



TennCare Operational Protocol

**Incorporating the October 5, 2007
Demonstration Extension**

**Bureau of TennCare
Nashville, Tennessee**

Revised Through November 2009

Disclaimer

The purpose of the TennCare Operational Protocol is to provide a general description of how the TennCare Demonstration functions. This is not an exhaustive discussion of the TennCare Demonstration, nor is it a legal document. It is a very basic discussion of the Demonstration and a referral to other documents that provide more information about the TennCare program.

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List of Abbreviations Used in This Document

ACCENT	Automated Client Certification and Eligibility Network for Tennessee
ADA-CDT	American Dental Association—Current Dental Terminology
BDCHMI	Bad Debt, Charity, and Medically Indigent Costs
BPN	Best Practice Network
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control and Prevention
CHOICES	The Long-Term Care Community CHOICES Act of 2008 or The TennCare program in which long-term care services for those qualifying are integrated into TennCare’s managed care delivery system (context of use)
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPE	Certified Public Expenditure
CPT	Current Procedural Terminology
CRA	Contractor Risk Agreement
DBM	Dental Benefits Manager
DCS	[Tennessee] Department of Children’s Services
DESI	Drug Efficacy Study Implementation
DHS	[Tennessee] Department of Human Services
DIDS	Division of Intellectual Disability Services (formerly Division of Mental Retardation Services)
DMHDD	See <i>TDMHDD</i>
DOH	[Tennessee] Department of Health
DSH	Disproportionate Share Hospital
EAH	Essential Access Hospital
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
FFP	Federal Financial Participation
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
FY	Fiscal Year
GHR	General Hospital Rate
HCBS	Home and Community Based Services
HCFA	Health Care Financing Administration (see CMS)
HCPCS	HCFA Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HEDIS	Health Plan Employer Data and Information Set
ICD-9	International Classification of Diseases, 9 th Revision
ICF/MR	Intermediate Care Facility for persons with Mental Retardation
IHS	Indian Health Service
IRS	Internal Revenue Service; or Identical, Related, or Similar [Drugs] (context of use)
IS	Information Systems
LTE	Less Than Effective [Drugs]
MCC	Managed Care Contractor

MCO	Managed Care Organization
MDSA	Medicare Disproportionate Share Adjustment
ME	Medically Eligible
MEGs	Medicaid Eligibility Groups
MEQC	Medicaid Eligibility Quality Control
MNIS	Medically Needy Income Standard
MR	Mental Retardation
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
PBM	Pharmacy Benefits Manager
PCP	Primary Care Provider
PLHSO	Prepaid Limited Health Service Organization
PMPM	Per Member Per Month
POS	Point of Service
PSA	Public Service Announcement
RFI	Request for Information
SED	Seriously Emotionally Disturbed
SFY	State Fiscal Year (July 1 through June 30)
SPA	State Plan Amendment
SPMI	Severely and/or Persistently Mentally Ill
SSA	Social Security Administration
SSD	Standard Spend Down
SSI	Supplemental Security Income
STC	Special Terms and Conditions
<i>T.C.A.</i>	<i>Tennessee Code Annotated</i>
TANF	Temporary Aid to Needy Families
TCMIS	TennCare Management Information System
TDCI	Tennessee Department of Commerce and Insurance
TDMHDD	Tennessee Department of Mental Health and Developmental Disabilities
TRHCA	Tax Relief & Health Care Act of 2006
TPA	Third Party Administrator
TPG	Target Population Group
TPL	Third Party Liability
TSU	TennCare Solutions Unit
YDC	Youth Development Center

List of “User Friendly” Definitions

Note: For legal purposes, the definitions in the state rules and the state’s contracts are to be used. The following list is intended to provide “user friendly” definitions for general reference only.

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-day basis is living in the home with the individuals for whom they are providing care.

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.

Applicant. A person who has applied for TennCare but whose application has not been approved or denied.

Assisted Care Living Facility Services (ACLF). Community-based residential alternative to nursing home care in a licensed Assisted Care Living Care Facility that provides and/or arranges for daily meals, personal, 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, a strobe light to signify the smoke alarm has been activated, etc.

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. This may include assistance with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation; 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 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.

Call-in Line. This is the toll-free number that is used as the single point of entry during an open enrollment period to accept new applications for Standard Spend Down.

Capitation Payment. The fee which is paid by the State to a managed care contractor operating under a risk-based contract for each enrollee covered by the plan for the provision of medical services, whether or not the enrollee utilizes services or without regard to the amount of services utilized during the payment period.

Caretaker Relative. A relative who is taking care of a Medicaid-eligible child. Caretaker relatives may be eligible for the Standard Spend Down (SSD) program if they meet the program criteria.

Case. A household that includes some members who are TennCare eligible.

CHOICES 1. An individual who is receiving Medicaid-reimbursed care in a Nursing Facility (NF).

CHOICES 2. Persons age 65 and older or 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 217-Like demonstration population, and who need and are receiving HCBS as an alternative to NF care.

CHOICES 217-Like HCBS Group. Persons age 65 and older or adults age 21 and older with physical disabilities who: (1) meet the CHOICES NF level of care requirement; (2) are receiving HCBS; and (3) would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 and Section 1924 of the Social Security Act, if the HCBS were provided under a 1915(c) waiver. With the implementation of CHOICES, the Bureau will no longer provide HCBS under a 1915(c) waiver.

Closed enrollment. A period of time during which the only persons who can enroll in TennCare as new members are those found eligible in an active Medicaid category.

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, and companion care.

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 or his/her behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.

Consumer Assessment of Healthcare Providers and Systems (CAHPS). A set of standardized surveys that measure patient satisfaction with experience of care. CAHPS is sponsored by the Agency for Healthcare Research and Quality (AHRQ).

Contractor Risk Agreement (CRA). The document that describes the terms of the agreement entered into by the Bureau of TennCare and the managed care contractor.

Cost-effective Alternative. Services provided at the sole discretion of the managed care contractor, but have been approved by CMS and the Bureau, that the managed care contractor believes can meet the enrollee's needs at a lower cost than a covered service. TennCare enrollees are not entitled to receive these services.

Cost Neutrality Test. The requirement that the cost of providing care to a member in CHOICES Group 2, including HCBS, home health, and private duty nursing, shall not exceed the cost of providing nursing facility services to the member.

Covered Services. Those services, medical, mental health and substance abuse, dental, and pharmacy, listed in TennCare Medicaid rules 1200-13-13-.04 and TennCare Standard rules 1200-13-14-.04 as being available to TennCare enrollees through their managed care contractor, and are paid for by the Bureau. As related to CHOICES, the additional covered services provided to CHOICES members are found at Waiver STC 30h – Table 2b.

Demonstration eligible. Persons who are not eligible under Tennessee's State plan (Medicaid) but who are otherwise eligible for the TennCare Demonstration project. Demonstration eligibles are enrolled in TennCare Standard.

Demonstration project. A project approved by the Centers for Medicare and Medicaid Services that allows certain Medicaid statutes and regulations to be "waived" for the purpose of "demonstrating" or "testing" a principle or set of principles about health care. TennCare is a demonstration project designed to show that a managed care approach can be used to extend coverage to people who would not otherwise be eligible for Medicaid, without costing the state more money than the state would have spent on a Medicaid program only and without compromising service quality.

Dental Benefits Manager (DBM). A contractor approved by the Tennessee Department of Finance and Administration to provide dental benefits to enrollees in the TennCare Program to the extent that such services are covered by TennCare.

Discontinued Demonstration Group. A group of non-Medicaid-eligible individuals who were enrolled in TennCare Standard on April 29, 2005, when the categories in which they were enrolled were terminated. These individuals have not yet been enrolled in TennCare Medicaid or disenrolled from the TennCare program.

Disenrollment. This term is used in two ways by TennCare. 42 CFR 438.56 uses the term "disenrollment" to refer to the process by which individuals change MCOs. TennCare has historically used the term "disenrollment" to refer to the process by which a person who has lost eligibility for TennCare is removed from the program. STC Section

XIII, Part 1 uses the term “disenrollment” in this manner. The proper interpretation of the term thus depends upon the context in which it is used.

Dual eligible. A person who is eligible for both Medicare and TennCare, meaning he is eligible in a TennCare category that permits access to insurance AND he has Medicare.

A “true dual” is a person who is entitled to all the benefits of Medicare and all the benefits of TennCare. He gets most of his services from Medicare, and he also gets the services TennCare covers that Medicare does not cover. Two examples of services that TennCare covers but Medicare does not are non-emergency transportation and mental health case management.

Eligible. A person who has been determined eligible to receive services and benefits under the TennCare program. As it relates to CHOICES, a person is eligible to receive CHOICES benefits only if he has been enrolled in CHOICES by TennCare.

Enrollee. A person who has been determined eligible for TennCare and who has been enrolled in the program.

Family. Parents and related children who live together in the same household. "Related" individuals include parents' spouses who live in the home, as well as siblings, half-siblings, and step-siblings. Caretakers (such as grandparents) who are not parents but who are present in the home are not included in the definition of "family" unless they request to be included. Children living at home are removed from the "family" once they turn 21 (for TennCare Medicaid) or they marry, whichever comes first. Children turning 19 and enrolled in TennCare Standard are reverified separately for eligibility in other categories as enrollment in TennCare Standard is currently closed.

Fraud. An intentional deception or misrepresentation made by a person who knows, or should have known, that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Health Maintenance Organization (HMO). An entity licensed by the Tennessee Department of Commerce and Insurance under applicable provisions of *Tennessee Code Annotated (T.C.A.)* Title 56, Chapter 32 to provide health care services.

Health Plan. A managed care organization (MCO) authorized by the Tennessee Department of Finance and Administration to provide medical and behavioral services to enrollees in the TennCare program.

Health Plan Employer Data and Information Set (HEDIS). The most widely used set of performance measures in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA).

Home and Community-Based Services (HCBS). Services not covered by Tennessee’s Title XIX state plan that are provided as an alternative to long-term care institutional services in a NF or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). HCBS does not include home health or private duty nursing services.

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. 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 a 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.

Immediate eligibility. A process by which children entering state custody (other than those going into Youth Development Centers) are assigned to TennCare Select so that they can start receiving TennCare-reimbursed health care services immediately. If the result of the eligibility determination process is that the child is not eligible for TennCare, DCS will refund to TennCare Select any payments made on the child's behalf.

There is also an immediate eligibility process for persons applying to enroll in the Statewide Home and Community Based Services Waiver for the Elderly and Disabled as set forth in State Rule 1200-13-1-.02(5). This allows an individual to begin receiving home and community based long term care services sooner than he otherwise would, in order to avoid institutionalization. To qualify for immediate eligibility, a person must be applying for enrollment into an applicable HCBS waiver program, be determined by TennCare to meet eligibility criteria for admission to a Level I Nursing Facility, as applicable (i.e., have an approved Pre-Admission Evaluation), have submitted an application for financial eligibility determination to DHS, and be expected, based on preliminary review of financial information, to qualify for TennCare Medicaid. If the result of the eligibility determination process by DHS is that the person is not eligible for TennCare Medicaid, any long term care services provided will be reimbursed with state funds, and FFP will not be claimed.

As is relates to CHOICES, a mechanism by which the State can, based on preliminary determination of a person's eligibility for the CHOICES 217-Like HCBS Group, enroll the person into CHOICES Group 2 and provide immediate access to a limited package of HCBS pending a final determination of eligibility. To qualify for immediate eligibility, a person must be applying to receive covered HCBS, be determined by TennCare to meet NF level of care, have submitted an application for financial eligibility determination to DHS, and be expected to qualify for CHOICES 2 based on a review of the financial information provided by the applicant. Immediate eligibility shall only be for specified HCBS (no other covered services) and for a maximum of 45 days.

Income. Monies received such as salaries, wages, pensions, certain rental income, interest income, dividends, royalties, etc., which produce a gain or a benefit to the recipient.

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.

Institutionalized. TennCare enrollees who are receiving TennCare-reimbursed long term care in nursing facilities, intermediate care facilities for persons with mental retardation, or under a home and community based services waiver program.

Managed Care Contractor (MCC).

- (a) A managed care organization, pharmacy benefits manager, and/or dental benefits manager, which has signed a TennCare Contractor Risk Agreement with the State and operates a provider network and provides covered health services to TennCare enrollees; or
- (b) A pharmacy benefits manager, behavioral health organization, or dental benefits manager which subcontracts with a managed care organization to provide services; or
- (c) A State government agency (i.e., Department of Children's Services and the Division of Mental Retardation Services) that contracts with TennCare for the provision of services.

Managed Care Organization (MCO). This is an appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical and behavioral services in the TennCare program.

Marketing. TennCare uses the term "marketing" to refer to all contacts made by managed care entities with enrollees, including letters, enrollee satisfaction surveys, newsletters, etc.

Medicaid. The program for medical assistance provided under Title XIX of the Social Security Act for certain persons with low incomes and special circumstances. Medicaid programs are administered jointly by the state and the federal government. The parameters under which the Bureau operates its Medicaid program are found in the Medicaid State plan.

Medicaid-eligible. People who are eligible under the Medicaid State plan (otherwise known as "TennCare Medicaid").

Medicaid Rollovers. Persons who are under age 19 who lack access to insurance and whose Medicaid eligibility is ending. These persons must have incomes below 200% of poverty OR be determined "Medically Eligible" at any income level in order to "roll over" into TennCare Standard. Medicaid Rollovers must complete their applications within specified time periods.

Medically Eligible. An uninsured person under age 19 who is not Medicaid eligible, and who qualifies for TennCare Standard based on certain medical conditions.

Medically Necessary. This term is defined in T.C.A. 71-5-144 as a medical item or service that meets the criteria in that statute, and applies to TennCare enrollees. An enrollee is not entitled to receive and TennCare shall not be required to pay for any items or services that do not satisfy all criteria of “medically necessary” items or services, as defined in the statute or in the Medical Necessity rule chapter at 1200-13-16.

Medically Needy. A category of TennCare Medicaid eligibles as defined in rule 1240-3-2-.03 of the Tennessee Department of Human Services – Division of Medical Services.

Medicare. The program for medical assistance provided under Title XVIII of the Social Security Act for elderly and certain disabled individuals. The Medicare program is administered solely by the federal government.

Minor Home Modification. 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 increases 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 of roof, ceiling, walls, 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.

National Committee for Quality Assurance (NCQA). A nonprofit organization committed to assessing, reporting on, and improving the quality of care provided by organized delivery systems. Useful information on NCQA may be accessed at the NCQA website: www.ncqa.org.

Nursing Facility (NF) Care. See Social Security Act, Section 1919(a).

Open enrollment. A period of time announced by the state during which enrollment in the SSD program is open and applications for that category are being taken.

Personal Care Visits. Intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day 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; 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.

Pharmacy Benefits Manager (PBM). An organization approved by the Tennessee Department of Finance and Administration to provide pharmacy benefits to enrollees to the extent such services are covered by the TennCare Program. A PBM may have signed a TennCare Contractor Risk Agreement with the State, or may be a subcontractor to an MCO.

Poverty Level (aka, Federal Poverty Level [FPL]). The poverty level is another version of the federal poverty measure (the first being poverty thresholds). The use of poverty levels is a simplification of the poverty thresholds for use for administrative purposes – for example – determining eligibility for TennCare. The poverty levels are established each year by the Federal government and usually published in January or February.

Presumptive eligibility. An established period of time (45 days) during which certain individuals — pregnant women; women identified by the Centers for Disease Control and Prevention (CDC) as being uninsured and needing treatment for breast or cervical cancer — are eligible for Medicaid. During this period of time the presumptively-eligible person must complete an application and qualify for Medicaid in order to stay on the program.

Redetermination. The annual process that occurs for all TennCare Medicaid and Standard enrollees during which they must provide documentation that they continue to meet the eligibility requirements for TennCare in order to stay on the program.

Reduction, Suspension, or Termination of benefits. The acts or omissions by TennCare or others acting on its behalf (i.e., MCCs, other State agencies under contract

with TennCare) which interrupts a course of necessary clinical treatment for a continuing spell or medical condition.

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: accommodation of a phased-in implementation of the CHOICES program; discharge from 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 accordance with the STCs of the TennCare II Waiver.

Resources. Assets such as savings accounts, personal property, etc., which are available to an individual. Resources are not counted for persons in the Demonstration population. However, enrollees in the TennCare Standard Spend Down (SSD) population will have resources counted in accordance with the criteria that apply to Medically Needy pregnant women and children under the State Plan.

Retroactive eligibility. Eligibility which begins as of a date in the past. TennCare eligibility is effective on the date of application, if the applicant is subsequently approved, or the date of the qualifying event (such as the date that spend down is met), whichever is later. TennCare eligibles do not get automatic periods of retroactive eligibility in Tennessee as Medicaid eligibles do in other states. This regulation was "waived" for the TennCare Demonstration project, since it is difficult to manage care for people whose enrollment date is prior to their enrollment into a managed care plan.

Room and Board. Refers to lodging, meals, and utilities. The kinds of items that are considered "room and board" and therefore are 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 (NF) Care. The provision of NF care for up to no more than 90 days to a CHOICES 2 participant who was receiving home and community-based services (HCBS) upon admission and who requires temporary placement in a NF – 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 member must meet the nursing facility level of care upon admission and in such case, while receiving short-term nursing facility care may continue enrollment in CHOICES 2 pending discharge from the NF 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.

Single Point of Entry. TennCare or its designee responsible for screening those individuals wishing to enroll in the CHOICES program, using the tools and protocols specified by TennCare to make such determinations. Such screening process shall assess: (1) whether the applicant appears to meet categorical and financial eligibility criteria for CHOICES; (2) whether the applicant appears to meet NF level of care; and (3) for applicants seeking access to HCBS through enrollment in CHOICES Group 2, whether it appears that the applicant's needs can be safely and effectively met in the community and at a cost that does not exceed NF care.

Special Terms and Conditions (STCs). The provisions approved by CMS and agreed to by the Bureau, which govern the operation of the TennCare Demonstration project.

Spend Down. A term associated with the Medicaid Medically Needy program, which is an optional eligibility category that states may choose to cover in their Medicaid programs. (See 42 CFR 436 Subpart D.) To "spend down" means that one has a sufficient amount of unreimbursed medical bills to reduce his monthly income to the state's Medically Needy Income Standard (MNIS). TennCare covers pregnant women and children to age 21 in its Medicaid Medically Needy program.

Standard Spend Down (SSD). An eligibility category in TennCare Standard. Standard Spend Down enrollees are defined as non-pregnant adults, aged 21 and older who are aged, blind, disabled, or caretaker relatives of Medicaid-eligible children and who have met spend down criteria patterned after the criteria used in the Medicaid Medically Needy program. The SSD program will have an enrollment target of 100,000 people.

State Children's Health Insurance Program (SCHIP). SCHIP is a program that offers coverage to uninsured children. Tennessee's SCHIP program is called "CoverKids." Uninsured TennCare Standard children with incomes below 200% of poverty are considered "SCHIP children" in the TennCare II extension. By being "SCHIP children," the funding for their services comes from Title XXI rather than Title XIX.

State Plan. A State Medicaid Plan outlines the design of each state's Medicaid program to the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicaid. Once CMS approves the original Plan, they must also approve all future changes (State Plan Amendments) to the Plan before any changes become effective.

Supplemental Security Income (SSI). A benefit program administered by the Social Security Administration (SSA) for those meeting program eligibility requirements. In Tennessee, residents determined to be eligible for SSI benefits are automatically enrolled in TennCare Medicaid.

TennCare CHOICES in Long-Term Care (CHOICES). A program to provide long-term care benefits to TennCare eligibles aged 65 and older or adults age 21 and older with physical disabilities through TennCare's managed care delivery system.

Transitional Medicaid. The availability of continuing Medicaid coverage for a period after an individual has ceased receiving benefits under the Families First (TANF) program.

Uninsurable. Under the previous TennCare demonstration, a person who did not have insurance, who did not have access to insurance other than Medicare, and who had been turned down for insurance because of a health condition. This category is replaced by “Medically Eligible” in the new demonstration.

Uninsured. A person who is not insured and who lacks access to group health insurance.

Valid Factual Dispute. A dispute which, if resolved in favor of the enrollee, would result in the proposed action not being taken. A valid factual dispute, for example, would be the Bureau having the wrong age or sex for the enrollee that result in the enrollee being denied an age- or sex-related service.

Waiver. See definition of “Demonstration Project.”

Understanding TennCare Terms

TennCare is the name for the state's Section 1115(a) managed care demonstration.

TennCare Select is the name of the managed care plan that is contracted by the state to handle certain populations and to be available in any area where there is inadequate MCO capacity. TennCare Select is also intended to serve as a back-up if one of the other managed care plans leaves the project unexpectedly.

TennCare Medicaid is the name for the package of benefits available for people who are eligible for Medicaid.

TennCare Standard is the name for the package of benefits available for individuals who are uninsured, low-income children already in TennCare Standard or are "Medicaid Rollovers," Medically Eligible children, adults enrolled in the Standard Spend Down program, or those adults who are eligible in the CHOICES 217-Like HCBS Group. Persons enrolled in TennCare Standard are not eligible in any Medicaid category.

TennCare CHOICES is the program which provides long-term care services through TennCare's managed care delivery system. The purpose of CHOICES is to demonstrate that long-term care services can be offered within the context of a managed care environment and can result in more options for people who are elderly or disabled and who would otherwise require nursing facility care. These options would allow eligible individuals to remain in their homes and communities rather than having to enter nursing facilities.