

12-22-12

STATE OF TENNESSEE

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December 20, 2012

The Honorable Tre Hargett  
Secretary of State  
First Floor  
State Capitol  
Nashville, Tennessee 37243

Re: TennCare Rule 1200-13-01-.05

Dear Secretary Hargett:

Prompted by the discovery of several numbering errors in the Bureau of TennCare's Rulemaking Hearing amendments of Rule 1200-13-01-.05, as filed with the Secretary of State on September 26, 2012, and in accordance with the suggestion of your Director of Publications, the Bureau of TennCare has requested that I submit this letter and attachment to you.

Please find attached the final version of Rule 1200-13-01-.05 TennCare CHOICES Program, in its entirety, as contemplated by the amendments made by the Emergency Rule filed with your office on June 29, 2012, and the Rulemaking Hearing Rule filed with your office on September 26, 2012. The filings were approved as to legality by this office on June 28 and September 25, 2012, respectively.

Sincerely,

Robert E. Cooper, Jr.  
Attorney General and Reporter

Attachment

REC/sas

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SECRETARY OF STATE  
RECORDS MANAGEMENT

## 1200-13-01-.05 TENNCARE CHOICES PROGRAM.

- (1) Definitions. See Rule 1200-13-01-.02.
- (2) Program components. The TennCare CHOICES Program is a managed LTSS program that is administered by the TennCare MCOs under contract with the Bureau. The MCOs are responsible for coordinating all covered physical, behavioral, and LTSS for their Members who qualify for and are enrolled in CHOICES. The program consists of two components:
  - (a) NF services, as described in this Chapter.
  - (b) CHOICES HCBS, as described in this Chapter.
- (3) Eligibility for CHOICES.
  - (a) There are three (3) groups in TennCare CHOICES:
    1. CHOICES Group 1. Participation in CHOICES Group 1 is limited to TennCare Members of all ages who qualify for and are receiving TennCare-reimbursed NF services. Eligibility for TennCare-reimbursed LTSS is determined by DHS. Medical (or LOC) eligibility is determined by the Bureau as specified in Rule 1200-13-01-.10. Persons in CHOICES Group 1 must be enrolled in TennCare Medicaid or in the CHOICES 1 and 2 Carryover Group and qualify for TennCare reimbursement of LTSS. Persons who qualify in the CHOICES 1 and 2 Carryover Group are enrolled in TennCare Standard.
    2. CHOICES Group 2.
      - (i) Participation in CHOICES Group 2 is limited to TennCare Members who qualify for and are receiving TennCare-reimbursed CHOICES HCBS. To be eligible for CHOICES Group 2, Applicants must meet the following criteria:
        - (I) Be in one of the defined target populations;
        - (II) Qualify in one of the specified eligibility categories;
        - (III) Meet NF LOC; and
        - (IV) Have needs that can be safely and appropriately met in the community and at a cost that does not exceed their Individual Cost Neutrality Cap as defined in Rule 1200-13-01-.02.
      - (ii) Target Populations for CHOICES Group 2. Only persons in one of the target populations below may qualify to enroll in CHOICES Group 2:
        - (I) Persons age sixty-five (65) and older.
        - (II) Persons twenty-one (21) years of age and older who have one or more physical disabilities as defined in Rule 1200-13-01-.02.
      - (iii) Eligibility Categories Served in CHOICES Group 2. Participation in CHOICES Group 2 is limited to TennCare Members who qualify in one of the following eligibility categories:
        - (I) SSI eligibles, who are determined eligible for SSI by the Social Security Administration. SSI eligibles are enrolled in TennCare Medicaid.
        - (II) The CHOICES 217-Like Group, as defined in Rule 1200-13-01-.02. Financial and categorical eligibility are determined by DHS. Persons who qualify in the CHOICES 217-Like Group in accordance with Rule 1200-13-14-.02 are enrolled in TennCare Standard.

- (III) The CHOICES 1 and 2 Carryover Group, as defined in Rule 1200-13-01-.02. Financial and categorical eligibility are determined by DHS. Persons who qualify in the CHOICES 1 and 2 Carryover Group are enrolled in TennCare Standard.
3. CHOICES Group 3, including Interim CHOICES Group 3.
- (i) Participation in CHOICES Group 3 is limited to TennCare Enrollees who qualify for and are receiving TennCare-reimbursed CHOICES HCBS. To be eligible for CHOICES Group 3, Enrollees must meet the following criteria:
    - (I) Be in one of the defined target populations;
    - (II) Qualify in one of the specified eligibility categories;
    - (III) Be At Risk for Institutionalization as defined in Rule 1200-13-01-.02; and
    - (IV) Have needs that can be safely and appropriately met in the community and at a cost that does not exceed their Expenditure Cap as defined in Rule 1200-13-01-.02.
  - (ii) Target Populations for CHOICES Group 3. Only persons in one of the target populations below may qualify to enroll in CHOICES Group 3:
    - (I) Persons age sixty-five (65) and older.
    - (II) Persons twenty-one (21) years of age and older who have one or more Physical Disabilities as defined in Rule 1200-13-01-.02.
  - (iii) Eligibility Categories served in CHOICES Group 3. Participation in CHOICES Group 3 is limited to TennCare Enrollees who qualify in one of the following eligibility categories:
    - (I) SSI eligibles, who are determined eligible for SSI by the Social Security Administration. SSI eligibles are enrolled in TennCare Medicaid.
    - (II) For Interim CHOICES Group 3 only, the CHOICES At-Risk Demonstration Group, as defined in Rule 1200-13-01-.02. Financial and categorical eligibility are determined by DHS. Persons who qualify in the CHOICES At-Risk Demonstration Group will be enrolled in TennCare Standard. This eligibility category is only open for enrollment between July 1, 2012 and December 31, 2013. Members enrolled in Interim CHOICES Group 3 on December 31, 2013 may continue to qualify in this group after December 31, 2013, so long as they continue to meet NF financial eligibility criteria and the LOC criteria in place at the time of enrollment into Interim CHOICES Group 3, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group, Interim CHOICES Group 3, and TennCare.
- (b) Level of Care (LOC). All Enrollees in TennCare CHOICES must meet the applicable LOC criteria, as determined by the Bureau in accordance with Rule 1200-13-01-.10. Physician certification of LOC shall be required only for NF services.
- 1. Persons shall meet NF LOC in order to enroll in CHOICES Group 1 or CHOICES Group 2.
  - 2. Persons shall be At Risk for Institutionalization, as defined in Rule 1200-13-01-.02, in order to enroll in CHOICES Group 3, including Interim CHOICES Group 3.

3. Members enrolled in CHOICES Group 1 on June 30, 2012, may continue to qualify in this group after June 30, 2012, so long as they continue to meet NF financial eligibility, continue to meet the NF LOC criteria in place on June 30, 2012, and remain continuously enrolled in CHOICES Group 1 and in TennCare.
  4. Members enrolled in CHOICES Group 1 on June 30, 2012, who wish to begin receiving HCBS and transition to CHOICES Group 2 shall, for purposes of LOC, be permitted to do so, so long as they continue to meet the NF LOC criteria in place on June 30, 2012, and have remained continuously enrolled in CHOICES Group 1 and in TennCare since June 30, 2012.
  5. Members enrolled in CHOICES Group 2 on June 30, 2012, may continue to qualify in this group after June 30, 2012, so long as they continue to meet NF financial eligibility, continue to meet the NF LOC criteria in place on June 30, 2012, and remain continuously enrolled in CHOICES Group 2 and in TennCare.
  6. Members enrolled in CHOICES Group 2 on June 30, 2012, who wish to be admitted to a NF and transition to CHOICES Group 1 shall be required to meet the NF LOC criteria in place at the time of enrollment into CHOICES Group 1 unless a determination has been made by TennCare that the Member's needs can no longer be safely met in the community within the Member's Individual Cost Neutrality Cap, in which case, the Member shall meet the NF LOC criteria in place on June 30, 2012, to qualify for enrollment into CHOICES Group 1.
- (c) With respect to the PASRR process described in Rule 1200-13-01-.23:
1. Members in CHOICES Group 1 must have been determined through the PASRR process described in Rules 1200-13-01-.10 and 1200-13-01-.23 to be appropriate for NF placement.
  2. Members in CHOICES Group 2 or CHOICES Group 3 are not required to complete the PASRR process unless they are admitted to a NF for Short-Term NF Care described in Paragraph (8) of this Rule and defined in Rule 1200-13-01-.02. Completion of the PASRR process is not required for Members of CHOICES Group 2 or CHOICES Group 3 who have elected the Inpatient Respite Care benefit described in Paragraph (8) of this Rule, since the service being provided is not NF services, but rather, Inpatient Respite Care, which is a CHOICES HCBS.
- (d) All Members in TennCare CHOICES must be admitted to a NF and require TennCare reimbursement of NF services or be receiving CHOICES HCBS in CHOICES Group 2 or CHOICES Group 3.
- (e) All Members in TennCare CHOICES Group 2 must be determined by the MCO to be able to be served safely and appropriately in the community and within their Individual Cost Neutrality Cap, in accordance with this Rule. If a person can be served safely and appropriately in the community and within their Individual Cost Neutrality Cap only through receipt of Companion Care services, the person may not be enrolled into CHOICES Group 2 until a qualified companion has been identified, an adequate back-up plan has been developed, and the companion has completed all required paperwork and training and is ready to begin delivering Companion Care services immediately upon the person's enrollment into CHOICES. Reasons a person cannot be served safely and appropriately in the community may include, but are not limited to, the following:
1. The home or home environment of the Applicant is unsafe to the extent that it would reasonably be expected that HCBS could not be provided without significant risk of harm or injury to the Applicant or to individuals who provide covered services.
  2. The Applicant refuses or fails to sign a Risk Agreement, or the Applicant's decision to receive services in the home or community poses an unacceptable level of risk.

3. The Applicant or his caregiver is unwilling to abide by the POC or Risk Agreement.
- (f) All Members in TennCare CHOICES Group 3 must be determined by the MCO to be able to be served safely and appropriately in the community within the array of services and supports available in CHOICES Group 3, including CHOICES HCBS up to the Expenditure Cap of \$15,000 (excluding the cost of minor home modifications), non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers. Reasons a person cannot be served safely and appropriately in the community may include, but are not limited to, the following:
1. The home or home environment of the Applicant is unsafe to the extent that it would reasonably be expected that HCBS could not be provided without significant risk of harm or injury to the Applicant or to individuals who provide covered services.
  2. The Applicant or his caregiver is unwilling to abide by the POC.
- (g) Immediate Eligibility. See definition in Rule 1200-13-01-.02.
1. The Bureau may elect, based on information provided in a TennCare application that has been submitted to DHS for determination, to grant a forty-five (45) day period of Immediate Eligibility for a person who meets the following criteria:
    - (i) Is deemed likely to qualify for TennCare in the CHOICES 217-Like eligibility category;
    - (ii) Has an approved CHOICES PAE; and
    - (iii) Meets all other specified criteria for enrollment into CHOICES Group 2, subject to categorical and financial eligibility determination.
  2. Members admitted to CHOICES Group 2 under the Immediate Eligibility option are persons who are not already eligible for TennCare.
  3. Immediate Eligibility is not a covered eligibility category in the Medicaid State Plan or the TennCare Section 1115 Waiver. There is no entitlement to apply or qualify for Immediate Eligibility. Should the Bureau not elect to provide a period of Immediate Eligibility, no notice shall be issued.
  4. If eligibility in the CHOICES 217-Like Group is denied by DHS, the Applicant shall receive notice and the right to request a fair hearing regarding the DHS eligibility decision. Continuation of Specified CHOICES HCBS benefits or Immediate Eligibility shall not be granted during the fair hearing process once the forty-five (45) day Immediate Eligibility period has expired. A fair hearing shall not be granted regarding either of the following:
    - (i) A decision by the Bureau to not grant the optional forty-five (45) day period of Immediate Eligibility; or
    - (ii) The end of a forty-five (45) day period of Immediate Eligibility granted by the Bureau.
  5. During a period of Immediate Eligibility, persons are eligible only for Specified CHOICES HCBS, as defined in Rule 1200-13-01-.02. They are not eligible for any other TennCare services, including other LTSS.
  6. During a period of Immediate Eligibility, persons who are also Medicare beneficiaries are not entitled to Medicare crossover payments on their Medicare benefits. They cannot be considered "dual eligibles" since they are not yet Medicaid-eligible.

- (4) Enrollment in TennCare CHOICES. Enrollment into CHOICES shall be processed by the Bureau as follows:
- (a) Enrollment into CHOICES Group 1. To qualify for enrollment into CHOICES Group 1, an Applicant must:
1. Have completed the PASRR process as defined in Rules 1200-13-01-.10 and 1200-13-01-.23;
  2. Have an approved unexpired PAE for NF LOC, including Level 1 reimbursement of NF services, Level 2 reimbursement of NF services, or Enhanced Respiratory Care Reimbursement for services in a NF. Eligibility for Enhanced Respiratory Care Reimbursement shall be established in accordance with Rule 1200-13-01-.10;
  3. Be approved by DHS for TennCare reimbursement of NF services;
  4. Be admitted to a NF. The Bureau must have received notification from the NF that Medicaid reimbursement is requested for the effective date of CHOICES enrollment (i.e., the individual is no longer privately paying for NF services and Medicare payment of NF services is not available). Enrollment into CHOICES Group 1 (and payment of a capitation payment for LTSS) cannot begin until the Bureau or the MCO will be responsible for payment of NF services.
- (b) Enrollment into CHOICES Group 2. To qualify for enrollment into CHOICES Group 2:
1. An Applicant must be in one of the target populations specified in this Rule;
  2. An Applicant must have an approved unexpired PAE for NF LOC;
  3. An Applicant must be approved by DHS for TennCare reimbursement of LTSS as an SSI recipient, in the CHOICES 217-Like Group, or in the CHOICES 1 and 2 Carryover Group. To be eligible in the CHOICES 217-Like Group, an Applicant must be approved by TennCare to enroll in CHOICES Group 2 or be approved by the Bureau for Immediate Eligibility for CHOICES Group 2, subject to determination of categorical and financial eligibility by DHS;
  4. The Bureau must have received a determination by the MCO that the Applicant's needs can be safely and appropriately met in the community, and at a cost that does not exceed his Individual Cost Neutrality Cap, as described in this Rule, except in instances where the Applicant is not eligible for TennCare at the time of CHOICES application, in which case, such determination shall be made by the MCO upon enrollment into CHOICES Group 2; and
  5. There must be capacity within the established Enrollment Target to enroll the Applicant in accordance with this Rule which may include satisfaction of criteria for Reserve Capacity, as applicable; or the Applicant must meet specified exceptions to enroll even when the Enrollment Target has been reached.
- (c) Individual Cost Neutrality Cap.
1. Each Member enrolling or enrolled in CHOICES Group 2 shall have an Individual Cost Neutrality Cap, which shall be used to determine:
    - (i) Whether or not he qualifies to enroll in CHOICES Group 2;
    - (ii) Whether or not he qualifies to remain enrolled in CHOICES Group 2; and
    - (iii) The total cost of CHOICES HCBS, HH Services, and PDN Services he can receive while enrolled in CHOICES Group 2. The Member's Individual Cost Neutrality Cap functions as a limit on the total cost of HCBS that can be provided to the Member in

the home or community setting, including CHOICES HCBS, HH Services and PDN Services.

2. A Member is not entitled to receive services up to the amount of his Cost Neutrality Cap. A Member shall receive only those services that are medically necessary (i.e., required in order to help ensure the Member's health, safety and welfare in the home or community setting and to delay or prevent the need for NF placement). Determination of the services that are needed shall be based on a comprehensive assessment of the Member's needs and the availability of Natural Supports and other (non-TennCare reimbursed) services to meet identified needs which shall be conducted by the Member's Care Coordinator.
3. Calculating a Group 2 Member's Individual Cost Neutrality Cap.
  - (i) Each Group 2 Member will have an Individual Cost Neutrality Cap that is based on the average cost of the level of NF reimbursement that would be paid if the Member were institutionalized in a NF as set forth in Items (I) through (III) below. CHOICES Group 2 does not offer an alternative to hospital level of care.
    - (I) A Member who would qualify only for Level 1 NF reimbursement shall have a Cost Neutrality Cap set at the average Level 1 cost of NF care.
    - (II) A Member who would qualify for Level 2 NF reimbursement shall have a Cost Neutrality Cap set at the average Level 2 cost of NF care.
    - (III) A Member who would qualify for the Enhanced Respiratory Care Reimbursement for persons who are chronically ventilator dependent, or for persons who have a functioning tracheostomy that requires frequent suctioning through the tracheostomy will have a Cost Neutrality Cap that reflects the higher payment that would be made to the NF for such care. There is no Cost Neutrality Cap for Ventilator Weaning Reimbursement, as such service is available only on a short-term basis in a SNF or acute care setting.
  - (ii) The PAE application shall be used to submit information to the Bureau that will be used to establish a Member's Individual Cost Neutrality Cap.
  - (iii) A Member's Individual Cost Neutrality Cap shall be the average Level 1 cost of NF care unless a higher Cost Neutrality Cap is established based on information submitted in the PAE application.
4. Application of the Individual Cost Neutrality Cap.
  - (i) The annual Cost Neutrality Cap shall be applied on a calendar year basis. The Bureau and the MCOs will track utilization of CHOICES HCBS, HH services, and PDN services across each calendar year.
  - (ii) A Member's Individual Cost Neutrality Cap must also be applied prospectively on a twelve (12) month basis. This is to ensure that a Member's POC does not establish a threshold level of supports that cannot be sustained over the course of time. This means that, for purposes of care planning, the MCO will always project the total cost of all CHOICES HCBS (including one-time costs such as Minor Home Modifications, short-term services or short-term increases in services) and HH and PDN Services forward for twelve (12) months in order to determine whether the Member's needs can continue to be safely and cost-effectively met based on the most current POC that has been developed. The cost of one-time services such as Minor Home Modifications, short-term services or short-term increases in services must be counted as part of the total cost of HCBS for a full twelve (12) month period following the date of service delivery.

- (iii) If it can be reasonably anticipated, based on the CHOICES HCBS, HH and PDN services currently received or determined to be needed in order to safely meet the person's needs in the community, that the person will exceed his Cost Neutrality Cap, then the person does not qualify to enroll in or to remain enrolled in CHOICES Group 2.
5. As the setting of an individual's Cost Neutrality Cap does not, in and of itself, result in any increase or decrease in a Member's services, notice of action shall not be provided regarding the Bureau's Cost Neutrality Cap calculation.
- (i) A Member has a right to due process regarding his Individual Cost Neutrality Cap when services are denied or reduced, when a determination is made that an Applicant cannot be enrolled into CHOICES, or a currently enrolled CHOICES Member can no longer remain enrolled in CHOICES because his needs cannot be safely and effectively met in the home and community-based setting at a cost that does not exceed his Individual Cost Neutrality Cap.
  - (ii) When an adverse action is taken, notice of action shall be provided, and the Applicant or Member shall have the right to a fair hearing regarding any valid factual dispute pertaining to such action, which may include, but is not limited to, whether his Cost Neutrality Cap was calculated appropriately.
    - (I) Denial of or reductions in CHOICES HCBS based on a Member's Cost Neutrality Cap shall constitute an adverse action under the Grier Revised Consent Decree (Modified), as defined in Rules 1200-13-13-.01 and 1200-13-14-.01, and shall give rise to Grier notice of action and due process rights to request a fair hearing in accordance with Rules 1200-13-13-.11 and 1200-13-14-.11.
    - (II) Denial of enrollment and/or involuntary disenrollment because a person's Cost Neutrality Cap will be exceeded shall constitute an eligibility/enrollment action, and shall give rise to notice of action and due process rights to request a fair hearing in accordance with this rule.
- (d) Enrollment Target for CHOICES Group 2.
1. There shall be an Enrollment Target for CHOICES Group 2. The Enrollment Target functions as a cap on the total number of persons who can be enrolled into CHOICES Group 2 at any given time.
- (i) Effective July 1, 2012, the Enrollment Target for CHOICES Group 2 will be twelve thousand five hundred (12,500).
  - (ii) Once the Enrollment Target (including Reserve Capacity as defined in 1200-13-01-.02 and as described in 1200-13-01-.05(d)(2)) is reached, qualified Applicants shall not be enrolled into CHOICES Group 2 or qualify in the CHOICES 217-Like eligibility category based on receipt of HCBS until such time that capacity within the Enrollment Target is available, with the following exceptions:
    - (I) NF-to-Community Transitions. A Member being served in CHOICES Group 1 who meets requirements to enroll in CHOICES Group 2 can enroll in CHOICES Group 2 even though the Enrollment Target has been met. This Member will be served in CHOICES Group 2 outside the Enrollment Target but shall be moved within the CHOICES Enrollment Target at such time that a slot becomes available. A request to transition a Member from CHOICES Group 1 to CHOICES Group 2 in excess of the CHOICES Group 2 Enrollment Target must specify the name of the NF where the Member currently resides, the date of admission and the planned date of transition.

- (II) CEA Enrollment. An MCO with an SSI-eligible recipient who meets all other criteria for enrollment into CHOICES Group 2, but who cannot enroll in CHOICES Group 2 because the Enrollment Target for that group has been met, has the option, at its sole discretion, of offering HCBS as a CEA to the Member. Upon receipt of satisfactory documentation from the MCO of its CEA determination and assurance of provider capacity to meet the Member's needs, the Bureau will enroll the person into CHOICES Group 2, regardless of the Enrollment Target. The person will be served in CHOICES Group 2 outside the Enrollment Target, but shall be moved within the CHOICES Group 2 Enrollment Target at such time that a slot becomes available. Satisfactory documentation of the MCO's CEA determination shall include an explanation of the Member's circumstances that warrant the immediate provision of NF services unless HCBS are immediately available. Documentation of adequate provider capacity to meet the Member's needs shall include a listing of providers for each HCBS in the Member's POC which the MCO has confirmed are willing and able to initiate HCBS within ten (10) business days of the Member's enrollment into CHOICES Group 2.
- (III) If enrollment into CHOICES Group 2 is denied because the Enrollment Target has been reached, notice shall be provided to the Applicant, including the right to request a fair hearing regarding any valid factual dispute pertaining to the Bureau's decision. If the person otherwise qualifies for enrollment into CHOICES Group 2, but does not meet the exceptions specified in 1200-13-01-.05(4)(d)(1)(ii), the Applicant shall be placed on a Waiting List for CHOICES Group 2.
- (IV) Once the CHOICES Group 2 Enrollment Target is reached, any persons enrolled in excess of the Enrollment Target in accordance with this Rule must receive the first available slots. Only after all persons enrolled in excess of the Enrollment Target have been moved under the Enrollment Target can additional persons be enrolled into CHOICES Group 2.

2. Reserve Capacity.

- (i) The Bureau shall reserve three hundred (300) slots within the CHOICES Group 2 Enrollment Target. These slots are available only when the Enrollment Target has otherwise been reached, and only to the following:
    - (I) Applicants being discharged from a NF; and
    - (II) Applicants being discharged from an acute care setting who are at imminent risk of being placed in a NF setting absent the provision of HCBS.
  - (ii) Once all other available (i.e., unreserved) slots have been filled, Applicants who meet specified criteria (including new Applicants seeking to establish eligibility in the CHOICES 217-Like Group as well as current SSI-eligible individuals seeking enrollment into CHOICES Group 2) may be enrolled into reserved slots. TennCare may require confirmation of the NF or hospital discharge and in the case of hospital discharge, written explanation of the Applicant's circumstances that warrant the immediate provision of NF services unless HCBS are immediately available.
  - (iii) If enrollment into a Reserve Capacity slot is denied, notice shall be provided to the Applicant, including the right to request a fair hearing regarding any valid factual dispute pertaining to the Bureau's decision. If the person otherwise qualifies for enrollment into CHOICES Group 2, but does not meet the specified criteria for Reserve Capacity, the Applicant shall be placed on a Waiting List for CHOICES Group 2.
- (e) Enrollment into CHOICES Group 3. To qualify for enrollment into CHOICES Group 3 (including Interim CHOICES Group 3):

1. An individual must be in one of the target populations specified in this Rule;
  2. An individual must be At Risk for Institutionalization, as defined in Rule 1200-13-01-.02;
  3. An individual must be approved by DHS for reimbursement of LTSS as an SSI recipient or for Interim CHOICES Group 3 only, in the CHOICES At-Risk Demonstration Group; as defined in Rule 1200-13-01-.02. To be eligible in the CHOICES At-Risk Demonstration Group, an individual must be enrolled in Interim CHOICES Group 3, subject to determination of categorical and financial eligibility by DHS;
  4. The Bureau must have received a determination by the MCO that the individual's needs can be safely and appropriately met in the community, and at a cost that does not exceed his Expenditure Cap, as described in this Rule, except in instances where the person is not eligible for TennCare at the time of CHOICES application, in which case, such determination shall be made by the MCO upon enrollment into CHOICES Group 3; and
  5. There must be capacity within the established Enrollment Target, as applicable, to enroll the individual in accordance with this Rule.
- (f) Expenditure Cap for CHOICES Group 3.
1. Each Member enrolling or enrolled in CHOICES Group 3 shall be subject to an Expenditure Cap on CHOICES HCBS. The Expenditure Cap shall be used to determine:
    - (i) Whether or not an Applicant qualifies to enroll in CHOICES Group 3;
    - (ii) Whether or not a Member qualifies to remain enrolled in CHOICES Group 3; and
    - (iii) The total cost of CHOICES HCBS a Member can receive while enrolled in CHOICES Group 3, excluding the cost of Minor Home Modifications. The Expenditure Cap functions as a limit on the total cost of CHOICES HCBS, excluding Minor Home Modifications, that can be provided by the MCO to the Member in the home or community setting.
  2. A Member is not entitled to receive services up to the amount of the Expenditure Cap. A Member shall receive only those services that are medically necessary (i.e., required in order to help ensure the Member's health, safety and welfare in the home or community setting and to delay or prevent the need for NF placement). Determination of the services that are needed shall be based on a comprehensive assessment of the Member's needs and the availability of Natural Supports and other (non-TennCare reimbursed) services to meet identified needs, which shall be conducted by the Member's Care Coordinator.
  3. The Expenditure Cap for CHOICES HCBS provided to CHOICES Group 3 Members shall be \$15,000 (fifteen thousand dollars) annually, excluding the cost of Minor Home Modifications.
  4. Application of the Expenditure Cap.
    - (i) The annual Expenditure Cap shall be applied on a calendar year basis. The Bureau and the MCOs will track utilization of CHOICES HCBS excluding Minor Home Modifications, across each calendar year.
    - (ii) A Member's Expenditure Cap must also be applied prospectively on a twelve (12) month basis. This is to ensure that a Member's POC does not establish a threshold level of supports that cannot be sustained over the course of time. This means that, for purposes of care planning, the MCO will always project the total cost of CHOICES HCBS (excluding Minor Home Modifications) forward for twelve (12) months in order to determine whether the Member's needs can continue to be

met based on the most current POC that has been developed. The cost of one-time services such as short-term services or short-term increases in services must be counted as part of the total cost of CHOICES HCBS for a full twelve (12) month period following the date of service delivery.

- (iii) If it can be reasonably anticipated, based on the CHOICES HCBS currently received or determined to be needed (in addition to non-CHOICES HCBS available through TennCare, e.g., home health, services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers) in order to safely meet the person's needs in the community, that the person will exceed his Expenditure Cap, then the person does not qualify to enroll in or to remain enrolled in CHOICES Group 3.
  - (iv) Any Short-Term NF Care received by a Member enrolled in CHOICES Group 3 shall not be counted against his Expenditure Cap.
- (g) Enrollment Target for CHOICES Group 3 (including Interim CHOICES Group 3).
- 1. The State may establish an Enrollment Target for CHOICES Group 3 which shall be at least ten (10) percent of the Enrollment Target established by the State for CHOICES Group 2.
  - 2. Notwithstanding any Enrollment Target established for CHOICES Group 3 as described in this subparagraph, Interim CHOICES Group 3 which is open for enrollment between July 1, 2012, and December 31, 2013, shall not be subject to an Enrollment Target.
- (5) Disenrollment from CHOICES. A Member may be disenrolled from CHOICES voluntarily or involuntarily.
- (a) Voluntary disenrollment from CHOICES means the Member has chosen to disenroll, and no notice of action shall be issued regarding a Member's decision to voluntarily disenroll from CHOICES. However, notice shall be provided regarding any subsequent adverse action that may occur as a result of the Member's decision, including any change in benefits, cost-sharing responsibility, or continued eligibility for TennCare when the Member's eligibility was conditioned on receipt of LTSS. Voluntary disenrollment shall proceed only upon:
    - 1. Discharge from a NF when the Member is not transitioning to CHOICES Group 2 or CHOICES Group 3, as described in these rules;
    - 2. Election by the Member to receive hospice services in a NF, which is not a LTSS; or
    - 3. Receipt of a statement signed by the Member or his authorized Representative voluntarily requesting disenrollment.
  - (b) A Member may be involuntarily disenrolled from CHOICES only by the Bureau, although such process may be initiated by a Member's MCO. Reasons for involuntary disenrollment include but are not limited to:
    - 1. The Member no longer meets one or more criteria for eligibility and/or enrollment as specified in this Rule.
    - 2. The Member's needs can no longer be safely met in the community. This may include but is not limited to the following instances:
      - (i) The home or home environment of the Member becomes unsafe to the extent that it would reasonably be expected that HCBS could not be provided without significant risk of harm or injury to the Member or to individuals who provide covered services to the Member.
      - (ii) The Member or his caregiver refuses to abide by the POC or Risk Agreement.

- (iii) Even though an adequate provider network is in place, there are no providers who are willing to provide necessary services to the Member.
    - (iv) The Member refuses or fails to sign a Risk Agreement, or the Member's decision to continue receiving services in the home or community poses an unacceptable level of risk.
  - 3. The Member's needs can no longer be safely met in the community at a cost that does not exceed the Member's Cost Neutrality Cap or Expenditure Cap, as applicable and as described in this Rule.
  - 4. The Member no longer needs or is no longer receiving LTSS.
  - 5. The Member has refused to pay his Patient Liability. The MCO and/or its participating providers are unwilling to serve the Member in CHOICES because he has not paid his Patient Liability, and/or no other MCO is willing to serve the Member in CHOICES.
- (6) Advance Determinations that an Applicant Would Not Qualify to Enroll in CHOICES Group 3 (including Interim CHOICES Group 3).
  - (a) For purposes of the Need for Inpatient Nursing Care, Effective July 1, 2012, as specified in TennCare Rule 1200-13-01-.10(4)(b)(2)(i)(II) and 1200-13-01-.10(4)(b)(2)(ii)(II), Advance Determination by TennCare that a CHOICES Applicant would not qualify for enrollment into CHOICES Group 3 shall be made only if all of the following criteria are met:
    - 1. The Applicant has a total acuity score of at least six (6) but no more than eight (8);
    - 2. The Applicant has an individual acuity score of at least three (3) for the Orientation measure;
    - 3. The Applicant has an individual acuity score of at least two (2) for the Behavior measure;
    - 4. The absence of intervention and supervision for dementia-related behaviors at the frequency specified in the PAE would result in imminent and serious risk of harm to the Applicant and/or others (documentation of the specific behaviors, the frequency of such behaviors, and the imminence and seriousness of risk shall be required); and
    - 5. There is sufficient evidence, as required and determined by TennCare, to demonstrate that the necessary intervention and supervision needed by the person cannot be safely provided within the array of services and supports that would be available if the Applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the Expenditure Cap of \$15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers.
  - (b) Documentation required to support an Advance Determination for Applicants enrolled in TennCare shall include all of the following:
    - 1. A comprehensive needs assessment performed by an MCO Care Coordinator pursuant to requirements set forth in the MCO's Contractor Risk Agreement, including:
      - (i) An assessment of the Member's physical, behavioral, functional, and psychosocial needs;
      - (ii) An assessment of the Member's home environment in order to identify any modifications that may be needed, and to identify and address any issues that may affect the Member's ability to be safely served in the community;

- (iii) An assessment of the Member's Natural Supports, including care being provided by family members and/or other caregivers, and LTSS the Member is currently receiving (regardless of payer), and whether there is any anticipated change in the Member's need for such care or services or the availability of such care or services from the current caregiver or payer; and
    - (iv) An assessment of the physical health, behavioral health, and LTSS and other social support services and assistance (e.g., housing or income assistance) that are needed to ensure the Member's health, safety and welfare in the community and to prevent the need for institutional placement. Such assessment shall specify the specific tasks and functions for which assistance is needed by the Member, the frequency with which such tasks must be performed, and the amount of paid assistance necessary to perform these tasks;
  - 2. A person-centered plan of care developed by the MCO Care Coordinator which specifies the CHOICES HCBS that would be necessary and that would be approved by the MCO to safely support the person in the community, as well as non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers (or attestation that the person could not be safely supported in the community with *any* combination of services and supports, as applicable);
  - 3. An explanation regarding why an array of covered services and supports, including CHOICES HCBS up to the Expenditure Cap of \$15,000 and non-CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the person's needs in the community;
  - 4. A detailed explanation of:
    - (i) The Member's living arrangements and the services and supports the Member has received for the six (6) months prior to application for CHOICES, including non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers; and
    - (ii) Any recent significant event(s) or circumstances that have impacted the Applicant's need for services and supports, including how such event(s) or circumstances would impact the person's ability to be safely supported within the array of covered services and supports that would be available if the person were enrolled in CHOICES Group 3.
  - (c) Documentation required to support an Advance Determination for Applicants not enrolled in TennCare at the time the PAE is submitted shall include all of the items specified in Subparagraph (b) above, except as follows:
    - 1. A comprehensive assessment, including an assessment of the Applicant's home environment, performed by the AAAD, or the most recent MDS assessment performed by a Nursing Facility contracted with one or more TennCare MCOs may be submitted in lieu of the MCO comprehensive needs assessment specified in Part (b)1. above.
    - 2. The person-centered plan of care as described in Part (b)2. above shall not be required.
- (7) Transitioning Between CHOICES Groups.
- (a) Transition from Group 1 to Group 2.

1. An MCO may request to transition a Member from Group 1 to Group 2 only when the Member chooses to transition from the NF to an HCBS setting. Members shall not be required to transition from Group 1 to Group 2. Only an MCO may submit to TennCare a request to transition a Member from Group 1 to Group 2.
  2. A Member that has already been discharged from the NF shall not be transitioned to CHOICES Group 2. Once a Member has discharged from the NF, he has voluntarily disenrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 2. A new PAE shall be required for enrollment into CHOICES Group 2.
  3. When Members move from Group 1 to Group 2, DHS must recalculate the Member's Patient Liability based on the Community PNA.
- (b) Transition from Group 2 to Group 1. An MCO may request to transition a Member from Group 2 to Group 1 only under the following circumstances:
1. Except as provided in TennCare Rule 1200-13-01-.05(3)(b)6, the Member meets the NF LOC criteria in place at the time of enrollment into CHOICES Group 1, and at least one (1) of the following is true:
    - (i) The Member chooses to transition from HCBS to NF, for example, due to a decline in the Member's health or functional status, or a change in the Member's natural caregiving supports; or
    - (ii) The MCO has made a determination that the Member's needs can no longer be safely met in the community and at a cost that does not exceed the average cost of NF services for which the Member would qualify, and the Member chooses to transition to the more appropriate institutional setting in order to safely meet his needs.
  2. When Members move from Group 2 to Group 1, DHS must recalculate the Member's Patient Liability based on the Institutional PNA.
- (c) At such time as a transition between CHOICES Groups 1 and 2 is made, the MCO shall issue notice of transition to the Member. Because the Member has elected the transition and remains enrolled in CHOICES, such transition between CHOICES groups shall not constitute an adverse action. Thus, the notice will not include the right to appeal or request a fair hearing regarding the Member's decision.
- (d) Transition from Group 1 or Group 2 to Group 3.
1. The Bureau or the MCO shall, subject to eligibility and enrollment criteria set forth in TennCare Rule 1200-13-01-.05(3) and (4), initiate a transition from Group 1 or from Group 2 to Group 3 when a Member who was enrolled in CHOICES Group 1 or Group 2 on or after July 1, 2012, no longer meets NF LOC, but is At Risk for Institutionalization as defined in Rule 1200-13-01-.02.
  2. A Member that has already been discharged from the NF shall not be transitioned from CHOICES Group 1 to CHOICES Group 3. Once a Member has discharged from the NF, he has voluntarily disenrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 3. A new PAE shall be required for enrollment into CHOICES Group 3.
  3. When a Member transitions from CHOICES Group 1 to Group 3, DHS must recalculate the Member's Patient Liability based on the Community PNA.
- (e) Transition from Group 3 to Group 1 or Group 2.
1. The Bureau or the MCO shall initiate a transition from Group 3 to Group 1 or Group 2, as appropriate, when the Member meets NF LOC in place at the time of the transition request and satisfies all requirements for enrollment into the requested Group.

2. When a member transitions from Group 3 to Group 1, DHS must recalculate the Member's Patient Liability based on the Institutional PNA.

(8) Benefits in the TennCare CHOICES Program.

- (a) CHOICES includes NF care and CHOICES HCBS benefits, as described in this Chapter. Pursuant to federal regulations, NF services must be ordered by the treating physician. A physician's order is not required for CHOICES HCBS.
- (b) Members of CHOICES Group 1 who are Medicaid eligible receive NF care, in addition to all of the medically necessary covered benefits available for Medicaid recipients, as specified in Rule 1200-13-13-.04. While receiving NF care, Members are not eligible for HCBS.
- (c) Members of CHOICES Group 1 who are eligible for TennCare Standard in the CHOICES 1 and 2 Carryover Group receive NF care, in addition to all of the medically necessary covered benefits available for TennCare Standard recipients, as specified in Rule 1200-13-14-.04. While receiving NF care, Members are not eligible for HCBS.
- (d) Members of CHOICES Group 2 who are Medicaid eligible receive CHOICES HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Medicaid recipients, as specified in Rule 1200-13-13-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.
- (e) Members of CHOICES Group 2 who are eligible for TennCare Standard in the CHOICES 217-Like Group or in the CHOICES 1 and 2 Carryover Group receive CHOICES HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Standard recipients, as specified in Rule 1200-13-14-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.
- (f) Members of CHOICES Group 3 who are SSI Eligible receive CHOICES HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Medicaid recipients, as specified in Rule 1200-13-13-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.
- (g) Members of CHOICES Group 3 who are eligible for TennCare Standard in the CHOICES At-Risk Demonstration Group receive CHOICES HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Standard recipients, as specified in Rule 1200-13-14-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.
- (h) Members are not eligible to receive any other HCBS during the time that Short-Term NF services are provided. CHOICES HCBS such as Minor Home Modifications or installation of a PERS which are required to facilitate transition from the NF back to the home or community may be provided during the NF stay and billed with date of service being on or after discharge from the NF.
- (i) Members receiving CBRA services, other than Companion Care, are eligible to receive only Assistive Technology services, since other types of support and assistance are within the defined scope of the 24-hour CBRA benefit and are the responsibility of the CBRA provider.
- (j) Members receiving Companion Care are eligible to receive only Assistive Technology, Minor Home Modifications, and Pest Control, since all needed assistance with ADLs and IADLs are within the defined scope of the 24-hour CBRA benefit.
- (k) All LTSS, NF services as well as CHOICES HCBS, must be authorized by the MCO in order for MCO payment to be made for the services. An MCO may elect to accept the Bureau's PAE determination as its prior authorization for NF services. NF care may sometimes start before

authorization is obtained, but payment will not be made until the MCO has authorized the service. CHOICES HCBS must be specified in an approved POC and authorized by the MCO prior to delivery of the service in order for MCO payment to be made for the service.

- (l) CHOICES HCBS covered under TennCare CHOICES and applicable limits are specified below. The benefit limits are applied across all services received by the Member regardless of whether the services are received through CD and/or a traditional provider agency. Corresponding limitations regarding the scope of each service are defined in Rule 1200-13-01-.02 and in Subparagraphs (a) through (k) above.

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction  ("Eligible HCBS")	Benefits for Immediate Eligibles  ("Specified HCBS")
1. Adult Day Care	Covered with a limit of 2080 hours per calendar year, per CHOICES Member.	No	Yes
2. Assistive Technology	Covered with a limit of \$900 per calendar year, per Member.	No	No
3. Attendant Care	<p>Covered only for persons who require hands-on assistance with ADLs when needed for more than 4 hours per occasion or visits at intervals of less than 4 hours between visits.</p> <p>For Members who do not require Homemaker Services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1080 hours per calendar year, per Member.</p> <p>For Members who require Homemaker Services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1240 hours for calendar year 2012, per Member.</p> <p>For Members who require Homemaker Services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, beginning January 1, 2013, covered with a limit of 1400 hours per calendar year, per Member.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving any of the following HCBS: Adult Day Care, CBRA services (including Companion Care), or Short-Term NF Care.</p>	Yes	Yes
4. CBRA	<p>Companion Care.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving any of the following HCBS: Adult Day Care, CBRA facility services, or Short-Term NF Care.</p>	Yes	No

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction  ("Eligible HCBS")	Benefits for Immediate Eligibles  ("Specified HCBS")
	CBRA facility services (e.g., ACLFs, Adult Care Homes).	No	No
5. Home-Delivered Meals	<p>Covered with a limit of 1 meal per day, per Member.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.</p>	No	Yes
6. Homemaker Services	<p>*Covered only for Members who also need hands-on assistance with ADLs and as a component of Attendant Care or Personal Care Visits as defined in these rules.</p> <p>Not covered as a stand-alone benefit.</p> <p>Not covered for persons who do not require hands-on assistance with ADLs.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.</p>	*	*
7. In-Home Respite Care	<p>Covered with a limit of 216 hours per calendar year, per Member.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.</p>	Yes	No
8. Inpatient Respite Care	<p>Covered with a limit of 9 days per calendar year, per Member.</p> <p>PASRR approval not required.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.</p>	No	No

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction  ("Eligible HCBS")	Benefits for Immediate Eligibles  ("Specified HCBS")
9. Minor Home Modifications	<p>Covered with a limit of \$6,000 per project, \$10,000 per calendar year, and \$20,000 per lifetime.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting. Not covered when the Member is receiving Short-Term NF Care, except when provided to facilitate transition from a NF to the community. See Rule 1200-13-01-.05(8)(h).</p>	No	No
10. Personal Care Visits	<p>Covered with a limit of 2 intermittent visits per day, per Member; visits limited to a maximum of 4 hours per visit and there shall be at least four (4) hours between intermittent visits.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving any of the following HCBS: Adult Day Care, CBRA services (including Companion Care), or Short-Term NF Care.</p>	Yes	Yes
11. PERS	<p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.</p>	No	Yes
12. Pest Control	<p>Covered with a limit of 9 treatment visits per calendar year, per Member.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving Short-Term NF Care.</p>	No	No
13. Short-Term NF Care	<p>Covered with a limit of 90 days per stay, per Member.</p> <p>Approved PASRR required.</p> <p>Members receiving Short-Term NF Care are not eligible to receive any other HCBS except when permitted to facilitate transition to the community. See Rule 1200-13-01-.05(8)(h).</p>	No	No

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction  ("Eligible HCBS")	Benefits for Immediate Eligibles  ("Specified HCBS")
1. Adult Day Care	Covered with a limit of 2080 hours per calendar year, per CHOICES Member.	No	N/A
2. Assistive Technology	Covered with a limit of \$900 per calendar year, per Member.	No	N/A
3. Attendant Care	<p>Covered only for persons who require hands-on assistance with ADLs when needed for more than 4 hours per occasion or visits at intervals of less than 4 hours between visits.</p> <p>For Members who do not require Homemaker Services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1080 hours per calendar year, per Member.</p> <p>For Members who require Homemaker Services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1240 hours for calendar year 2012, per Member.</p> <p>For Members who require Homemaker Services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, beginning January 1, 2013, covered with a limit of 1400 hours per calendar year, per Member.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving any of the following HCBS: Adult Day Care, CBRA services (including Companion Care), or Short-Term NF Care.</p>	Yes	N/A
4. Home-Delivered Meals	<p>Covered with a limit of 1 meal per day, per Member.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.</p>	No	N/A

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction  ("Eligible HCBS")	Benefits for Immediate Eligibles  ("Specified HCBS")
5. Homemaker Services	<p>*Covered only for Members who also need hands-on assistance with ADLs and as a component of Attendant Care or Personal Care Visits as defined in these rules.</p> <p>Not covered as a stand-alone benefit.</p> <p>Not covered for persons who do not require hands-on assistance with ADLs.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.</p>	*	*
6. In-Home Respite Care	<p>Covered with a limit of 216 hours per calendar year, per Member.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.</p>	Yes	N/A
7. Inpatient Respite Care	<p>Covered with a limit of 9 days per calendar year, per Member.</p> <p>PASRR approval not required. NF LOC not required.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.</p>	No	N/A
8. Minor Home Modifications	<p>Covered with a limit of \$6,000 per project, \$10,000 per calendar year, and \$20,000 per lifetime.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting. Not covered when the Member is receiving Short-Term NF Care, except when provided to facilitate transition from a NF to the community. See Rule 1200-13-01-.05(8)(h).</p>	No	N/A

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction  ("Eligible HCBS")	Benefits for Immediate Eligibles  ("Specified HCBS")
9. Personal Care Visits	<p>Covered with a limit of 2 intermittent visits per day, per Member; visits limited to a maximum of 4 hours per visit and there shall be at least four (4) hours between intermittent visits.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving any of the following HCBS: Adult Day Care, CBRA services (including Companion Care), or Short-Term NF Care.</p>	Yes	N/A
10. PERS	<p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.</p>	No	N/A
11. Pest Control	<p>Covered with a limit of 9 treatment visits per calendar year, per Member.</p> <p>Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving Short-Term NF Care.</p>	No	N/A
12. Short-Term NF Care	<p>Covered with a limit of 90 days per stay, per Member.</p> <p>Approved PASRR required. Member must meet NF LOC.</p> <p>Members receiving Short-Term NF Care are not eligible to receive any other HCBS except when permitted to facilitate transition to the community. See Rule 1200-13-01-.05(8)(h).</p>	No	N/A

(m) Applicants who qualify as "Immediate Eligibles" are eligible only for Specified CHOICES HCBS, as defined in these rules. Immediate Eligibles are not eligible for any other TennCare benefits, including other CHOICES benefits. The benefit limits are the same as those specified in Subparagraph (l) above. When the limit is an annual limit, the services used in the Immediate Eligibility period count against the annual limit if the Applicant should become eligible for TennCare. These Specified CHOICES HCBS, are listed below.

1. Personal Care Visits.
2. Attendant Care.
3. Home-Delivered Meals.
4. PERS.
5. Adult Day Care.

(n) Transportation.

1. Emergency and non-emergency transportation for TennCare covered services other than CHOICES services is provided by the MCOs in accordance with Rules 1200-13-13-.04 and 1200-13-14-.04.
2. Transportation is not provided to HCBS covered by CHOICES, except in the circumstance where a Member requires Adult Day Care that is not available within 30 miles of the Member's residence.

For CHOICES Members not participating in CD, provider agencies delivering CHOICES HCBS may permit staff to accompany a Member outside the home. In circumstances where the Member is unable to drive, assistance by provider agency staff in performing IADLs (e.g., grocery shopping, picking up prescriptions, banking) specified in the POC may include transporting the Member when such assistance would otherwise be performed for the Member by the provider staff, and subject to the provider agency's agreement and responsibility to ensure that the Worker has a valid driver's license and proof of insurance prior to transporting a Member. The decision of whether or not to accompany the Member outside the home (and in the circumstances described above, to transport the Member) is at the discretion of the agency/Worker, taking into account such issues as the ability to safely provide services outside the home setting, the cost involved, and the provider's willingness to accept and manage potential risk and/or liability. In no case will additional hours of service and/or an increased rate of reimbursement be provided as a result of an agency/Worker decision to accompany or transport a Member outside the home.

3. For CHOICES Members participating in CD, the Member may elect to have his Consumer-Directed Workers (including Companion Care workers) to accompany and/or transport the Member if such an arrangement is agreed to by both the Member and the Workers and specified in the Service Agreement; however, no additional hours or reimbursement will be available. Consumer-Directed Worker(s) must provide to the FEA a valid driver's license and proof of insurance prior to transporting a Member.

(o) Freedom of Choice.

1. CHOICES Members who meet NF LOC as defined in Rule 1200-13-01-.10 shall be given freedom of choice of NF care or CHOICES HCBS, so long as the Member meets all criteria for enrollment into CHOICES Group 2, as specified in this Chapter and the Member may be enrolled into CHOICES Group 2 in accordance with requirements pertaining to the CHOICES Group 2 Enrollment Target as described in this Chapter.
2. CHOICES Members shall also be permitted to choose providers for CHOICES HCBS specified in the POC from the MCO's list of participating providers, if the participating provider selected is available and willing to initiate services timely and to deliver services in accordance with the POC. The Member is not entitled to receive services from a particular provider. A Member is not entitled to a fair hearing if he is not able to receive services from the provider of his choice.

(p) Transition Allowance. For CHOICES Members moving from CHOICES 1 to CHOICES 2 or CHOICES 3, the MCO may, at its sole discretion, provide a Transition Allowance not to exceed two thousand dollars (\$2,000) per lifetime as a CEA to facilitate transition of the Member from the NF to the community. An MCO shall not be required to provide a Transition Allowance, and Members transitioning out of a NF are not entitled to receive a Transition Allowance, which is not a covered benefit. Items that an MCO may elect to purchase or reimburse are limited to the following:

1. Those items which 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;

2. Rent and/or utility deposits; and
3. Essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

(9) Consumer-Direction (CD).

(a) CD is a model of service delivery that affords CHOICES Group 2 and CHOICES Group 3 Members the opportunity to have more choice and control with respect to Eligible CHOICES HCBS that are needed by the Member, in accordance with this Rule. CD is not a service or set of services.

1. The model of CD that will be implemented in CHOICES is an employer authority model.
2. The determination regarding the services a Member will receive shall be based on a comprehensive needs assessment performed by a Care Coordinator that identifies the Member's needs, the availability of family and other caregivers to meet those needs, and the gaps in care for which paid services may be authorized.
3. Upon completion of the comprehensive needs assessment, CHOICES Members determined to need Eligible CHOICES HCBS may elect to receive one or more of the Eligible CHOICES HCBS through a Contract Provider, or they may participate in CD. Companion Care is available only through CD.
4. CHOICES Members who do not need Eligible CHOICES HCBS shall not be offered the opportunity to enroll in CD.

(b) CHOICES HCBS eligible for CD (Eligible CHOICES HCBS).

1. CD is limited to the following HCBS:
  - (i) Attendant Care.
  - (ii) Companion Care (available only to Members electing CD and in CHOICES Group 2; not available to CHOICES Group 3 members).
  - (iii) In-Home Respite Care.
  - (iv) Personal Care Visits.
2. CHOICES Members do not have budget authority. The amount of a covered benefit available to the Member shall not increase as a result of his decision to participate in CD, even if the rate of reimbursement for the service is lower in CD. The amount of each covered benefit to be provided to the Member is specified in the approved POC.
3. HH Services, PDN Services, and CHOICES HCBS other than those specified above shall not be available through CD.

(c) Eligibility for CD. To be eligible for CD, a CHOICES Member must meet all of the following criteria:

1. Be a Member of CHOICES Group 2 or CHOICES Group 3.
2. Be determined by a Care Coordinator, based on a comprehensive needs assessment, to need one or more Eligible CHOICES HCBS.
3. Be willing and able to serve as the Employer of Record for his Consumer-Directed Workers and to fulfill all of the required responsibilities for CD, or he must have a qualified Representative who is willing and able to serve as the Employer of Record and

to fulfill all of the required responsibilities for CD. Assistance shall be provided to the Member or his Representative by the FEA.

4. Any additional risks associated with a Member's decision to participate in CD must be identified and addressed in a signed Risk Agreement, as applicable, and the MCO must determine that the Member's needs can be safely and appropriately met in the community while participating in CD.
  5. The Member or his Representative for CD and any Workers he employs must agree to use the services of the Bureau's contracted FEA to perform required Financial Administration and Supports Brokerage functions.
- (d) Enrollment in CD.
1. A CHOICES Group 2 or CHOICES Group 3 Member assessed to need one or more Eligible CHOICES HCBS may elect to participate in CD at any time.
  2. If the Member is unable to make a decision regarding his participation in CD or to communicate his decision, only a legally appointed Representative may make such decision on his behalf. The Member, or a family member or other caregiver, must sign a CD participation form reflecting the decision the Member has made.
  3. If the Member is unable to make a decision regarding CD or to communicate his decision and does not have a legally appointed Representative, the Member cannot participate in CD since there is no one with the legal authority to assume and/or delegate the Member's CD responsibilities.
  4. Self-Assessment Tool. If a Member elects to participate in CD, he must complete a self-assessment tool developed by the Bureau to determine whether he requires the assistance of a Representative to perform the responsibilities of CD.
  5. Representative. If the Member requires assistance in order to participate in CD, he must designate, or have appointed by a legally appointed Representative, a Representative to assume the CD responsibilities on his behalf.
    - (i) A Representative must meet all of the following criteria:
      - (I) Be at least eighteen (18) years of age;
      - (II) Have a personal relationship with the Member and understand his support needs;
      - (III) Know the Member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, strengths and weaknesses; and
      - (IV) Be physically present in the Member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each Consumer-Directed Worker.
    - (ii) If a Member requires a Representative but is unwilling or unable to appoint one, the MCO may submit to the Bureau, for review and approval, a request to deny the Member's participation in CD.
    - (iii) If a Member's Care Coordinator believes that the person selected as the Member's representative for CD does not meet the specified requirements (e.g., the Representative is not physically present in the Member's residence at a frequency necessary to adequately supervise Workers), the Care Coordinator may request that the Member select a different Representative who meets the specified requirements. If the Member does not select another Representative who meets

the specified requirements, the MCO may, in order to help ensure the Member's health and safety, submit to the Bureau, for review and approval, a request to deny the Member's participation in CD.

- (iv) A Member's Representative shall not receive payment for serving in this capacity and shall not serve as the Member's Worker for any Consumer-Directed Service.
  - (v) Representative Agreement. A Representative Agreement must be signed by the Member (or person authorized to sign on the Member's behalf) and the Representative in the presence of the Care Coordinator. By completing a Representative agreement, the Representative confirms that he agrees to serve as a Member's representative and that he accepts the responsibilities and will perform the duties associated with being a Representative.
  - (vi) A Member may change his Representative at any time by notifying his Care Coordinator and his Supports Broker that he intends to change Representatives. The Care Coordinator shall verify that the new Representative meets the qualifications as described above. A new Representative Agreement must be completed and signed, in the presence of a Care Coordinator, prior to the new Representative assuming his respective responsibilities.
- (e) Employer of Record.
- 1. If a Member elects to participate in CD, either he or his Representative must serve as the Employer of Record.
  - 2. The Employer of Record is responsible for the following:
    - (i) Recruiting, hiring and firing Workers;
    - (ii) Determining Workers' duties and developing job descriptions;
    - (iii) Scheduling Workers;
    - (iv) Supervising Workers;
    - (v) Evaluating Worker performance and addressing any identified deficiencies or concerns;
    - (vi) Setting wages from a range of reimbursement levels established by the Bureau;
    - (vii) Training Workers to provide personalized care based on the Member's needs and preferences;
    - (viii) Ensuring that Workers deliver only those services authorized, and reviewing and approving hours worked by Consumer-Directed Workers;
    - (ix) Reviewing and ensuring proper documentation for services provided; and
    - (x) Developing and implementing as needed a Back-up Plan to address instances when a scheduled Worker is not available or fails to show up as scheduled.
- (f) Denial of Enrollment in CD.
- 1. Enrollment into CD may be denied by the Bureau when:
    - (i) The person is not enrolled in TennCare or in CHOICES Group 2 or CHOICES Group 3.

- (ii) The Member does not need one or more of the HCBS eligible for CD, as specified in the POC.
  - (iii) The Member is not willing or able to serve as the Employer of Record for his Consumer-Directed Workers and to fulfill all of the required responsibilities for CD, and does not have a qualified Representative who is willing and able to serve as the Employer of Record and to fulfill all of the required responsibilities for CD.
  - (iv) The Member is unwilling to sign a Risk Agreement which identifies and addresses any additional risks associated with the Member's decision to participate in CD, or the risks associated with the Member's decision to participate in CD pose too great a threat to the Member's health, safety and welfare.
  - (v) The Member does not have an adequate Back-up Plan for CD.
  - (vi) The Member's needs cannot be safely and appropriately met in the community while participating in CD.
  - (vii) The Member or his Representative for CD, or the Consumer-Directed Workers he wants to employ are unwilling to use the services of the Bureau's contracted FEA to perform required Financial Administration and Supports Brokerage functions.
  - (viii) Other significant concerns regarding the Member's participation in CD which jeopardize the health, safety or welfare of the Member.
2. Denial of enrollment in CD gives rise to notice and due process including the right to a fair hearing, as set forth in this rule.
- (g) Fiscal Employer Agent (FEA).
- 1. The FEA shall perform the following functions on behalf of all Members participating in CD:
    - (i) Financial Administration functions in the performance of payroll and related tasks; and
    - (ii) Supports Brokerage functions to assist the Member or his Representative with other non-payroll related tasks such as recruiting and training workers.
  - 2. The FEA shall:
    - (i) Assign a Supports Broker to each CHOICES Member electing to participate in CD of HCBS.
    - (ii) Provide initial and ongoing training to Members and their Representatives (as applicable) on CD and other relevant issues.
    - (iii) Verify Worker qualifications, including conducting background checks on Workers, enrolling Workers into TennCare, assigning Medicaid provider ID numbers, and holding TennCare provider agreements.
    - (iv) Provide initial and ongoing training to workers on CD and other relevant issues.
    - (v) Assist the Member and/or Representative in developing and updating Service Agreements.
    - (vi) Withhold, file and pay applicable federal, state and local income taxes; employment and unemployment taxes; and worker's compensation.
    - (vii) Pay Workers for authorized services rendered within authorized timeframes.

(h) Back-up Plan for Consumer-Directed Workers.

1. Each Member participating in CD or his Representative is responsible for the development and implementation of a Back-up Plan that identifies how the Member or Representative will address situations when a scheduled Worker is not available or fails to show up as scheduled.
2. The Member or Representative may not elect, as part of the Back-up Plan, to go without services.
3. The Back-up Plan for CD shall include the names and telephone numbers of contacts (Workers, agency staff, organizations, supports) for alternate care, the order in which each shall be notified and the services to be provided by contacts.
4. Back-up contacts may include paid and unpaid supports; however, it is the responsibility of the Member electing CD and/or his Representative to secure paid (as well as unpaid) back-up contacts who are willing and available to serve in this capacity, and for initiating the back-up plan when needed.
5. The Member's Back-up Plan for Consumer-Directed Workers shall be integrated into the Member's Back-up Plan for services provided by Contract Providers, as applicable, and the Member's POC.
6. The Care Coordinator shall review the Back-up Plan developed by the Member and/or his Representative to determine its adequacy to address the Member's needs. If an adequate Back-up Plan cannot be provided to CD, enrollment into CD may be denied, as set forth in this Rule.
7. The Back-up Plan shall be reviewed and updated at least annually, and as frequently as necessary if there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in Workers (when such Workers also serve as a back-up to other Workers) and changes in the availability of paid or unpaid back-up Workers to deliver needed care.
8. A Member may use Contract Providers to serve as back-up to Consumer Directed Workers only upon prior arrangement by the Member (or Representative for CD) with the Contract Provider, inclusion in the Member's back-up plan, verification by the Supports Broker, prior approval by the MCO and subject to the Member's Individual Cost Neutrality Cap as described in Rule 1200-13-01-.05(4)(c). If the higher cost of services delivered by a Contract Provider would result in a Member's Cost Neutrality Cap being exceeded, a Member shall not be permitted to use Contract Providers to provide back-up workers. A Member's MCO shall not be required to maintain Contract Providers on "stand-by" to provide back-up for services delivered through Consumer Direction.

(i) Consumer-Directed Workers (Workers).

1. Hiring Consumer-Directed Workers.
  - (i) Members shall have the flexibility to hire individuals with whom they have a close personal relationship to serve as Workers, such as neighbors or friends.
  - (ii) Members may hire family members, excluding spouses, to serve as Workers. However, a family member shall not be reimbursed for a service that he would have otherwise provided without pay. A Member shall not be permitted to employ any person who resides with the Member to deliver Personal Care Visits, Attendant Care, or In-Home Respite Care. A Member or his Representative for CD shall not be permitted to employ either of the following to deliver Companion Care services:
    - (l) An Immediate Family Member as defined in Rule 1200-13-01-.02.

- (II) Any person with whom the Member currently resides, or with whom the Member has resided in the last five (5) years.
  - (iii) Members may elect to have a Worker provide more than one service, have multiple Workers, or have both a Worker and a Contract Provider for a given service, in which case, there must be a set schedule which clearly defines when Contract Providers will be used.
2. Qualifications of Consumer-Directed Workers. Workers must meet the following requirements prior to providing services:
- (i) Be at least eighteen (18) years of age or older.
  - (ii) Pass a background check that includes a criminal background check (including fingerprinting), or, as an alternative, a background check from a licensed private investigation company.
  - (iii) Verification that the person's name does not appear on the State abuse registry.
  - (iv) Verification that the person's name does not appear on the State and national sexual offender registries and licensure verification, as applicable.
  - (v) Complete all required training.
  - (vi) Complete all required applications to become a TennCare provider.
  - (vii) Sign an abbreviated Medicaid agreement.
  - (viii) Be assigned a Medicaid provider ID number.
  - (ix) Sign a Service Agreement.
  - (x) If the Worker will be transporting the Member as specified in the Service Agreement, a valid driver's license and proof of insurance must also be provided.
3. Disqualification from Serving as a Consumer-Directed Worker. A Member cannot waive a background check for a potential Worker. The following findings shall disqualify a person from serving as a Worker:
- (i) Conviction of an offense involving physical, sexual or emotional abuse, neglect, financial exploitation or misuse of funds, misappropriation of property, theft from any person, violence against any person, or manufacture, sale, possession or distribution of any drug.
  - (ii) Entering of a plea of nolo contendere or when a jury verdict of guilty is rendered but adjudication of guilt is withheld with respect to a crime reasonably related to the nature of the position sought or held.
  - (iii) Identification on the abuse registry.
  - (iv) Identification on the State or national sexual offender registry.
  - (v) Failure to have a required license.
  - (vi) Refusal to cooperate with a background check.
4. Exception to Disqualification of a Consumer-Directed Worker. If a Worker fails the background check, an exception to disqualification may be granted at the Member's discretion if all of the following conditions are met:

- (i) Offense is a misdemeanor;
- (ii) Offense occurred more than five (5) years prior to the background check;
- (iii) Offense is not related to physical or sexual or emotional abuse of another person;
- (iv) Offense does not involve violence against another person or the manufacture, sale, or distribution of drugs; and
- (v) There is only one disqualifying offense.

5. Service Agreement.

- (i) A Member shall develop a Service Agreement with each Worker, which includes, at a minimum:
  - (I) The roles and responsibilities of the Worker and the Member;
  - (II) The Worker's schedule (as developed by the Member and/or Representative), including hours and days;
  - (III) The scope of each service (i.e., the specific tasks and functions the Worker is to perform);
  - (IV) The service rate; and
  - (V) The requested start date for services.
- (ii) The Service Agreement must be in place for each Worker prior to the Worker providing services.
- (iii) The Service Agreement shall also stipulate if a Worker will provide one or more Self-Directed Health Care Tasks, the specific task(s) to be performed, and the frequency of each Self-Directed Health Care Task.

6. Payments to Consumer-Directed Workers.

- (i) Rates.

With the exception of Companion Care Services, Members participating in CD have the flexibility to set wages for their Workers from a range of reimbursement levels established by TennCare.

- (I) Monthly Companion Care rates are only available for a full month of service delivery and will be pro-rated when a lesser number of days are actually delivered.
  - (II) The back-up per diem rate is available only when a regularly scheduled companion is ill or unexpectedly unable to deliver services, and shall not be authorized as a component of ongoing Companion Care Services.
- (ii) Payments to Consumer-Directed Workers. In order to receive payment for services rendered, all Workers must:
    - (I) Deliver services in accordance with the schedule of services specified in the Member's POC and in the MCO's service authorization, and in accordance with Worker assignments determined by the Member or his Representative.
    - (II) Use the EVV system to log in and out at each visit.

- (III) Provide detailed documentation of service delivery including but not limited to the specific tasks and functions performed for the Member at each visit, which shall be maintained in the Member's home.
  - (IV) Provide no more than forty (40) hours of services within a consecutive seven (7) day period, unless explicitly permitted by program guidelines and in accordance with service authorizations.
- (iii) Termination of Consumer-Directed Workers' Employment.
- (I) A Member may terminate a Worker's employment at any time.
  - (II) The MCO may not terminate a Worker's employment, but may request that a Member be involuntarily withdrawn from CD if it is determined that the health, safety and welfare of the Member may be in jeopardy if the Member continues to employ a Worker but the Member and/or Representative does not want to terminate the Worker.
- (j) Self-Direction of Health Care Tasks.
1. A Competent Adult, as defined in this Chapter, with a functional disability living in his own home, enrolled in CHOICES Group 2 or CHOICES Group 3, and participating in CD, or his Representative for CD, may choose to direct and supervise a Consumer-Directed Worker in the performance of a Health Care Task as defined in this Chapter.
  2. For purposes of this rule, home does not include a NF or ACLF.
  3. A Member shall not receive additional amounts of any service as a result of his decision to self-direct health care tasks. Rather, the Health Care Tasks shall be performed by the Worker in the course of delivering Eligible CHOICES HCBS already determined to be needed, as specified in the POC.
  4. Health Care Tasks that may be self-directed for the purposes of this Subparagraph are limited to administration of oral, topical and inhaled medications.
  5. The Member or Representative who chooses to self-direct a health care task is responsible for initiating self-direction by informing the health care professional who has ordered the treatment which involves the Health Care Task of the individual or caregiver's intent to perform that task through self-direction. The provider shall not be required to prescribe self-direction of the health care task.
  6. When a licensed health care provider orders treatment involving a Health Care Task to be performed through self-directed care, the responsibility to ascertain that the Member or caregiver understands the treatment and will be able to follow through on the Self-Directed Health Care Task is the same as it would be for a Member or caregiver who performs the Health Care Task for himself, and the licensed health care provider incurs no additional liability when ordering a Health Care Task which is to be performed through self-directed care.
  7. The Member or his Representative for CD will identify one or more Consumer-Directed Workers who will perform the task in the course of delivery of Eligible CHOICES HCBS. If a Worker agrees to perform the Health Care Tasks, the tasks to be performed must be specified in the Service Agreement. The Member or his Representative for CD is solely responsible for identifying a Worker who is willing to perform Health Care Tasks, and for instructing the paid personal aide on the task(s) to be performed.
  8. The Member or his Representative for CD must also identify in his Back-up Plan for CD who will perform the Health Care Task if the Worker is unavailable, or stops performing the task for any reason.

9. Ongoing monitoring of the Worker performing self-directed Health Care Tasks is the responsibility of the Member or his Representative. Members are encouraged to use a home medication log as a tool to document medication administration. Medications should be kept in original containers, with labels intact and legible.
- (k) Withdrawal from Participation in Consumer Direction (CD).
1. General.
    - (i) Voluntary Withdrawal from CD. Members participating in CD may voluntarily withdraw from participation in CD at any time. The Member's request must be in writing. Whenever possible, notice of a Member's decision to withdraw from participation in CD should be provided in advance to permit time to arrange for delivery of services through Contracted Providers.
    - (ii) Voluntary or involuntary withdrawal of a Member from CD of Eligible CHOICES HCBS shall not affect a Member's eligibility for LTSS or enrollment in CHOICES, provided the Member continues to meet all requirements for enrollment in CHOICES as defined in this Chapter.
    - (iii) If a Member voluntarily withdraws or is involuntarily withdrawn from CD, any Eligible CHOICES HCBS he receives, with the exception of Companion Care, shall be provided through Contract Providers, subject to the requirements in this Chapter. Companion Care is only available through CD.
  2. Involuntary Withdrawal.
    - (i) A person may be involuntarily withdrawn from participation in CD of HCBS for any of the following reasons:
      - (I) The person is no longer enrolled in TennCare.
      - (II) The person is no longer enrolled in either CHOICES Group 2 or CHOICES Group 3.
      - (III) The Member no longer needs any of the Eligible CHOICES HCBS, as specified in the POC.
      - (IV) The Member is no longer willing or able to serve as the Employer of Record for his Consumer-Directed Workers and to fulfill all of the required responsibilities for CD, and does not have a qualified Representative who is willing and able to serve as the Employer of Record and to fulfill all of the required responsibilities for CD.
      - (V) The Member is unwilling to sign a Risk Agreement, as applicable, which identifies and addresses any additional risks associated with the Member's decision to participate in CD, or the risks associated with the Member's decision to participate in CD pose too great a threat to the Member's health, safety and welfare.
      - (VI) The health, safety and welfare of the Member may be in jeopardy if the Member or his Representative continues to employ a Worker but the Member or Representative does not want to terminate the Worker.
      - (VII) The Member does not have an adequate Back-up Plan for CD.
      - (VIII) The Member's needs cannot be safely and appropriately met in the community while participating in CD.

- (IX) The Member or his Representative for CD, or Consumer-Directed Workers he wants to employ are unwilling to use the services of the Bureau's contracted FEA to perform required Financial Administration and Supports Brokerage functions.
- (X) The Member or his Representative for CD is unwilling to abide by the requirements of the CHOICES CD program.
- (XI) If a Member's Representative fails to perform in accordance with the terms of the Representative Agreement and the health, safety and welfare of the Member is at risk, and the Member wants to continue to use the Representative.
- (XII) If a Member has consistently demonstrated that he is unable to manage, with sufficient supports, including appointment of a Representative, his services and the Care Coordinator or FEA has identified health, safety and/or welfare issues.
- (XIII) A Care Coordinator has determined that the health, safety and welfare of the Member may be in jeopardy if the Member continues to employ a Worker but the Member or Representative does not want to terminate the Worker.
- (XIV) Other significant concerns regarding the Member's participation in CD which jeopardize the health, safety or welfare of the Member.
  - (ii) The Bureau must review and approve all MCO requests for involuntary withdrawal from CD of HCBS before such action may occur. If the Bureau approves the request, written notice shall be given to the Member at least ten (10) days in advance of the withdrawal. The date of withdrawal may be delayed when necessary to allow adequate time to transition the Member to Contract Provider services as seamlessly as possible.
  - (iii) The Member shall have the right to appeal involuntary withdrawal from CD.
  - (iv) If a person is no longer enrolled in TennCare or in CHOICES, his participation in CD shall be terminated automatically.

(10) Nursing Facilities (NFs) in CHOICES.

- (a) Conditions of participation. NFs participating in CHOICES must meet all of the conditions of participation and conditions for reimbursement outlined in their provider agreements with the TennCare MCOs.
- (b) Level 1 reimbursement methodology for NF care: See Rule 1200-13-01-.03(6).
- (c) Level 2 reimbursement methodology for NF care: See Rule 1200-13-01-.03(7).
- (d) Enhanced Respiratory Care reimbursement methodology for NF care: See Rule 1200-13-01.03(8).
- (e) Non-participating providers. NFs that wish to continue serving existing residents without entering into provider agreements with TennCare MCOs will be considered non-participating providers.
  1. Non-participating NF providers must comply with Rules 1200-13-01-.03, 1200-13-01-.06, and 1200-13-01-.09.
  2. Non-participating providers must sign a modified contract (called a case agreement) with the MCO to continue receiving reimbursement for existing residents, including residents who may become Medicaid eligible.

3. Non-participating NF providers will be reimbursed eighty percent (80%) of the lowest rate paid to any participating NF provider in Tennessee for the applicable level of NF services.
    - (f) Bed holds. See Rule 1200-13-01-.03(9).
    - (g) Other reimbursement issues. See Rule 1200-13-01-.03(10).
- (11) HCBS Providers in CHOICES.
- (a) HCBS providers delivering care under CHOICES must meet specified license requirements and shall meet conditions for reimbursement outlined in their provider agreements with the TennCare MCOs.
  - (b) Non-participating HCBS providers will be reimbursed by the Member's MCO at eighty percent (80%) of the lowest rate paid to any HCBS provider in the state for that service.
- (12) Appeals.
- (a) Appeals related to determinations of eligibility for TennCare Medicaid or TennCare Standard are processed by DHS, in accordance with Chapters 1200-13-13 and 1200-13-14.
  - (b) Appeals related to the denial, reduction, suspension, or termination of a covered service are processed by the Bureau in accordance with Rules 1200-13-13-.11 and 1200-13-14-.11.
  - (c) Appeals related to the PAE process (including decisions pertaining to the PASRR process) are processed by the Bureau's Division of Long-Term Services and Supports in accordance with Rule 1200-13-01-.10(7).
  - (d) Appeals related to the enrollment or disenrollment of an individual in CHOICES or to denial or involuntary withdrawal from participation in CD are processed by the Division of Long-Term Services and Supports in the Bureau, in accordance with the following procedures:
    1. If enrollment into CHOICES or if participation in CD is denied, notice containing an explanation of the reason for such denial shall be provided. The notice shall include the person's right to request a fair hearing within thirty (30) days from receipt of the written notice regarding valid factual disputes pertaining to the enrollment denial decision.
    2. If a Member is involuntarily disenrolled from CHOICES, or if participation in CD is involuntarily withdrawn, advance notice of involuntary disenrollment or withdrawal shall be issued. The notice shall include a statement of the Member's right to request a fair hearing within thirty (30) days from receipt of the written notice regarding valid factual disputes pertaining to the decision.
    3. Appeals regarding denial of enrollment into CHOICES, involuntary disenrollment from CHOICES, or denial or involuntary withdrawal from participation in CD must be filed in writing with the TennCare Division of Long-Term Services and Supports within thirty-five (35) days of issuance of the written notice if the appeal is filed with the Bureau by fax, and within forty (40) days of issuance of the written notice if the appeal is mailed to the Bureau. This allows five (5) days mail time for receipt of the written notice and when applicable, five (5) days mail time for receipt of the written appeal.
    4. In the case of involuntary disenrollment from CHOICES only, if the appeal is received prior to the date of action, continuation of CHOICES benefits shall be provided, pending resolution of the disenrollment appeal.
    5. In the case of involuntary withdrawal from participation in CD, if the appeal is received prior to the date of action, continuation of participation in CD shall be provided, unless such continuation would pose a serious risk to the Member's health, safety and welfare,

in which case, services specified in the POC shall be made available through Contract Providers pending resolution of the appeal.