of their management of the reserve capacity, including a summary (as of the last day of the quarter) that states the total enrollment targets for CHOICES 2 and 3, the number enrolled in each CHOICES group, and the numbers of slots being held in reserve for various purposes.

(B) **HCBS as a Cost-Effective Alternative.** An MCO with a TennCare enrollee who meets the criteria for CHOICES 2, but which cannot enroll the individual in CHOICES 2 because the enrollment target for CHOICES 2 has been met, has the option, at its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care, in accordance with paragraph 29 *(Cost-Effective Alternatives)*. (Consistent with paragraph 32.d.iii.(C), this person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.) The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. The state may require the MCO to provide documentation of its cost-effective alternative determination and assurance of provider capacity to meet the member's needs prior to enrollment in CHOICES.

(C) **Transition from CHOICES 1 to CHOICES 2.** An enrollee being served in CHOICES 1 who meets the requirements to enroll in CHOICES 2 can enroll in CHOICES 2 at any time such a transition can be accomplished, even if an enrollment target for CHOICES 2 has been reached. This person would be served in CHOICES 2

outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.

e. **Waiting Lists for TennCare CHOICES.** The use of enrollment targets as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*) may mean that there will be waiting lists for CHOICES 2 and/or 3. (There will be no enrollment target or waiting list for CHOICES 1 or the Interim CHOICES 3 Group.) These lists must be managed on a statewide basis using a standardized assessment tool and in accord with criteria to be established by the state. Waiting list policies must be based on objective criteria and applied consistently in all geographic areas served. The state may use separate criteria for prioritization of services under CHOICES 2 and CHOICES 3, and may revise these upon notification to CMS.

f. **Consumer Direction.** CHOICES members who have been determined by a care coordinator, as a part of the needs assessment and plan of care processes, to require attendant care, personal care, in-home respite services, companion care or other services specified by the state as eligible for consumer direction, will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e., consumer direction of HCBS). The state will notify CMS in advance of any changes to the list of services eligible for consumer direction. All CHOICES members requiring these services will be offered the option to participate in consumer direction of HCBS. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E.

g. **Miscellaneous Provisions Related to CHOICES Enrollment and Implementation**

i. The state will maintain an electronic visit verification system (as defined in Attachment D) as part of the CHOICES quality program.

ii. The state must ensure that the Care Plan is considered part of the medical record of a CHOICES participant, subject to all associated requirements and protections, and available for review by the state upon request.

33. Operations of Employment and Community First (ECF) CHOICES

a. Determination of ECF CHOICES Benefits by Designation into an ECF CHOICES Benefit Group. The ECF CHOICES Program provides long-term services and supports (LTSS) as identified in Tables 2c and 2d to three groups of people, as defined below:

i. Essential Family Supports (ECF CHOICES Group 4): Children under age 21 with I/DD living at home with family who meet the NF LOC and need and are receiving HCBS as an alternative to NF Care, or who, in the absence of HCBS, are "At risk of NF placement;" and adults age 21 and

older with I/DD living at home with family caregivers who meet the NF LOC and need and are receiving HCBS as an alternative to NF care, or who, in the absence of HCBS, are "At risk of NF placement," and elect to be in this group. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like, Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk Demonstration Group or ECF CHOICES Working Disabled Demonstration Group.

ii. **Essential Supports for Employment and Independent Living (ECF CHOICES Group 5):** Adults age 21 and older with I/DD who, in the absence of HCBS, are "at risk of NF placement." To qualify in this group, the adult must be SSI eligible or qualify in the Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

iii. **Comprehensive Supports for Employment and Community Living (ECF CHOICES Group 6):** Adults age 21 and older with I/DD who meet the NF LOC and need and are receiving specialized services for I/DD. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group.

b. **Eligibility for TennCare ECF CHOICES Benefits.** Individuals can be eligible for one of the three ECF CHOICES benefit group defined in paragraph a. above depending upon their functional and/or medical needs, their TennCare eligibility group, their age, their I/DD status, the need for and receipt of HCBS under ECF CHOICES, and the ability of the state to provide them with a safe, appropriate, and cost-effective LTSS.

i. I/DD and medical and/or functional needs are assessed according to criteria published by the state in the state rules.

ii. Financial eligibility:

(A) Eligible for TennCare as an SSI recipient; or

(B) Meet the criteria for the ECF CHOICES 217-Like Group; the Interim ECF CHOICES At-Risk Demonstration Group or, upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES At-Risk Demonstration Group or the ECF CHOICES Working Disabled Group.

iii. Need and receive home and community-based services under ECF CHOICES.

iv. The state's ability to provide applicants with appropriate ECF CHOICES home and community based services is determined by the availability of slots under an established enrollment target (see paragraph 33.d., *Enrollment Targets for ECF CHOICES*).

c. **Enrollment in ECF CHOICES.** The effective date of enrollment in ECF CHOICES shall be established by the state based on a determination that an applicant is eligible for and will begin receiving LTSS. To be eligible for ECF CHOICES, individuals must be determined by TennCare to meet all applicable eligibility and enrollment criteria.

i. For enrollment in Comprehensive Supports for Employment and Community Living (CHOICES Group 6), the State may grant an exception to individuals transitioning from the Statewide or Comprehensive Aggregate Cap Waivers who are "at risk" of institutionalization and meet the ICF/IID but not the NF level of care.

ii. Individuals enrolled in a Section 1915(c) waiver shall not be permitted to transition into ECF CHOICES, even if they meet the criteria for ECF CHOICES eligibility, until such time that the State determines that such transitions can be permitted and in accordance with timeframes and procedures established by the State.

iii. Individuals enrolled in CHOICES Group 2 or 3 shall not be permitted to transition into ECF CHOICES, even if they meet the criteria for ECF CHOICES eligibility, unless the State determines that the individual qualifies for ECF CHOICES, the individual's needs can be more appropriately met in ECF CHOICES, and in accordance with timeframes and procedures established by the State.

d. **Enrollment Targets for ECF CHOICES.** The state may establish enrollment targets for ECF CHOICES. The purpose of the targets is to permit ECF CHOICES to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately and cost effectively within available state and Federal resources. Information on ECF CHOICES groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Progress Report as set forth in paragraphs 46 *(Quarterly Progress Reports),* 50 *(Enrollment Reporting)* and Attachment A.

i. The ECF CHOICES targets will include both upper limits and lower limits shown in the table below; with the actual target number to be published in state rules. The upper limit will serve as a ceiling on the enrollment target; TennCare will not set the target above the upper limit. The lower limit will

serve as an enrollment floor; TennCare will not set the target below the lower limit. To help ensure continuity of eligibility and benefits, the target for each benefit group will not be less than enrollment in that group at the time the target is established. Persons transitioning into ECF CHOICES from a Section 1915(c) waiver or from CHOICES Groups 2 or 3 shall not count against the enrollment target for the ECF CHOICES Group in which they are enrolled.

ii. The State will submit to CMS at least 60 days prior to the implementation of ECF CHOICES and at least 60 days prior to the beginning of each program year a proposed enrollment target range for each benefit group. The State may, during the course of each year, adjust the specific enrollment target for each group so long as the target remains within the approved enrollment target range for that benefit group and the State provides notification to CMS at least 30 days prior to the desired effective date of the change. Except as specified in paragraph 33.d.iii, an amendment is required for any proposed adjustment in the enrollment target outside the approved range.

iii. Any enrollment target for Essential Supports for Employment and Independent Living will be at least twice as high as any enrollment target for Comprehensive Supports for Employment and Community Living.

iv. If the enrollment target established by the state for ECF CHOICES is reached or exceeded, the state shall not enroll additional persons in ECF CHOICES, except as provided below. The state may also establish a waiting list, subject to the following:

(A) **Reserve Capacity.** The state may reserve slots in ECF CHOICES for individuals being discharged from a NF or an ICF/IID, and for individuals being discharged from an acute care setting who are in imminent risk of being placed in an NF or ICF/IID setting, absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved must be included as an attachment to the Annual Report. The state may establish additional criteria or modify procedures for allocating reserve slots upon 30 days advance written notification to CMS; the operational procedure documents included as attachments to subsequent Annual Reports must reflect any such changes. In each Quarterly Progress Report, the state must provide an accounting of their management of the reserve capacity, including a summary (as of the last day of the quarter) that states the total enrollment targets for ECF CHOICES, the number enrolled in each ECF CHOICES group, and the numbers of slots being held in reserve for various purposes.

(B) HCBS as a Cost-Effective Alternative. An MCO with a TennCare enrollee who meets the criteria for ECF CHOICES, but which cannot enroll the individual in ECF CHOICES because the enrollment target has been met, has the option, at its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care, in accordance with paragraph 29 *(Cost- Effective Alternatives).* The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. The state may require the MCO to provide documentation of its cost-effective alternative determination and assurance of provider capacity to meet the member's needs prior to enrollment in ECF CHOICES.

e. Waiting Lists for ECF CHOICES. The use of enrollment targets as described in paragraph 33.d. *(Enrollment Targets for ECF CHOICES*) may mean that there will be waiting lists for ECF CHOICES. These lists will be managed on a statewide basis in accord with criteria to be established by the state. Waiting list policies must be based on objective criteria and applied consistently in all geographic areas served.

f. Consumer Direction. ECF CHOICES members will have the option for consumer direction, including budget authority. The consumer direction model will be a modified budget authority model. The consumer direction budget will be established in accordance with the benefit group, including expenditure cap, in which the person is enrolled and will be based on a comprehensive assessment of the individual's needs. Once determined, the member (or his/her representative) will be able to manage those services available through participant direction, so long as individual benefit limits (as applicable) and the member's total participant direction budget is not exceeded. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E.

i. Individuals in the Comprehensive Supports for Employment and Community Living benefit group will have the option to use a "Health Partner Agency (HPA) with Choice" model. The HPA with Choice model will allow an individual with I/DD who has more significant needs to elect to work with a qualified provider of residential services to help direct his/her services and supports budget. In the HPA with Choice model, the enrollee will have the opportunity to help select and supervise his or her direct support staff, who will be employed by the Agency. The Agency will support the enrollee in deciding how s/he will direct his/her services and supports budget, based on the needs identified in the person-centered support plan. The enrollee's MCO Support Coordinator will be involved in the planning process to ensure that the planning process remains conflict free and will monitor the ongoing provision of HCBS to ensure that the individual's needs are met. In addition, the HPA Agency must agree to:

work with the MCO Support Coordinator and with the accountable primary care entity—Patient Centered Medical Home and/or Health Home to facilitate access to and coordination of physical and behavioral health services and LTSS; support a comprehensive approach to preventive care, chronic disease and care management; assist in health promotion; help facilitate comprehensive transitional care/follow-up; and use HIT, as can be made available, to help facilitate communication between and among providers, the member, and caregivers.

VII. COST SHARING

34. Cost Sharing.

a. TennCare Medicaid enrollees under the state plan are subject to cost sharing for pharmacy services (see Table 6 below).

b. Demonstration-only eligible adults enrolled in the SSD category or the CHOICES At Risk Demonstration Group are subject to cost sharing for pharmacy services (see Table 6 below).

c. TennCare Standard children, except for children enrolled in ECF CHOICES, are subject to cost sharing for both non-pharmacy services and pharmacy services (see Table 5 and Table 6).

d. Individuals participating in CHOICES 1 or CHOICES 2 or the ECF CHOICES Comprehensive Supports for Employment and Community Living benefit group are exempt from all cost sharing, as are individuals participating in the Essential Family Supports Group who meet NF level of care and individuals participating in the Essential Family Supports Group who are under age 21.

e. Individuals participating in CHOICES 3 or Interim CHOICES 3 are subject to cost sharing for pharmacy services (see Table 6 below), similar to other Medicaid state plan adult enrollees.

f. Individuals participating in the ECF CHOICES Essential Supports for Employment and Independent Living benefit group are subject to cost sharing for pharmacy services (see Table 6 below), similar to other Medicaid state plan adult enrollees, as are individuals participating in the Essential Family Supports group who do not meet the NF level of care but are "at risk" of institutional placement.

35. Co-Payments. For demonstration-only eligible children in TennCare Standard (title XXI Medicaid Expansion children and medically eligible title XIX children), co-payments are collected by the provider when services are rendered. The requirements at Section 1916A of the Act and at 42 CFR §§ 447.50, 57, 58, and 62 through 82 will apply to cost sharing for this group.

a. **Non-Pharmacy Co-pays.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), the non-pharmacy co-pay amounts are presented in Table 5 (*TennCare Non-Pharmacy Co-Pays).*

Table 5
TennCare Non-Pharmacy Co-pays

Poverty Level	Co-payment Amounts
0%-99%	$0.00
100% - 199%	$10.00 Non-emergency Hospital Emergency Room (waived if admitted) $5.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $5.00 Physician Specialists (including Psychiatrists and Dentists) $5.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)
200% and above	$50.00 Non-emergency Hospital Emergency Room (waived if admitted) $15.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $20.00 Physician Specialists (including Psychiatrists and Dentists) $100.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode)

b. **Co-Pays on Pharmacy.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), adults in the Standard Spend Down Demonstration Group, persons in the CHOICES At Risk Demonstration Group, persons in the ECF CHOICES Essential Supports for Employment and Independent Living benefit group, and adults participating in the Essential Family Supports who do not meet the NF LOC, co-pays on outpatient pharmacy services are presented in Table 6 (*Co-Pays on Pharmacy)*.

Table 6
Co-Pays on Pharmacy

Population	Covered outpatient brand name drugs or refills	Covered outpatient generic drugs or refills
TennCare Medicaid adults who are not exempt from cost-sharing under 42 CFR § 447.53	$3.00	$1.50

Population	Covered outpatient brand name drugs or refills	Covered outpatient generic drugs or refills
TennCare Standard under age 21 (except for ECF CHOICES) with incomes below 100% FPL	$0	$0
TennCare Standard under age 21 (except for ECF CHOICES) with incomes at or above 100% FPL	$3.00	$1.50
TennCare Standard aged 21 and older -- SSD enrollees	$3.00	$1.50
CHOICES 1 and CHOICES 2	$0	$0
Interim CHOICES 3	$3.00	$1.50
CHOICES 3	$3.00	$1.50
ECF CHOICES under age 21 in the Essential Family Supports Benefit Group	$0	$0
ECF CHOICES aged 21 and older in the Essential Family Supports Benefit Group who do not meet NF LOC	$3.00	$1.50
ECF CHOICES Essential Family Supports Benefit Group who meet NF LOC	$0	$0
ECF CHOICES Essential Supports for Employment and Independent Living Benefit Group	$3.00	$1.50
ECF CHOICES Comprehensive Supports for Employment and Community Living Benefit Group	$0	$0

36. Compliance of TennCare Standard Cost Sharing With Federal Regulations. The state submitted a plan for ensuring that cost sharing for TennCare Standard complies with the statutory and regulatory requirements, including the implementation of an aggregate cost sharing cap as described in 42 CFR § 447.78. The state implemented its plan on January 1, 2013.

VIII. DELIVERY SYSTEMS

37. Managed Care Entities. TennCare II operates totally in a managed care environment and uses various types of managed care entities for delivering covered services to TennCare enrollees. The types of managed care entities used are listed in Table 7 below, with the reimbursement and rate-setting methodologies for each one. Title XXI Medicaid Expansion demonstration population children use the same delivery systems as other enrollees.

Table 7– Types of Managed Care Entities

Type of Entity	BBA Definition	Description of Services Covered	Reimbursement and Rate-Setting Methodology
Managed Care Organizations (MCOs)—at full risk	MCO	All TennCare physical health, behavioral health, and LTSS*	MCO rates are actuarially certified by an independent third party actuary
TennCare Select—non-risk or partial risk	Prepaid Inpatient Health Plan (PIHP)	All TennCare physical health, behavioral health, and LTSS* for enrollees selected for participation in TennCare Select rather than enrolled in MCOs (see paragraph 39, *TennCare Select*)	Provider payment rates are negotiated between the PIHP and providers; an administrative fee is approved by CMS and paid to the PIHP
Dental Benefits Manager (DBM)—non-risk (may be renegotiated as at risk)	Prepaid Ambulatory Health Plan (PAHP)	Dental benefits for all TennCare enrollees with this coverage	Provider payment rates are established within DBM contract as approved by CMS; an administrative fee, approved by CMS, is paid to the DBM
Pharmacy Benefits Manager (PBM)—non-risk (may be renegotiated as at risk)	PAHP	Pharmacy benefits for all TennCare enrollees with this coverage.	Provider payment rates are established in accordance with the state plan; an administrative fee, approved by CMS, is paid to the PBM

*****LTSS refers to services for persons who are elderly or who have physical disabilities and certain HCBS for individuals with intellectual or developmental disabilities enrolled in the ECF CHOICES program..

38. Enrollment in Managed Care Organizations (MCOs). With the exception of individuals enrolled in TennCare Select, all individuals eligible for TennCare (TennCare Medicaid or TennCare Standard), including those dually eligible for Medicare, shall be enrolled in a managed care organization providing the benefits described in paragraphs 28 *(TennCare Benefits)* and 29 *(Cost-Effective Alternatives)* of these STCs. Individuals with intellectual and developmental disabilities must enroll in an at-risk MCO in order to participate in ECF CHOICES. During the phased implementation of ECF CHOICES and as determined appropriate for efficient operation of the ECF CHOICES program, choice may be limited to two managed care organizations in each region. In addition to the managed care organization, enrollees are enrolled with a Pharmacy Benefits Manager for covered pharmacy services and a Dental Benefits Manager for covered dental services. The Pharmacy Benefits Manager administers the pharmacy benefits program, using a preferred drug list that is established by the state (in consultation with a Pharmacy Advisory Committee), taking into account the cost, therapeutic equivalency, and clinical efficacy in accordance with waiver authority.

39. TennCare Select. TennCare Select is a prepaid inpatient health plan (PIHP) (as defined in 42 CFR § 438.2) which operates in all areas of the state and covers the same services as the MCOs. The state's TennCare Select contractor is reimbursed on a non-risk, non-capitated basis or a partial risk basis for services rendered to covered populations, and in addition receives fees from the state to offset administrative costs.

a. The TennCare Medicaid and TennCare Standard populations included in the TennCare Select delivery system and the services provided to these populations by the TennCare Select contractor are as follows:

i. Children who are eligible for Supplemental Security Income. TennCare Select provides medical case management and all MCO covered services.

ii. Children in state custody and children leaving state custody for 6 months post-custody as long as the child remains eligible. TennCare Select provides medical case management, all MCO covered services, and coordination with the Department of Children's Services (DCS) around medical and behavioral services.

iii. Children who are receiving care in a nursing facility or an intermediate care facility for individuals with intellectual disabilities. For children and adults in a Home and Community Based Services 1915(c) waiver for individuals with intellectual disabilities, current enrollees may opt-in to receive services through TennCare Select, and new participants may opt-out of TennCare Select in order to receive services through another MCO. TennCare Select provides medical case management and all MCO covered services.

iv . Enrollees living in areas where there is insufficient capacity to serve them. TennCare Select provides medical case management and all MCO covered services.

After being assigned to TennCare Select, persons in categories i. and iii. above may choose to disenroll from TennCare Select and enroll in an MCO if one is available. Persons in categories ii. and iv. must remain in TennCare Select. The state must request a demonstration amendment (as described in paragraphs 6 and 7 regarding amendments) in order to change the list of populations included in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

b. TennCare Select also provides the following functions:

i. It is the back-up plan should one of the MCOs have to leave the TennCare program unexpectedly. For TennCare enrollees previously enrolled with the MCO, TennCare Select provides medical case management and all MCO covered services.

ii. It is the only entity responsible for payment of the services described in 42 CFR § 431.52 (regarding services provided to residents temporarily absent from the state), and provides all MCO covered services (primarily emergency services).

iii. It is also the only entity responsible for payment of the services described in 42 CFR § 440.255 (regarding emergency services for aliens), and is responsible for payment of emergency medical services only. TennCare Select is paid an administrative fee for processing these claims.

40. Plan Enrollment and Disenrollment. The state maintains a managed care enrollment and disenrollment process that must comply with 42 CFR Part 438, except that, in accordance with waiver authority, TennCare participants have 45 days in which to disenroll from an MCO without cause. After 45 days, a participant may disenroll from an MCO only for cause, as set forth in 42 CFR § 438.56(d)(2). The "other reasons" that will be considered cause under 42 CFR § 438.56(d)(2)(iv) do not include the following:

- The enrollee is unhappy with the current plan or primary care provider (PCP), but there is no hardship medical situation (as defined by the state);
- The enrollee claims lack of access to services but the plan meets the state's access standards;
- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- The enrollee is concerned that a current provider might drop out of the plan in the future;
- The enrollee is a Medicare recipient who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation; and
- The enrollee's Primary Care Provider (PCP) is no longer in the MCO's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO.

In the event that a CHOICES or ECF CHOICES member is determined, based on an assessment of needs, to require long term services and supports that are not currently available under the MCO in which he is currently enrolled, but that are available through another MCO, the state shall work with the current MCO to arrange for the provision of the required services, which may involve providing such services out-of-network. It shall be considered to be cause for disenrollment only if the current MCO, after working with the state, is unable to provide the required services. In such cases, the MCO that is unable to provide the required services after working with the state may be subject to sanctions.

41. Contracts. The following subparagraphs provide additional requirements pertaining to contracts awarded by the state for the provision of health care services under TennCare II.

a. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation.

b. Payments under contracts with public agencies that are not competitively bid in a process involving multiple bidders shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

c. With respect to CHOICES and ECF CHOICES, the state established minimum guidelines regarding the person-centered service plan, the processes for the development of the plan, and the monitoring of its implementation. These expectations were submitted to CMS and are reflected in the MCO contract. Any changes in the contract requirements related to the subjects enumerated below will be submitted to CMS for review prior to executing a contract amendment with an MCO. CMS will respond within 15 working days of receipt of the draft. The required subject areas are as follows:

i. The individuals who develop the person-centered service plan (and their requisite qualifications);

ii. The individuals who are expected to participate in the plan development process;

iii. Timing of the plan, how and when it is updated, including mechanisms to address changing circumstances and needs (and expectations regarding scheduling and location of meetings to accommodate individuals receiving services);

iv. Types of assessments that are conducted as a part of the service plan development process;

v. How participants are informed of the services available to them;

vi. How the process ensures that the service plan addresses the participants' desired outcomes, needs and preferences; and

vii. The plans' responsibilities for implementing and monitoring the plan of care.

d. The state will require the MCOs to develop and maintain emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. These contingency plans will be available for inspection by state officials upon request.

e. The state will monitor loss ratios of the managed care plans.

IX. GENERAL REPORTING REQUIREMENTS

42. General Financial Requirements. The state shall comply with all general financial requirements under title XIX and title XXI set forth in these STCs.

43. Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality. The state shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request.

44. Additional Reporting Requirements.

a. **Compliance with Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR §§ 438 *et seq.*

b. **Compliance with Specified HCBS Requirements.** The following regulations, which govern the provision of HCBS under Section 1915(c) waivers, shall apply to the HCBS program authorized under Section 1115 and provided through CHOICES and ECF CHOICES:

- 42 CFR § 440.180(a);
- 42 CFR §441.301(c)(1) – (6)
- 42 CFR § 441.302;
  - (a),
  - (c) (insofar as it relates to NF level of care, and applying only to CHOICES 2),
  - (d) (consistent with a waiver of Section 1902(a)(23) of the Act),
  - (g) (applies only to CHOICES 2), and
  - (j);
- 42 CFR § 441.303
  - (a),
  - (c) (except that the requirements following the semi-colon in (c)(2) do not apply to CHOICES 3 or Interim CHOICES 3),
  - (d) (consistent with Table 2b, paragraph 28), and
  - (e); and
- 42 CFR § 441.310.

Any conflict between the regulations listed in this subparagraph and these STCs shall be resolved in favor of the STCs. The state shall include a description of the steps taken to ensure compliance with these regulations as part of the Annual Report discussed in paragraph 47 *(Annual Report).*

c. **Quality Improvement Strategy for the CHOICES and ECF CHOICES Programs.** The state must submit to CMS an integrated quality improvement (QI) strategy which builds on existing managed care quality requirements as defined in 42 CFR § 438, Subpart E, and incorporates applicable 1915(c) Home and

Community-Based Services waiver regulatory assurances as discussed in paragraph 44.b.

The state must identify: 1) measures of process, health outcomes, functional status, quality of life, member choice, autonomy, satisfaction, and TennCare, CHOICES, and ECF CHOICES system performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

The MCOs must be required to establish methods for discovery, remediation and systems improvement and, per state prescribed timeframes, regularly report on outcomes associated with continuous quality improvements.

The state must clearly demonstrate its oversight of the process.

The QI strategy must be submitted to CMS for approval prior to implementation.

No less frequently than annually, the state must provide to CMS information regarding QI activities which must include evidence regarding system performance based on identified objectives and measures, and which demonstrates efficacy in implementing the quality strategy, including but not limited to external quality review, discovery, remediation and systems improvement activities.

d. **CHOICES and ECF CHOICES Data.**

i. **CHOICES Data Plan.** The state will collect and submit data to CMS, including the following data elements:

(A) Numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services at a point in time,

(B) Unduplicated numbers of persons receiving HCBS and unduplicated numbers of persons receiving NF services during a 12 month period,

(C) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period,

(D) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period as a percentage of total long-term services and supports expenditures (excluding expenditures on the population of persons with intellectual disabilities),

(E) Average per person HCBS expenditures and NF expenditures on the elderly and disabled populations during a 12 month period,

(F) Average length of stay in HCBS during a 12 month period,

(G) Percent of new LTSS recipients admitted to NFs during a 12 month period,

(H) Average length of stay in NFs during a 12 month period,

(I) Number of persons transitioned from NFs to HCBS during a 12 month period.

"Point in time" refers to June 30 of each year.

ii. **ECF CHOICES Data Plan.** The state will collect and submit data to CMS, including the following data elements:

(A) Number of persons with ID actively receiving HCBS upon implementation of ECF CHOICES and at a point in time. Data shall be reported for ECF CHOICES and across Medicaid HCBS programs (including Section 1915(c) waivers).

(B) Number of persons with DD (other than ID) actively receiving HCBS upon implementation of ECF CHOICES and at a point in time. Data shall be reported only for ECF CHOICES;

(C) Number of persons with I/DD actively receiving HCBS upon implementation of ECF CHOICES and at a point in time. Data shall be reported for ECF CHOICES and across Medicaid HCBS programs (including Section 1915(c) waivers);

(D) Unduplicated number of persons with ID actively receiving HCBS during a 12 month period prior to implementation of ECF CHOICES and each demonstration year thereafter. Data shall be reported for ECF CHOICES and across Medicaid HCBS programs (including Section 1915(c) waivers);

(E) Unduplicated number of persons with DD (other than ID) actively receiving HCBS during a 12 month period prior to implementation of ECF CHOICES and each demonstration year thereafter. Data shall be reported only for ECF CHOICES;

(F) Unduplicated numbers of persons with I/DD receiving HCBS during a 12 month period prior to implementation of ECF CHOICES and each demonstration year thereafter. Data shall be reported for ECF CHOICES and across Medicaid HCBS programs (including Section 1915(c) waivers);

(G) Average per person LTSS expenditures for individuals with I/DD during a 12 month period prior to implementation of ECF CHOICES and each demonstration year thereafter. Data shall be reported for ECF CHOICES, Section 1915(c) waivers, ICF/IID services, and across Medicaid HCBS programs (including Section 1915(c) waivers);

(H) Total HCBS expenditures for individuals with I/DD during a 12 month period prior to implementation of ECF CHOICES and each demonstration year thereafter, including as a percentage of total LTSS expenditures for individuals with I/DD.

(I) Number of persons with I/DD employed in an integrated setting at or above the minimum wage upon implementation of ECF CHOICES and at a point in time. Data shall be reported for ECF CHOICES and across Medicaid HCBS programs (including Section 1915(c) waivers);

(J) Percentage of persons with I/DD reporting improved quality of life as measured by a standardized instrument upon enrollment into ECF CHOICES and one year following enrollment into ECF CHOICES.

"Point in time" refers to June 30 of each year.

iii. **Electronic Collection of CHOICES and ECF CHOICES Data.** The systems must be in place to record the requisite data elements for the CHOICES and ECF CHOICES Programs.

iii. **CHOICES and ECF CHOICES Data Reporting.** The state must report to CMS, in the Quarterly and Annual Progress Reports, on data and trends of the designated CHOICES and ECF CHOICES data elements, as applicable. An electronic copy of the actual data addressing the required data elements must be submitted to CMS within 3 months following each point in time (e.g., by September 30 of each DY).

e. **Requirements Related to the Affordable Care Act.** Subparagraphs i. and ii. below describe elements that must be included in an extension proposal or phase-out plan, as discussed in paragraph 8 *(Extension of the Demonstration)* and paragraph 9 *(Demonstration Phase-Out).*

i. **Affordable Care Act Transition Plan for Extension.** The extension proposal submitted to CMS in June 2012 included a Transition Plan. This plan will be updated consistent with the provisions of the Affordable Care Act and CMS regulations for any individuals enrolled in Demonstration Eligible Groups (as defined in paragraph 17, Table 1a) who will be eligible for coverage under the state plan as of January 1, 2014, including under the

new Medicaid eligibility group identified in Section 1902(a)(10)(A)(i)(VIII) of the Act, or who elect to move to an Exchange plan. Persons who are demonstration eligibles at the time of transition will continue to receive demonstration benefits as long as they are enrolled in a Medicaid category and they continue to meet the criteria for their particular demonstration program. The updated Transition Plan will include procedures for ensuring that these individuals transition to their new eligibility status without interruption in coverage to the maximum extent possible.

ii. **Demonstration Phase-Out and Affordable Care Act Transition.** As part of a phase-out plan submitted under paragraph 9, the state must include a plan for using information already in its possession on members of demonstration Eligible Groups to make advance determinations of eligibility for TennCare under its Medicaid state plan on January 1, 2014, consistent with guidance to be issued by CMS.

45. **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the state's progress on enrolling individuals into the TennCare Standard Spend Down Demonstration Group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

46. **Quarterly Progress Reports.** The state must submit progress reports containing the items listed below (see also Attachment A for format), no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. An updated CHIP allotment neutrality monitoring spreadsheet, if necessary;

c. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the TennCare Standard Spend Down Demonstration Group; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the demonstration; pertinent legislative

or litigation activity; and other operational issues;

d. Action plans for addressing any policy, administrative, or budget issues identified;

e. Quarterly enrollment reports for demonstration eligibles that include the member months for each demonstration population;

f. Quarterly enrollment reports for individuals who would otherwise be eligible for Interim CHOICES 3 but who meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual;

g. Evaluation activities and interim findings; and

h. Other reports as indicated in these STCs.

47. Annual Report. The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The state shall also submit the title XXI annual state report for its Medicaid Expansion children in the demonstration, by December 31 of each year.

48. Beneficiary Survey. The state shall conduct a beneficiary survey each demonstration year for a statistically valid sample of all TennCare enrollees. The survey shall measure satisfaction, enrollee efforts to secure out-of-network care, average waiting time for physician office visits, and enrollee efforts to change plans, along with reasons for requesting plan changes. Results of the survey must be provided to CMS by September after the end of in each demonstration year (e.g. survey results for demonstration year 12 are due no later than September 30, 2014).

49. Final Evaluation Report. The state shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act and as specified in Section XII of these STCs.

50. Enrollment Reporting.

a. Each quarter the state will provide CMS with an enrollment report for the title XXI Medicaid Expansion demonstration population and for title XIX Medicaid children, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the state into the Statistical Enrollment Data System (SEDS) within 30 days after the end of each quarter. SEDS reporting is required for any title XXI-funded population, including Medicaid Expansions, and is also required for title XIX Medicaid child enrollment.

b. Enrollment reporting in the Quarterly and Annual Reports (see paragraphs 46 *Quarterly Progress Reports* and 47 *Annual Report*) is required by Eligibility Group (EG) and Type for the TennCare title XIX and XXI state plan and demonstration populations.

X. GENERAL FINANCIAL REQUIREMENTS

51. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under Section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period and pool payments and certified public expenditures made for the demonstration period. CMS shall provide Federal financial participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X of these Terms and Conditions.

52. Reporting Expenditures in the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Tennessee must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which capitation payments were made. For this purpose, demonstration year 1 (DY 1) is defined as the year beginning July 1, 2002, and ending June 30, 2003. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures should be reported on Forms CMS-64.9 Base/64.9P Base.

Expenditures for Medicaid Expansion children claimed under the authority of title XXI of the Act shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

b. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by demonstration year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the eligibility groups (EGs) from which collections were made (see paragraph 54, *Assignment of Expenditures and Member Months to EGs*). In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations shall be offset against

expenditures. These Section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver or 64.9P Waiver schedules, and allocated to forms named for the different EGs described in e.i. through e.xii. below as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to demonstration populations shall be offset against expenditures.

e. **Use of Forms**. The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration and title XIX expenditures made in other payment categories as follows. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system. The terms "EG1" through "EG12" refer to the demonstration Eligibility Groups defined in paragraph 54 *(Assignment of Expenditures and Member Months to EGs)* of these STCs.

i. "EG1 Disabled" expenditures (see paragraph 54.a.i.)

ii. "EG2 Over 65" expenditures (see paragraph 54.a.ii.)

iii. "EG3 Children" expenditures (see paragraph 54.a.iii.)

iv. "EG4 Adults" expenditures (see paragraph 54.a.iv.)

v. "EG5 Duals" expenditures (see paragraph 54.a.v.)

vi. "EG6E Expan Adult" expenditures (see paragraph-54.b.i.)

vii. "EG7E Expan Child" expenditures (see paragraph 54.b.ii.)

viii. "EG8 Med Exp Child" expenditures (see paragraph 54.b.iii.)

ix. "EG9 H-Disabled" expenditures (see paragraph 54.b.iv.)

x. "EG10 H-Over 65" expenditures (see paragraph 54.b.v.)

xi. "EG11 H-Duals" expenditures (see paragraph 56.b.vi.)

xii. "EG12E Carryover" expenditures (see paragraph 56.b.vii.)

xiii. "GME" (Graduate Medical Education) (see paragraph 56.d.)

xiv. "EAH Pool" (Essential Access Hospital Pool) (see paragraph 56.e.)

xv. "CAH Pool" (Critical Access Hospital Pool) (see paragraph 56.f.)

xvi. "Meharry Pool" (see paragraph 56.g.)

xvii. "CPE" (Certified Public Expenditures) for Unreimbursed Public Hospital Costs Pool (see paragraph 56.h.)

xviii. "DSH" (Disproportionate Share Hospital Payments) (see paragraph 56.i.)

xix. "UHC Pool" (Unreimbursed Hospital Cost Pool) (see paragraph 56.k.)

xx. "PHSP Pool" (Public Hospital Supplemental Payment Pool) (see 56.l.)

f. **Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population.**

i. **Expenditures Subject to the Allotment Neutrality Limit.** The state will be subject to a limit on the amount of Federal title XXI funding that the state may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including available reallocated funds published in the *Federal Register*. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of demonstration until the next allotment becomes available.

ii. The state is eligible to receive title XXI funds for expenditures for TennCare Medicaid Expansion children described on the last row of Table 1a in Section IV, paragraph 17 *(Eligibility)*, up to the amount of its title XXI allotment. Waiver expenditures for these children under title XXI must be reported as a Medicaid expansion population on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver, in accordance with the instructions in Section 2115 of the State Medicaid Manual, under waiver name "Med Exp Child," identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which

capitation payments were made. They are reported in Column C for the enhanced match under title XXI.

iii. If the state exhausts its title XXI allotment, title XIX funds are available for title XXI children in this demonstration. To access this funding, the state must submit for approval a written request to CMS, referencing this STC, to access title XIX funds for the title XXI Medicaid Expansion Demonstration Group. This request must be submitted at least 90 days prior to the date on which the state anticipates its title XXI allotment will be exhausted, and must include:

(A) An updated budget neutrality assessment that adds Medicaid Expansion children to budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that removes Medicaid Expansion children.

iv. Once the title XXI allotment is again available, the state will claim title XXI funding for the title XXI children in this demonstration. To access this funding, the state shall submit for approval a written request to CMS, referencing this STC, to access title XXI funds for the title XXI Medicaid Expansion Demonstration Group, which includes a request to update the STCs related to claiming. This formal request must be submitted prior to the change in funding source and include:

(A) An updated budget neutrality assessment that removes Medicaid Expansion children from budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that adds Medicaid Expansion children.

v. During periods in which the state is claiming title XIX funds for Title XXI Medicaid Expansion demonstration population children, the member months attributable to this demonstration population will count toward calculation of the budget neutrality expenditure limit, using the per member per month (PMPM) amounts for "EG8 Med Exp Child." The expenditures will be considered expenditures subject to the budget neutrality expenditure limit, so that the state is not fully at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

g. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to:

i. All TennCare title XIX expenditures on behalf of individuals who are enrolled in this demonstration (excluding the services specified in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*), including all service expenditures and applicable administrative costs (see subparagraph h. below) net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse), and

ii. All expenditures described in paragraph 56.d. through i. *(Extent of Federal Financial Participation for the Demonstration).*

All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver, with the exception of those described in h. below.

h. **Administrative Costs.** In general, administrative costs are not included in the budget neutrality expenditure limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. Administrative costs subject to budget neutrality (see below) must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, according to the EGs for which the expenditure was made (following the list in e.i. through e.xii. above). Other administrative costs not subject to budget neutrality will not be broken out by EG, and will be reported under waiver name "TennCare II."

In accordance with Federal regulations at 42 CFR § 438.812(b)(2), during the periods that services are provided in accordance with MCO, pharmacy benefit

manager, or dental benefit manager non-risk contracts, the portion of the state's payments that is for reimbursement of the non-risk contractors' administrative services can only be claimed by the state as an administration cost at the Federal matching rates available for the costs of administration of the Medicaid program. The administrative services portion of the amounts paid by the state to compensate any non-risk contractors for their administration costs incurred in accordance with non-risk contracts are costs of the demonstration waiver that are subject to the budget neutrality expenditure limit explained in Section XI of these STCs.

i. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the Section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.

53. Reporting Member Months. The following describes the reporting of member months for TennCare Medicaid and TennCare Standard enrollees:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 46 *(Quarterly Progress Reports)* of these STCs, the actual number of eligible member months for all TennCare Medicaid and TennCare Standard Eligibility Groups (EGs) defined in paragraph 54 *(Assignment of Expenditures and Member Months to EGs)*. The state must submit a statement accompanying the quarterly report, which recognizes the accuracy of this information. Member months should be reported only for individuals who are included in TennCare, as defined in paragraph 17 *(Eligibility)*. Persons for whom Medicaid only pays for services carved out of TennCare (as described in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*) are not enrolled in TennCare (e.g., QMBs, SLMBs).

b. A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for Type 1 and Type 2 eligibles (as defined in paragraph 62, *Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement*) are reported in Section VIIIA of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for Type 3 demonstration expansion populations and for title XXI Medicaid Expansion demonstration eligibles are reported in Section VIIIB of the template, and are not used to calculate the budget neutrality expenditure limit. Detailed instructions for assigning member months to Types and to EGs are provided in paragraphs 54 *(Assignment of Expenditures and Member Months to EGs)* and 62 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)*.

c. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the state must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

d. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

e. The state will ensure that eligible member month totals reported to CMS for the TennCare II demonstration from July 1, 2002, forward conform to the EG definitions contained in paragraph 54 *(Assignment of Expenditures and Member Months to EGs).*

54. Assignment of Expenditures and Member Months to EGs: The following rules govern the:

- Reporting of expenditures subject to the budget neutrality expenditure limit on separate waiver forms by EG, as described in paragraph 52.e. *(Use of Forms)* above, for the period beginning July 1, 2007, through the end of the TennCare II demonstration, and
- Reporting of eligible member months for the TennCare II demonstration from July 1, 2002, forward.

Beginning July 1, 2007, and as subsequently modified, the quarterly progress report template in Attachment A, Part VIII should be used to report separate member month totals for Type 1, Type 2, and Type 3 eligibles, and for other subgroups as specified below.

a. **Title XIX State Plan Mandatory or Optional Groups (Type 1 Eligibles)– TennCare Medicaid:**

i. For Medicaid eligibles of any age who have qualified for Medicaid on the basis of disability but who are not eligible for Medicare, report under **EG1 Disabled, Type 1.** This includes non-dual SSI eligibles in CHOICES 1, 2, and 3, the CHOICES 1 and 2 Carryover Group, or the PACE Carryover Group.

ii. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are 65 years of age or older, report under **EG2 Over 65, Type 1.**

iii. For Medicaid eligibles who have not qualified for Medicaid on the basis of

disability, who are not eligible for Medicare, and who are age 18 or younger, report under **EG3 Children, Type 1.**

iv. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are between the ages of 19 and 64, report under **EG4 Adults, Type 1.**

v, For Medicaid eligibles of any age who are also eligible for Medicare, report under **EG5 Duals, Type 1.** This category includes dually eligible Medicaid/Medicare individuals who have been classified as "disabled." It does not include any dually eligible members of demonstration populations such as the CHOICES 217-Like HCBS Group or the CHOICES At Risk Demonstration Group.

b. **Title XIX Demonstration Eligible Groups (Type 2 or 3 Eligibles) – TennCare Standard**

i. For demonstration eligibles who are enrolled in the Standard Spend Down category, report under **EG6E Expan Adult, Type 3.** This category includes SSD enrollees who have Medicare or who have been classified as "disabled."

ii. For demonstration eligible children under age 19 who have been determined to be "Medically Eligible" and who have incomes at or above 200 percent of poverty, report under **EG7E Expan Child, Type 3.**

iii. For demonstration eligible children under age 19 who have been determined to be uninsured and who have incomes below 200 percent of poverty, report under **EG8 Med Expan Child, Type 2, only when Title XIX funds are being used.** This is the Title XXI population. This EG is in effect only when the state is using Title XIX funds for this population. In periods when the state is using Title XXI funds, these children would not be included in any EG but would be reported as indicated in c. below.

iv. For persons in the CHOICES 217-Like HCBS Group or the ECF CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are under age 65, report under **EG9 H-Disabled, Type 2.** This category should also be used for members of any age in the CHOICES At Risk Demonstration Group, the ECF CHOICES At-Risk Demonstration Group, the ECF CHOICES Working Disabled Group, and the Interim ECF CHOICES At-Risk Demonstration Group who are not eligible for Medicare.

v. For persons in the CHOICES 217-Like HCBS Group or the ECF CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are age 65 or older, report under **EG10 H-Over 65, Type 2.**

vi. For persons in the CHOICES 217-Like HCBS Group, the CHOICES At Risk Demonstration Group, the ECF CHOICES 217-Like HCBS Group, the Interim ECF CHOICES At-Risk Demonstration Group: and, upon implementation of Phase 2 of ECF CHOICES, the ECF At-risk Demonstration Group or the ECF CHOICES Working Disabled Group who are also eligible for Medicare, report under **EG11 H-Duals, Type 2.**

vii. For demonstration eligible (non-SSI) persons in the CHOICES 1 and 2 Carryover Group or the PACE Carryover Group, report under **EG12E Carryover, Type 3.** This category should be used for both duals and non-duals in the Carryover Groups.

c. Expenditures for title XXI Medicaid Expansion children matched at the title XXI enhanced FMAP should be reported on Forms 64.21U Waiver/64.21UP Waiver, using waiver name "Med Exp Child." Report member months for quarterly reporting using Attachment A, Part VIII. For periods in which the state claims title XIX FMAP for this population (paragraph 51.f. *Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population*), follow the instructions in b.iii. above.

d. Type 2 eligibles can be identified as disabled for reporting purposes (see b.iv. above) if information exists in their enrollment record that would result in a capitation rate for disabled populations being paid on their behalf.

55. Standard Funding Process.

a. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

b. **Standard CHIP Funding Process.** The standard CHIP funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the allotment neutrality expenditure limit and separately report these expenditures by quarter for

each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit quarterly CHIP expenditure reports as described in paragraph 52.f. *(Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population)*, showing CHIP expenditures made in the quarter just ended. CMS shall reconcile expenditures with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

56. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding (see Section X, paragraph 58, *Sources of Non-Federal Share*), CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section XI of these STCs.

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

d. **Graduate Medical Education (GME) Pool.** Actual cash disbursements, up to $50 million in total computable expenditures for each demonstration year, paid by the state from a supplemental pool to pay for GME costs in accordance with the pool distribution methodology described below. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology, authorized by the demonstration's expenditure authorities. Should CMS promulgate new regulations, the TennCare GME program must come into compliance in accordance with the effective date of the new regulations.

GME Pool Methodology: GME Pool payments will be made to the following medical universities that operate graduate physician medical education programs. These payments are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics: East Tennessee State University, Meharry Medical College, University of Tennessee at Memphis, and Vanderbilt University. The annual GME Pool funds will be allocated based on the annual ratio derived by dividing each hospital's average of its Primary Care Position Allocation and its Total Filled Positions Allocation by the aggregate of the medical hospitals' averages. The Primary Care Position Allocation is computed by taking each hospital's total number of primary care residents in years 1 through 4

of residency and dividing it by the total of all primary care residents in the medical hospitals in years 1 through 4 of residency. The Total Filled Positions Allocation is computed by taking each hospital's total number of residents in years 1 through 4 of residency and dividing it by the total of the medical hospitals' number of residents in years 1 through 4 of residency. This annual ratio is applied to the total GME Pool funding to be allocated. The annual GME Pool funds will be disbursed quarterly. The state must make these payments directly to the universities, and not through any third party or intermediary.

e. **Essential Access Hospital (EAH) Pool.** Actual cash disbursements paid each quarter from a $25 million quarterly supplemental pool to pay for the uncompensated costs of the designated EAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and appropriate charity care patients in accordance with the pool distribution methodology described below. The purpose of this pool is to address the uncompensated care situation of high volume and charity hospitals that serve a disproportionate number of low-income patients with special needs. Hospitals designated as Critical Access Hospitals (CAHs) or as state mental health institutes do not participate in this pool. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

For FFYs 2008 and beyond, EAH Pool payments will be assumed to pertain to the FFY during which the payments were made. To the extent required by Federal law, EAH Pool payments made during a given FFY shall be reduced on a dollar for dollar basis by the amount of DSH payments made under the DSH allotment for that FFY.

EAH Pool Methodology: TennCare will make pool payments to certain hospitals designated as Essential Access Hospitals.

Qualifications -- Hospitals eligible to receive EAH Pool payments include all hospitals licensed to operate in the State of Tennessee excluding the four (4) state mental health institutes and the CAHs. The four regional mental health institutes are Memphis Mental Health Institute, Moccasin Bend Mental Health Institute, Western Mental Health Institute, and Middle Tennessee Mental Health Institute. The CAHs receive cost-based reimbursement from the TennCare program subject to limitations outlined in subsection f. of this paragraph.

- All hospitals, with the exception of free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program.
- The free standing psychiatric hospitals must be a contracted provider with at least one of the Managed Care Organizations in the TennCare program and at least 30% of their total adjusted days must be covered by TennCare.

- All acute care hospitals must have either of the following: (i) at least 13.5% or more of their total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days.
- All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare cost.

Allocation of the EAH Pool to Segments of Hospitals -- The $25 million Pool should be segmented into 4 distinct parts as follows:

- Essential Service Safety Net – $12.5 Million -- These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved.
- Children's Safety Net – $1.25 Million -- These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children under the age of 21 in Tennessee.
- Free Standing Psychiatric Hospitals - $0.5 Million -- These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health for the provision of psychiatric hospital services in Tennessee, excluding the state mental health institutes.
- Other Essential Acute Care – $10.75 Million -- These hospitals include all other hospitals licensed by the Tennessee Department of Health to provide services in Tennessee, excluding the Critical Access Hospitals.

Quarterly Reports – The state must include in its Quarterly Progress Reports a list of the current hospitals in each of the above categories (see Attachment A).

Data -- Calculation of the quarterly payment amounts will be based on the most recently completed Joint Annual Report of Hospitals at the time of the first quarterly payment for a given fiscal year.

Allocation will be based on an assignment of points for:
- TennCare adjusted days expressed as a percent of total adjusted patient days; and
- Charity, medically indigent care, and bad debt expressed as a percent of total expenses.

Calculation of Points
(1) TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:
- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all

acute care hospitals, excluding the critical access, pediatric and safety net providers;

- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 34.5%;
- 3 points – greater that 34.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

(2) Bad Debt, Charity and Medically Indigent – BDCHMI costs as a percent of total expenses

- 0 points - less than 4.5%
- 1 point - greater than or equal to 4.5% and less than 9.5%
- 2 points - greater than or equal to 9.5% and less than 14.5%
- 3 points - greater than or equal to 14.5%

Calculation of Amounts of Pool Payments for Hospitals -- These points will then be used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate included all inpatient costs (operating, capital, direct education) but excluded add-ons (indirect education, MDSA, return on equity). The GHR for Safety Net Hospitals is $908.52. The GHR for Other Essential Access Hospitals is $674.11. The points for each qualifying hospital will be summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each of the 4 pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initially calculated amount will then be adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. For example, if the sum of the initial calculated amounts for the pediatric group is $9 million and the total pool for children's hospitals is $5 million, each hospital's initial calculated amount will be multiplied by $5 million / $9 million.

Pool Payments -- Hospitals will be paid on a quarterly basis following the end of each quarter. The initial payment will include all quarters that have ended at the time that the payment is made. All subsequent quarterly payments will be made following the end of the quarter. In order to receive a payment for the quarter, all hospitals, with the exception of the free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, with at least one Managed Care Organization, and must have contracted with TennCare Select for

the entire quarter that the payment represents. In order for a free standing psychiatric hospital to receive a payment for the quarter, it must be a contracted provider with at least one of the Managed Care Organizations.

Additional Payment. For the 12 month period beginning on April 1, 2014, and ending on March 31, 2015, an additional $81.3 million may be allocated to hospitals meeting the qualifications listed in this subparagraph. Payments to individual hospitals will be calculated according to the stated methodology. TennCare will have the flexibility to distribute these payments on a quarterly or multi-quarterly basis, as long as the total expenditure under this authority does not exceed $81.3 million.

f. **Critical Access Hospital (CAH) Pool.** Actual cash disbursements, of up to $10 million per demonstration year, paid from a supplemental pool to pay for the uncompensated costs of the designated CAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and the appropriate charity care patients in accordance with the pool distribution methodology that has been given CMS prior approval. CAHs are designated by the Tennessee Department of Health, and they are typically small, rural hospitals that are part of a rural health network. CAHs allow communities to maintain access to primary care and emergency care when the maintenance of a full-service acute care hospital is no longer feasible. The purpose of this pool is to address the uncompensated care situation of CAHs in serving a disproportionate number of low-income patients in rural areas who have special needs. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

CAH Pool Methodology: TennCare will make pool payments to certain hospitals designated as Critical Access Hospitals.

Qualifications -- To qualify for payment as a Critical Access Hospital, a hospital must meet the following criteria:

- The hospital is an acute care hospital located and licensed in the state of Tennessee;
- The hospital has been designated a Critical Access Hospital by the Tennessee Department of Health; and
- The hospital contracts with a managed care organization participating in TennCare.

Reimbursement -- TennCare will provide reimbursement to Critical Access Hospitals under the following terms. Reimbursement to hospitals will be limited to specific annual legislative appropriation. In any state fiscal year that reimbursable TennCare costs incurred by Critical Access Hospitals exceed annual appropriations, equitable adjustments will be made to the rates described below, in order to cap reimbursement at the annual appropriation.

Inpatient Services -- Effective for dates of service beginning July 1, 2002, TennCare inpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly with interim per diem rates and will be cost-settled at year-end. Using the Joint Annual Reports filed for the most recent year available, interim per diem rates for TennCare inpatient services will be determined with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs. Inpatient Critical Access Hospital services will not include more than 15 acute inpatient beds. An exception to the 15 bed requirement is made for swing bed hospitals. Critical Access Hospitals are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that not more than 15 beds are used at any one time for acute care.

Outpatient Services -- Effective for dates of service beginning July 1, 2002, TennCare outpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly based on a percentage of charges with year-end cost settlements. Using the Joint Annual Reports filed for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges, with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs.

Cost Settlements -- Cost settlements are determined from provider submitted Medicare cost reports that include the title XIX schedules based on 100 percent (100%) of TennCare reasonable costs. The term "reasonable costs" is defined for this purpose as total reimbursable costs under Medicare principles of cost reimbursement for Critical Access Hospitals.

New Designations of Critical Access Hospitals -- For new hospitals that qualify after July 1, 2002, the state will begin reimbursement at the rates established by this part on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its Critical Access Hospital designation. At that time, interim rates will be established according to this part and the designation will be confirmed with the Tennessee Department of Health.

Audit Trail and Audit Requirements -- Each CAH is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than 5 years from the date of the submission of the Joint Annual Report, and the provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint

Annual Reports are subject to audit at any time by Federal and state auditors, including the Comptroller of the Treasury and the Bureau of TennCare, or their designated representative.

g. **Meharry Medical College (Meharry) Pool.** Actual cash disbursements paid from a $10 million supplemental pool per demonstration year to pay for the uncompensated costs of the two Medicaid clinics operated by the Meharry Medical College for TennCare covered services provided to TennCare enrollees and the appropriate charity care patients. The Meharry Pool payments will be limited to the uncompensated costs of the care as determined by an independent audit each year and subject to the review and approval by the CMS staff. Before paying the annual pool amount to the providers, the state will provide CMS with a copy of the annual independent audit report. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

h. **Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (CPE).** Actual costs incurred by government operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients are eligible as CPE. The state must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital from the following sources: the MCOs; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds). With regard only to hospital CPE, the state will report actual CPE within 12 months after the end of each fiscal year. At that time, the state will revise its FFP claim to reconcile actual CPEs with the CPE estimates used during the preceding fiscal year (FY).

State Certification of Public Expenditures. Nothing in these STCs concerning certification of public expenditures relieves the state of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

CPE Methodology and Protocol. The state must follow the CPE protocol, as contained in Attachment F of these STCs, which was approved by CMS for use beginning July 1, 2008.

i. **Disproportionate Share Hospital (DSH) Payments.** The Tax Relief and Health Care Act of 2006 (TRHCA 2006) established a DSH allotment for Tennessee for FFY 2007, as described at Section 1923(f)(6) of the Act. The relationship between DSH payments made by Tennessee under TRHCA 2006 and payments from the EAH Pool is further specified in the second paragraph of subparagraph (e) above. If Congress should establish a DSH allotment for Tennessee for any subsequent Federal fiscal year, the state may make DSH payments to hospitals on the basis of

a state plan amendment approved by CMS. Depending on the specifics of the legislation establishing the DSH allotment, modifications to the budget neutrality expenditure limit may be required, in the manner specified in paragraph 4.a. (*Impact on Demonstration of Changes in Federal Law, Regulation, and Policy).* Unless otherwise specified by law, DSH payments shall be considered payments made under the demonstration and subject to the budget neutrality expenditure limit and the limit described in subparagraph (j) below. When determining hospital-specific DSH limits and DSH payments, the state must take into account all Medicaid payments under the Medicaid state plan and demonstration projects including amounts paid to hospitals through the GME, EAH, Meharry Medical College, UHC, PHSP, and CAH Pools, as well as any payments by or on behalf of individuals with no source of third party coverage. The state must make these payments directly to the providers of the services as specified at Section 1923(i) of the Social Security Act.

j. Beginning in DY 6 (state fiscal year 2008), the combined total of the payments to hospitals listed in i. below shall not exceed annual limits described in iv. Beginning in DY 11 (state fiscal year 2013), the combined total of the payments to the hospitals listed in iii. below shall not exceed annual limits described in iv. Any unused amount from the annual cap for one DY may not be rolled over and added to the annual cap for any subsequent DY.

i. The following payments are subject to the limit in DY 6 through 9:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of DSH payments (see 55.i. subject to the allotment for the FFY ending during the DY);
- Three-quarters of DSH payments (see 55.i. subject to the allotment for the FFY beginning during the DY);
- Hospital CPE (see-55.h.).

ii. The following payments are subject to the limit in DY 10:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of the DSH payments (see 55.i., subject to the allotment for the FFY 2011);
- Additional DSH payments equal to the DSH allotment for the first quarter of FFY 2012;
- Hospital CPE (see 55.h.)

iii. The following payments are subject to the limit in DYs 11-14:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);

- Hospital CPE (see 55.h.).

iv. The annual limit for DY 6 – DY 14 shall be $540 million (total computable).

k. **Unreimbursed Hospital Cost (UHC) Pool.** Actual costs incurred by eligible Tennessee hospitals that are unreimbursed by TennCare. The total amount of funds to be distributed to hospitals each DY from the pool will be determined annually, in a manner defined by the Tennessee General Assembly's Annual Coverage Assessment Act and this subparagraph, but in no event may exceed the limit defined below. For any demonstration year in which it elects to make payments under the UHC Pool authority described in this paragraph, the state may not implement a reduction in benefits or elimination of coverage for any of the following services: physical therapy, occupational therapy, speech therapy, inpatient hospital, lab and x-ray, non-emergency outpatient hospital, physician, podiatrist, certified nurse practitioner, or physician assistant services; or implement any co-payment for non-emergency medical transportation. (Nothing in this paragraph is intended to limit the state's ability to manage utilization of these services through changes to prior authorization requirements or other managed care practices.)

Eligible Hospitals. Hospitals eligible to receive a pool payment include all hospitals licensed to operate in the State of Tennessee, except the following groups:

- Critical Access Hospitals;
- Public hospitals eligible to certify public expenditures, including state mental health institutes;
- Rehabilitation and long term care hospitals; and
- Pediatric research hospitals that limit patients to those that meet research protocols.

Any hospitals that have closed between 2008 and the time that the amounts of the payments are calculated are not eligible to receive payments.

Minimum Qualifications. In order to receive a payment, the hospital must be contracted with at least one TennCare MCO and must have unreimbursed TennCare costs, unless the hospital is capitated and accepts the capitation from TennCare as full reimbursement for services to TennCare patients.

Data Source. The Joint Annual Report (JAR) of Hospitals, which is a report containing data that each licensed hospital in the state is required to file annually in accordance with T.C.A. 68-11-310. This law says:

> All hospitals that submit a joint annual report to the department of health as designated in this section shall also submit to the department, at the same time they send the signed paper copy of the report, a notarized statement from their chief financial officer stating that the financial data reported on the joint annual report is consistent with the audited financials for the

hospitals for that reporting year. The notarized statement shall also be attested to by the chief executive officer of the hospital.

Reports are submitted to the Tennessee Department of Health (DOH), edited by DOH, corrected by the hospital and placed in a final data file for that year by DOH. The instructions for completing the form require the hospitals to use the same accounting method required for the Medicare cost reports.

Payment amounts for each DY will be based on the final JAR from 3 years prior to the DY.

Calculation. TennCare costs shall be determined by multiplying TennCare charges for hospital inpatient and outpatient services reported by the hospital by the ratio of reported total expenses to reported total charges (cost to charge ratio). Unreimbursed TennCare Costs are calculated as the difference between the calculated TennCare costs and the TennCare revenue as reported on the JAR.

Each hospital shall receive an annual payment each DY equal to a percentage of its Unreimbursed TennCare Costs, using the same percentage to calculate each hospital's payment.

Funding. TennCare shall adjust payments if necessary to ensure no hospital receives supplemental payments in excess of unreimbursed TennCare costs. Payments may be prorated subject to available appropriations.

Payments. The annual payment to each hospital shall be made in four equal quarterly payments.

Annual Limit: The total amount of UHC Pool payments made each DY may not exceed $500 million total computable.

l. **Public Hospital Supplemental Payment (PHSP) Pool.** Actual cash disbursements paid from a $100 million (total computable) supplemental pool per demonstration year to selected public hospitals. The amount paid each DY to each hospital must not exceed the hospital's uncompensated cost of TennCare covered services provided to TennCare enrollees and uninsured patients. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10. PHSP Pool payments may be made to the following hospitals:
   - Regional Medical Center at Memphis, and
   - Nashville General Hospital at Meharry, and
   - Erlanger Medical Center at Chattanooga.

57. Medicare Part D Drugs. No FFP is available under this demonstration for Medicare Part D drugs.

58. Sources of Non-Federal Share. The state certifies that the matching non-Federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-Federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding.

c. Under all circumstances, health care providers must retain 100 percent of the TennCare II reimbursement amounts claimed by the state as a demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

59. Monitoring the Demonstration. The state shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

60. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of Federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, with an aggregate adjustment for projected disproportionate share hospital payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section X, paragraph 52 *(Reporting Expenditures in the Demonstration).*

61. **Risk.** Tennessee shall be at risk for the per capita cost (as determined by the method described below in this Section) for Type 1 and Type 2 TennCare enrollees in the eligibility groups (EGs) described in paragraph 62 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)* under this budget neutrality agreement, but not for the number of demonstration eligibles in each of the groups. By providing FFP for all Type 1 and Type 2 TennCare enrollees in the specified EGs, Tennessee shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Tennessee at risk for the per capita costs for TennCare enrollees in each of the EGs under this agreement, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration. Tennessee will be at risk for both per capita costs and enrollment for Type 3 TennCare eligibles.

62. **Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement.** Individuals who are eligible under TennCare and whose expenditures are funded at title XIX matching rates will be one of three types:

a. Type 1 - are currently eligible under Tennessee's Medicaid state plan (Title XIX state plan mandatory or optional eligible population) - counted in the "with" and "without" waiver calculations;

b. Type 2 - could be eligible under Tennessee's Medicaid state plan if Tennessee amended its state plan or could be eligible for a Section 1915(c) waiver for aged and disabled adults pursuant to 42 C.F.R. § 435.217 (Title XIX demonstration-eligible hypothetical population) or is eligible under the CHOICES At Risk Demonstration Group for the Interim CHOICES 3 program - counted in the "with" and "without" waiver calculations (the state cannot generate savings from these populations); and

c. Type 3 – are only eligible with Section 1115 demonstration authority (Title XIX demonstration-eligible expansion population) - counted only in the "with" waiver calculations.

63. **Budget Neutrality Ceiling.** The following describes the method for calculating the budget neutrality expenditure limit:

a. For each DY of the budget neutrality agreement, an annual target is calculated as the sum of two components:

   i. The sum of six sub-components calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the state in accordance with paragraph 53 *Reporting Member Months*) for Type 1 and Type 2 eligibles claimed under title XIX for the following six EGs: EG1 Disabled, EG2 Over 65, EG3 Children, EG4 Adults, EG5 Duals, and EG8 Med Exp Child (when title XXI allotment is exhausted); and

   ii. A Disproportionate Share Hospital (DSH) adjustment for the year described in d. below.

b. Member months for the following populations are not used for calculation of the budget neutrality expenditure limit:

   i. EG6E Expan Adult, EG7E Expan Child, and EG12E Carryover Type 3 eligibles

   ii. Med Exp Child: Medicaid Expansion children funded at the title XXI enhanced FMAP.

c. The following tables give the projected PMPM costs for the calculation described in paragraph 63.a. by DY. The PMPM costs for DY 8 and earlier are calculated following Attachment B of the November 14, 2006 Special Terms and Conditions and paragraph 65.c. of the July 22, 2009 STCs.

Table 8
Projected PMPM Costs After CHOICES Implementation

	Trend	DY 12	DY 13	DY 14
EG1 Disabled*	5.1%	$1,561.46	$1,641.09	$1,724.79
EG2 Over 65**	4.6%	$1,022.17	$1,069.19	$1,118.37
EG3 Children	3.4%	$468.46	$484.39	$500.86
EG4 Adults	4.9%	$917.79	$962.76	$1,009.94
EG5 Duals	4.6%	$652.99	$683.02	$714.44
EG8 Med Exp Child***	3.4%	$468.46	$484.39	$500.86

* Includes EG 9 H-Disabled
** Includes EG10 H-Over 65
***Optional Targeted Low Income Children funded using title XIX

d. The DSH adjustment is based upon Tennessee's DSH allotment for 1992 and calculated in accordance with current law.

i. For the purpose of this subparagraph, the Average FMAP (AFMAP) for each DY is defined as 0.25 times the FMAP applicable to DSH expenditures for the Federal fiscal year that ends during that DY, plus 0.75 times the FMAP applicable to DSH expenditures for the Federal fiscal year that begins during that DY.

ii. A DSH allotment has been established for Tennessee under provisions of TRHCA 2006 (and extended through subsequent legislation). Beginning with DY 5, the DSH adjustment will be based on the DSH allotments established for Tennessee, following Section 1923(f)(6)(A)(i) of the Act, which are published in the *Federal Register*. The Federal share of the DSH adjustment for each DY will be equal to one quarter of the DSH allotment for the FFY ending during the DY, plus three quarters of the DSH allotment for the FFY beginning during the DY. A total computable equivalent for

each DSH adjustment can be calculated as the DSH adjustment divided by the AFMAP for that DY. For DY 5, the figure $305,541,928 will be used to compute the Federal share of the DSH adjustment in place of the FFY 2006 DSH allotment.

iii. The calculation of the DSH adjustment will be appropriately altered if legislation is enacted that impacts the calculation of DSH allotments, including any law that would affect the calculation of the DSH allotment for Tennessee.

iv. Table 9 gives the DSH adjustments for DY 1 through DY 14, and shows both total computable and Federal share. These totals reflect changes to the calculation of DSH allotments resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the temporary increase in DSH allotments provided under Section 5002 of the American Recovery and Reinvestment Act of 2009. Some of the figures are labeled "preliminary" because the final DSH allotments needed to calculate them have not yet been published in the *Federal Register,* and are best estimates based on current law.

Table 9
DSH Adjustments for DY 1 Through DY 14

	DSH Adjustment (total computable)	**DSH Adjustment (Federal share)**
DY 1	$413,700,907	$268,409,148
DY 2	$479,893,052	$310,106,890
DY 3	$479,893,052	$310,538,794
DY 4	$479,893,052	$308,091,339
DY 5	$479,356,649	$305,451,928
DY 6	$479,657,638	$305,451,928
DY 7	$485,299,094	$311,270,839
DY 8	$488,969,517	$319,052,610
DY 9	$470,369,327	$309,408,043
DY 10	$463,996,853	$305,451,928
DY 11	$463,996,853	$305,451,928
DY 12 (preliminary)	$463,996,853	$305,451,928
DY 13 (preliminary)	$463,996,853	$305,451,928
DY 14 (preliminary)	$463,996,853	$305,451,928

e. The budget neutrality expenditure limit is the Federal share of the annual PMPM limits for the demonstration period, plus DSH adjustments, for DY 1 through 14, and represents the maximum amount of FFP that the state may receive for title XIX

expenditures during the demonstration period, as described in paragraph 52.g. *(Reporting Expenditures in the Demonstration: Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit).* The budget neutrality expenditure limit is equal to (1) the sum of all of the subcomponents described in a.i. above for all DYs, times the Composite Federal Share (defined in f. below), plus (2) the sum of the Federal shares to the DSH adjustments for all DYs, as defined in d. above.

f. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional demonstration expenditures or offsets such as, but not limited to, premium collections and administrative costs subject to budget neutrality under paragraph 52.h. *(Reporting Expenditures in the Demonstration: Administrative Costs)* by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for DSH payments made under the Medicaid state plan must be subtracted from the numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

64. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under TennCare II. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of Section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

65. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Years 1 through 6	Cumulative budget neutrality cap plus:	0.5 percent
Years 1 through 7	Cumulative budget neutrality cap plus:	0.25 percent
Years 1 through 14	Cumulative budget neutrality cap plus:	0 percent

66. Exceeding Budget Neutrality. If the budget neutrality expenditure limit has been exceeded at the end of this demonstration period, the excess Federal funds shall be returned

to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

67. Submission of a Draft Evaluation Plan. The state shall submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after CMS approval of the demonstration extension. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

68. Inclusion of CHOICES and ECF CHOICES Special Study Components.

a. CHOICES Special Study Components. Suggested special study topics from which the state may choose for its Evaluation Plan include, but are not limited to, the following:

i. The rebalancing of the long-term care system including impacts on outcomes, utilization and cost;

ii. Implementation lessons, successes and evolution of the Single Point of Entry and streamlined eligibility processes;

iii. The expansion and development of a more robust HCBS infrastructure under managed care;

iv. Implementation of Consumer Directed options under manage care;

v. Enrollee satisfaction, based on surveys that include feedback on assessment and care planning processes, quality of care coordination, actual service delivery, and (when relevant) the appeals process; and

vi. Provider satisfaction from surveys.

When developing its research approach, CMS encourages Tennessee to consider adapting research questions and methodologies from the CMS sponsored Evaluation of the Money Follows the Person (MFP) Grant Program. MFP and CHOICES share many of the same goals, and by using a common study approach, the Tennessee's planned reforms can be viewed within a national context. CMS staff will be available to provide technical assistance in this regard.

b. **ECF CHOICES Special Study Components**. Suggested special study topics from which the state may choose for its Evaluation Plan include, but are not limited to, the following:

i. The impact of a tiered benefits structure, based on the needs of individuals, on the utilization and cost of HCBS and other Medicaid services delivered to individuals with I/DD, as compared to utilization and cost of HCBS delivered under the State's Section 1915(c) waivers, and the ability to serve more people within available resources;

ii. The impact of the program design, including benefit structure and financial incentives, on improving employment and quality of life outcomes;

iii. Building capacity for person-centered planning and service delivery in MLTSS;

iv. Implementation lessons and successes, including the critical role of stakeholders in designing and implementing MLTSS programs and preparing HCBS providers for MLTSS; and

v. Enrollee satisfaction and quality of life, including measures of employment and community integration, using a standardized survey instrument, such as National Core Indicators.

69. Evaluation of Eligibility and Enrollment Systems. The state shall propose data collection and reporting measures designed to assess the ongoing need for retroactive Medicaid eligibility after changes specified in the Affordable Care Act are effectuated. The interim evaluation report required in paragraph 8 *(Extension of the Demonstration)* and paragraph 71 *(Interim Evaluation Reports)* should contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid and the Exchange. CMS may issue further guidance to the state on the specific performance measures. The state may include the following areas of interest in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other relevant data.

a. Evaluation of eligibility determinations by type, e.g. application, redetermination, transfer to the Exchange.

b. Evaluation of Medicaid denial and termination reasons.

c. Evaluation of average application processing times and timeliness.

d. Evaluation of reasons for disenrollment and internal churn.

e. Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable.

70. Evaluation of Uncompensated Care Costs for the Uninsured. The following sets forth the requirements for evaluation of Tennessee's uncompensated care pools through an independent report on the use of such pools and the relationship of such payments to base Medicaid provider payment rates.

a. General Description. The state must commission a report from an independent entity on Medicaid provider payment in the state that reviews the role of uncompensated care pool payments in the overall Medicaid system for paying hospitals. The report should consider adequacy of base Medicaid payment levels and their relation to Medicaid shortfalls (as reported in provider cost reports), and should indicate the degree to which uncompensated care pool payments reflect insufficient base payment levels. The report should also identify the percentage of uncompensated care pool payments that are not specifically related to Medicaid shortfalls, and should estimate the extent to which that uncompensated care for Tennessee hospitals could be addressed by expanding Medicaid coverage to the extent authorized under the Affordable Care Act.

b. Funding for Uncompensated Care Pool Evaluation. $500,000 (total computable) will be funded from the TennCare program's general administrative budget for commissioning this report, unless the state receives written authorization from CMS to expand a lower amount. The state may use more than $500,000 of its general administrative budget for this report, and any amount beyond the $500,000 would count against the overall savings of the demonstration. Expenditures for the creation of the report will be considered Medicaid administrative expenditures and be eligible for FFP at the usual matching rate for administrative expenditures.

c. Specific Evaluation Requirements. The report must meet the following criteria:

i. **Goal of the Report**. The goal is to ensure sustainable, transparent, equitable, appropriate, accountable and actuarially sound Medicaid payment systems and funding mechanisms for hospital providers that will ensure quality health care services to Tennessee's Medicaid beneficiaries throughout the state.

ii. **Framework of the Report**. The report must include a detailed description and analysis of the current Medicaid provider payment (for all Tennessee hospitals) and financing system, with a major focus on services currently supported with pool funds. The report must also include information regarding the non-federal share for the various payments and how payments to providers correspond to amounts reported on the CMS-64. The report must note any shortfall or overages in provider payments across all payment types in the current funding structure.

(A) In particular, the report must include detailed information on the historical methods of funding hospital payments, the way in which the source of non-federal share interacts with pool payment distribution methodology, and describe the composition of payments, including base and supplemental payments, and the percentage of payment providers receive and retain.

(B) The report must analyze the adequacy of current payment levels for Medicaid hospital providers, and the adequacy, equity, accountability and sustainability of the state's funding mechanisms

for making these payments. The report will primarily focus on the types of providers supported by the pool, and will describe the use and effects of various provider assessment funds, including a thorough explanation of how CPE claims are determined.

(C) The report must include the cost of uncompensated care provided to uninsured individuals by hospitals, distinguishing between cost associated with charity care from those associated with bad debt, and the extent that historical pool payments have addressed these costs. The report should also include an estimate of the uncompensated care that would remain uncompensated if the state adopted Medicaid expansion.

(D) All data presented in the report must be submitted to CMS in unlocked Excel worksheets to assist in review of the analysis.

(E) The report should recommend reforms to the Tennessee Medicaid financing system that can allow the state, beginning in state fiscal year 2016-2017, to make any changes needed to move toward Medicaid managed care payments to hospital providers that ensure access and quality of care for Medicaid beneficiaries.

d. Deadlines, Monitoring and Funding.

i. A final report will be due no later than February 29, 2016.

ii. Monthly monitoring calls with the state will include an update of progress on the report.

iii. If the state does not timely submit a final report, including all requested analyses and recommendations, the state's expenditure authority for uncompensated care pools will be reduced by $500,000. The state may seek, and CMS may grant, relief from this reduction, if needed.

71. Interim Evaluation Reports. In the event the state requests to extend the demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request.

72. Final Evaluation Design and Implementation. CMS shall provide comments on the draft evaluation plan within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports. The state shall submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

73. Cooperation with Federal Evaluators. Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

XIII. TENNCARE ELIGIBILITY REDETERMINATION AND DISENROLLMENT AND RIGHTS; APPEALS PROCESS FOR CHANGES IN BENEFITS; AND ENROLLMENT IN STANDARD SPEND DOWN

The state will follow these procedures throughout the demonstration approval period unless modified through an approved demonstration amendment.

PART I: MEDICALLY NEEDY AND TENNCARE STANDARD ELIGIBILITY REDETERMINATION AND DISENROLLMENT PROCESS

This Part summarizes the process Tennessee will use, in accordance with paragraph 21.a. *(Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category)*, of these STCs, to: (i) redetermine eligibility and terminate the adult (non-pregnant) Medically Needy; and (ii) disenroll adults who are TennCare/Medicare dual eligible, uninsured, and Medically Eligible. This process was approved as an amendment to the TennCare II demonstration on March 24, 2005. It is used for redetermining the eligibility of those enrollees whose eligibility is ending, including when their period of eligibility has ended or the category in which they have been enrolled is being closed. The state will continue to follow this process for all redeterminations and terminations of eligibility throughout the demonstration approval period unless modified through an approved demonstration amendment.

I. Termination of Adult Non-Pregnant Medically Needy

1. Ex Parte Review

A. The state will conduct a data match of the Social Security numbers of individuals classified as adult non-pregnant Medically Needy in its InterChange Information System (which contains information on TennCare enrollees) with Social Security Administration (SSA) data to determine whether the individual has lost supplemental security income (SSI) eligibility for reasons that would qualify them as Medicaid eligible.[3]

B. The state will conduct a data match of the Social Security numbers (SSNs) of individuals classified as adult non-pregnant Medically Needy in InterChange with individuals classified as participants in its Food Stamps or Families First (TANF) program in its ACCENT system (a database maintained by the Department of Human Services (DHS)). In all instances in which there is a match between an adult Medically Needy individual with an individual with an open Food Stamps or Families First record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

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[3] Such reasons include (i) they lost SSI eligibility because of Social Security cost of living adjustment(s) ("COLA(s)") but would be SSI eligible if the COLA(s) was/were disregarded ("Passalong" eligibles); or (ii) they lost SSI eligibility for some reason other than a Social Security COLA, but would be eligible for SSI if the COLA(s) received since their SSI termination was/were disregarded ("Pickle" eligibles).

2. Request for Information

A. At least 30 days prior to the end of the individual's current eligibility period, the state will send notification (Request for Information) to those adult non-pregnant Medically Needy enrollees who have not been identified through the ex parte review process as eligible for open categories of TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for Medicaid is ending, and that they will only remain eligible for TennCare Medicaid if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for a Medicaid category that is not ending (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for open Medicaid categories. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for Medicaid and the enrollee will receive an advance notice that will provide appeal rights.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be fair hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with Limited English Proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as Seriously and/or Persistently Mentally Ill (SPMI). Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package—i.e., elimination of pharmacy coverage for adult non-institutionalized non-pregnant Medically Needy) until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a "Verification Request." Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package). If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain TennCare Medicaid coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), enrollees will retain Medicaid coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. The state will make the determination that enrollees are not eligible for open TennCare Medicaid categories in the following two scenarios: (i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or (ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Expiration Notice**

A. Upon making a determination that enrollees are no longer eligible for TennCare Medicaid, the state will provide a notice (Expiration Notice) to enrollees at least 20 days in advance of the end date of the enrollees' eligibility period.

B. Expiration Notices will:

i. Inform enrollees that they will be terminated from Medicaid as of a date specified in the notice because their current eligibility period has ended, their category of TennCare Medicaid is closed and they have not proven their eligibility for other open categories of TennCare Medicaid.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Expiration Notice to request a hearing for factual disputes related to the termination and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing prior to the date of termination specified in the Notice, Medicaid benefits for non-pregnant Medically Needy (subject to changes in the benefit package) will continue until the appeal has been resolved.

C. If enrollees submit information to qualify for Medicaid prior to their termination, enrollees will continue to be eligible for TennCare Medicaid for non-pregnant Medically Needy (subject to changes in the TennCare Medicaid benefit package) pending the determination as to whether the individual is eligible for other open TennCare Medicaid categories.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Expiration Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the termination. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. Valid factual disputes include:

i. Enrollees received the Expiration Notice in error (i.e., they are currently enrolled in other categories of TennCare Medicaid including Medically Needy pregnant women or enrollees under 21 years of age);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Request for Information but failed to extend the time;

iv. Enrollees requested assistance because of a health, mental health, learning problem, or disability but the state failed to provide this assistance; or

v. The state sent the Expiration Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the request for a hearing is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid

factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of termination identified in the Expiration Notice, TennCare Medicaid benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute as described above, or the appeal is resolved.

E. If the enrollee does not request a hearing prior to the date of termination identified in the Expiration Notice, the enrollee will be disenrolled from TennCare Medicaid.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

II. Disenrollment of Adult Medicare/TennCare Dual Eligible, Uninsured, Medically Eligible

1. Ex Parte Review

A. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in InterChange (which contains information on TennCare enrollees) with SSA data to determine whether the individual has lost SSI eligibility for reasons that would qualify them as Medicaid eligible.[4]

B. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in Interchange with individuals classified as participants in the state's TANF program in DHS' ACCENT system. In all instances when there is a match between an adult member of these demonstration populations with an individual with an open TANF record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

2. Request for Information

A. At least 30 days prior to disenrollment, the state will send a Request for Information to all adult Medicare/TennCare Dual Eligible, Uninsured, and Medically Eligible enrollees not identified through the ex parte review process as eligible for TennCare Medicaid.

B. The Request for Information will:

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[4] See footnote 1

i. Inform enrollees that their eligibility category for TennCare Standard is ending and that they will only maintain coverage if they qualify for open Medicaid categories.

ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for Medicaid (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for TennCare Medicaid. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for TennCare Medicaid and the enrollee will receive a Disenrollment Notice prior to disenrollment from TennCare Standard.

iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with limited English proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as SPMI. Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Standard until DHS determines that the individual does not qualify for open categories of Medicaid (and proper disenrollment and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a Verification Request. Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid. If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper disenrollment and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), the enrollee will retain

coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in an appropriate TennCare Medicaid category. The state will make the determination that enrollees are no longer eligible for TennCare in the following two scenarios:

i. if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or

ii. if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. <u>Termination Notice</u>

A. Upon determination or confirming that enrollees are not eligible for TennCare Medicaid, the state will provide a Termination Notice to enrollees 20 days in advance of the date upon which the coverage will be terminated.

B. Termination Notices will:

i. Inform enrollees that they will be disenrolled from TennCare as of the date specified in the Notice (20 days after the date of the Notice) because their category of TennCare Standard is ending and they have not proven their eligibility for open TennCare Medicaid categories.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the notice to appeal factual disputes related to the action of disenrollment and inform enrollees how they may request a hearing.

iii. Inform enrollees that if prior to the date of disenrollment specified in the Termination Notice, an enrollee appeals the action of disenrollment, he or she will not lose eligibility for TennCare until the state determines that the enrollee has not raised a valid factual dispute or the appeal is resolved.

iv. Inform enrollees that they may submit new information to demonstrate Medicaid eligibility at any time before or after disenrollment. Such information will be treated as a new application for Medicaid. The enrollee will not continue benefits pending the state's review and processing of this information.

4. <u>Appeals Process</u>

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:

   i. Enrollee received the Termination Notice in error (e.g., he or she is currently enrolled in Medicaid or in a TennCare Standard category that is not ending);

   ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

   iii. The state granted a "good cause" extension of time to reply to the Termination Notice but failed to extend the time;

   iv. Enrollee requested assistance because of a health, mental health, learning problem, or disability, but the state failed to provide this assistance; or

   v. The state sent the Termination Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the appeal is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

   i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

   ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

   iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of disenrollment as identified in the Termination Notice, TennCare Standard benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute, or the appeal is resolved.

E. If the enrollee does not appeal prior to the date of disenrollment as identified in the Termination Notice, the enrollee will be disenrolled from TennCare Standard.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

PART II: NOTICE AND APPEALS PROCESS FOR CHANGES IN COVERAGE OF TENNCARE BENEFITS

This Part summarizes the process Tennessee will use upon and after the implementation of changes in coverage of TennCare benefits. These procedures were approved as an amendment to the TennCare II demonstration on March 31, 2006. This detailed process is used by the state to implement benefit changes, specifically benefit limits. It is used daily with enrollees who are subject to pharmacy benefit limits when they reach their monthly maximum. With this process, Tennessee provides one notice per month when benefit limits have been reached. The state will continue to follow this process with enrollees who are subject to pharmacy or other benefit limits throughout the Demonstration approval period unless modified through an approved Demonstration amendment. To change benefits covered under the Demonstration, the state must submit a Demonstration amendment in accordance with paragraphs 6 and 7 regarding amendments of these STCs.

I. Implementation of Changes in Coverage Policies

1. Initial Notice

A. At least 30 days prior to the effective date of changes in coverage of TennCare benefits (e.g., implementation of pharmacy benefit limits and elimination of covered services), the state shall provide a notice (Benefit Notice) to enrollees who are impacted by such changes in coverage of TennCare benefits.

B. Benefit Notices will:

i. Inform enrollees of how changes in coverage of TennCare benefits will apply to enrollees.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Benefit Notice to request a hearing for valid factual disputes related to the changes in coverage and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing for a valid factual dispute prior to the effective date of the change in coverage of TennCare benefits, benefits will be continued at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the level for Non- Institutionalized Medicaid Adults (Default Level). The state will apply the Default Level of benefits until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary. (The resolution of an appeal, for purposes of this Part, is defined as when the appeal is dismissed or resolved prior to a hearing or when a decision is rendered at or after the hearing.)

2. Appeals Process

A. An enrollee will have the opportunity to request a state fair hearing for 40 days (inclusive of mail time) from the date of the Benefit Notice.

B. The state will grant state fair hearings only for those enrollees raising valid factual disputes related to the changes in coverage. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to a different level of TennCare benefits than that identified in the Benefit Notice. Valid factual disputes include when an enrollee claims to have received the Benefit Notice in error (e.g., he or she is already in a TennCare category that is not subject to the particular changes in coverage).

C. When an enrollee requests a hearing prior to the effective date of changes in coverage as identified in the Benefit Notice, the enrollee shall continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the Default Level. The state will apply the Default Level until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary.

D. If the enrollee appeals, the changes in coverage in dispute shall become effective upon resolution of the appeal.

E. If the enrollee does not appeal prior to the effective date of changes in coverage as identified in the Benefit Notice, such changes in benefits will become effective, as applied to the enrollee, upon this date.

F. If the enrollee appeals and:

(i) The appeal is dismissed because the enrollee has not asserted a valid factual dispute; or

(ii) The enrollee is granted a hearing and the hearing decision sustains the state's action.

The state reserves its right to recover from the enrollee the cost of services provided as a result of the appeal.

II. Post-Implementation Appeals from Denials of Prior Authorization for Pharmacy Products

1. Prior Authorization Requirements

A. Any prescription of a branded drug may be subjected to a prior authorization requirement by the state; and prior authorization will be required as a condition of coverage for branded prescription drugs that are not included on the state's Preferred Drug List.

B. Physicians (or other providers with prescribing authority) participating in TennCare will be responsible for requesting prior authorization, according to procedures to be established by the state.

2. <u>Notice of Prior Authorization Denial</u>

A. Requests for prior authorization of covered outpatient drugs shall be transmitted to and acted upon by appropriate staff of the Pharmacy Benefit Manager (PBM) Clinical Call Center.

B. Written notice of denial of a request for prior authorization shall be mailed by the PBM on behalf of the state to the enrollee and transmitted by facsimile to the prescribing physician. Such Notice will inform the enrollee that the request for prior authorization of the prescribed drug has been denied and that TennCare does not cover the drug absent prior authorization, briefly state the reason or reasons for denial of the request, explain the procedures that are available to the enrollee to appeal from that decision, and inform the enrollee that TennCare will not cover the cost of the prescribed medication during the pendency of any appeal. The state's failure to act on a request for prior authorization within a 24-hour period after receiving a submission that complies with the state's requirements for a completed prior authorization request may be deemed a denial from which the enrollee can appeal.

3. <u>Procedures for Filing and Pursuing an Appeal</u>

A. Appeals of denials of requests for prior authorization may be initiated within 20 days of the Notice of denial of prior authorization, at the option of the enrollee, by the enrollee (or an individual appointed or otherwise authorized under state law to act as the enrollee's representative) submitting to the TennCare Solutions Unit via hand delivery, mail, or facsimile, a written statement of intent to appeal on a form prescribed by the state. Such form will be available on the PBM Web site, and the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's managed care organization (MCO), or from the TennCare Solutions Unit. Undue delay by the state in deciding a prior authorization request (i.e., delay in excess of the 24-hour period permitted for such decisions) will be considered a denial of prior authorization for purposes of appeal.

B. The state will dismiss any appeal that does not raise a valid factual dispute without a hearing, and will retain the authority to determine whether an appeal raises a valid factual dispute relating to denial of a prior authorization request or the state's failure to act on a request for prior authorization within a 24-hour period after such request. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the prescribed drug. A dispute concerning whether a particular drug or dosage is medically necessary for the enrollee, will be considered a valid factual dispute.

C. An initial determination on appeals involving issues of medical necessity will be made by appropriately qualified medical professionals on the staff of the TennCare Solutions Unit as promptly as possible after the enrollee's submission of the appeal. After submission of the appeal, the TennCare Solutions Unit may seek additional information or documentation in support of the appeal, before any initial determination is made.

D. Upon initially deciding an appeal, the state shall send a letter communicating its decision to the enrollee and stating the reasons for that decision, and shall also communicate any decision granting prior authorization to the enrollee and/or the prescribing physician by the fastest means practicable. A letter initially denying an appeal shall also inform the enrollee of his or her opportunity to request a state fair hearing, and the procedures that must be followed to pursue such further appeal.

4. Benefits During the Pendency of an Appeal

A. During the pendency of any appeal from denial of a pharmacy service due to the lack of required prior authorization, the enrollee will continue to be eligible for pharmacy benefits within applicable pharmacy service limits, but will not have any right to receive on a covered basis the drug that is the subject of the appeal.

B. If the enrollee chooses to purchase the unauthorized, prescribed drug at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the drug upon prevailing in his or her appeal, but only to the extent that applicable, monthly pharmacy benefit limits would not thereby be exceeded.

III. Post Implementation Appeals of Application of Benefit Limits

1. Initial Notice

A. Pharmacists will be required to verify TennCare coverage for all prescriptions presented by enrollees through an electronic database maintained by the PBM. If, through the database, the PBM denies coverage of a prescription because the enrollee has reached or exceeded the monthly pharmacy benefit limit ("the pharmacy limit"), the PBM on behalf of the state will mail a written notice of the denial to the enrollee (Service Notice). Service Notice shall be provided only upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five prescription limit, and/or upon the first denial in that month of a pharmacy service sought by the enrollee that exceeds the two prescriptions limit on branded drugs. (For purposes of this Part, "the pharmacy limit" is defined as a five prescription limit per month, of which no more than two prescriptions or refills could be for branded drugs and at least three out of any five prescriptions or refills in the same month must be for generic drugs.)

B. If a pharmacist fills a prescription in excess of the pharmacy limit and submits a claim for such service, the PBM will deny payment for the claim. Upon denial of payment for such claim, the PBM on behalf of the state will mail a written notice (Notice of Limit) to enrollees.

C. If a provider denies a non-pharmacy service or charges the enrollee for the service because the enrollee has reached or exceeded a benefit limit, the provider need not give specific notice of appeal rights to the enrollee but must direct the enrollee to the responsible arm of the managed care contractor (MCC).

D. If a provider renders a non-pharmacy service in excess of a non-pharmacy benefit limit and the provider or the enrollee submits a claim for such service, the MCC will deny payment for the claim. Upon denial of payment for such claims, the MCC, on behalf of the state, will mail a Notice of Limit to enrollees. A Notice of Limit shall be provided only upon the first denial of coverage of a non-pharmacy service sought by the enrollee that exceeds the applicable limit for the kind and number of services during a given time period specified in the state's program.

E. The Notice of Limit and Service Notice will:

i. Inform an enrollee that he or she has reached or exceeded the applicable benefit limit.

ii. Provide enrollees with at least 20 days from the Notice of Limit or Service Notice to request a hearing for valid factual disputes related to the benefit limit and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing, they will not receive continuation of benefits (i.e., services in excess of the applicable limit) during the pendency of their appeal.

iv. Remind enrollees of any exceptions to the limits and inform them how to obtain more information about such exceptions.

2. <u>Appeals Process</u>

A. Enrollees will have the opportunity to request a state fair hearing for at least 20 days from the date of the Notice of Limit or Service Notice.

B. The enrollee will be required to submit a designated form in order to request a state fair hearing. The form, which must be signed by the enrollee (or an individual appointed or otherwise authorized to act as the enrollee's representative under state law), would include the basis for the appeal and the enrollee must attest, under penalty of perjury, that his contention is true to the best of his knowledge and is made in good faith. Enrollees may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its discretion of an exemption from a signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or by an individual authorized under state law to act as the enrollee's representative.

C. The state will grant a state fair hearing only for those enrollees raising valid factual disputes related to the benefit limit. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the service that was denied because the enrollee had reached or exceeded the applicable benefit limit. Valid factual disputes include:

i. An administrative error was allegedly made and the enrollee has not yet reached the relevant benefit limit.

ii. The enrollee alleges that his or her circumstances have changed and he or she has been re-classified in a TennCare eligibility category that is not subject to the benefit limit the state has applied. The state, however, shall not grant a hearing to individuals who allege solely that they are not subject to the benefit limit without further alleging a change of circumstances that has been reported to TennCare and has resulted in a change in their eligibility category. These enrollees will be granted a hearing because they did not have the opportunity to appeal the application of the benefit limit to them in connection with the Benefit Notice.

iii. The enrollee alleges an administrative error in the processing of a request for a special exemption to the benefit limit (i.e., the enrollee's physician submitted the required attestation necessary to obtain a special exemption from the benefit limit and the prescribed drug is on the special exemption list but coverage for the drug was nonetheless denied).

D. The enrollee shall not receive continuation of benefits when appealing a denial of services based on the application of a benefit limit. This policy shall apply even for items or services that have been previously authorized as medically necessary to the extent that the denial of services is based on the application of a benefit limit.

E. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal with respect to those benefits.

F. If the enrollee does not request a hearing, the benefit limit deemed applicable by the state will continue to apply to the enrollee.

G. Providers will be permitted to bill enrollees for services that were provided in excess of the benefit limits.

IV. Post Implementation Appeals of Elimination of Coverage for Certain Services

1. Neither the state nor the MCC will provide notification in addition to the Benefit Notice described above with respect to services that are eliminated from TennCare coverage as those services are no longer covered by TennCare.

2. Upon denial of non-covered services, TennCare enrollees will have the opportunity to request a state fair hearing. The enrollee will be required to submit a designated form in order to request a hearing. Such form would include a statement, which must be signed by the enrollee, or an individual appointed or otherwise authorized to act as the enrollee's representative under state law that sets out or describes the factual contention on which the appeal is based, and attests, under penalty of perjury, that the contention is true to the best of the signatory's knowledge and is made in good faith. Enrollees or their representatives may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its discretion of an exemption from the signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or his/her authorized representative.

3. The state will grant a state fair hearing only for those enrollees who raise valid factual disputes related to the elimination of coverage. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to coverage of the disputed service. In the context of excluded services, valid factual disputes are limited to when an enrollee claims that he or she is already in a TennCare category that is entitled to coverage of the particular service at issue. Appeals that do not raise a valid factual dispute will be dismissed without a hearing.

4. If the request for a hearing is granted, the enrollee will not receive continuation of the benefits in dispute pending the appeal.

5. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee may be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal.

XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

Monthly Deliverables		
Monthly	Monitoring Call	~~45~~
Quarterly Deliverables		
60 days after end of each quarter	Quarterly progress reports	46
Per Sections 2500 & 2115 of State Medicaid Manual, or upon request	Quarterly expenditure, budget neutrality, member month reports	42,43 Sections X and XI
Annual Deliverables		
120 days after end of each demonstration year	Draft Annual Progress Report	47
Within 30 days of receipt of comments from CMS on the Draft Annual Progress Report	Final Annual Progress Report	47
Dec. 31st of each year	Annual CHIP Report entered into CHIP Annual Report Template System (SARTS)	47
Sept. of each demonstration year	Annual beneficiary survey report	48
Other Deliverables		
6 months before expiration of demonstration	Request for extension	8
5 months prior to suspending or terminating the demonstration	Phase-out plan	9
6 months before expiration of demonstration	Interim evaluation report.	8, 71
120 days after expiration of demonstration	Draft Final Evaluation Report	49, 72
60 days after receipt of CMS comments on	Final Evaluation Report	49, 72

Draft Final Evaluation Report		
Implementation of compliance plan by January 1, 2013.	Enrollee notification and implementation of the new cost-sharing requirements	36
At least annually	MEQC plan proposal and report on findings	23
Upon receipt by state	Financial audits and quality assessment reviews of participating health plans, and other managed care and HCBS requirements	41, 44
Upon receipt by state	Fraud and abuse and program integrity reports related to 1115 Demonstration beneficiaries and providers	
As required by CMS	Corrective Action Plans and findings	
Upon submission to Regional Office	Courtesy copy of all state plan amendments to be sent to the CMS Project Officer	7
60 days advance notice	Modification of CHOICES benefits defined in Attachment D or ECF CHOICES benefits defined in Attachment G	7
No later than 120 days prior to planned implementation and may not be implemented until approved	Demonstration amendments, including requests for services not defined in Attachment D	6, 7
30 days advance notice	Notice on increases in CHOICES or ECF CHOICES Enrollment Targets within allowable range	32, 33
3 months after each point in time. i.e. September 30 of each demonstration year	Submission of CHOICES or ECF CHOICES data	44.d.
Annually	Integrated Quality Improvement Strategy Update	44.c.
Subject to CMS approval prior to implementation	Final MCO contracts developed for CMS approval	41
When issued or amended by state	Procedural manuals or operating protocols related to the 1115 Demonstration	
All Reports Required by Sections 2500 and 2115 of the State Medicaid Manual		

ATTACHMENT A
QUARTERLY PROGRESS REPORT

Under Section IX, paragraph 46 *(Quarterly Progress Reports)* of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One – TennCare II

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example: Demonstration Year: 6 (7/1/2007 – 6/30/2008)
Federal Fiscal Quarter: 1/2008 (10/07 - 12/07)

Footer: Approval Period July 1, 2013 – June 30, 2016

I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to TennCare eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.
    - Progress on implementing TennCare Standard Spend Down.
    - Progress on phasing out closed eligibility categories.
    - Other

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Enrollment Counts for Quarter

Note: Enrollment counts should be person counts, not member months

Demonstration Populations	
EG1 Disabled, Type 1 state plan eligible	
EG 9 H-Disabled, Type 2 demonstration population	
EG2 Over 65, Type 1 state plan eligible	
EG10 H-Over 65, Type 2 demonstration population	
EG3 Children, Type 1 state plan eligible	
EG4 Adults, Type 1 state plan eligible	
EG4 Adults, Type 2 demonstration population	
EG5 Duals, Type 1 state plan eligibles and EG-11 H-Duals 65, Type 2 demonstration population	
EG6E Expan Adult, Type 3 demonstration population	
EG7E Expan Child, Type 3 demonstration population	
EG8, Med Exp Child, Type 2 demonstration population, Optional Targeted Low Income Children funded by Title XIX	
Med Exp Child, Title XXI demonstration population	
EG12E Carryover, Type 3, demonstration population	

III. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for TennCare enrollees or potential eligibles.

IV. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

V. Operational/Policy/Systems/Fiscal Developments/Issues

Identify all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

VI. Action Plans for Addressing Any Issues Identified

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration.

VII. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

VIII. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Medicaid eligibles (Type 1)				
EG1 Disabled, Type 1 state plan eligibles (paragraph 54.a.i.)				
EG2 Over 65, Type 1 state plan eligibles (paragraph 54.a.ii.)				
EG3 Children, Type 1 state plan eligibles (paragraph 54.a.iii.)				
EG4 Adults, Type 1 state plan eligibles (paragraph 54.a.iv.)				
EG5 Duals, Type 1 state plan eligibles (paragraph 54.a.v.)				
Demonstration eligibles (Type 2)				
EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX (paragraph 54.b.iii.)				
EG9 H-Disabled, Type 2 Demonstration Population (paragraph 54.b.iv.)				
EG10 H-Over 65, Type 2 Demonstration Population (paragraph 54.b.v.)				
EG11 H-Duals, Type 2 Demonstration Population (paragraph 54.b.vi.)				

B. Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
EG6E Expan Adult, Type 3, Demonstration Population (paragraph 54.b.i.)				
EG7E Expan Child, Type 3, Demonstration Population (paragraph 54.b.ii.)				
Med Exp Child, Title XXI Demonstration Population (paragraph 54.c.)				
EG12E Carryover, Type 3, Demonstration Population (paragraph 54.b.vii.)				

IX. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

X. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XI. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XII. Essential Access Hospital Pool

List the Essential Access Hospitals and specify their type from the following:
Essential Service Safety Net
Children's Safety Net
Free Standing Psychiatric Hospitals
Other Essential Acute Care

XIII. Graduate Medical Education (GME) Hospitals

List the GME hospitals and their affiliated teaching universities.

XIV. Critical Access Hospitals

List the Critical Access Hospitals.

Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B
LIMITATIONS ON HOME HEALTH SERVICES

Home health services are delivered in accordance with 42 CFR § 440.70. Prior authorization may be required. Definitions and coverage limitations used by the state are as follows:

1. Home health services shall include any of the following services ordered by a treating physician and provided by a licensed home health agency pursuant to a plan of care at an enrollee's place of residence.

   a. Part-time or intermittent nursing services.

      (1) To be considered "part-time and intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, AND no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide care combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. The above limits may be exceeded when medically necessary for children under the age of 21.

      (2) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on an as needed basis. Part-time or skilled nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.

   b. Home health aide services.

      (1) Home health aide care must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

      (2) The above limits may be exceeded when medically necessary for children under the age of 21.

   c. Physical therapy, occupational therapy, speech pathology and audiology services.

d. Medical supplies, equipment, and appliances ordered by a treating physician and suitable for use at an enrollee's place of residence.

2. Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, or preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:

   a. The child is non-ambulatory; and

   b. The child has no or extremely limited ability to interact with caregivers; and

   c. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and

   d. No other children shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult.

ATTACHMENT C
LIMITATIONS ON PRIVATE DUTY NURSING SERVICES

Private duty nursing services are delivered in accordance with 42 CFR § 440.80. Prior approval may be required. Definitions and coverage limitations used by the state are as follows:

PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period. A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members.

1. If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home that determines whether the nursing services are continuous or intermittent.

2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:

    a. Have a demonstrated understanding, ability, and commitment to the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration, and feeding, as applicable; and

    b. Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and

    c. Are willing and available as needed to meet the recipient's non-nursing support needs.

3. Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:

    a. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

    b. Has a functioning tracheostomy

        (1) Requiring suctioning, AND

(2) Oxygen supplementation, AND

(3) Receiving nebulizer treatments or requiring the use of Cough Assist/inexsufflator devices.

(4) In addition, for persons with a functioning tracheostomy, at least one from each of the following (I and II) must be met:

(I) Medication

(a) Receiving medication via a gastrostomy tube (G-tube), OR

(b) Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port. AND

(II) Nutrition

(a) Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube), OR

(b) Receiving total parenteral nutrition.

4. Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.

5. A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period, or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of this Attachment may receive medically necessary nursing care as an intermittent service under home health.

6. General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have other non-medical caregiving needs which must be met, to the extent that private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

a. The child is non-ambulatory; and

b. The child has no or extremely limited ability to interact with caregivers; and

c. The child would not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse would be present in the home without the presence of another responsible adult; and

d. No other children will be present in the home during the time the private duty nurse would be present in the home without the presence of another responsible adult.

ATTACHMENT D
GLOSSARY OF TERMS FOR TENNCARE CHOICES

Adult care homes. A state-licensed community-based residential alternative which offers 24-hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet nursing facility level of care, but who would prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-basis is living in the home with the individuals for whom they are providing care. Coverage shall not include the costs of room and board.

Adult day care. Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day provided pursuant to an individualized plan of care by a licensed provider not related to the participating adult.

Assisted care living facility services. Community-based residential alternative to nursing facility care in a licensed Assisted Care Living Facility that provides and/or arranges for daily meals, personal care, homemaker and other supportive services or health care including medication oversight (to the extent permitted under state law), in a home-like environment to persons who need assistance with activities of daily living. Coverage shall not include the costs of room and board.

Assistive technology. Assistive device, adaptive aids, controls or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive or control their environment. Examples include, but are not limited to, 'grabbers' to pick objects off the floor, strobe lights to signify the smoke alarm has been activated, etc.

At-Risk. As it relates to the CHOICES program, SSI eligible adults age 65+ or age 21+ with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined by the state in administrative rule, such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As is relates to Interim CHOICES 3, open for enrollment starting on July 1, 2012 and closed to enrollment on June 30, 2015, "at risk" is defined as adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meeting nursing facility financial eligibility criteria, and also meet the nursing facility level of care in effect on June 30, 2012.

Attendant care. Hands-on assistance, safety monitoring and supervision for an enrollee who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visits (more than four (4) hours per visit or visits at intervals of less than four (4) hours between visits). This may include assistance

with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, attendant care may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home, or continuous monitoring and supervision because there is no household member, relative, caregiver, or volunteer to meet the specified need. Attendant care shall not be provided for enrollees who do not require hands-on assistance with ADLs.

Attendant care does not include:

1) Care or assistance including meal preparation or household tasks for other residents of the same household;
2) Yard work; or
3) Care of non-service related pets and animals.

Only for persons who require homemaker services in addition to hands-on assistance with ADLs, the annual benefit shall be up to 1400 hours per full calendar year.

Community-based residential alternatives to institutional care (Community-based residential alternatives). Residential services which offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, assisted care living facilities, adult care homes, community living supports, community living supports – family model, and companion care.

Community living supports (CLS). A community-based residential alternative service for seniors and adults with disabilities that encompasses a continuum of support options for up to four individuals living in a home that supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and comports fully with standards applicable to HCBS settings delivered under section 1915(c) of the Act, including those requirements applicable to provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need and set forth in the person-centered plan of care.

CLS services are individualized based on the needs of each resident and specified in the person-centered plan of care. Services may include hands-on assistance, supervision, transportation, and other supports intended to help the individual exercise choices such as:

- Selecting and moving into a home
- Locating and choosing suitable housemates
- Acquiring and maintaining household furnishings
- Acquiring, retaining, or improving skills needed for activities of daily living or assistance with activities of daily living as needed, such as bathing,

dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility

- Acquiring, retaining, or improving skills needed for instrumental activities of daily living or assistance with instrumental activities of daily living as needed, such as household chores, meal planning, shopping, preparation and storage of food, and managing personal finances
- Building and maintaining interpersonal relationships with family and friends
- Pursuing educational goals and employment opportunities
- Participating fully in community life, including faith-based, social, and leisure activities selected by the individual
- Scheduling and attending appropriate medical services
- Self-administering medications, including assistance with administration of medications as permitted pursuant to T.C.A. § 68-1-904 and 71-5-1414
- Managing acute or chronic health conditions, including nurse oversight and monitoring, and skilled nursing services as needed for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.
- Becoming aware of, and effectively using, transportation, police, fire, and emergency help available in the community to the general public
- Asserting civil and statutory rights through self-advocacy

Community living supports – Family Model (CLS-FM). A community-based residential alternative service for seniors and adults with disabilities that encompasses a continuum of support options for up to three individuals living in the home of trained family caregivers (other than the individual's own family) in an adult foster care arrangement. In this type of shared living arrangement, the provider allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and a family, and provide the individualized services that support each resident's independence and full integration into the community, ensure each resident's choice and rights, and support each resident in a manner that comports fully with standards applicable to HCBS settings delivered under section 1915(c) of the Act, including those requirements applicable to provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need and set forth in the person-centered plan of care.

CLS-FM services are individualized based on the needs of each resident and specified in the person-centered plan of care. Services may include hands-on assistance, supervision, transportation, and other supports intended to help the individual exercise choices such as:

- Selecting and moving into a home
- Locating and choosing suitable housemates
- Acquiring and maintaining household furnishings
- Acquiring, retaining, or improving skills needed for activities of daily living or assistance with activities of daily living as needed, such as bathing, dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility

- Acquiring, retaining, or improving skills needed for instrumental activities of daily living or assistance with instrumental activities of daily living as needed, such as household chores, meal planning, shopping, preparation and storage of food, and managing personal finances
- Building and maintaining interpersonal relationships with family and friends
- Pursuing educational goals and employment opportunities
- Participating fully in community life, including faith-based, social, and leisure activities selected by the individual
- Scheduling and attending appropriate medical services
- Self-administering medications, including assistance with administration of medications as permitted pursuant to T.C.A. § 68-1-904 and 71-5-1414
- Managing acute or chronic health conditions, including nurse oversight and monitoring, and skilled nursing services as needed for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.
- Becoming aware of, and effectively using, transportation, police, fire, and emergency help available in the community to the general public
- Asserting civil and statutory rights through self-advocacy

Companion care. A consumer-directed residential model in which a CHOICES member may choose to select, employ, supervise and pay, utilizing the services of a fiscal intermediary, on a daily, weekly, or monthly basis, as applicable, a live-in companion who will be present in the member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration. Such model will be available only for a CHOICES member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with activities of daily living or supervision and monitoring for extended periods of time that cannot be met more cost-effectively with other non-residential services. A CHOICES member who requires assistance in order to direct his or her companion care may designate a representative to assume consumer direction of companion care services on his/her behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.

Consumer direction of eligible CHOICES HCBS. The opportunity for a member assessed to need specified types of HCBS including attendant care, personal care visits, homemaker services (provided only as part of attendant care or personal care visits), in-home respite care, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed service(s).

Electronic visit verification (EVV) system. An electronic system in which caregivers can check-in at the beginning and check-out at the end of each period of service delivery

to monitor member receipt of HCBS and which may also be utilized for submission of claims.

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.

Homemaker services. Effective July 1, 2012, homemaker services are only available as part of attendant care or personal care visits for individuals who need hands-on assistance with ADLs. Services covered include general household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the member, changing the member's linens, making the member's bed, washing the member's dishes, doing the member's personal laundry, ironing, or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the member, assistance with maintenance of safe environment, and errands such as grocery shopping and having the member's prescriptions filled. Homemaker services are to be provided only for the member (and not for other household members) and only when the member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the member.

In-home respite care. Services provided to individuals unable to care for themselves, furnished on a short-term basis in the individual's place of residence, because of the absence or need for relief of those persons normally providing the care.

In-patient respite care. Services provided to individuals unable to care for themselves, furnished on a short-term basis in a licensed nursing facility or licensed community-based residential alternative, because of the absence or need for relief of those persons normally providing the care.

Minor home modifications. Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. 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.

Nursing facility care. See Social Security Act, Section 1919(a).

Personal care visits. Intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance to an enrollee who, due to age and/or physical disability, needs help with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, personal care visits may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need.

Personal care visits do not include:

1) Companion or sitter services, including safety monitoring and supervision;
2) Care or assistance including meal preparation or household tasks for other residents of the same household;
3) Yard work; or
4) Care of non-service related pets and animals.

Personal emergency response system (PERS). An electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. The individual may also wear a portable 'help' button to allow for mobility. The system is programmed to signal a response center once the 'help' button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed.

PERS services are limited to those individuals who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time, such that the individual's safety would be compromised without access to a PERS.

Pest control. The use of sprays, poisons and traps, as appropriate, in the enrollee's residence (excluding NF, ACLF) to regulate or eliminate the intrusion of roaches, wasps, mice, rats and other species of pests into the household environment thereby removing an environmental issue that could be detrimental to a frail elderly or disabled enrollee's health and physical well-being.

Reserve capacity. The state's right to maintain some capacity within an established enrollment target to enroll individuals into HCBS under certain circumstances. These

circumstances could include, but are not limited to: discharge from a nursing facility; discharge from an acute care setting where institutional placement is otherwise imminent, or other circumstances which the state may establish from time to time in accord with these STCs.

Room and board. Refers to lodging, meals, and utilities. The kinds of items that are considered "room and board" and are therefore not reimbursable by Medicaid include:

- Rent, or, if the individual owns his home, mortgage payments, depreciation, or mortgage interest
- Property taxes
- Insurance (title, mortgage, property and casualty)
- Building and/or grounds maintenance costs
- Resident "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included)
- Household supplies necessary for the room and board of the individual
- Furnishings used by the resident
- Utilities (electricity, water and sewer, gas)
- Resident telephone
- Resident cable television

Short Term Nursing Facility Care. The provision of nursing facility care for no more than 90 days to a CHOICES 2, CHOICES 3, or ECF CHOICES participant who was receiving home and community based services upon admission and who requires temporary placement in a nursing facility—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 90 days. Such CHOICES 2 or CHOICES 3 or ECF CHOICES member must meet the nursing facility level of care upon admission (which for CHOICES 3 and CHOICES 5 participants is anticipated to be due to a short-term condition), and in such case, while receiving short-term nursing facility care may continue enrollment in CHOICES 2, CHOICES 3 or ECF CHOICES, as applicable, pending discharge from the nursing facility within no more than 90 days or until such time it is determined that discharge within 90 days from admission is not likely to occur, at which time the person shall be transitioned to CHOICES 1, as appropriate. The community personal needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

Transition Allowance. A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of a managed care organization, be provided as a cost-effective alternative to continued institutional care for a CHOICES member in order to facilitate transition from a nursing facility to the community when such member will, upon transition, receive more cost-effective non-residential home and community based services or companion care. Items which may be purchased or reimbursed are only those items that the member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already

established and to facilitate the person's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

ATTACHMENT E
BEST PRACTICES GUIDANCE REGARDING
CONSUMER DIRECTION OF HOME AND COMMUNITY BASED SERVICES

The state will define services that eligible members may elect to direct. Members determined, as a part of the needs assessment and plan of care processes, to require such services will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e. consumer direction of HCBS).

All eligible members requiring these services will be offered the option to participate in consumer direction of HCBS.

i. Upon enrollment in HCBS and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.

ii. Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at anytime, service by service, without affecting their enrollment in HCBS. Only the state can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare.

iii. A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or be a member's paid worker.

iv. The state will utilize a fiscal employer agency (FEA) to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services rendered; and withholding, filing and paying applicable Federal, state and local income and employment taxes for workers) and to provide supports broker assistance.

v. The plan of care process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports, contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.

vi. Members will have the flexibility to hire persons close to them, including family members but excluding spouses, to serve as their workers. All workers must meet the state specified qualifications for providers of comparable non-consumer directed services and must sign a service agreement.

vii. Members will have flexibility in establishing payment rates that do not exceed the state specified ceiling for each service.

viii. Members and/or representatives must receive training prior to participating in consumer direction of HCBS and re-enrolling in consumer direction of HCBS. Ongoing training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.

ix. Workers must receive training, as a condition for hire, certain aspects of which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.

x. A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care, and the adequacy of payment rates.

ATTACHMENT F
CERTIFIED PUBLIC EXPENDITURES PROTOCOL

Preamble

This protocol governs the use of certified public expenditures to furnish the non-Federal share of expenditures claimed for Federal participation under the Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (paragraph 56.h.). The protocol is based on the following elements:

1) Units of government, including governmentally operated health care providers, may certify that costs have been incurred for providing services to TennCare and uninsured individuals. The CPE process contained in this attachment is in accordance with Federal regulations and CMS guidance or policy.

   i. Units of government have been determined by the state as eligible to certify public expenditures.

   ii. Certification must be supported by cost documentation, which represents both the Federal and non-Federal share of funds (i.e., total computable expenditures) under the Demonstration. Federal matching funds are available as a percentage of such eligible costs.

2) To the extent the state continues to utilize certified public expenditures (CPEs) as the funding mechanism for title XIX and XXI (or under Section 1115 authority) payments beyond the date defined in this section, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs as eligible under title XIX or XXI (or under Section 1115 authority) for purposes of certifying public expenditures.

3) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the state the amount of such tax revenue (state or local) appropriated to the non-governmental provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the state's claim for Federal match. Federal matching funds will be available as a percentage of such eligible costs.

I. Cost Computation

A. TN CPE 1115 – Medicaid Fee-For-Service

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552)

covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from MMIS for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the

Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

B. <u>TN CPE 1115 – Medicaid Managed Care</u>

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated

by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

C. TN CPE 1115 – Hospital Uninsured Care

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently as-filed Medicare cost report (CMS 2552), as-filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the as-filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospital's audited financial statements and other auditable documentation. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage

are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of Uninsured care usable organs to total usable organs. This is determined by dividing the number of Uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible Uninsured care costs are determined by adding the Uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual Uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

II. Payments and Recoveries

All payments and recoveries, from MCO's; BHO's; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except

for local government indigent care funds) including any related patient co-payments, or payments from other non-state payers will be offset against the costs computed in Section I above. Payments to the hospital from uninsured individuals for their care for the fiscal year are identified from the hospital's records. Such uninsured data must be supported by auditable documentation.

III. Interim Reconciliation

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3

Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5

Actual Medicaid paid days and charges from MMIS paid claims data for services furnished during the payment year are used.

Step 6

Organ acquisition costs and total usable organs from the as-filed CMS 2552 cost report for the payment year are used.

IV. Final Reconciliation

Upon finalization of the CMS-2552 by the Medicare fiscal intermediary, the methodologies as prescribed above will be used to determine final Medicaid FFS cost, Medicaid managed care cost, and uninsured cost. The routine per diems and ancillary cost-to-charge ratios will be determined using cost, day and charge data from the finalized cost report. The Medicaid FFS, Medicaid managed care, and uninsured days, charges, and payment offsets will be updated with the latest MMIS reports and other auditable financial records.

Cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include:

1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS data to the per diem amount;

2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and

3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly excepted for Medicaid.

If, at the end of the reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Recoveries are updated and offset to cost as calculated per Steps above.

For hospitals whose cost report year is different from the state's fiscal year, the state will proportionally allocate to the state plan rate year the costs of two cost report periods encompassing the state Plan payment year. To do so, the state will obtain the actual Medicaid FFS, Medicaid managed care, and uninsured days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS, Medicaid managed care, and uninsured costs for the reporting periods; these costs will then be proportionally allocated to the state plan rate year. All allocations will be made based upon number of months. (For example, a hospital's cost reporting period ending 12/31/07 encompasses three-fourths of the state plan rate year ending 9/30/2007, and one-fourth of the state plan rate year ending 9/30/2008. To fulfill reconciliation requirements for state plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2006, to the state plan rate year.) The state will ensure that the total costs claimed in a state plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

Attachment G
Employment and Community First CHOICES Service Definitions

I. NON-RESIDENTIAL HABILITATION SERVICES:

All references to individualized integrated employment or self-employment in any of the following definitions shall have this meaning:
Individualized Integrated Employment: Sustained paid employment in a competitive or customized job with an employer for which an individual is compensated at or above the state's minimum wage, with the optimal goal being not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
Individualized Integrated Self-Employment: Sustained paid self-employment that is home-based or conducted in an integrated setting(s) where net income in relation to hours worked is equivalent to no less than the state's minimum wage, after a reasonable self-employment start-up period.

Limitations on Braiding of Non-Residential Habilitation Services for an ECF Member: An individual's PCSP may include more than one non-residential habilitation service; however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time).

When any combination of non-residential habilitation services, which does not include at least one employment service, are authorized for an ECF member who is not working in Individualized Integrated Employment or Self-Employment, the maximum combined authorization shall be limited to twenty (20) hours per week.

When any combination of non-residential habilitation services, which includes at least one employment service, are authorized for an ECF member who is not working in Individualized Integrated Employment or Self-Employment, the maximum combined authorization shall be limited to thirty (30) hours per week.

When any combination of non-residential habilitation services are authorized for an ECF member who is working in Individualized Integrated Employment and/or Self-Employment, the maximum combined authorization shall be limited to forty (40) hours per week. The member's hours spent working without paid supports in Individualized Integrated Employment and Self-Employment shall be included in the forty (40) hour limit. The only exception to this policy shall be for individuals working thirty (30) or more hours per week in Individualized Integrated Employment and/or Self-Employment; for these individuals, the maximum combined authorization shall be limited to fifty (50) hours per week. The member's hours spent working without paid supports in Individualized Integrated Employment and Self-Employment shall be included in the fifty (50) hour limit.

Other limitations that may apply to authorizing specific non-habilitation services in combination with other specific non-habilitation services will be noted in the individual service definitions below.

A. Employment Services/Supports

Supported Employment—Individual Employment Support
These services are provided on an individual basis for a person who, because of his or her disabilities, needs support that is not available to the person through a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) in order to obtain, maintain and/or advance in a competitive or customized job, or self-employment, in an integrated community setting for which the individual is compensated at or above the minimum wage.

The expected outcome of these services is individualized integrated employment or self-employment defined as follows:
(1) Sustained paid employment in a competitive or customized job with an employer for which an individual is compensated at or above the state's minimum wage, with the optimal goal being not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities; or
(2) Sustained paid self-employment that is home-based or conducted in an integrated setting(s) where net income in relation to hours worked is equivalent to no less than the state's minimum wage, after a reasonable self-employment start-up period.

These services are designed to support the achievement of individualized integrated employment and self-employment outcomes consistent with the individual's personal and career goals, as determined through Exploration, Discovery and/or other similar career planning processes and which include an introduction to the variety of work incentives available to individuals receiving SSI and/or SSDI, Medicaid and/or Medicare.

The Supported Employment—Individual Employment Support provider shall be responsible for any personal assistance needs during the time that Supported Employment-Individual Employment Support services are provided; however, personal assistance services may not comprise the entirety of the Supported Employment—Individual Employment Support service(s) being rendered at any given time. All providers of personal assistance under Supported Employment—Individual Employment Support shall meet the Personal Assistance service provider qualifications, except that a separate PSSA license shall not be required.

Transportation of the individual to and from these services is not included in the rates paid for these services. Transportation *during* the provision of these services is included in the rates paid for these services.

An individual's person-centered support plan may include more than one non-residential habilitation service; however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time).
ECF CHOICES will not cover Supported Employment-Individual Employment Support services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If one or more of these services are authorized, documentation is maintained that the service is not available to the individual under a program

funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

These services will not duplicate other services provided through ECF CHOICES or the Medicaid State Plan.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
- Payments that are passed through to users of supported employment services; or
- Payments for training that is not directly related to an individual's supported employment program.

A provider of Supported Employment-Individual Employment Support services may also receive Social Security's Ticket to Work Outcome and Milestone payments. These payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided.

Supported Employment—Individual Employment Support services are individualized and may include one or more of the following components:

1. **Exploration:**

This is a time-limited and targeted service designed to help a person make an informed choice about whether s/he wishes to pursue individualized integrated employment or self-employment, as defined above. The Exploration service shall be completed no more than thirty (30) calendar days from the date of service initiation. This service is not appropriate for ECF members who already know they want to pursue individualized integrated employment or self-employment.

This service includes career exploration activities to identify a person's specific interests and aptitudes for paid work, including experience and skills transferable to individualized integrated employment or self-employment. This service also includes exploration of individualized integrated employment or self-employment opportunities in the local area that are specifically related to the person's identified interests, experiences and/or skills through four to five uniquely arranged business tours, informational interviews and/or job shadows. (Each person receiving this service should participate in business tours, informational interviews and/or job shadows uniquely selected based on his or her individual interests, aptitudes, experiences, and skills most transferable to employment. All persons should not participate in the same experiences.) Each business tour, informational interview and/or job shadow shall include time for set-up, prepping the person for participation, and debriefing with the person after each opportunity.

This service also includes introductory education on the numerous work incentives for individuals receiving publicly funded benefits (e.g. SSI, SSDI, Medicaid, Medicare, etc.). This service further includes introductory education on how Supported Employment services work (including Vocational Rehabilitation services). Educational information is provided to the person and the legal guardian/conservator and/or most involved family member(s), if applicable, to ensure legal guardian/conservator and/or family support for the person's choice to pursue

individualized integrated employment or self-employment. The educational aspects of this service shall include addressing any concerns, hesitations or objections of the person and the legal guardian/conservator and/or most involved family member(s), if applicable.

This service is expected to involve, on average, forty (40) hours of service. The provider shall document each date of service, the activities performed that day, and the duration of each activity. This service culminates in a written report summarizing the process and outcomes, using a standard template prescribed by TennCare. The written report is due no later than fourteen (14) calendar days after the last date of service is concluded. Exploration is paid on an outcome basis, after the written report is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

After an individual has received the service for the first time, re-authorization may occur a maximum of once per year (with a minimum 365-day interval between services) and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment.

2. **Benefits Counseling:**

A service designed to inform the individual (and guardian, conservator and/or family, if applicable) of the multiple pathways to ensuring individualized integrated employment or self-employment results in increased economic self-sufficiency (net financial benefit) through the use of various work incentives. This service should also repudiate myths and alleviates fears and concerns related to seeking and working in individualized integrated employment or self-employment through an accurate, individualized assessment. The service provides information to the individual (and guardian, conservator and/or family, if applicable) regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, ECF, housing subsidies, food stamps, etc.

The service also will provide information and education to the person (and guardian, conservator and/or family, if applicable) regarding income reporting requirements for public benefit programs, including the Social Security Administration.

Benefits counseling provides work incentives counseling and planning services to persons actively considering or seeking individualized integrated employment or self-employment, or career advancement in either of these types of employment.

This service is provided by a certified Community Work Incentives Coordinator (CWIC). In addition to ensuring this service is not otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), ECF may not fund this service if CWIC Benefits Counseling services funded through the Federal Work Incentives Planning and Assistance (WIPA) program are available to the individual.

Service must be provided in a manner that supports the person's communication style and needs, including, but not limited to, age-appropriate communications, translation/interpretation services for persons of limited English-proficiency or who have other communication needs requiring

translation including sign language interpretation, and ability to communicate with a person who uses an assistive communication device.

Benefits Counseling services are paid for on an hourly basis and limited in the following ways:

a. Initial Benefits Counseling for someone actively considering or seeking individualized integrated employment or self-employment, or career advancement in these types of employment: up to twenty (20) hours. This service may be authorized no more than once every two (2) years (with a minimum of two 365-day intervals between services).
b. Supplementary Benefits Counseling for someone evaluating an individualized integrated job offer/promotion or self-employment opportunity: up to an additional six (6) hours. This service may be authorized up to three (3) times per year if needed.
c. PRN Problem-Solving services for someone to maintain individualized integrated employment or self-employment: up to eight (8) hours per situation requiring PRN assistance. This service may be authorized up to four (4) times per year if necessary for the individual to maintain individualized integrated employment or self-employment.

3. **Discovery**

This is a time-limited and targeted service for an individual who wishes to pursue individualized integrated employment or self-employment but for whom more information is needed to determine the following prior to pursuing individualized integrated employment or self-employment:

- Strongest interests toward one or more specific aspects of the labor market;
- Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment;
- Conditions necessary for successful employment or self-employment.

Discovery involves a comprehensive analysis of the person in relation to the three bullets above. Activities include observation of person in familiar places and activities, interviews with family, friends and others who know the person well, observation of the person in an unfamiliar place and activity, identification of the person's strong interests and existing strengths and skills that are transferable to individualized integrated employment or self-employment, Discovery also involves identification of conditions for success based on experience shared by the person and others who know the person well, and observation of the person during the Discovery process. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized integrated employment or self-employment.

Discovery results in the production of a detailed written Profile, using a standard template prescribed by TennCare, which summarizes the process, learning and recommendations to inform identification of the person's individualized integrated employment or self-employment goal(s) and strategies to be used in securing this employment or self-employment for the person..

If Discovery is paid for through ECF, the person should be assisted to apply to Vocational Rehabilitation (VR) for services to obtain individualized integrated employment or self-employment. The Discovery Profile should be shared with VR staff to facilitate the expeditious development of an Individual Plan for Employment (IPE).

Discovery shall be limited to no more than ninety (90) calendar days from the date of service initiation. This service is expected, on average, to involve fifty (50) hours of service.
The provider shall document each date of service, the activities performed that day, and the duration of each activity. The written Profile is due no later than fourteen (14) days after the last date of service is concluded. Discovery is paid on an outcome basis, after the written Profile is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

After an individual has received the service for the first time, re-authorization may occur a maximum of once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within twelve (12) months.

4. Situational Observation and Assessment

This is a time-limited service that involves observation and assessment of an individual's interpersonal skills, work habits and vocational skills through practical experiential, community integrated volunteer experiences and/or paid individualized, integrated work experiences that are uniquely arranged and specifically related to the interests, preferences and transferable skills of the job seeker as established through Discovery or a similar process. This service involves a comparison of the actual performance of the individual being assessed with core job competencies and duties required of a skilled worker in order to further determine the work competencies and skills needed by the individual to be successful in environments similar to where the Assessment is taking place. The individual shall be reimbursed at least the minimum wage and all applicable overtime for work performed, except as permitted pursuant to the Fair Labor Standards Act for unpaid internships.

Situational Observation and Assessment shall be limited to no more than thirty (30) calendar days from the date of service initiation. Each job seeker may be authorized for up to four (4) such experiences <u>within</u> the thirty (30) calendar day period. A summary report, using a standard template prescribed by TennCare, is due within ten (10) days after the last date of service is concluded. Reimbursement is paid on an outcome basis for each individual experience, which is expected to involve an average of twelve (12) hours of service per individual experience. The Situational Observation and Assessment outcome payment is made after the written summary report is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

The learning from this service described in the summary report is to be used to help inform the job development plan or self-employment plan.

After an individual has received the service for the first time, re-authorization may occur a maximum of once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-

employment within twelve (12) months.

5. **Job Development Plan or Self-Employment Plan**

This is a time-limited and targeted service designed to create a clear and detailed plan for Job Development or for the start-up phase of Self-Employment. This service is limited to thirty (30) calendar days from the date of service initiation. This service includes a planning meeting involving the individual and other key people who will be instrumental in supporting the individual to become employed in individualized integrated employment or self-employment.

This service culminates in a written plan, using a template prescribed by TennCare, that incorporates the results of Exploration, Discovery, and/or Situational Observation and Assessment, if previously authorized. The written plan is due no later than thirty (30) calendar days after the service commences. For self-employment goals, this service results in the development of a self-employment business plan, including potential sources of business financing (such as VR, Small Business Administration loans, PASS plans), given that Medicaid funds may not be used to defray the capital expenses associated with starting a business. This service is paid on an outcome basis, after the written plan is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

After an individual has received the service for the first time, re-authorization may occur a maximum of once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within twelve (12) months.

6. **Job Development or Self-Employment Start Up**

This is a time-limited service designed to implement a Job Development or Self-Employment Plan as follows:

- **Job Development** is support to obtain an individualized competitive or customized job in an integrated employment setting in the general workforce, for which an individual is compensated at or above the minimum wage, but ideally not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The Job Development strategy should reflect best practices and adjusted based on whether the individual is seeking competitive or customized employment.
- **Self-Employment Start Up** is support in implementing a self-employment business plan.

The outcome of this service is expected to be the achievement of an individualized integrated employment or self-employment outcome consistent with the individual's personal and career goals, as determined through Exploration, Discovery and/or the Situational Observation and Assessment, if authorized, and as identified in the Job Development or Self-Employment Plan that guides the delivery of this service.

This service will be paid on an outcome basis once the person has completed two calendar weeks

of individualized integrated employment or self-employment Outcome payment amounts are tiered based upon the assessed level of challenge anticipated to achieve the intended outcome of this service for the individual being served. Outcome payments are also paid over three phases to incentivize retention of the job or self-employment situation.

After an individual has received the service for the first time, re-authorization may occur a maximum of once per year (with a minimum 365-day interval between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within nine (9) months.

7. **Job Coaching**

o **Job Coaching for Individualized, Integrated Employment** includes identifying, through job analysis, and providing services and supports that assist the individual in maintaining individualized integrated employment that pays at least minimum wage but ideally not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Job coaching includes supports provided to the individual and his/her supervisor and/or co-workers, either remotely (via technology) or face-to-face. Supports during each phase of employment must be guided by a Job Coaching Fading Plan which incorporates an appropriate mix of best practices for the individual to achieve fading goals as identified in the Plan (e.g. systematic instruction utilizing task analysis to teach the individual to independently complete as much of his/her job duties as possible; high or low tech assistive technology; and effective engagement of natural supports including co-workers and supervisor(s) as needed). If progress on fading ceases at some point, adaptations to job duties, negotiated with the supervisor/employer, or transition to Co-Worker Supports may be utilized if no reduction in hours or hourly pay results.

The amount of time authorized for this service is a percentage of the individual's hours worked and is tiered, based on the individual's level of disability and the length of time the person has been employed on the job. An exception policy applies for individuals with exceptional circumstances.

Transportation of the supported employee to and from the job site is not included in the rate paid for the service. Transportation of the supported employee, if necessary, during the provision of job coaching is included in the rate paid for the service.

o **Job Coaching for Individualized, Integrated Self-Employment** includes identification and provision of services and supports that assist the individual in maintaining self-employment., Job coaching for self-employment includes supports provided to the individual, either remotely (via technology) or face-to-face. Supports must enable the individual to successfully operate the business (with assistance from other sources of professional services or suppliers of goods necessary for the type of business). Job Coaching supports should never supplant the individual's role or responsibility in all aspects of the business. Supports during each phase of self-employment must be guided by a Job Coaching Fading Plan which incorporates an appropriate

mix of best practices for the individual to achieve fading goals as identified in the Plan (e.g. systematic instruction utilizing task analysis to teach the individual to independently complete as much of his/her roles and responsibilities as possible; high or low tech assistive technology; and effective engagement of any business partners and/or associates and/or suppliers of goods or services. If progress on fading ceases at some point, business plan adaptations may be utilized if no reduction in paid hours or net hourly pay results.

The amount of time authorized for this service is a percentage of the individual's hours engaged in self-employment and is tiered, based on the individual's level of disability and the length of time the person has been self-employed in the current business. An exception policy applies for individuals with exceptional circumstances.

Transportation of the supported self-employed person to and from the place of work is not included in the rate paid for the service. Transportation of the supported self-employed person, if necessary, during the provision of job coaching is included in the rate paid for the service.

8. **Co-Worker Supports**

This service involves a provider of Job Coaching for Individualized Integrated Employment entering into an agreement with an individual's employer to reimburse the employer for supports provided by one or more supervisors and/or co-workers, acceptable to the individual, to enable the person to maintain individualized integrated employment with the employer. This service cannot include payment for the supervisory and co-worker supports rendered as a normal part of the business setting and that would otherwise be provided to an employee without a disability. As well, additional natural supports for the individual, already negotiated with the employer, and provided through supervisors and co-workers, are not eligible for reimbursement under Co-Worker Supports. Only supports that must otherwise be provided by a Job Coach may be reimbursed under this service category. Co-Worker Supports would be authorized in situations where any of the following is true:

1. From the start of employment or at any point during employment, if the employer prefers (or the individual prefers and the employer agrees) to provide needed Job Coach supports, rather than having a Job Coach, either employed by a third party agency or self-employed, present in the business. Fading expectations should still be in place to maximize independence of the employed individual.
2. At any point in the individual's employment where needed Job Coaching supports can be most cost effectively provided by Co-Worker Supports and both the employer and individual agree to the use of Co-Worker Supports. Fading of Job Coaching supports may or may not still be occurring, but Co-Worker Supports should always be considered when on-going fading of Job Coaching has stopped occurring.
3. For individuals who are expected to be able to transition to working only with employer supports available to any employee and additional negotiated natural supports if applicable. In this situation, Co-Worker Supports are authorized as a temporary (maximum twelve months) bridge to relying only on employer supports, and additional negotiated natural (unpaid) supports if applicable, to maintain employment.

The supervisor(s) and/or co-worker(s) identified to provide the support to the individual must meet the qualifications for a legally responsible individual as provider of this service. The

provider is responsible for ensuring these qualifications are met and also for oversight and monitoring of paid co-worker supports.

The amount of time authorized for this service is negotiated with the employer and reflective of the specific needs the individual has for co-workers supports above and beyond negotiated natural supports and supervisory/co-worker supports otherwise available to employees without disabilities. A 10% add-on to the 15 minute unit rate for the employer is applied to cover the service provider's role in administering Co-Worker Supports.

9. **Career Advancement:**

This is a time-limited career planning and advancement support service for persons currently engaged in individualized integrated employment or self-employment who wish to obtain a promotion and/or a second individualized integrated employment or self-employment opportunity. The service is time-limited and focuses on developing and successfully implementing a plan for achieving increased income and economic self-sufficiency through promotion to higher paying position or through a second individualized integrated employment or self-employment opportunity.

The outcomes of this service are: (1) the identification of the person's specific career advancement objective; (2) development of a viable plan to achieve this objective; and (3) implementation of the plan which results in the person successfully achieving his/her specific career advancement objective.

Career Advancement is paid on an outcome basis, after key milestones are accomplished:

a. Outcome payment number one is paid after the written plan to achieve the person's specific career advancement objective is reviewed and approved. Note: The written plan must follow the template prescribed by TennCare.
b. Outcome payment number two is paid after the person has achieved his/her specific career advancement objective and has been in the new position or second job for a minimum of two (2) weeks.

This service may not be included on an Person-Centered Support Plan if the PCSP also includes any of the above services numbered one (1) through six (6). This service may not be authorized retroactive to a promotion or second job being made available to a person. Supports for Career Advancement may be authorized and paid once every three (3) years (with a minimum of three 365-day intervals between services), if evidence exists that the individual is eligible for promotion or able to present as a strong candidate for employment in a second job (e.g. has strong reference, performance reviews and attendance record from current employer). The only exception is in situations where the provider previously authorized and paid for outcome payment number one did not also earn outcome payment number two (because they did not successfully obtain a promotion or second job for the person). In this situation, reauthorization for outcome payments number one and two may occur a maximum of once per year (with a minimum 365-day interval between services), so long as the reauthorization involves the use of a new/different provider.

Supported Employment – Individual Employment Supports Service Limitations:

- These services are *only* for individuals seeking or engaged in individualized integrated employment or self-employment. These services are not for group employment of any size or variation.
- Job Coaching services do not include supports for volunteering or any form of unpaid internship, work experience or employment.
- These services do not include supporting paid employment or training in a sheltered workshop or similar facility-based setting.

These services do not include supporting paid employment or training in a business enterprise owned or operated by a provider of these services. These services do not include payment for supervisory activities rendered as a normal part of the business setting and supports otherwise available to employees without disabilities filling the same or similar positions in the business.

Supported Employment – Small Group Supports (max of 3 persons supported together as a small group)

This service provides employment services and training activities to support successful transition to individualized integrated employment or self-employment, or to supplement such employment and/or self-employment when it is only part-time. Service may involve small group career planning and exploration, small group Discovery classes/activities, other educational opportunities related to successful job acquisition and working successfully in individualized integrated employment. Service may also include employment in integrated business, industry and community settings. Examples include mobile crews, small enclaves and other small groups participating in integrated employment that is specifically related to the identified interests, experiences and/or skills of each of the persons in the small group and that results in acquisition of knowledge, skills and experiences that facilitate transition to individualized integrated employment or self-employment, or that supplement such employment or self-employment when it is only part-time. Minimum staffing ratio is 1:3 for this service.

- Career planning and exploration activities, Discovery classes/activities, other educational opportunities related to successful job acquisition and working successfully in individualized integrated employment or self-employment must be conducted in appropriate non-disability-specific settings (e.g. Job Centers, businesses, post-secondary education campuses, libraries, etc.) All settings must meet all HCBS setting standards and must not isolate participants from others who do not have disabilities.
- In the **enclave** model, a small group of people with disabilities (no more than 3 people) is trained and supervised to work among employees who are not disabled at the host company's work site. Persons in the enclave may work as a team at a single work area or may work in multiple areas throughout the company. The Supported Employment—Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in integrated business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others in the setting who do not have disabilities. The experience should allow opportunities for routine interactions with others without disabilities in the setting and involvement from supervisors and co-workers without disabilities (not paid to deliver this service) in the supervision and support of individuals receiving this service.

- In the **mobile work crew** model, a small crew of workers (including no more than three persons with disabilities and ideally also including workers without disabilities) work as a distinct unit and operate as a self-contained business that generates employment for their crew members by selling a service. The crew typically works at several locations within the community. The Supported Employment—Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in integrated business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. The experience should allow opportunities for routine interactions with people without disabilities (including fellow crew members, customers, etc.) in the course of performing services.

Paid work under Supported Employment—Small Group must be compensated at minimum wage or higher.

Supported Employment—Small Group does not include vocational or prevocational services, employment or training provided in facility based work settings. Supported Employment—Small Group service settings cannot be provider-owned, leased or operated settings. The settings must be integrated in, and support full access of participants to the greater community, including opportunities to learn about and seek individualized integrated employment or self-employment, engage in community life, and control their earned income.

The expected outcome of this service is the acquisition of knowledge, skills and experiences that facilitate career development and transition to individualized integrated employment or self-employment, or that supplement such employment and/or self-employment when it is only part-time. The individualized integrated employment or self-employment shall be consistent with the individual's personal and career goals.

Supported Employment—Small Group services shall be provided in a way that presumes all participants are capable of working in individualized integrated employment and/or self-employment. Participants in this service shall be encouraged, on an ongoing basis, to explore and develop their interests, strengths, and abilities relating to individualized integrated employment and/or self-employment. In order to reauthorize this service, the Person-Centered Support Plan (PCSP) must document that such opportunities are being provided through this service, to the individual, on an on-going basis. The PCSP shall also document and address any barriers to the individual transitioning to individualized integrated employment or self-employment if the person is not already participating in individualized integrated employment or self-employment. Any individual using this service to supplement part-time individualized integrated employment or self-employment shall be offered assistance to increase hours in individualized integrated employment and/or self-employment as an alternative or partial alternative to continuing this service.

As a component part of this service, Supported Employment—Small Group service providers shall support individuals in identifying and pursuing opportunities that will move them into individualized integrated employment or self-employment. A one-time incentive payment for full transition of a person from Supported Employment-Small Group services to individualized

integrated employment or self-employment shall be paid to the Supported Employment—Small Group provider upon successful transition (defined as successfully completing at least four weeks in the individualized integrated employment or self-employment situation) out of Supported Employment—Small Group services to individualized integrated employment or self-employment.

Transportation of participants to and from the service is not included in the rate paid for the service; however transportation provided during the course of Supported Employment—Small Group services is considered a component part of the service and the cost of this transportation is included in the rate paid to providers of this service.

The Supported Employment—Small Group provider shall be responsible for any personal assistance needs during the hours that Supported Employment-Small Group services are provided; however, the personal assistance services may not comprise the entirety of the Supported Employment—Small Group service. All providers of personal care under Supported Employment—Small Group shall meet the Personal Assistance service provider qualifications, except that a separate PSSA license shall not be required.

Supported Employment—Small Group services exclude services available to an individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
- Payments that are passed through to users of supported employment services; or
- Payments for training that is not directly related to an individual's supported employment program.

Supported Employment—Small Group does not include supports provided in facility based (sheltered, prevocational, vocational or habilitation) work settings and does not include supports for volunteering.

Integrated Employment Path Services (Time-Limited, Community-Based Prevocational Training)

The provision of time-limited learning and work experiences, including volunteering opportunities, where a person can develop general, non-job-task-specific strengths and skills that contribute to employability in individualized integrated employment or self-employment. Services are expected to specifically involve strategies that facilitate a participant's successful transition to individualized integrated employment or self-employment.

Individuals receiving Integrated Employment Path Services must have a desire to obtain some type of individualized integrated employment or self-employment and this goal must be documented in the PCSP as the goal that Integrated Employment Path Services are specifically authorized to address.

Services should be customized to provide opportunities for increased knowledge, skills and experiences specifically relevant to the person's *specific* individualized integrated employment and/or self-employment goals and career goals. If such *specific* goals are not known, this service can also be used to assist a person to identifying his/her specific individualized integrated employment and/or self-employment goals and career goals.

The expected outcome of this service is measurable gains in knowledge, skills and experiences that contribute to the individual achieving individualized integrated employment or self-employment.

Integrated Employment Path Services are intended to develop and teach general skills that lead to individualized integrated employment or self-employment including but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; and general workplace safety and mobility training.

Service limitations:

- This service is limited to no more than twelve (12) months. One extension of up to twelve (12) months can be allowed only if the individual is actively pursuing individualized integrated employment or self-employment in an integrated setting and has documentation that a service(s) (i.e.. Job Development or Self-Employment Start-Up funded by Tennessee Rehabilitation Services, ECF CHOICES or another similar source) is concurrently authorized for this purpose. The twelve (12) month authorization and one twelve (12) month reauthorization may be repeated only if a person loses individualized integrated employment or self-employment and is seeking replacement opportunities.
- This service must be delivered in integrated, community settings and may not be provided in sheltered workshops or other segregated facility-based day, vocational or prevocational settings.
- Integrated Employment Path Services shall not be provided or reimbursed if the person is receiving Job Coaching (for Individualized Integrated Employment or Self-Employment) Co-Worker Supports or is working in individualized integrated employment or self-employment without any paid supports. Integrated Employment Path Services are only appropriate for individuals who are not yet engaged in individualized integrated employment or self-employment.

Transportation of the individual to and from this service is not included in the rate paid for this service but transportation during the service is included in the rate.

ECF CHOICES will not cover services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

This service will not duplicate other services provided through the waiver or Medicaid state plan services.

B. Other (non-Employment) Non-Residential Habilitation Services and Supports

Community Integration Support Services: Services which coordinate and provide supports for valued and active participation in integrated daytime and nighttime activities that build on the person's interests, preferences, gifts, and strengths while reflecting the person's goals with regard to community involvement and membership. This service involves participation in one or more integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers. Community Integration Support Services are designed to promote maximum participation in integrated community life while facilitating meaningful relationships, friendships and social networks with persons without disabilities who share similar interests and goals for community involvement and participation.
Community Integration Support Services shall support and enhance, rather than supplant, an individual's involvement in public education, post-secondary education/training and individualized integrated employment or self-employment (or services designed to lead to these types of employment).

Community Integration Support Services enable the person to increase or maintain his/her capacity for independent participation in community life and to develop age-appropriate social roles valued by the community by learning, practicing and applying skills necessary for full inclusion in the person's community, including skills in arranging and using public transportation for individuals aged 16 or older.

Community Integration Support Services provide assistance for active and positive participation in a broad range of integrated community settings that allow the person to engage with people who do not have disabilities who are not paid or unpaid caregivers. The service is expected to result in the person developing and sustaining a range of valued, age-appropriate social roles and relationships; building natural supports; increasing independence; and experiencing meaningful community integration and inclusion. Activities are expected to increase the individual's opportunity to build connections within his/her local community and include (but are not limited to) the following:

- Supports to participate in age-appropriate community activities, groups, associations or clubs to develop social networks with community organizations and clubs to;
- Supports to participate in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness (e.g. yoga class, walking group, etc.);
- Supports to participate in adult education and postsecondary education classes;
- Supports to participate in formal/informal associations or community/neighborhood groups;
- Supports to participate in volunteer opportunities;
- Supports to participate in opportunities focused on training and education for self-determination and self-advocacy;
- Supports for learning to navigate the local community, including learning to use public

transportation and/or private transportation available in the local area;

- Supports to maintain relationships with members of the broader community (e.g. neighbors, co-workers and other community members who do not have disabilities and who are not paid or unpaid caregivers) through natural opportunities and invitations that may occur.

This service includes a combination of training and supports as needed by the individual. The Community Integration Support Services provider shall be responsible for any personal assistance needs during the hours that Community Integration Support Services are provided; however, the personal assistance services may not comprise the entirety of the Community Integration Support Service. All providers of personal care under Community Integration Support Services meet the Personal Assistance provider qualifications.
This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve his or her personally identified goals for community integration, involvement, exploration and for developing and sustaining a network of positive natural supports. All settings where Community Integration Support Services are provided must be non-disability specific and meet all federal standards for HCBS settings. This service is provided separate and apart from the person's place of residence. This service does not take place in licensed facilities, sheltered workshops or any type of facility owned, leased or operated by a provider of this service.

This service is available only:

- For children not yet old enough to work and/or not yet eligible for employment services who are enrolled in Essential Family Supports;
- As "wrap-around" supports to employment or employment services (Supported Employment Individual or Small Group services and/or Integrated Employment Path Services) for individuals not receiving Community Living Supports or Community Living Supports-Family Model; or
- For individuals who are of legal working age (16+) not receiving Community Living Supports or Community Living Supports-Family Model who, after an Employment Informed Choice Process as defined by TennCare (see below), have decided not to pursue employment; or
- For individuals of retirement age not receiving Community Living Supports or Community Living Supports-Family Model who have made a choice not to pursue further employment opportunities.

For individuals receiving Community Integration Support Services and not participating in employment or employment services, the option to pursue employment should be discussed at least semi-annually.

For individuals receiving Community Living Supports or Community Living Supports-Family Model, all services necessary to support community integration and participation are part of the scope of benefits provided under the CLS or CLS-FM benefit.

For individuals of appropriate age (18+), fading of the service and less dependence on paid support for on-going participation in community activities and relationships is expected. Fading

strategies, similar to those used in Supported Employment Job Coaching, should be utilized. Milestones for the reduction/fading of paid supports and the enhancement of natural supports must be established and monitored for this service.

Payment for registration, materials and supplies for participation in classes, conferences and similar types of activities, or club/association dues can be covered, but cannot exceed $500 per year for children under age 21 or $1,000 per year for adults age 21 and older. These costs are not included in the rates paid to the providers of Community Integration Support Services and must be prior approved before being incurred.

Transportation to and from the service is not included in the rate paid for the service; but transportation during the service (when no-cost forms of transportation are not available or not being accessed) is included in the rate paid for the service.

Independent Living Skills Training

Independent Living Skills Training services provide education and skill development or training to improve the person's ability to independently perform routine daily activities and utilize community resources as specified in the person's person-centered support plan. Services are instructional, focused on development of skills identified in the person-centered support plan and are not intended to provide substitute task performance. Daily living skills training may include only education and skill development related to:

- Personal hygiene;
- Food and meal preparation;
- Home upkeep/maintenance;
- Money management;
- Accessing and using community resources;
- Community mobility;
- Parenting;
- Computer use; and
- Driving evaluation and lessons.

Independent Living Skills Training is intended as a short-term service designed to allow a person not receiving Community Living Supports or Community Living Supports-Family Model to acquire specific additional skills that will support his/her transition to or sustained independent community living. Individuals receiving Independent Living Skills Training must have specific independent-living goals in their person-centered support plan that Independent Living Skills Training is specifically designed to support.

The provider must prepare and follow a specific plan and strategy for teaching specific skills for the independent living goals identified in the person-centered support plan. Systematic instruction and other strategies used in Supported Employment Job Coaching should also be employed in this service. The provider must document monthly progress toward achieving each independent living skill identified in the person-centered support plan.

This service will typically originate from the person's home and take place in the person's home and their home community. Providers of this service should meet people in these natural

environments to provide this service rather than maintaining a separate service location. Transportation during the service (when no-cost forms of transportation are not available or not being accessed) is included in the rate paid for the service.

Individuals receiving Community Living Supports or Community Living Supports-Family Model are not eligible to receive this service, since the scope of benefits provided to a person under the CLS and CLS-FM benefits include habilitation training and supports to help the person achieve maximum independence and sustained community living.

NON-RESIDENTIAL HABILITATION SERVICES
Employment Informed Choice Process

As part of Support Coordination responsibilities, an Employment Informed Choice Process must be completed by the MCO for all working age individuals prior to authorization of Non-Work Services/Supports included in the ECF Non-Residential Habilitation Services Category (Community Integration Support Services and Daily Living Skills Training that do not wrap employment or employment services (Supported Employment Individual or Small Group services and/or Integrated Employment Path Services).

Employment Informed Choice Process required components:

1. Initial meeting with individual and involved family, guardian and conservator (as applicable) to provide an orientation to employment, including Supported Employment services, how it works, including the role of VR and basic benefits education. Describe Exploration and Discovery Services, and discuss questions/concerns/hopes.
2. Authorize Exploration service included under Supported Employment-Individual Employment Supports.
3. Upon completion of Exploration services and receipt of the written report, if the individual wishes to pursue individualized, integrated employment or self-employment, proceed with authorization of appropriate service(s) which may include Community Integration Support Services as wraparound.
4. If the individual has not decided to pursue individualized, integrated employment or self-employment, meet with the individual and involved family, guardian, conservator (if applicable) to review results of Exploration services, provide re-education or additional education on the benefits of employment and supports available for employment. If the person still declines to pursue employment and declines to participate in any employment service, obtain written confirmation of the person's informed choice not to pursue individualized, integrated employment or self-employment at this time. For persons not receiving Community Living Supports or Community Living Supports-Family Model services, Non-Work Services/Supports included in the ECF Non-Residential Habilitation Services Category may then be authorized up to a combined maximum of twenty (20) hours per week.

II. OTHER ECF SERVICES:

Personal Assistance:

A range of services and supports designed to assist an individual with a disability to perform activities and instrumental activities of daily living at the person's own home, on the job or in the community that the individual would typically do for themselves if he/she did not have a disability. Personal Assistance services may be provided outside of the person's home as long as the outcomes are consistent with the supports defined in the person-centered support plan with the goal of ensuring full participation and inclusion.

Personal Assistance services may be used to:

- Support the person at home in getting ready for work and/or community participation;
- Support the person in getting to work and/or community participation opportunities; and
- Support the person in the workplace and/or in the broader community.

The only exception is if Supported Employment Services or Community Integration Support Services are being provided, in which case the provider of Supported Employment and/or Community Integration Support Services shall be responsible for personal assistance needs during the hours that Supported Employment services are provided as long as the Personal Assistance Services do not comprise the entirety of the Supported Employment or Community Integration Support Service. If a person only needs personal assistance to participate in employment or community opportunities, then this service should be authorized rather than Supported Employment or Community Integration Support Services.

Personal Assistance services that are covered also include the following:

- Support, supervision and engaging participation with eating, toileting, personal hygiene and grooming, and other activities of daily living as appropriate and needed to sustain community living, except when provided as a component of another covered service the person is receiving at that time; and
- Direction and training to individuals in the person's social network or to his/her co-workers who choose to learn how to provide some of the Personal Assistance services.

In the Comprehensive Supports for Employment and Community Living Benefit Group, Personal Assistance services will be limited to 215 hours per month. An MCO may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered benefits.

Community Transportation:
Community Transportation services are non-medical transportation services offered in order to enable individuals, and their personal assistants as needed, to gain access to employment, community life, activities and resources that are identified in the person-centered support plan. These services allow individuals to get to and from typical day-to-day, non-medical activities such as individualized integrated employment or self-employment (if not home-based), the grocery store or bank, social events, clubs and associations and other civic activities, or attending a worship service. This service is made available when public or other no-cost community-based transportation services are not available and the person does not have access to transportation through any other means (including natural supports).

Whenever possible, family, neighbors, co-workers, carpools or friends are utilized to provide transportation assistance without charge. When this service is authorized, the most cost-effective

option should be considered first. This service is in addition to the medical transportation service offered under the Medicaid State Plan, which includes transportation to medical appointments as well as emergency medical transportation.

Community Living Supports
As defined in Attachment D.

Community Living Supports-Family Model
As defined in Attachment D.

Assistive Technology, Adaptive Equipment and Supplies:
An item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities and to support the individual's increased independence in the home, community living and participation, and individualized integrated employment or self-employment. The service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required by the person to increase, maintain or improve his/her functional capacity to perform daily tasks in the community and in employment that would not be possible otherwise. All items must meet applicable standards of manufacture, design and installation. The person-centered support plan must include strategies for training the individual and any others who the individual will or may rely on in effectively using the assistive technology or adaptive equipment (e.g. his/her support staff; co-workers and supervisors in the place of employment; natural supports).

Assistive Technology Equipment and Supplies also covers the following:

- Evaluation and assessment of the assistive technology and adaptive equipment needs of the individual by an appropriate professional, including a functional evaluation of the impact of the provision of appropriate assistive technology and adaptive equipment through equipment trials and appropriate services to him/her in all environments with which the person interacts over the course of any 24 hour day, including the home, integrated employment setting(s) and community integration locations;
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, updating, repairing, or replacing assistive technology devices and adaptive equipment;
- Adaptive equipment to enable the individual to feed him/herself and/or complete oral hygiene as indicated while at home, work or in the community (e.g. utensils, gripping aid for utensils, adjustable universal utensil cuff, utensil holder, scooper trays, cups, bowls, plates, plate guards, non-skid pads for plates/bowls, wheelchair cup holders, adaptive cups that are specifically designed to allow a person to feed him/herself or for someone to safely assist a person to eat and drink, and adaptive toothbrushes);
- Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the person-centered support plan;
- Training, programming, demonstrations or technical assistance for the individual and for his/her providers of support (whether paid or unpaid) to facilitate the person's use of the assistive technology and adaptive equipment;
- Adaptive switches and attachments;

- Adaptive toileting equipment;
- Communication devices and aids that enable the person to perceive, control or communicate with the environment, including a variety of devices for augmentative communication;
- Assistive devices for persons with hearing and vision loss (e.g. assistive listening devices, TDD, large visual display services, Braille screen communicators, FM systems, volume control telephones, large print telephones and tele touch systems and long white canes with appropriate tips to identify footpath information for people with visual impairment
- Computer equipment, adaptive peripherals and adaptive workstations to accommodate active participation in the workplace and in the community;
- Software also is approved when required to operate accessories included for environmental control;
- Pre-paid, pre-programmed cellular phones that allow an individual who is participating in employment or community integration activities without paid or natural supports and who may need assistance due to an accident, injury or inability to find the way home. The person's Individual Support Plan outlines a protocol that is followed if the individual has an urgent need to request help while in the community;
- Such other durable and non-durable medical equipment not available under the State Plan that is necessary to address functional limitations in the community, in the workplace, and in the home;
- Repairs of equipment is covered for items purchased through this waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The individual must own any piece of equipment that is repaired.

A written recommendation by an appropriate professional must be obtained to ensure that the equipment will meet the needs of the person. The recommendation of the Job Accommodation Networks (JAN) will meet this requirement for worksite technology. Depending upon the financial size of the employer or the public entity, those settings may be required to provide some of these items as part of their legal obligations under Title I or Title III of the ADA. Federal financial participation is not claimed for accommodations that are the legal responsibility of an employer or public entity, pursuant to Title I or Title III of the ADA.

ECF CHOICES will not cover Assistive Technology or Adaptive Equipment and services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Assistive Technology, Adaptive Equipment and Supplies shall be limited to $5,000 per person per calendar year. An MCO may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered benefits.

Minor Home Modifications

As defined in Attachment D, including applicable limitations.

Individual Education and Training Services:
Reimbursement up to $500 per year to offset the costs of training programs, workshops and conferences that help the person develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. This service may include education and training for participants, their caregivers and/or legal representatives that is directly related to building or acquiring such skills. Managed care organizations assure that information about educational and/or training opportunities is available to participants and their caregivers and legal representatives. Covered expenses may include enrollment fees, books and other educational materials and transportation related to participation in training courses, conferences and other similar events. Limited to $500 per individual per year.

Peer–to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living.
These services assist an individual and his/her family member(s) or conservator in one or more of the following areas:

- Directing the person-centered planning process;
- Understanding and considering self-direction;
- Understanding and considering individualized integrated employment/self-employment; and
- Understanding and considering independent community living options.

The service involves addressing questions and concerns related to such options. Services are provided by a peer who has successfully directed his or her person-centered planning process, self-directed his or her own services, successfully obtained individualized integrated employment or self-employment and/or utilized independent living options.

Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living services are provided by individuals with intellectual or developmental disabilities (with paid supports if needed) who have successfully directed their person-centered planning processes, and/or self-directed their own services, and/or successfully utilized independent living options. Individuals with intellectual or developmental disabilities qualified to provide these services will have also completed training in best practices for offering peer to peer supports in the areas covered by this service.

Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living services are focused on mentoring and training others based upon their personal experience and success in one or more areas this service is focused on. A qualified service provider understands, empathizes with and can support three important areas important for enhancing self-esteem:

- The human need for connections;
- Overcoming the disabling power of learned helplessness, low expectations and the stigma of labels; and,
- Supporting self-advocacy, self-determination and informed choice in decision making.

The Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living service provider offers:

- One-on-one training and information to encourage the person to lead their person-centered planning process, pursue self-direction, seek integrated employment/self-employment and/or independent community living options;
- Education on informed decision making, risk taking, and natural consequences;
- Education on self-direction, including recruiting, hiring and supervising staff;
- Planning support regarding integrated employment
- Planning support regarding independent community living opportunities, including selection of living arrangements and housemates; and
- Assistance with identifying potential opportunities for community participation, the development of valued social relationships, and expanding unpaid supports to address individual needs in addition to paid services.

These services are intended to support an individual in knowledge and skill acquisition and should not be provided on an ongoing basis, nor should these services be provided for companionship purposes. Reimbursement shall be limited to $1,500 per person per lifetime.

Specialized Consultation and Training:
Expertise, training and technical assistance in one or more specialty areas (behavior services, occupational therapy, physical therapy, speech language pathology, nutrition, orientation and mobility, or nurse education, training and delegation) to assist paid or natural or co-worker supports in supporting individuals who have long-term intervention needs, consistent with the person-centered support plan, therefore increasing the effectiveness of the specialized therapy or service. This service also is used to allow the specialists listed above to be an integral part of the person-centered planning team, as needed, to participate in team meetings and provide additional intensive consultation for individuals whose functional, medical or behavioral needs are determined to be complex. The consultation staff and the paid support staff are able to bill for their service time concurrently. Activities that are covered include:

- Observing the individual to determine and assess functional, medical or behavioral needs;
- Assessing any current interventions for effectiveness;
- Developing a written, easy-to-understand intervention plan, which may include recommendations for assistive technology/equipment, workplace and community integration site modifications; the Intervention plan will clearly define the interventions, activities and expected timeline for completion of activities;
- Identification of activities and outcomes to be carried out by paid and natural supports and co-workers;
- Training of family caregivers or paid support personnel on how to implement the specific interventions/supports detailed in the intervention plan; in the case of nurse education, training and delegation, shall include specific training, assessment of competency, and delegation of skilled nursing tasks to be performed as permitted under state law;
- Development of and training on how to observe, record data and monitor implementation of therapeutic interventions/support strategies;
- Monitoring the individual, family caregivers and/or the supports personnel during the

implementation of the plan;

- Reviewing documentation and evaluating the activities conducted by relevant persons as detailed in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes or revision of the plan as needed;
- Participating in team meetings; and/or,
- Tele-Consulting, as permitted under state law, through the use of two-way, real time-interactive audio and video between places of greater and lesser clinical expertise to provide clinical consultation services when distance separates the clinical expert from the individual.

Specialized Consultation Services are provided by a certified, licensed, and/or registered professional or qualified assistive technology professional appropriate to carry out the relevant therapeutic interventions.

Specialized Consultation Services are limited to $5,000 per person per calendar year, except for adults in the Comprehensive Supports for Employment and Community Living benefit group determined to have exceptional medical and/or behavioral support needs.

For adults in the Comprehensive Supports for Employment and Community Living benefit group determined to have exceptional medical and/or behavioral support needs, Specialized Consultation Services shall be limited to $10,000 per person per calendar year.

An MCO may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered benefits.

Adult Dental Services

Preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments to relieve pain and infection) which have dental procedure codes listed in the current TennCare Maximum Reimbursement Rate Schedule for Dental Services that is used specifically for adult dental services provided under the State's Section 1915(c) waivers for individuals with intellectual disabilities; and intravenous sedation or other anesthesia services provided in the dentist's office by, and billed by, the dentist or by a nurse anesthetist or anesthesiologist who meets the waiver provider qualifications.

Orthodontic services are excluded from coverage.

All Dental Services for children enrolled in the waiver are provided through the TennCare EPSDT program. Dental Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

Adult Dental Services shall be limited to a maximum of $5,000 per member per calendar year, and a maximum of $7,500 per member across three (3) consecutive calendar years.

Respite

Respite shall mean services provided to a person supported when unpaid caregivers are absent or

need relief from routine caregiving responsibilities.

Respite shall be limited to 30 days of service per person per calendar year or to 216 hours per person per calendar year, depending on the needs and preferences of the individual as reflected in the Individual Support Plan. (The 2 limits cannot be combined in a calendar year.) Respite services shall be provided in settings that meet the federal HCBS regulatory standards, which promote community involvement and inclusion and which allow individuals to sustain their lifestyle and routines when an unpaid caregiver is absent for a period of time.

Supportive Home Care (SHC):
This service involves the provision of services and supports in the home and community by a paid caregiver who does not live in the family home to an individual living with his or her family that directly assist the individual with activities of daily living and personal needs to insure adequate functioning in their home and maintain community living. Supportive Home Care services may be provided outside of the person's home as long as the outcomes are consistent with the supports defined in the person-centered support plan with the goal of ensuring full participation and inclusion.
Services include:

- Hands-on assistance with activities of daily living such as dressing/undressing, bathing, feeding, toileting, assistance with ambulation (including the use of a walker, cane, etc.), care of hair and care of teeth or dentures. This can also include preparation and cleaning of areas used during personal care activities such as the bathroom and kitchen.
- Observation of the person supported to assure safety, oversight direction of the person to complete activities of daily living or instrumental activities of daily living.
- Routine housecleaning and housekeeping activities performed for the person supported (and not other family members or persons living in the home, as applicable), consisting of tasks that take place on a daily, weekly or other regular basis, including: washing dishes, laundry, dusting, vacuuming, meal preparation and shopping for food and similar activities that do not involve hands-on care of the person.
- Necessary cleaning of vehicles, wheelchairs and other adaptive equipment and home modifications such as ramps.

Family Caregiver Stipend in lieu of Supportive Home Care
A monthly payment to the primary family caregiver of a person supported when the person lives with the family in the family home and the family is providing daily services and supports that would otherwise be defined within the scope of Supportive Home Care services. This service is available only in lieu of Supportive Home Care (including Personal Assistance) services and shall not be authorized for a person receiving Supportive Home Care (including Personal Assistance) services. The funds may be used to compensate lost wage earning opportunities that are entailed in providing support to a family member with a disability and to help offset the cost of other services and supports the person needs that are not covered under this program.

For a child under age 18, the Family Caregiver Stipend shall be limited to $500 per month. For an adult age 18 or older, the Family Caregiver Stipend shall be no more than $1,000 per month. The amount of Family Caregiver Stipend approved shall be based on the needs of the individual taking into account the supports necessary for employment and community integration

and participation, and shall ensure that supports necessary for employment and community integration and participation are provided first, or available to the person through other sources (whether paid or unpaid) or as part of the supports provided by the family caregiver.

Family-to-Family Support
These services provide information, resources, guidance, and support from an experienced and trained parent or other family member to another parent or family caregiver who is the primary unpaid support to a child with intellectual or developmental disabilities enrolled in ECF CHOICES. The service shall include facilitation of parent or family member "matches" and follow-up support to assure the matched relationship meets peer expectations.

Community Support Development, Organization and Navigation
Assists individuals and families in 1) promoting a spirit of personal reliance and contribution, mutual support and community connection; 2) developing social networks and connections within local communities, and 3) emphasizes, promotes and coordinates the use of unpaid supports to address individual and family needs in addition to paid services.

Supports provided include:

- Helping individuals and family caregivers to develop a network for information and mutual support from others who receive services or family caregivers of individuals with disabilities;
- Assisting individuals with disabilities and family caregivers with identifying and utilizing supports available from community service organizations, such as churches, schools, colleges, libraries, neighborhood associations, clubs, recreational entities, businesses and community organizations focused on exchange of services (e.g. time banks); and
- Assisting individuals with disabilities and family caregivers with providing mutual support to one another (through service/support exchange), and contributions offered to others in the community.

These services are provided by a Community Navigator and reimbursed on a per person (or family) per month basis, based on specific goals and objectives as specified in the person-centered support plan.

Family Caregiver Education and Training
This service provides reimbursement up to $500 per year to offset the costs of educational materials, training programs, workshops and conferences that help the family caregiver to:

- Understand the disability of the person supported;
- Achieve greater competence and confidence in providing supports;
- Develop and access community and other resources and supports;
- Develop advocacy skills; and
- Support the person in developing self-advocacy skills.

Family Caregiver Education and Training is offered only for a family caregiver who is providing unpaid support, training, companionship, or supervision for a person participating in ECF CHOICES who is living in the family home. The intent of the service is to provide education and support to the caregiver that preserves the family unit and increases confidence, stamina and

empowerment. Education and training activities are based on the family/caregiver's unique needs and are specifically identified in the person-centered support plan prior to authorization.

Conservatorship and Alternatives to Conservatorship Counseling and Assistance
This service offers up to $500 in one-time consultation, education and assistance to family caregivers in understanding conservatorship and alternatives to conservatorship. These services shall be provided in a manner that seeks to preserve the rights and freedoms of the individual to the maximum extent possible and appropriate. This service may include assistance with completing necessary paperwork and processes to establish an alternative to conservatorship or conservatorship, if appropriate. Reimbursable services may include payment of court fees necessary to formalize an alternative to conservatorship or conservatorship.

Health Insurance Counseling/Forms Assistance
Health Insurance Counseling/Forms Assistance services offers training and assistance to individuals enrolled in ECF CHOICES and/or their family caregiver and policy holder in understanding the benefits offered through their private or public insurance program, completing necessary forms, accessing covered benefits, and navigating member appeal processes regarding covered benefits. An insurance company or its affiliate shall not be reimbursed for providing this service.

This is a time-limited service intended to develop the person and/or family caregiver's understanding and capacity to self-manage insurance benefits. Reimbursement shall be limited to 15 hours per person per year.

Persons choosing to receive this service must agree to complete an online assessment of its efficacy following the conclusion of counseling and/or forms assistance.