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Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. T.C.A. § 4-5-205

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Revision Type (check all that apply):
X Amendments
___ New
___ Repeal

Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1200-13-01	TennCare Long-Term Care Program
Rule Number	**Rule Title**
1200-13-01-.01	Purpose
1200-13-01-.02	Definitions
1200-13-01-.05	TennCare CHOICES Program
1200-13-01-.08	Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC
1200-13-01-.10	Medical (Level of Care) Eligibility Criteria for Medicaid Reimbursement of Care in Nursing Facilities

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Rule title 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC in the Table of Contents is amended by replacing "LTC" with "LTSS" so as amended Rule title 1200-13-01-.08 shall read as follows:

Rule 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTSS

Rule title 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for Medicaid Reimbursement of Care in Nursing Facilities in the Table of Contents is deleted its entirety and replaced with a new Rule title 1200-13-01-.10 which shall read as follows:

Rule 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for TennCare Reimbursement of Care in Nursing Facilities, CHOICES HCBS and PACE

Paragraph (1) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and replaced with a new Paragraph (1) which shall read as follows:

(1) The purpose of this Chapter is to set forth requirements pertaining to the Long-Term Services and Supports (LTSS; formerly and also known as the Long-Term Care or LTC) delivery system.

The introductory language to Subparagraph (2) of Rule 1200-13-01-.01 Purpose is amended by deleting "LTC" and replacing it with "LTSS" so as amended the introductory language shall read as follows:

(2) The Bureau of TennCare (Bureau) offers the following LTSS programs and services:

Subparagraphs (a) and (b) of Paragraph (2) of Rule 1200-13-01-.01 Purpose are deleted in their entirety and subsequent Subparagraphs re-lettered accordingly.

Part 2. of Subparagraph (c) re-lettered as (a) of Paragraph (2) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and replaced with a new Part 2. which shall read as follows:

2. HCBS for the elderly and adults who have Physical Disabilities.

Paragraph (3) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and replaced with a new Paragraph (3) which shall read as follows:

(3) Individuals receiving LTSS shall be enrolled in Managed Care Contractors (MCCs) as follows:

(a) Individuals receiving TennCare-reimbursed LTSS, other than those enrolled in the PACE Program or persons approved for Immediate Eligibility pursuant to these rules, are also enrolled in a TennCare MCO for primary care, behavioral health services, and acute care services.

(b) In addition to enrollment in an MCO, the following LTSS Enrollees, other than those enrolled in the PACE Program or persons approved for Immediate Eligibility pursuant to these rules, are enrolled with the TennCare Pharmacy Benefits Manager for coverage of prescription drugs:

1. Children under the age of twenty-one (21); and

2. Adults aged twenty-one (21) and older who are not Medicare beneficiaries.

(c) Children under the age of twenty-one (21) who are LTSS Enrollees are also enrolled with the TennCare Dental Benefits Manager (DBM) for coverage of dental services.

Subparagraph (d) ALA – Administrative Lead Agency of Paragraph (4) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and subsequent Subparagraphs re-lettered accordingly.

Subparagraphs (k) and (l) re-lettered as (j) and (k) of Paragraph (4) of Rule 1200-13-01-.01 Purpose are deleted in their entirety and replaced with new Subparagraphs (j) and (k) which shall read as follows:

(j) DIDD – Tennessee Department of Intellectual and Developmental Disabilities (formerly known as Tennessee Department of Finance and Administration's Division of Intellectual Disabilities Services or DIDS)

(k) DMH – Tennessee Department of Mental Health and Substance Abuse Services (formerly known as the Tennessee Department of Mental Health and Developmental Disabilities)

Subparagraph (m) E/D Elderly and/or Disabled re-lettered as (l) of Paragraph (4) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and subsequent Subparagraphs re-lettered accordingly.

Subparagraph (u) ICF/MR re-lettered as (s) of Paragraph (4) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and subsequent Subparagraphs re-lettered accordingly.

Paragraph (4) of Rule 1200-13-01-.01 Purpose is amended by adding new Subparagraphs (t) and (u) and re-lettering the current re-lettered Subparagraphs (t) and (u) as (v) and (w) with subsequent Subparagraphs re-lettered accordingly so as amended the new Subparagraphs (t) and (u) shall read as follows:

(t) ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities (formerly and also known as Intermediate Care Facility for persons with Mental Retardation or ICF/MR).

(u) ID – Intellectual Disability(ies) (formerly and also known as MR).

Subparagraph (x) re-lettered as (w) of Paragraph (4) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and replaced with a new Subparagraph (w) which shall read as follows:

(w) LTC – Long-Term Care (also known as LTSS)

Paragraph (4) of Rule 1200-13-01-.01 Purpose is amended by adding a new Subparagraph (x) and re-lettering the current re-lettered Subparagraph (x) as (y) with subsequent Subparagraphs re-lettered accordingly so as amended the new Subparagraph (x) shall read as follows:

(x) LTSS – Long-Term Services and Supports (formerly and also known as LTC)

Subparagraph (bb) of Paragraph (4) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and replaced with a new Subparagraph (bb) which shall read as follows:

(bb) MR – Mental Retardation (also known as ID)

Paragraph (4) of Rule 1200-13-01-.01 Purpose is amended by adding a new Subparagraph (tt) and re-lettering the current Subparagraph (tt) as (uu) so as amended the new Subparagraph (tt) shall read as follows:

(tt) TPAES – TennCare Pre-Admission Evaluation System

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Rule 1200-13-01-.02 Definitions is deleted in its entirety and replaced with a new Rule 1200-13-01-.02 which shall read as follows:

1200-13-01-.02 Definitions.

(1) Activities of Daily Living (ADLs). Routine self-care tasks that people typically perform independently on a daily basis. One of the components of Level of Care eligibility for LTSS is a person's ability to independently perform (or the amount of assistance needed to perform) certain ADLs, such as:

(a) Personal hygiene and grooming;

(b) Dressing and undressing;

(c) Self feeding;

(d) Functional transfers (getting into and out of bed or wheelchair, getting onto or off toilet, etc.);

(e) Bowel and bladder management; and

(f) Ambulation (walking with or without use of an assistive device, e.g., walker, cane or crutches; or using a wheelchair).

(2) Adult Care Home. For purposes of CHOICES:

(a) A CBRA licensed by the DOH (see Rule 1200-08-36) that offers twenty-four (24) hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet NF LOC, but who prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-day basis is living in the home with the individuals for whom he is providing care.

(b) Coverage shall not include the costs of Room and Board.

(c) Pursuant to State law, licensure is currently limited to Critical Adult Care Homes for persons who are ventilator dependent or adults with traumatic brain injury.

(3) Adult Day Care.

(a) Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day and delivered in an Adult Day Care facility permanently licensed by DHS or a Mental Retardation Adult Habilitation Day Facility licensed by DMH, or as of July 1, 2012, by DIDD.

(b) Services shall be provided pursuant to an individualized POC by a licensed provider not related to the participating adult.

(c) The provider shall be responsible for the provision of all assistance and supervision required by program participants. Such assistance is a component of the Adult Day Care benefit and shall not be billed as a separate HCBS.

(4) Advance Determination. A decision made by the Bureau in accordance with the process and requirements described in Rule 1200-13-01-.05(6) that an Applicant would not qualify to enroll in CHOICES Group 3 (including Interim CHOICES Group 3) when enrollment into CHOICES Group 3 has not actually been denied or terminated, and which may impact the person's NF LOC eligibility (see Rule 1200-13-01-.10(4)(b)(2)(i)(II) and 1200-13-01-.10(4)(b)(2)(ii)(II)).

(5) Applicant. A person applying for TennCare-reimbursed LTSS, for whom a PAE has been submitted to TennCare, and/or by or on behalf of whom a Medicaid application has been submitted to DHS. For purposes of compliance with the Linton Order, the term shall include all individuals who have affirmatively expressed an intent to be considered for current or future admission to a NF or requested that their name be entered on any "wait list." All individuals who contact a NF to casually inquire about the facility's services or admissions policies shall be informed by the facility of that individual's right to apply for admission and be considered for admission on a nondiscriminatory basis and in conformance with Rule 1200-13-01-.06.

(6) Area Agencies on Aging and Disability (AAAD). Agencies designated by the Commission on Aging and Disability or its successor organization to plan for and provide services to the elderly and disabled within a defined geographic area as provided by T.C.A. Title 71, Chapter 2.

(7) Arlington ID Waiver. HCBS Waiver for persons with ID under Section 1915(c) of the Social Security Act (limited to members of the Arlington class certified in United States v. Tennessee, et al.).

(8) Assisted Care Living Facility (ACLF) Services.

(a) CBRA to NF care in an ACLF licensed by the DOH pursuant to Rule 1200-08-25 that provides and/or arranges for daily meals, personal care, homemaker and other supportive services or health care including medication oversight (to the extent permitted under State law), in a home-like environment to persons who need assistance with ADLs.

(b) Coverage shall not include the costs of Room and Board.

(9) Assistive Technology. Assistive devices, adaptive aids, controls or appliances that enable an Enrollee to increase his ability to perform ADLs or to perceive or control his environment. Examples include, but are not limited to, "grabbers" to pick objects off the floor, a strobe light to signify the smoke alarm has been activated, etc.

(10) At Risk for Institutionalization. A requirement for eligibility to enroll in CHOICES Group 3 (including Interim CHOICES Group 3), whereby an individual does not meet the NF LOC criteria in place as of July 1, 2012, but meets the NF LOC criteria in place as of June 30, 2012, as defined in TennCare Rule 1200-13-01-.10(4) such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement.

(11) Attendant Care. For purposes of CHOICES, services to a Member who, due to age and/or Physical Disabilities, needs more extensive assistance than can be provided through intermittent Personal Care Visits (i.e., more than four (4) hours per occurrence or visits at intervals of less than four (4) hours between visits) to provide hands-on assistance and related tasks as specified below, and that may also include safety monitoring and/or supervision.

(a) Attendant Care may include assistance with the following:

1. ADLs such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation.

2. Continuous safety monitoring and supervision during the period of service delivery.

(b) For Members who require hands-on assistance with ADLs, Attendant Care may also include the following homemaker services that are essential, although secondary, to the hands-on assistance with ADLs needed by the Member in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:

1. Picking up the Member's medications or shopping for the Member's groceries.

2. Preparing the Member's meals and/or educating caregivers about preparation of nutritious meals for the Member.

3. Household tasks such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, and doing the Member's personal laundry, ironing and mending.

(c) Attendant Care shall not be provided for Members who do not require hands-on assistance with ADLs.

(d) Attendant Care shall be primarily provided in the Member's place of residence, except as permitted by rule and within the scope of service (e.g., picking up medications or shopping for groceries) when accompanying or transporting the Member into the community pursuant to Rule 1200-13-01-.05(8)(n), or under exceptional circumstances as authorized by an MCO in the POC to accommodate the needs of the Member.

(e) A single Contract Provider staff person or Consumer-Directed Worker may provide Attendant Care services to multiple CHOICES Members in the same home and during the same hours, as long as he can provide the services safely and appropriately to each Member. Such arrangements shall be documented in each Member's POC. In such instances, the total units of service provided by the staff person shall be allocated among the CHOICES Members, based on the percentage of total service units required by each Member on average. The Provider shall bill the MCO only once for each of the service units provided, and shall not bill an MCO or multiple MCOs separately to provide services to multiple Members at the same time.

(f) Regardless of payer, Attendant Care shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services, or while a Member is receiving Adult Day Care services.

(g) Attendant Care shall not include:

1. Care or assistance including meal preparation or household tasks for other residents of the same household;

2. Yard work; or

3. Care of non-service related pets and animals.

(12) Back-up Plan.

(a) A written plan that is a required component of the POC for all CHOICES Members receiving Companion Care or non-residential CHOICES HCBS in their own homes and that specifies unpaid persons and in the case of services provided through Consumer Direction, paid Consumer-Directed Workers and/or Contract Providers (as applicable and in accordance with 1200-13-01-.05(9)(h)(8)) who are available, and have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled CHOICES HCBS providers or Workers are unavailable or do not arrive as scheduled.

(b) A CHOICES Member or his Representative may not elect, as part of the Back-up Plan, to go without services.

(c) The Back-up Plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The Member and his Representative (as applicable) shall have primary responsibility for the development and implementation of the Back-up Plan for consumer-directed services with assistance from the FEA as needed.

(13) Bed Hold. The policy by which NFs receiving Level 1 reimbursement for NF care and ICFs/IID are reimbursed for holding a resident's bed while he is away from the facility, in accordance with this Chapter.

(14) Bureau of TennCare (Bureau). The division of the Department of Finance and Administration, the single state Medicaid agency that administers the TennCare Program. For the purposes of this Chapter, the Bureau shall represent the State of Tennessee.

(15) Care Coordinator. For purposes of CHOICES, a person who is employed or contracted by an MCO to perform the continuous process of care coordination:

(a) Assessing a Member's physical, behavioral, functional, and psychosocial needs;

(b) Identifying the physical health, behavioral health, and LTSS and other social support services and assistance (e.g., housing or income assistance) necessary to meet identified needs;

(c) Ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and LTSS needed to help the Member maintain or improve his physical or behavioral health status or functional abilities and maximize independence; and

(d) Facilitating access to other social support services and assistance needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.

(16) Centers for Medicare and Medicaid Services (CMS). The agency within the United States Department of Health and Human Services that is responsible for administering Titles XVIII, XIX, and XXI of the Social Security Act.

(17) Certification.

(a) A process by which a Physician who is licensed as a doctor of medicine or doctor of osteopathy signs and dates a PAE signifying the following:

1. The person requires the requested level of institutional care or reimbursement (Level 1 NF, Level 2 NF, Enhanced Respiratory Care, or ICF/IID) or, in the case of a Section 1915(c) HCBS Waiver program or PACE, requires HCBS as an alternative to the applicable level of institutional care for which the individual would qualify; and

2. The requested LTSS are medically necessary for the individual.

(b) Consistent with requirements pertaining to certification of the need for SNF care set forth at 42 CFR § 424.20 and in Section 3108 of the Affordable Care Act, certification of the need for NF care may be performed by a nurse practitioner, clinical nurse specialist, or physician assistant, none of whom has a direct or indirect employment relationship with the facility but who is working in collaboration with a Physician.

(c) Physician certification is not required for CHOICES HCBS.

(18) CHOICES. See "TennCare CHOICES in Long-Term Services and Supports."

(19) CHOICES 1 and 2 Carryover Group.

(a) Individuals who were enrolled in CHOICES Group 1 or CHOICES Group 2 as of June 30, 2012, but who, upon redetermination, no longer qualify for enrollment due solely to the State's modification of its NF LOC criteria.

(b) Subject to the requirements set forth in 1200-13-01-.05(3)(b)6., Members eligible for TennCare in the CHOICES 1 and 2 Carryover Group 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 as of June 30, 2012, and remain continuously enrolled in the CHOICES 1 and 2 Carryover Group and in CHOICES Group 1 or CHOICES Group 2.

(20) CHOICES 217-Like Group. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with Physical Disabilities who meet the NF LOC criteria, who could have been eligible for HCBS under 42 C.F.R. § 435.217 had the State continued its Section 1915(c) Statewide E/D Waiver and who need and are receiving CHOICES HCBS as an alternative to NF care. This group is subject to the Enrollment Target for CHOICES Group 2.

(21) CHOICES At-Risk Demonstration Group.

(a) Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with Physical Disabilities who meet NF financial eligibility requirements for TennCare-reimbursed LTSS, meet the NF LOC in place on June 30, 2012, but not the NF LOC in place on July 1, 2012, and who, in the absence of CHOICES HCBS available through CHOICES Group 3, are At Risk for Institutionalization as defined in these rules.

(b) Members eligible for TennCare in the CHOICES At-Risk Demonstration Group 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, continue to be At Risk for Institutionalization as defined in these rules, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES Group 3.

(22) CHOICES Group 1. Individuals of all ages who are receiving TennCare-reimbursed care in a NF.

(23) CHOICES Group 2. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with Physical Disabilities who meet the NF LOC criteria and who qualify for TennCare either as SSI recipients or in an institutional category (i.e., as Members of the CHOICES 217-Like demonstration population), and who need and are receiving CHOICES HCBS as an alternative to NF care. The Bureau has the discretion to apply an Enrollment Target to this group, as described in this Chapter.

(24) CHOICES Group 3. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with Physical Disabilities who qualify for TennCare as SSI recipients, who do not meet the NF LOC, but who, in the absence of CHOICES HCBS, are At Risk for Institutionalization, as defined by the State. The Bureau has the discretion to apply an Enrollment Target to this group, as described in this Chapter.

(25) CHOICES Home and Community Based Services (HCBS). Services specified in Rule 1200-13-01-.05(8)(l) that are available only to eligible persons enrolled in CHOICES Group 2 or CHOICES Group 3 as an alternative to long-term care institutional services in a Nursing Facility or to delay or prevent placement in a Nursing Facility. Only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include Home Health or Private Duty Nursing services or any other HCBS that are covered by Tennessee's Title XIX State Plan or under the TennCare demonstration for all eligible Enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES Member's needs can be safely met in the community within his or her Individual Cost Neutrality Cap.

(26) CHOICES Member. An individual who has been enrolled by the Bureau into CHOICES.

(27) Chronic Ventilator Care Reimbursement. The rate of reimbursement provided for NF services, including enhanced respiratory care assistance, delivered by a NF that meets the requirements in Rule 1200-13-01-.03(5) to residents determined by the Bureau to meet the medical eligibility criteria in Rule 1200-13-01-.10(5)(d).

(28) Community Personal Needs Allowance. See "Personal Needs Allowance (PNA)."

(29) Community-Based Residential Alternatives (CBRA) to institutional care. For purposes of CHOICES:

(a) Residential services that offer a cost-effective, community-based alternative to NF care for individuals who are elderly and/or adults with Physical Disabilities, and meet NF LOC.

(b) CBRAs include, but are not limited to:

1. CBRA facilities such as ACLFs and Adult Care Homes; and

2. Companion Care.

(30) Companion Care. For purposes of CHOICES:

(a) A consumer-directed residential model in which a CHOICES Member may choose to select, employ, supervise and pay, using the services of an FEA, a live-in companion who will be present in the Member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration.

(b) Such model shall be available only for a CHOICES Member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with ADLs or supervision and monitoring for extended periods of time that cannot be accomplished more cost-effectively with other non-residential services.

(c) A CHOICES Member who requires assistance in order to direct his Companion Care may designate a Representative to assume CD of Companion Care services on his behalf, pursuant to requirements for Representatives otherwise applicable to CD.

(d) Regardless of payer, Companion Care shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving Short-Term NF services or Adult Day Care services.

(e) Companion Care is only available through CD.

(31) Competent Adult. For purposes of Self-Direction of Health Care Tasks in CD, a person age twenty-one (21) or older who has the capability and capacity to evaluate knowledgeably the options available and the risks attendant upon each and to make an informed decision acting in accordance with his own preferences and values. A person is presumed competent unless a decision to the contrary is made.

(32) Consumer Direction (CD) of Eligible CHOICES HCBS. For purposes of CHOICES, the opportunity for a Member assessed to need Eligible CHOICES HCBS (limited to Attendant Care, Personal Care Visits, In-Home Respite Care, or Companion Care) to elect to direct and manage (or to have a Representative direct and manage) certain aspects of the provision of such services, primarily the hiring, firing, and day-to-day supervision of Consumer-Directed Workers delivering the needed service(s).

(33) Consumer-Directed Worker (Worker).

(a) An individual who has been hired by a CHOICES Member participating in CD of Eligible CHOICES HCBS or by his Representative to provide one or more Eligible CHOICES HCBS to the Member.

(b) Does not include an employee of an agency that is being paid by an MCO to provide CHOICES HCBS to the Member.

(34) Contract Provider. A provider who is under contract with an Enrollee's MCO. Also called "Network Provider" or "In-Network Provider."

(35) Cost-Effective Alternative (CEA) Service.

(a) A service that is not a covered service but that is approved by TennCare and CMS and provided at an MCO's discretion. There is no entitlement to receive these services.

(b) CEA services may be provided because they are:

1. Alternatives to covered TennCare services that, in the MCO's judgment, are cost effective; or

2. Preventive in nature and offered to avoid the development of conditions that, in the MCO's judgment, would require more costly treatment in the future.

(c) CEA services need not be determined medically necessary except to the extent that they are provided as an alternative to covered TennCare services. Even if medically necessary, CEA services are not covered services and are provided only at an MCO's discretion.

(d) For purposes of CHOICES, CEA services may include the provision of CHOICES HCBS as an alternative to NF care when the Enrollment Target for CHOICES Group 2 has been reached as described in Rule 1200-13-01-.05.

(36) Cost Neutrality Cap. For purposes of CHOICES Group 2, the average cost of the level of NF reimbursement that would be paid if the Member were institutionalized. The Cost Neutrality Cap functions as a limit on the total cost of HCBS that can be provided to the individual in the home or community setting, including CHOICES HCBS, HH Services and PDN Services. The Cost Neutrality Cap shall be individually applied.

(37) Dental Benefits Manager (DBM). See "Dental Benefits Manager" in Rule 1200-13-13-.01.

(38) Department of Intellectual and Developmental Disabilities (DIDD). The State entity contracted by TennCare to serve as the OAA for day-to-day operation of the HCBS waivers for persons with ID. Formerly known as the Division of Intellectual Disabilities Services (DIDS).

(39) Designated Correspondent. A person or agency authorized by an individual on the PAE form to receive correspondence related to NF or ICF/IID services on his behalf.

(40) Disenrollment. The voluntary or involuntary termination of an individual's enrollment in an LTSS Program.

(41) Electronic Visit Verification (EVV) system. An electronic system that paid caregivers use to check-in at the beginning and check-out at the end of each period of service delivery. The system is used to monitor Member receipt of specified CHOICES HCBS and also to generate claims for submission by the provider.

(42) Eligible CHOICES HCBS. For purposes of CD, CHOICES HCBS that may be consumer-directed are limited to Attendant Care, Personal Care Visits, In-Home Respite Care, or Companion Care. Eligible CHOICES HCBS do not include Home Health or Private Duty Nursing services.

(43) Employer of Record. The Member participating in CD of Eligible CHOICES HCBS or a Representative designated by the Member to assume the CD of Eligible CHOICES HCBS functions on the Member's behalf.

(44) Enhanced Respiratory Care Reimbursement. Specified levels of reimbursement (i.e., Chronic Ventilator Care, Tracheal Suctioning and Ventilator Weaning) provided for NF services delivered by a SNF that meets the requirements set forth in Rule 1200-13-01-.03(5) to persons determined by the Bureau or an MCO, as applicable, to meet specified medical eligibility criteria for such level of reimbursement.

(45) Enrollee. A TennCare-eligible individual who is enrolled in a TennCare LTSS Program.

(46) Enrollment Target.

(a) The maximum number of individuals who can be enrolled in CHOICES Group 2 or CHOICES Group 3 at any given time, subject to the exceptions provided in this Chapter.

(b) The Enrollment Target is not calculated on the basis of "unduplicated participants." Vacated slots in CHOICES Group 2 or CHOICES Group 3 may be refilled immediately, rather than being held until the next program year, as is required in the HCBS Waiver programs.

(c) Persons enrolled in CHOICES Group 2 prior to July 1, 2012, who remain enrolled in CHOICES Group 2 and continue to qualify for TennCare in the CHOICES 1 and 2 Carryover Group shall be counted against the Enrollment Target for CHOICES Group 2.

(47) Expenditure Cap. For purposes of CHOICES Group 3, the annual limit on expenditures for CHOICES HCBS, excluding Minor Home Modifications, that a CHOICES Group 3 Member can receive. The Expenditure Cap shall be $15,000 (fifteen thousand dollars) per Member per calendar year.

(48) Expiration Date.

(a) A date assigned by the Bureau at the time of approval of a PAE after which TennCare reimbursement will not be made unless a new PAE is submitted and approved, or 365 days after the PAE Approval Date when the PAE has not been used.

(b) A PAE is "used" when the individual has begun receiving LTSS based on the LOC approved in the PAE.

(c) A PAE is "expired" when the individual has not begun receiving LTSS on or before the 365th day or when an assigned approval end date is reached or as specified in 1200-13-01-.10(2)(e).

(d) The first claim for reimbursement may be submitted after the 365th day, so long as the first date of service is on or before the 365th day.

(49) Federal Estate Recovery Program (FERP). A federal program set forth under Section 1917(b) of the Social Security Act that requires states offering Medicaid-reimbursed LTSS to seek adjustment or recovery for certain types of medical assistance from the estates of individuals who were age fifty-five (55) or older at the time such assistance was received, and from permanently institutionalized individuals of any age. For both mandatory populations, the State may elect to recover up to the total cost of all medical assistance provided.

(a) For persons age fifty-five (55) and older, the State is obligated to seek adjustment or recovery for NF (including ICF/IID) services, HCBS, and related hospital and prescription drug services.

(b) For permanently institutionalized persons, states are obligated to seek adjustment or recovery for the institutional services.

(50) Fee-for-Service (FFS) System. An arrangement whereby the Bureau, rather than the MCO, is responsible for arranging for covered LTSS and paying claims for these services.

(51) Fiscal Employer Agent (FEA). An entity contracting with the Bureau and/or an MCO that helps CHOICES Members participating in CD of Eligible CHOICES HCBS. The FEA provides both financial administration and supports brokerage functions for CHOICES Members participating in CD of Eligible CHOICES HCBS. This term is used by the IRS to designate an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6, and Notice 2003-70 as the agent to Members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA, and FUTA taxes. The FEA also files state income tax withholding and unemployment insurance tax forms and pays the associated taxes and processes payroll based on the Eligible CHOICES HCBS authorized and provided.

(52) Grand Divisions. See "Grand Divisions" in Rule 1200-13-13-.01.

(53) Health Care Tasks. For CHOICES Members participating in CD, those medical, nursing, or HH Services, beyond ADLs, that:

(a) A person without a functional disability or a caregiver would customarily perform without the assistance of a licensed health care provider;

(b) The person is unable to perform for himself due to a functional or cognitive limitation;

(c) The treating physician, advanced practice nurse, or registered nurse determines can safely be performed in the home and community by an unlicensed Consumer-Directed Worker under the direction of a Competent Adult or caregiver; and

(d) Enable the person to maintain independence, personal hygiene, and safety in his own home.

(54) Home and Community Based Services (HCBS). Services that are provided under the authority of a Section 1915(c) HCBS waiver or (in the case of CHOICES) a Section 1115 waiver pursuant to a written POC as an alternative to institutional LTSS in a NF or an ICF/IID to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require the LOC provided in the institution to which the HCBS offer an alternative, or in the case of CHOICES Group 3, are At Risk for Institutionalization. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX State Plan or under the TennCare demonstration for all eligible enrollees, including Home Health or Private Duty Nursing.

(55) Home and Community Based Services (HCBS) Waiver. A Waiver approved by CMS under the Section 1915(c) authority.

(56) Home-Delivered Meals.

(a) Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the Enrollee's home. Special diets shall be provided in accordance with the individual POC when ordered by the Enrollee's physician.

(b) Regardless of payer, Home-Delivered Meals shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services.

(57) Home Health (HH) Services. See "Home Health Services" in Rule 1200-13-13-.01.

(58) Homemaker Services.

(a) General household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, doing the Member's personal laundry, ironing or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the Member, assistance with maintenance of a safe environment, and errands such as grocery shopping and having the Member's prescriptions filled.

(b) Provided only for the Member (and not for other household members) and only when the Member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the Member.

(c) Effective July 1, 2012, provided only as part of Personal Care Visits and Attendant Care services for Members who also require hands-on assistance with ADLs. Homemaker Services authorized in an approved POC on or before June 30, 2012, shall continue to be provided for no more than ninety (90) days after July 1, 2012, pending a reassessment of the Member's needs and modifications to the Member's POC to comport with the new benefit structure, as well as individual notice of action, when required. Homemaker Services shall not be continued pending resolution of any appeal filed on or after July 1, 2012, as Homemaker Services are no longer covered as a stand-alone benefit. Homemaker Services are not covered for anyone who does not also require hands-on assistance with ADLs.

(d) Regardless of payer, shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services.

(59) ICF/IID Eligible. An individual determined by DHS to qualify for Medicaid ICF/IID services and determined by the Bureau to meet the ICF/IID LOC.

(60) ICF/IID PAE Effective Date. The beginning date of LOC eligibility for Medicaid-reimbursed care in an ICF/IID or HCBS Waiver services offered as an alternative to care in an ICF/IID, for which the ICF/IID PAE has been approved by the Bureau.

(61) ICF/IID PAE Form. The assessment form used by the Bureau to document the current medical and habilitative needs of an individual with MR and to document that the individual meets the Medicaid LOC eligibility criteria for care in an ICF/IID.

(62) Identification Screen (Level I). See "PreAdmission Screening/Resident Review."

(63) Immediate Eligibility.

(a) A mechanism by which the Bureau may elect, based on a preliminary determination of an individual's eligibility for the CHOICES 217-Like Group, to enroll the individual into CHOICES Group 2 and provide immediate access to a limited package of CHOICES HCBS pending a final determination of eligibility.

(b) To qualify an individual must:

1. Be applying to receive covered CHOICES HCBS;

2. Be determined by the Bureau to meet NF LOC;

3. Have submitted an application for financial eligibility determination to DHS;

4. Be expected to qualify in the CHOICES 217-Like Group based on review of the financial information provided by the applicant; and

5. Meet all other specified criteria for enrollment into CHOICES Group 2, subject to categorical and financial eligibility determination.

(c) Immediate Eligibility shall only be for Specified CHOICES HCBS (no other covered services) and for a maximum of forty-five (45) days.

(d) Immediate Eligibility is not available for individuals who are already enrolled in TennCare or for persons who may qualify in the CHOICES At-Risk Demonstration Group.

(64) Immediate Family Member. For purposes of employment as a Consumer-Directed Worker in CHOICES, a spouse, parent, grandparent, child, grandchild, sibling, mother-in-law, father-in-law, sister-in-law, brother in-law, daughter-in-law, and son-in-law. Adopted and step members are included in this definition.

(65) Individual Acuity Score. The weighted value assigned by TennCare to:

(a) The response to a specific ADL or related question in the PAE for NF LOC that is supported by the medical evidence submitted with the PAE; or

(b) A specific skilled or rehabilitative service determined by TennCare to be needed by the applicant on a daily basis or at least five (5) days per week for rehabilitative services based on the medical evidence submitted with the PAE and for which TennCare would authorize level 2 or Enhanced Respiratory Care Reimbursement in a NF.

(66) Individual Cost Neutrality Cap. See "Cost Neutrality Cap."

(67) In-Home Respite Care. For purposes of CHOICES:

(a) Services provided to Members unable to care for themselves, furnished on a short-term basis in the Member's place of residence, because of the absence or need for relief of those family members or other unpaid caregivers normally providing the care; and

(b) Regardless of payer, shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services.

(68) Inpatient Respite Care. For purposes of CHOICES:

(a) Services provided to individuals unable to care for themselves, furnished on a short-term basis in a licensed NF or licensed CBRA facility, because of the absence or need for relief of those family members or other unpaid caregivers normally providing the care.

(b) Regardless of payer, shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services.

(69) Inpatient Nursing Care. Nursing services that are available twenty-four (24) hours per day by or under the supervision of a licensed practical nurse or registered nurse and which, in accordance with general medical practice, are usually and customarily provided on an inpatient basis in a NF. Inpatient Nursing Care includes, but is not limited to, routine nursing services such as observation and assessment of the individual's medical condition, administration of legend drugs, and supervision of nurse aides; and other skilled nursing therapies or services that are performed by a licensed practical nurse or registered nurse.

(70) Institutional Personal Needs Allowance. See "Personal Needs Allowance (PNA)."

(71) Interim CHOICES Group 3 (open only between July 1, 2012, and December 31, 2013).

(a) Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with Physical Disabilities who qualify for TennCare as SSI recipients or as Members of the CHOICES At-Risk Demonstration Group, and who are At Risk for Institutionalization as defined in these rules. There will be no Enrollment Target applied to Interim CHOICES Group 3.

(b) 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, continue to be At Risk for Institutionalization, can be safely served in Interim CHOICES Group 3, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES Group 3.

(72) Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (formerly and also known as Intermediate Care Facility for persons with Mental Retardation or ICF/MR). A licensed facility approved for Medicaid reimbursement that provides specialized services for individuals with ID or related conditions and that complies with current federal standards and certification requirements set forth in 42 C.F.R., Part 483.

(73) Involuntary Transfer or Discharge. Any transfer or discharge that is opposed by the resident or a Representative of the resident of a NF or ICF/IID. For purposes of compliance with the requirements of this Chapter, a discharge or transfer is involuntary when the NF initiates the action to transfer or discharge.

(74) Legally Appointed Representative. Any person appointed by a court of competent jurisdiction or authorized by legal process (e.g., power of attorney for health care treatment, declaration for mental health treatment) to determine the legal and/or health care interests of an individual and/or his estate.

(75) Level of Care (LOC). Medical eligibility criteria for receipt of an institutional service, HCBS offered as an alternative to the institutional service, or in the case of persons At Risk for Institutionalization, to delay or prevent institutional placement. An individual who meets the LOC criteria for NF care is an individual who has been determined by the Bureau to meet the medical eligibility criteria established for that service.

(76) Level 1 Nursing Facility (NF) Care Reimbursement. The level of reimbursement provided for NF services delivered to residents eligible for TennCare reimbursement of NF services determined by the Bureau to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(4) by a NF that meets the requirements set forth in Rule 1200-13-01-.03(3), and in accordance with the reimbursement methodology for Level 1 NF Care set forth in Rule 1200-13-01-.03(6).

(77) Level 2 Nursing Facility (NF) Care Reimbursement. The level of reimbursement provided for NF services delivered to residents eligible for TennCare reimbursement of NF services determined by the Bureau to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(5) by a NF that meets the requirements set forth in Rule 1200-13-01-.03(4), and in accordance with the reimbursement methodology for Level 2 NF Care set forth in Rule 1200-13-01-.03(7).

(78) Linton. The lawsuit known as Linton v. Tennessee Commissioner of Health and Environment resulting in a series of Orders issued by the United States District Court and the Sixth Circuit Court of Appeals regarding NF services.

(79) Long-Term Care (LTC) Ombudsman. An individual with expertise and experience in the fields of LTSS and advocacy, who assists in the identification, investigation, and resolution of complaints that are made by, or on behalf of, NF residents, and persons residing in CBRA settings, including ACLFs and Adult Care Homes. The Tennessee LTC Ombudsman Program is administered by the TCAD.

(80) Long-Term Services and Supports (LTSS) Enrollee or Participant. An individual who is participating in a TennCare LTSS Program.

(81) Long-Term Services and Supports (LTSS) Program. One of the programs offering LTSS to individuals enrolled in TennCare. LTSS Programs include institutional programs (NFs and ICFs/IID), HCBS offered through CHOICES or through a Section 1915(c) HCBS Waiver Program, and the PACE Program.

(82) Managed Care Organization (MCO). See "Managed Care Organization" in Rule 1200-13-13-.01.

(83) Managed Care System. A system under which the MCOs are responsible for arranging for services and paying claims for delivery of these services to Members enrolled in their plans.

(84) Medicaid. As used in this Chapter, the term Medicaid refers to:

(a) The Social Security Act Title XIX program administered by the Single State Agency through CMS and any of the waivers granted to the State of Tennessee; or,

(b) Specific categories of eligibility established by Title XIX. The eligibility category in which a person qualifies for TennCare may determine the benefits the person is eligible to receive, and his cost sharing obligations.

(85) Medicaid Only Payer Date (MOPD). The date a NF certifies that Medicaid reimbursement for NF services will begin because the Applicant has been admitted to the facility and all other primary sources of reimbursement (including Medicare and private pay) have been exhausted. (This does not preclude the Applicant's responsibility for payment of Patient Liability as described in these rules.) The MOPD must be known (and not projected) as it will result in the determination of eligibility for Medicaid reimbursement of NF services and in many cases, eligibility for Medicaid, as well as a capitation payment and payments for Medicaid services received, including but not limited to LTSS. The PAE may be submitted without an MOPD date, in which case the MOPD shall be submitted by the facility when it is known. Enrollment into CHOICES Group 1 and eligibility for reimbursement of NF services shall be permitted only upon submission of a MOPD. The effective date of CHOICES enrollment and Medicaid reimbursement of NF services shall not be earlier than the MOPD.

(86) Medicare Savings Program. The mechanisms by which low-income Medicare beneficiaries can get assistance from Medicaid in paying for their Medicare premiums, deductibles, and/or coinsurance. These programs include the Qualified Medicare Beneficiary (QMB) program, the Specified Low Income Medicare Beneficiary (SLMB) program, and the Qualified Individual (QI) program.

(87) Member. See "CHOICES Member."

(88) Mental Illness (MI). For the purposes of compliance with federal PASRR regulations, an individual who meets the following requirements on diagnosis, level of impairment and duration of illness:

(a) The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, which is a schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another

mental disorder that may lead to a chronic disability; but is not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

(b) The level of impairment must result in functional limitations in major life activities within the past three (3) to six (6) months that would be appropriate for the individual's developmental stage; or

(c) The treatment history of the individual has at least one of the following: a psychiatric treatment more intensive than outpatient care more than once in the past two (2) years, or within the last two (2) years, due to a mental disorder, the individual has experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

(89) Mental Retardation (MR) and Related Conditions. For the purposes of compliance with federal PASRR regulations, an individual is considered to have MR if he has a level of retardation (mild; moderate, severe and profound) as described in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation (1983).

(a) MR refers to significantly subaverage general intellectual functioning, indicated by an IQ test score of 70 or below, existing concurrently with deficits in adaptive behavior and manifested during the developmental period (i.e., prior to age eighteen).

(b) The provisions of this Paragraph also apply to persons with "related conditions", as defined by 42 C.F.R. § 435.1010, which states: "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

1. It is attributable to:

(i) Cerebral palsy or epilepsy, or

(ii) Any other condition, other than MI, found to be closely related to MR because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR, and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age twenty-two (22).

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

(i) Self-care;

(ii) Understanding and use of language;

(iii) Learning;

(iv) Mobility;

(v) Self-direction; and

(vi) Capacity for independent living.

(90) Minor Home Modifications. For purposes of CHOICES:

(a) Included are the following:

1. The provision and installation of certain home mobility aids, including but not limited to:

(i) Wheelchair ramps and modifications directly related to and specifically required for the construction or installation of the ramps;

(ii) Hand rails for interior or exterior stairs or steps; or

(iii) Grab bars and other devices.

2. Minor physical adaptations to the interior of a Member's place of residence that are necessary to ensure his health, welfare and safety, or which increase his mobility and accessibility within the residence, including but not limited to:

(i) Widening of doorways; or

(ii) Modification of bathroom facilities.

(b) Excluded are the following:

1. Installation of stairway lifts or elevators;

2. Adaptations that are considered to be general maintenance of the residence;

3. Adaptations that are considered improvements to the residence;

4. Adaptations that are of general utility and not of direct medical or remedial benefit to the individual, including but not limited to:

(i) Installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring;

(ii) Installation, repair, or replacement of heating or cooling units or systems;

(iii) Installation or purchase of air or water purifiers or humidifiers;

(iv) Installation or repair of driveways, sidewalks, fences, decks, and patios; and

(v) Adaptations that add to the total square footage of the home are excluded from this benefit.

(c) All services shall be provided in accordance with applicable State or local building codes.

(d) Regardless of payer, Minor Home Modifications shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting. Minor Home Modifications shall not be provided to Members receiving Short-Term NF services, except as provided in Rule 1200-13-01-.05 to facilitate transition to the community.

(91) Natural Supports. For purposes of CHOICES:

(a) Unpaid support and assistance critical to ensuring the health, safety, welfare and quality of life of a Member residing in the community delivered by family members, friends, neighbors, and other entities including clubs, churches and community organizations.

(b) May be supplemented, but not supplanted by paid HCBS in order to help sustain the Natural Supports over time, and to help insure the delivery of cost effective community based care.

(92) Network Provider. See "Contract Provider."

(93) Non-Contract Provider. A provider who does not have a contract with an Enrollee's MCO. Also called "Out-of-Network Provider."

(94) Notice. When used in rules and regulations pertaining to NFs, information that must be provided by the facility to "residents" or "Applicants," and shall also include notification to the person identified in a PAE

application as the resident's or Applicant's Designated Correspondent and any other individual who is authorized by law to act on the resident's or Applicant's behalf or who is in fact acting on the resident's or Applicant's behalf in dealing with the NF.

(95) Notice of Disposition or Change. A notice issued by DHS of an individual's financial eligibility for TennCare, including the effective date for which a person may qualify for TennCare reimbursement of LTSS, subject to Level of Care and other applicable eligibility/enrollment criteria as defined in this Chapter.

(96) Nursing Facility (NF). A Medicaid-certified NF.

(97) Nursing Facility (NF) Eligible. An individual determined by DHS to qualify for TennCare reimbursement of NF services and determined by the Bureau to meet NF Level of Care.

(98) One-Time CHOICES HCBS. Certain CHOICES HCBS which occur as a distinct event or which may be episodic in nature (occurring at irregular intervals or on an as needed basis for a limited duration of time), including In-Home Respite Care, Inpatient Respite, Assistive Technology, Minor Modifications, and Pest Control.

(99) Ongoing CHOICES HCBS. Certain CHOICES HCBS which are delivered on a regular and ongoing basis, generally one or more times each week, or (in the case of Community-Based Residential Alternatives and PERS) on a continuous basis, including Community-Based Residential Alternatives, Personal Care Visits, Attendant Care, Home-Delivered Meals, Personal Emergency Response Systems, and Adult Day Care.

(100) Out-of-Network Provider. See "Non-Contract Provider."

(101) PACE Carryover Group.

(a) Individuals who were enrolled in PACE as of June 30, 2012, but who, upon redetermination, no longer qualify for enrollment due solely to the State's modification of its NF LOC criteria.

(b) Members eligible for TennCare in the PACE Carryover Group may continue to qualify in this group after June 30, 2012, so long as they:

1. Continue to meet NF financial eligibility;

2. Continue to meet the NF LOC criteria in place as of June 30, 2012;

3. Meet all other eligibility requirements for PACE in the Medicaid State Plan; and

4. Remain continuously enrolled in PACE.

(102) PAE Effective Date. The beginning date of LOC eligibility for TennCare-reimbursed LTSS for which the PAE has been approved by the Bureau and which, for purposes of care in a NF, cannot precede completion of the PASRR process.

(103) Patient Liability. The amount determined by DHS that a TennCare Eligible is required to pay for covered services provided by a NF, an ICF/IID, an HCBS waiver program, or CHOICES.

(104) Personal Care Visits. For purposes of CHOICES:

(a) Visits to a Member who, due to age and/or Physical Disabilities, needs assistance that can be provided through intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance and related tasks as specified below.

(b) Personal Care Visits may include assistance with ADLs such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation.

(c) For Members who require hands-on assistance with ADLs, Personal Care Visits may also include the following homemaker services that are essential, although secondary, to the hands-on assistance

with ADLs needed by the Member in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:

1. Picking up the Member's medications or shopping for the Member's groceries.

2. Preparing the Member's meals and/or educating caregivers about the preparation of nutritious meals for the Member.

3. Household tasks such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, and doing the Member's personal laundry, ironing and mending.

(d) Personal Care Visits shall not be provided for Members who do not require hands-on assistance with ADLs.

(e) Personal Care Visits shall be primarily provided in the Member's place of residence, except as permitted within the scope of service (e.g., picking up medications or shopping for groceries), when accompanying or transporting the Member into the community pursuant to rule 1200-13-01-.05(8)(n), or under exceptional circumstances as authorized by an MCO in the POC to accommodate the needs of the Member.

(f) A single Contract Provider staff person or Consumer-Directed Worker may provide Personal Care Visits to multiple CHOICES Members in the same home and during the same hours, as long as he can provide the services safely and appropriately to each Member. Such arrangements shall be documented in each Member's plan of care. In such instances, the total units of service provided by the staff person shall be allocated among the CHOICES Members, based on the percentage of total service units required by each Member on average. The Provider shall bill the MCO only once for each of the service units provided, and shall not bill an MCO or multiple MCOs separately to provide services to multiple Members at the same time.

(g) Regardless of payer, Personal Care Visits shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services, or while a Member is receiving Adult Day Care services.

(h) Personal care visits shall not include:

1. Companion or sitter services, including safety monitoring and supervision.

2. Care or assistance including meal preparation or household tasks for other residents of the same household.

3. Yard work.

4. Care of non-service related pets and animals.

(105) Personal Emergency Response System (PERS). For purposes of CHOICES:

(a) An electronic device that enables certain Members at high risk of institutionalization to summon help in an emergency. The Member may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once the "help" button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed. PERS services are limited to those Members who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time, such that the Member's safety would be compromised without access to a PERS.

(b) Regardless of payer, PERS shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services.

(106) Personal Needs Allowance (PNA). A reasonable amount of money that is deducted by DHS from the individual's funds pursuant to federal and State law and the Medicaid State Plan in the application of post-eligibility provisions and the calculation of Patient Liability for LTSS. The PNA is set aside for clothing and other personal needs of the individual while in the institution (Institutional PNA), and to also pay room, board and other living expenses in the community (Community PNA).

(107) Pest Control.

(a) The one-time or intermittent use of sprays, poisons and traps, as appropriate, in the Member's residence (excluding NFs or ACLFs) to regulate or eliminate the intrusion of cockroaches, wasps, mice, rats and other species of household pests into the household environment thereby removing an environmental issue that could be detrimental to a Member's health and physical well-being.

(b) Regardless of payer, shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving Short-Term NF services.

(c) A treatment visit for Pest Control is a visit by the Pest Control provider to the Member's residence during which the Pest Control treatment is applied.

(d) Shall not be provided solely as a preventive measure. There must be documentation of a need for this service either through Care Coordinator direct observation or determination through a needs assessment that a household pest is causing or is expected to cause more harm than is reasonable to accept.

(e) Shall not include treatment for termites, bed bug infestations or any pest infestation that cannot be addressed through intermittent visits as provided through the current benefit and reimbursement structure.

(108) Pharmacy Benefits Manager (PBM). See "Pharmacy Benefits Manager" in Rule 1200-13-13-.01.

(109) Physical Disabilities.

(a) One or more medically diagnosed chronic, physical impairments, either congenital or acquired, that limit independent, purposeful physical movement of the body or of one or more extremities, as evidenced by substantial functional limitations in one or more ADLs that require such movement—primarily mobility or transfer—and that are primarily attributable to the physical impairments and not to cognitive impairments or mental health conditions.

(b) An individual with cognitive impairments or mental health conditions who also has one or more Physical Disabilities as defined above may qualify as "Physically Disabled," and may be enrolled into CHOICES Group 2 or CHOICES Group 3 so long as such individual can be safely served in the community and at a cost that does not exceed the individual's Cost Neutrality Cap or Expenditure Cap, as applicable. This includes consideration of whether or not the CHOICES Group 2 or CHOICES Group 3 benefit package, as applicable, adequately addresses any specialized service needs the applicant may have pertaining to the cognitive impairment or mental health condition, as applicable.

(110) Physically Disabled. For purposes of enrollment into CHOICES Group 2 or CHOICES Group 3, an adult aged twenty-one (21) or older who has one or more Physical Disabilities.

(111) Physician. A doctor of medicine or osteopathy who has received a degree from an accredited medical school and who is licensed to practice his profession in Tennessee.

(112) Plain Language. Any notice or explanation written at a level that does not exceed the sixth grade reading level as measured by the Flesch Index, Fog Index, or Flesch-Kincaid Index.

(113) Plan of Care. A written document that is developed through a person-centered planning process based on an individualized assessment of an Enrollee's needs that specifies the types and frequency of LTSS that the Enrollee receives.

(114) PreAdmission Evaluation (PAE). A process of assessment by the Bureau used to determine an individual's medical (or LOC) eligibility for TennCare-reimbursed care in a NF or ICF/IID, and in the case of NF services, the appropriate level of reimbursement for such care, as well as eligibility for HCBS as an alternative to institutional care, or in the case of persons At Risk for Institutionalization, in order to delay or prevent NF placement. For purposes of CHOICES, the PAE application shall be used for the purposes of determining LOC and for persons enrolled in CHOICES Group 2, calculating the Member's Individual Cost Neutrality Cap.

(115) PreAdmission Screening/Resident Review (PASRR). The process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified NF has, or is suspected of having, MI or MR, and, if so, whether the individual requires specialized services and is appropriate for NF placement.

(a) Identification Screen (Level I). The initial screening conducted to determine which NF Applicants or residents have MI or MR and are subject to PASRR. Individuals with a supportable primary diagnosis of Alzheimer's disease or dementia will also be detected through the Identification Screen. NFs are responsible for ensuring that all Applicants receive a Level I identification screen prior to admission to the facility, and for submission of the Level I Identification Screen to the Bureau.

(b) PASRR Evaluation (Level II). The process whereby a determination is made about whether the individual identified in the Level I screen requires the level of services provided by a NF or another type of facility and, if so, whether the individual requires specialized services. These reviews shall be the responsibility of the DMH and/or DIDD, as applicable.

(116) Private Duty Nursing (PDN) Services. See "Private Duty Nursing Services" in Rule 1200-13-13-.01.

(117) Program of All-Inclusive Care for the Elderly (PACE). A program for dually eligible Enrollees in need of LTSS that is authorized under the Medicaid State Plan, Attachment 3.1-A, #26.

(118) Provider. See "Provider" in Rule 1200-13-13-.01. Provider does not include Consumer-Directed Workers (see Consumer-Directed Worker); nor does Provider include the FEA (see Fiscal Employer Agent).

(119) Qualified Assessor. A practicing professional who meets the qualifications established by TennCare to certify the accuracy of a level of care assessment as reflected in the PAE application. For the CHOICES program, Qualified Assessors shall include only the following: a licensed physician, nurse practitioner, physician assistant, registered or licensed nurse, or licensed social worker.

(120) Qualifying Income Trust (QIT). See "Qualified Income Trust" in DHS Rules Chapter 1240-03-03.

(121) Related Conditions. See "Mental Retardation (MR) and Related Conditions."

(122) Representative.

(a) In general, for CHOICES Members, a Representative is an individual who is at least eighteen (18) years of age and is authorized by the Member to participate in care planning and implementation and to speak and make decisions on the Member's behalf, including but not limited to identification of needs, preference regarding services and service delivery settings, and communication and resolution of complaints and concerns.

(b) As it relates to CD of Eligible CHOICES HCBS, a Representative is an individual who is authorized by the Member to direct and manage the Member's Worker(s), and signs a Representative Agreement. The Representative for CD of Eligible CHOICES HCBS must also:

1. Be at least eighteen (18) years of age;

2. Have a personal relationship with the Member and understand his support needs;

3. Know the Member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and

4. Be physically present in the Member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate workers.

(123) Representative Agreement. The agreement between a CHOICES Member electing CD of Eligible CHOICES HCBS who has a Representative direct and manage the Member's Worker(s) and the Member's Representative that specifies the roles and responsibilities of the Member and the Member's Representative.

(124) Reserve Capacity. The State's right to maintain some capacity within an established Enrollment Target to enroll individuals into CHOICES HCBS under certain circumstances. These circumstances could include, but are not limited to:

(a) Discharge from a NF;

(b) Discharge from an acute care setting where institutional placement is otherwise imminent; or

(c) Other circumstances which the State may establish from time to time in accord with this Chapter.

(125) Risk Agreement.

(a) An agreement signed by a Member who will receive CHOICES HCBS (or his Representative) that includes, at a minimum:

1. Identified risks to the Member of residing in the community and receiving HCBS;

2. The possible consequences of such risks, strategies to mitigate the identified risks; and

3. The Member's decision regarding his acceptance of risk.

(b) For Members electing to participate in CD, the Risk Agreement must include any additional risks associated with the Member's decision to act as the Employer of Record, or to have a Representative act as the Employer of Record on his behalf.

(126) Room and Board. Lodging, meals, and utilities that are the responsibility of the individual receiving HCBS in a CBRA facility. The kinds of items that are considered "Room and Board" and are therefore not reimbursable by TennCare include:

(a) Rent, or, if the individual owns his home, mortgage payments, depreciation, or mortgage interest;

(b) Property taxes;

(c) Insurance (title, mortgage, property and casualty);

(d) Building and/or grounds maintenance costs;

(e) Resident "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included);

(f) Household supplies necessary for the room and board of the individual;

(g) Furnishings used by the resident;

(h) Utilities (electricity, water and sewer, gas);

(i) Resident telephone; or

(j) Resident cable or pay television.

(127) Self-Determination ID Waiver. Tennessee's Self Determination Waiver under Section 1915(c) of the Social Security Act.

(128) Self-Direction of Health Care Tasks.

(a) The decision by a CHOICES Member participating in CD to direct and supervise a paid Worker delivering Eligible CHOICES HCBS in the performance of Health Care Tasks that would otherwise be performed by a licensed nurse.

(b) The Self-Direction of Health Care Tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that a CHOICES Member participating in CD may elect to have performed by a Consumer-Directed Worker as part of the delivery of Eligible CHOICES HCBS he is authorized to receive.

(129) Service Agreement. The agreement between a CHOICES Member electing CD of Eligible CHOICES HCBS (or the Member's Representative) and the Member's Consumer-Directed Worker that specifies the roles and responsibilities of the Member (or the Member's Representative) and the Worker.

(130) Short-Term Nursing Facility (NF) Care. For purposes of CHOICES:

(a) The provision of NF care for up to ninety (90) days to a CHOICES Group 2 or CHOICES Group 3 Member who was receiving HCBS upon admission and who meets NF LOC and requires temporary placement in a NF—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such Member is reasonably expected to be discharged and to resume HCBS participation within no more than ninety (90) days.

(b) Such CHOICES Group 2 or CHOICES Group 3 Member must meet the NF LOC upon admission and in such case, while receiving Short-Term NF Care may continue enrollment in CHOICES Group 2 or CHOICES Group 3, pending discharge from the NF within no more than ninety (90) days or until such time it is determined that discharge within ninety (90) days from admission is not likely to occur, at which time the Member shall be transitioned to CHOICES Group 1, as appropriate.

(c) The Community PNA shall continue to apply during the provision of Short-Term NF care, up to the ninetieth (90th) day, in order to allow sufficient resources for the Member to maintain his community residence for transition back to the community.

(d) The PASRR process is required for CHOICES Group 2 and CHOICES Group 3 Members entering Short-Term NF Care.

(e) Persons receiving Short-Term NF Care are not eligible to receive any other HCBS, except as permitted in 1200-13-01-.05 to facilitate transition to the community.

(131) Single Point of Entry (SPOE). The agency charged with screening, intake, and facilitated enrollment processes for non-TennCare eligible individuals seeking enrollment into CHOICES.

(132) Skilled Nursing Facility (SNF). A Medicare-certified SNF.

(133) Skilled Nursing Service. A Physician-ordered nursing service the complexity of which is such that it can only be safely and effectively provided directly by a registered nurse or licensed practical nurse.

(134) Skilled Rehabilitative Service. A Physician-ordered rehabilitative service the complexity of which is such that it can only be safely and effectively provided by qualified health care personnel (e.g., registered physical therapist, licensed physical therapist assistant, registered occupational therapist, certified occupational therapy assistance, licensed respiratory therapist, licensed respiratory therapist assistant).

(135) Specialized Services for Individuals with MI.

(a) The implementation of an individualized POC developed under and supervised by a Physician, provided by a Physician and other qualified mental health professionals that accomplishes the following;

1. Prescribes specific therapies and activities for the treatment of individuals who are experiencing an acute episode of severe MI, which necessitates continuous supervision by trained mental health personnel; and

2. Is directed toward diagnosing and reducing the individual's behavioral symptoms that necessitated institutionalization, improving his level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible convenience.

(b) Services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program are not included in this definition.

(136) Specialized Services for Individuals with MR and Related Conditions.

(a) The implementation of an individualized POC specifying a continuous program for each individual, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed towards the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.

(b) Services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program are not included.

(137) Specified CHOICES HCBS. The CHOICES HCBS that are available to persons who qualify for and are granted Immediate Eligibility by the Bureau. Specified CHOICES HCBS are limited to Adult Day Care, Attendant Care, Home-Delivered Meals, Personal Care Visits, and PERS.

(138) Statewide ID Waiver. Tennessee's HCBS Waiver for the Mentally Retarded and Developmentally Disabled under Section 1915(c) of the Social Security Act.

(139) Supports Broker. For purposes of CD:

(a) An individual assigned by the FEA to each CHOICES Member participating in CD who assists the Member/Representative in performing the Employer of Record functions, including, but not limited to: developing job descriptions; locating, recruiting, interviewing, scheduling, monitoring, and evaluating Workers.

(b) The Supports Broker collaborates with, but does not duplicate, the functions of the Member's Care Coordinator.

(c) The Supports Broker does not have authority or responsibility for CD. The Member or Member's Representative must retain authority and responsibility for CD.

(140) TennCare. The program administered by the Single State Agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration Waiver granted to the State of Tennessee.

(141) TennCare CHOICES in Long-Term Services and Supports Program (CHOICES). The program in which NF services for TennCare eligibles of any age and HCBS for individuals aged sixty-five (65) and older and/or adults aged twenty-one (21) and older with Physical Disabilities are integrated into TennCare's Managed Care System.

(142) TennCare Eligible. For purposes of this Chapter, an individual who has been determined by DHS to be financially eligible to have TennCare reimbursement for covered LTSS.

(143) Tennessee Pre-Admission Evaluation System (TPAES). A component of the State's Medicaid Management Information System and the system of record for all PreAdmission Evaluation (LOC) submissions and LOC determinations, as well as enrollments into and transitions between LTSS programs, including CHOICES and the State's Money Follows the Person Rebalancing Demonstration (MFP), and which shall also be used to gather data required to comply with tracking and reporting requirements pertaining to MFP.

(144) Third Party Liability (TPL). See "Third Party Liability" in Rule 1200-13-13-.01.

(145) Tracheal Suctioning Reimbursement. The rate of reimbursement provided for NF services, including enhanced respiratory care assistance, delivered by a NF that meets the requirements set forth in Rule 1200-13-01-.03(5), to residents determined by the Bureau to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(5)(e) or determined by an MCO to require short-term intensive respiratory intervention during the post-weaning period.

(146) Transfer Form. For purposes of ICF/IID services and HCBS ID waiver programs, a form approved by the Bureau which is used in lieu of a new PAE to document the transfer of an ICF/IID eligible individual having an approved unexpired ICF/IID PAE from one ICF/IID to another ICF/IID, from an HCBS ID Waiver Program to an ICF/IID, from an ICF/IID to an HCBS ID Waiver Program, or from one HCBS ID Waiver Program to another HCBS ID Waiver Program.

(147) Transition Allowance. For purposes of CHOICES.

(a) A per Member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of an MCO, be provided as a CEA to continued institutional care for a CHOICES Member in order to facilitate transition from a NF to the community when such Member will, upon transition, receive more cost-effective non-residential HCBS or Companion Care.

(b) Items which may be purchased or reimbursed are only those items the Member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

(c) Transition Allowance cannot be provided to CHOICES Members transitioning to a CBRA facility.

(148) Ventilator Weaning Reimbursement. The rate of reimbursement provided for ventilator weaning services delivered by a NF that meets the requirements set forth in Rule 1200-13-01-.03(5) to residents determined by an MCO to require such services based on medical necessity criteria.

(149) Wait List. The list maintained by NFs of all individuals who have affirmatively expressed an intent to be considered for current or future admission to the NF or requested that their name be entered on any "wait list."

(150) Waiting List. For purposes of CHOICES, the list maintained by the Bureau of individuals who have applied for CHOICES HCBS but who cannot be served because an Enrollment Target has been reached.

(151) Worker. See "Consumer-Directed Worker."

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Paragraph (2) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Paragraph (2) which shall read as follows:

(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.

The introductory Emergency Rule Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a Rulemaking Hearing Rule introductory Subparagraph (a) which shall read as follows:

(a) There are three (3) groups in TennCare CHOICES:

Part 1. of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Part 1. which shall read as follows:

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.

Introductory Subpart (i) of Part 2. Of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new introductory Subpart (i) which shall read as follows:

(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:

Subpart (iii) of Part 2. of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "Enrollees" with the word "Members" so as amended Subpart (iii) shall read as follows:

(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:

Subpart (iii) of Part 2. of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Item (III) which shall read as follows:

(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.

Emergency Rule Part 3. of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 3. which shall read as follows:

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.

Emergency Rule Subparagraph (b) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (b) which shall read as follows:

(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.

Part 1. of Subparagraph (c) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "Persons" with the word "Members" so as amended Part 1. shall read as follows:

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.

Emergency Rule Part 2. of Subparagraph (c) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 2. which shall read as follows:

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.

Emergency Rule Subparagraph (d) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (d) which shall read as follows:

(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.

Subparagraph (e) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subparagraph (e) which shall read as follows:

(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.

Emergency Rule Subparagraph (f) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (f) which shall read as follows:

(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.

Parts 2., 4., 5. and 6. of Subparagraph (g) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with new Parts 2., 4., 5. and 6. which shall read as follows:

2. Members admitted to CHOICES Group 2 under the Immediate Eligibility option are persons who are not already eligible for TennCare.

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.

Introductory Subparagraph (a) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "individual" with the word "Applicant" so as amended introductory Subparagraph (a) shall read as follows:

(a) Enrollment into CHOICES Group 1. To qualify for enrollment into CHOICES Group 1, an Applicant must:

Emergency Rule Part 2. of Subparagraph (a) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 2. which shall read as follows:

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.

Part 3. of Subparagraph (a) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "Medicaid" with the word "TennCare" so as amended Part 3. shall read as follows:

3. Be approved by DHS for TennCare reimbursement of NF services.

Part 4. of Subparagraph (a) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the acronym and word "LTC Services" with the acronym "LTSS" so as amended Part 4. shall read as follows:

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.

Subparagraph (b) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Subparagraph (b) which shall read as follows:

(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.

Emergency Rule Subpart (iii) of Part 1. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (iii) which shall read as follows:

(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.

Part 2. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the phrase "cost neutrality cap" in the first sentence with the phrase "Cost Neutrality Cap" so as amended Part 2. shall read as follows:

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.

Items (I), (II) and (III) of Subart (i) of Part 3. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with new Items (I), (II) and (III) which shall read as follows:

(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.

Subart (iii) of Part 3. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subpart (iii) which shall read as follows:

(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.

Part 4. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Part 4. which shall read as follows:

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.

Subpart (i) and introductory Subpart (ii) of Part 5. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program are amended by replacing the word "applicant" with the word "Applicant" so as amended Subpart (i) and introductory Subpart (ii) shall read as follows:

(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

Emergency Rule Item (I) of Subpart (ii) of Part 5. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Item (I) which shall read as follows:

(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.

Subparagraph (d) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subparagraph (d) which shall read as follows:

(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.

Emergency Rules Subparagraphs (e), (f), and (g) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with Rulemaking Hearing Rule Subparagraphs (e), (f), and (g) which shall read as follows:

(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 services 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.

Paragraph (5) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Paragraph (5) which shall read as follows:

(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.

Emergency Rule Paragraph (6) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (6) which shall read as follows:

(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.

Emergency Rule Paragraph (7) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (7) which shall read as follows:

(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.

Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Paragraph (8) which shall read as follows:

(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

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
3. Attendant Care	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. 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. 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. 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. 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.	Yes	Yes
4. CBRA	Companion Care. 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.	Yes	No
	CBRA facility services (e.g., ACLFs, Adult Care Homes).	No	No
5. Home-Delivered Meals	Covered with a limit of 1 meal per day, per Member. 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.	No	Yes

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
6. Homemaker Services	*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. Not covered as a stand-alone benefit. Not covered for persons who do not require hands-on assistance with ADLs. 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.	*	*
7. In-Home Respite Care	Covered with a limit of 216 hours per calendar year, per Member. 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.	Yes	No
8. Inpatient Respite Care	Covered with a limit of 9 days per calendar year, per Member. PASRR approval not required. 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.	No	No
9. Minor Home Modifications	Covered with a limit of $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime. 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).	No	No

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
10. Personal Care Visits	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. 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.	Yes	Yes
11. PERS	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.	No	Yes
12. Pest Control	Covered with a limit of 9 treatment visits per calendar year, per Member. 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.	No	No
13. Short-Term NF Care	Covered with a limit of 90 days per stay, per Member. Approved PASRR required. 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).	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

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
3. Attendant Care	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. 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. 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. 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. 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.	Yes	N/A
4. Home-Delivered Meals	Covered with a limit of 1 meal per day, per Member. 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.	No	N/A
5. Homemaker Services	*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. Not covered as a stand-alone benefit. Not covered for persons who do not require hands-on assistance with ADLs. 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.	*	*

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
6. In-Home Respite Care	Covered with a limit of 216 hours per calendar year, per Member. 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.	Yes	N/A
7. Inpatient Respite Care	Covered with a limit of 9 days per calendar year, per Member. PASRR approval not required. NF LOC not required. 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.	No	N/A
8. Minor Home Modifications	Covered with a limit of $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime. 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).	No	N/A
9. Personal Care Visits	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. 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.	Yes	N/A
10. PERS	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.	No	N/A

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
11. Pest Control	Covered with a limit of 9 treatment visits per calendar year, per Member. 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.	No	N/A
12. Short-Term NF Care	Covered with a limit of 90 days per stay, per Member. Approved PASRR required. Member must meet NF LOC. 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).	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.

Subparagraph (a) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subparagraph (a) which shall read as follows:

(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.

Subparagraph (b) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Subparagraph (b) which shall read as follows:

(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.

Introductory Subparagraph (c) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "Members" with the word "Member" so as amended the introductory Subparagraph (c) shall read as follows:

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

Part 1. of Subparagraph (c) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 1. which shall read as follows:

1. Be a Member of CHOICES Group 2 or CHOICES Group 3.

Part 2. of Subparagraph (c) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Part 2. which shall read as follows:

2. Be determined by a Care Coordinator, based on a comprehensive needs assessment, to need one or more Eligible CHOICES HCBS.

Part 4. of Subparagraph (c) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "as applicable" after the word and comma "Agreement," so as amended Part 4. shall read as follows:

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.

Emergency Rule Part 1. of Subparagraph (d) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 1. which shall read as follows:

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.

Emergency Rule Subpart (i) of Part 1. of Subparagraph (f) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (i) which shall read as follows:

(i) The person is not enrolled in TennCare or in CHOICES Group 2 or CHOICES Group 3.

Subpart (iv) of Part 1. of Subparagraph (f) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "members" with the word "Members" after the words "with the" in the third line so as amended Subpart (iv) shall read as follows:

(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.

Part 7. of Subparagraph (h) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "of eligible" so as amended Part 7. shall read as follows:

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.

Subparagraph (h) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Part 8. which shall read as follows:

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.

Subpart (ii) of Part 1. of Subparagraph (i) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subpart (ii) which shall read as follows:

(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:

(I) 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.

Emergency Rule Part 1. of Subparagraph (j) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 1. which shall read as follows:

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.

Emergency Rule Part 3. of Subparagraph (j) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 3. which shall read as follows:

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.

Emergency Rule Part 7. of Subparagraph (j) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 7. which shall read as follows:

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.

Subpart (ii) of Part 1. of Subparagraph (k) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Subpart (ii) which shall read as follows:

(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.

Emergency Rule Subpart (iii) of Part 1. of Subparagraph (k) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (iii) which shall read as follows:

(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.

Emergency Rule Item (II) of Subpart (i) of Part 2. of Subparagraph (k) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Item (II) which shall read as follows:

(II) The person is no longer enrolled in either CHOICES Group 2 or CHOICES Group 3.

Item (III) of Subpart (i) of Part 2. of Subparagraph (k) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Item (III) which shall read as follows:

(III) The Member no longer needs any of the Eligible CHOICES HCBS, as specified in the POC.

Item (V) of Subpart (i) of Part 2. of Subparagraph (k) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding ",as applicable," after the word "Agreement" so as amended Item (V) shall read as follows:

(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.

Subparagraphs (b), (c) and (d) of Paragraph (10) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with new Subparagraphs (b), (c) and (d) which shall read as follows:

(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).

Part 3. of Subparagraph (e) of Paragraph (10) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Part 3. which shall read as follows:

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.

Subparagraph (b) of Paragraph (11) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and current Subparagraph (c) re-lettered as (b).

Subparagraph (c) re-lettered as (b) of Paragraph (11) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new re-lettered Subparagraph (b) which shall read as follows:

(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.

Emergency Rule Subparagraph (c) of Paragraph (12) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

(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).

Introductory language of Subparagraph (d) of Paragraph (12) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the word "Care" after the phrase "Long-Term" and adding the words "Services and Supports" so as amended introductory language of Subparagraph (d) shall read as follows:

(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:

Part 3. of Subparagraph (d) of Paragraph (12) of rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the word "Care" after the phrase "Long-Term" in the first sentence and adding the words "Services and Supports" so as amended Part 3. shall read as follows:

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.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Emergency Rule 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC is deleted in its entirety and replaced with Rulemaking Hearing Rule 1200-13-01-.08 which shall read as follows:

1200-13-01-.08 PERSONAL NEEDS ALLOWANCE (PNA), PATIENT LIABILITY, THIRD PARTY INSURANCE AND ESTATE RECOVERY FOR PERSONS RECEIVING LTSS.

(1) Personal Needs Allowance (PNA). The PNA is established for each Enrollee receiving LTSS in accordance with the Tennessee Medicaid State Plan, approved Section 1915(c) Waiver applications, and these rules. It is deducted from the Enrollee's monthly income in calculating Patient Liability for LTSS.

(a) The PNA for each person receiving TennCare-reimbursed services in a NF or an ICF/IID is $50. Persons with no income have no PNA. Persons with incomes that are less than $50 per month (including institutionalized persons receiving SSI payments) may keep the entire amount of their income as their PNA.

(b) The maximum PNA for persons participating in CHOICES Group 2 or CHOICES Group 3 is 300% of the SSI FBR.

(c) The maximum PNA for persons participating in one of the State's Section 1915(c) HCBS Waivers is as follows:

1. The Statewide ID Waiver: 200% of the SSI FBR.

2. The Arlington ID Waiver: 200% of the SSI FBR.

3. The Self-Determination ID Waiver: 300% of the SSI FBR.

(2) Patient Liability.

(a) Enrollees receiving LTSS are required to contribute to the cost of their LTSS if their incomes are at certain levels. They are subject to the post-eligibility treatment of income rules set forth in Section 1924 of the Social Security Act (42 U.S.C.A. § 1396r-5), and 42 C.F.R. § 435.725.

(b) For Enrollees being served in HCBS Waivers, the State must also use institutional eligibility and post-eligibility rules for determining Patient Liability.

(c) For Members of the CHOICES 217-Like Group and the CHOICES At-Risk Demonstration Group, the State uses institutional eligibility and post-eligibility rules for determining Patient Liability in the same manner as specified under 42 C.F.R. §§ 435.217, 435.236, and 435.726 and Section 1924 of the Social Security Act (42 U.S.C.A. § 1396r-5), if the HCBS were provided under a Section 1915(c) Waiver.

(d) For a Member of CHOICES Group 2 or CHOICES Group 3 receiving the Short-Term NF Care benefit (for up to 90 days) or an Enrollee in one of the State's Section 1915(c) Waiver programs who is temporarily placed in a medical institution, i.e., a hospital, NF or ICF/IID (for up to 90 days), the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. The purpose is to ensure that the individual can maintain a community residence for transition back to the community. After 90 days, or as soon as it appears that the inpatient stay will not be a short-term stay, whichever comes first, a CHOICES Group 2 or CHOICES Group 3 Member will be transitioned to CHOICES Group 1, or a waiver participant must be disenrolled from the waiver, and the institutional post-eligibility calculation shall apply.

(e) Patient Liability shall be collected as follows:

1. If the Enrollee resides in a NF, ICF/IID, or CBRA facility (i.e., an ACLF or Critical Adult Care Home), the Enrollee must pay his Patient Liability to the residential facility. The facility shall reduce the amount billed to the Bureau or the MCO, as applicable, by the amount of the Enrollee's Patient Liability obligation, regardless of whether such amount is actually collected by the facility.

2. If a CHOICES Group 2 Member does not reside in a CBRA facility, i.e., the Member is receiving HCBS (including Companion Care) in his own home, and for all CHOICES Group 3 members (who are not eligible to receive CBRA services), the Member must pay his Patient Liability to the MCO. The amount of Patient Liability collected will be used to offset the cost of CHOICES Group 2 or CHOICES Group 3 benefits or CEA services provided as an alternative to covered CHOICES Group 2 or CHOICES Group 3 benefits that were reimbursed by the MCO for that month. The amount of Patient Liability collected by the MCO cannot exceed the cost of CHOICES Group 2 or CHOICES Group 3 benefits (or CEA services provided as an alternative to CHOICES Group 2 or CHOICES Group 3 benefits) reimbursed by the MCO for that month.

(f) A CHOICES provider, including an MCO, may decline to continue to provide LTSS to a CHOICES Member who fails to pay his Patient Liability. If other Contract Providers or the other TennCare MCO(s) operating in the Grand Division are unwilling to provide LTSS to a CHOICES Member who has failed to pay his Patient Liability, the Member may be disenrolled from the CHOICES program in accordance with the procedures set out in this Chapter.

(3) TPL for LTSS.

(a) LTC insurance policies are considered TPL and the Bureau is subrogated to all rights of recovery.

(b) Applicants for the CHOICES program who have LTC insurance policies must report these policies to DHS upon enrollment in the CHOICES program. Applicants may be subject to criminal prosecution for knowingly providing incorrect information.

(c) Obligations of CHOICES Members receiving NF or CBRA services (other than Companion Care) having insurance that will pay for care in a NF or other residential facility (including cash benefits to the Member for the cost of such services):

1. If the benefits are assignable, the Member must assign them to the NF or residential facility. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay the NF or the residential facility for LTSS.

2. If the benefits are not assignable, the Member must provide payment to the NF or the residential facility immediately upon receipt of the benefits. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay the NF or the residential facility for LTSS.

(d) Obligations of CHOICES Members receiving non-residential CHOICES HCBS or Companion Care services having insurance that will pay for CHOICES HCBS (including cash benefits to the Member for the cost of such services):

1. If the benefits are assignable, the Member must assign them to the MCO. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay for CHOICES HCBS for the Member.

2. If the benefits are not assignable, the Member must make payment to the MCO immediately upon receipt of the benefits. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay for CHOICES HCBS for the Member.

(e) TPL payments do not reduce the amount of Patient Liability an Enrollee is obligated to contribute toward the cost of LTSS, except in instances where the total cost of LTSS for the month is less than the combined total of TPL payments and the member's Patient Liability amount, in which case, TPL shall be collected first. The NF shall then collect Patient Liability up to the total cost of LTSS provided for the month.

(f) If benefits received by the policyholder are not paid to the facility or MCO, as applicable, such benefits shall be considered income, and may render the person ineligible for TennCare (including LTSS) benefits.

(4) Estate Recovery. Persons enrolled in TennCare LTSS programs are subject to the requirements of the FERP as set forth under Section 1917(b) of the Social Security Act, 42 U.S.C.A. § 1396p(b).

(a) The State is required to seek adjustment or recovery for certain types of medical assistance from the estates of individuals as follows:

1. For persons age fifty-five (55) and older, the State is obligated to seek adjustment or recovery for NF (including ICF/IID) services, HCBS, and related hospital and prescription drug services.

2. For permanently institutionalized persons under age fifty-five (55), the State is obligated to seek adjustment or recovery for the institutional services.

(b) Estate recovery shall apply to the estates of individuals under age fifty-five (55) who are inpatients in a NF, ICF/IID, or other medical institution and who cannot reasonably be expected to be discharged home.

(c) A determination that an individual cannot reasonably be expected to be discharged to return home shall be made in accordance with the following.

1. The PAE for LOC that is certified by the physician shall specify whether discharge is expected and the anticipated length of stay in the institution.

2. The following shall be deemed sufficient evidence that a person cannot reasonably be expected to be discharged to return home and is thus permanently institutionalized:

(i) An approved PAE certified by the physician indicating that discharge is not expected; or,

(ii) The continued stay of a resident of a medical institution at the end of a temporary stay predicted by his physician at the time of admission to be no longer than six (6) months in duration.

(d) Written notice of the determination that the individual residing in a medical institution cannot reasonably be expected to be discharged to return home shall be issued to the individual or his Designated Correspondent. The notice shall explain the right to request a reconsideration review. Such request must be submitted in writing to the Bureau, Long-Term Services and Supports, within thirty (30) days of receipt of the written notice. The reconsideration review shall be conducted as a Commissioner's Administrative Hearing in the manner set out in Rule 1200-13-01-.10(7).

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Rule 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for Medicaid Reimbursement of Care in Nursing Facilities as amended by Emergency Rule 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for Medicaid Reimbursement of Care in Nursing Facilities is deleted in its entirety and replaced with Rulemaking Hearing Rule 1200-13-01-.10 which shall read as follows:

1200-13-01-.10 MEDICAL (LEVEL OF CARE) ELIGIBILITY CRITERIA FOR TENNCARE REIMBURSEMENT OF CARE IN NURSING FACILITIES, CHOICES HCBS AND PACE.

(1) Definitions. See Rule 1200-13-01-.02.

(2) PreAdmission Evaluations and Discharge/Transfer/Hospice Forms.

(a) A PAE is required in the following circumstances:

1. When a TennCare Eligible is admitted to a NF for receipt of TennCare-reimbursed NF Services.

2. When a private-paying resident of a NF attains TennCare Eligible status.

3. When Medicare reimbursement for SNF services has ended and TennCare Level 2 reimbursement for NF services is requested.

4. When a NF Eligible is changed from TennCare Level 1 to TennCare Level 2 reimbursement, or from TennCare Level 1 or Level 2 reimbursement to a Chronic Ventilator or Tracheal Suctioning Enhanced Respiratory Care rate, except as specified in Rule 1200-13-01-.10(5)(f).

5. When a NF Eligible is changed from TennCare Level 2 reimbursement or an Enhanced Respiratory Care rate to TennCare Level 1 reimbursement, unless the person has an approved unexpired Level 1 PAE.

6. When a NF Eligible is changed from an Enhanced Respiratory Care rate to TennCare Level 2 reimbursement, unless the person has an approved unexpired Level 2 PAE.

7. When a NF Eligible requires continuation of the same LOC beyond the expiration date assigned by the Bureau.

8. When a NF Eligible no longer requires the specific skilled nursing or rehabilitative services for which a Level 2 PAE was approved but requires other skilled nursing or rehabilitative services for which Level 2 reimbursement may be authorized in a NF.

9. When a Member enrolled in CHOICES Group 1 or Group 2 on or after July 1, 2012, no longer meets NF LOC and wants to enroll in CHOICES Group 3 for HCBS.

10. When a Member enrolled in CHOICES Group 3 (including Interim CHOICES Group 3) on or after July 1, 2012, wants to enroll in CHOICES Group 1 or 2.

(b) NFs are required to complete and submit to the Member's MCO a Discharge/Transfer/Hospice Form any time a Member discharges from the facility or stops receiving NF services in the facility, which shall include but is not limited to the following circumstances:

1. When a CHOICES Member transfers from one NF to another such facility.

2. When a CHOICES Member discharges to the hospital (even when readmission to the NF is expected following the hospital stay).

3. When a CHOICES Member elects to receive hospice services (even if Medicare will be responsible for payment of the hospice benefit).

4. When a CHOICES Member discharges home, with or without HCBS. In this case, the NF is obligated to notify the MCO before the Member is discharged from the facility and to coordinate with the MCO in discharge planning in order to ensure that any home and community based services needed by the Member will be available upon discharge, and to avoid a lapse in CHOICES and/or TennCare eligibility.

5. Upon the death of a CHOICES Member.

(c) A PreAdmission Evaluation is not required in the following circumstances:

1. When a NF Eligible with an approved unexpired Level 1 PAE returns to the NF after being hospitalized.

2. When a NF Eligible with an approved unexpired Level 2 PAE returns to the NF after being hospitalized, if there has been no change in the skilled nursing or rehabilitative service for which the PAE was approved.

3. When a NF Eligible changes from Level 2 to Level 1 NF reimbursement and has an approved unexpired Level 1 PAE.

4. To receive Medicaid co-payment when Medicare is the primary payer of SNF care.

5. When a Discharge/Transfer/Hospice Form is appropriate in accordance with (2)(b).

6. For authorization by an MCO of Ventilator Weaning services or short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention. Medical necessity determinations and authorization of Ventilator Weaning services and short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate during the post-weaning period will be managed by the person's MCO.

7. When a person will be receiving hospice services in the NF.

(d) If a NF admits or allows continued stay of a TennCare Eligible without an approved PAE, it does so at its own risk and in such event the NF shall give the Applicant a plain language written notice, in a format approved by the Bureau, that Medicaid reimbursement will not be paid unless the PAE is approved and if it is not finally approved the Applicant can be held financially liable for services provided, including services delivered prior to the effective date of the PAE and enrollment in CHOICES Group 1, unless a third party is liable.

(e) Except as specified in 1200-13-01-.10(2)(e)2., an approved PAE is valid for ninety (90) calendar days beginning with the PAE Approval Date, unless an earlier expiration date has been established by TennCare (see 1200-13-01-.10(2)(h)). A valid approved PAE that has not been used within ninety (90) calendar days of the PAE Approval Date must be updated before it can be used. For purposes of Medicaid-reimbursed NF services, such update may be completed only upon submission of a confirmed Medicaid Only Payer Date. To update the PAE, the physician (in the case of NF services) or a Qualified Assessor (in the case of HCBS) shall certify that the Applicant's medical condition on the revised PAE Request Date is consistent with that described in the initial certification and/or assessment and that NF services, or alternative HCBS, as applicable, are medically necessary for the Applicant. If the Applicant's medical condition has significantly changed such that the previously approved PAE does not reasonably reflect the Applicant's current medical condition and functional capabilities, a new PAE shall be required.

1. A PAE that is not used within 365 days of the PAE Approval Date shall expire and shall not be updated.

2. A PAE shall also expire upon the person's discharge from a NF, unless:

   (i) The person transfers to another NF.

   (ii) The person is discharged to the hospital and returns directly to the NF or to another NF.

   (iii) The person is discharged home for therapeutic leave and returns to the NF within no more than ten (10) days.

   (iv) The person is discharged home and a request to transition to CHOICES Group 2 is submitted by the MCO and approved by TennCare prior to the person's discharge from the NF.

3. For persons electing hospice:

   (i) If a person receiving NF services elects to receive hospice, is disenrolled from CHOICES Group 1, and subsequently withdraws the hospice election and wishes to re-enroll in CHOICES Group 1, the approved PAE may be used so long as:

      (I) the person has remained in the NF;

      (II) the person's condition has not changed;

      (III) no more than thirty (30) days have lapsed since the person's disenrollment from CHOICES Group 1; and

      (IV) NF LOC criteria have not changed.

   (ii) If the person's condition has changed or if more than thirty (30) days have lapsed since the person's disenrollment from CHOICES Group 1, a new PAE shall be required.

   (iii) If the PAE effective date was prior to July 1, 2012, a new PAE must be submitted and the person must qualify based on the new NF LOC criteria in place as of July 1, 2012.

(f) A PAE must include a recent history and physical or current medical records that support the Applicant's functional and/or skilled nursing or rehabilitative needs, as reflected in the PAE. A history and physical performed within 365 calendar days of the PAE Request Date may be used if the

Applicant's condition has not significantly changed. Medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed, or may be used in lieu of a history and physical, so long as the records provide medical evidence sufficient to support the functional and/or skilled or rehabilitative needs reflected in the PAE.

(g) A PAE must be certified as follows:

1. Physician certification shall be required for reimbursement of NF services and enrollment into CHOICES Group 1. Consistent with requirements pertaining to certification of the need for SNF care set forth at 42 CFR § 424.20 and in Section 3108 of the Affordable Care Act, certification of the need for NF care may be performed by a nurse practitioner, clinical nurse specialist, or physician assistant, none of whom has a direct or indirect employment relationship with the facility but who is working in collaboration with a physician.

2. Certification of the level of care assessment by a Qualified Assessor shall be required for all PAEs.

(h) A PAE may be approved by the Bureau for a fixed period of time with an expiration date based on an assessment by the Bureau of the Applicant's medical condition and anticipated continuing need for inpatient nursing care. Notice of appeal rights shall be provided when a PAE is approved with an expiration date.

(i) PASRR.

1. All Applicants who reside in or seek admission to a Medicaid-certified NF must have a PASRR Level I screen for mental illness and mental retardation. The initial Level I screen must be completed prior to admission to the NF and submitted to TennCare regardless of:

   (i) payer source;

   (ii) whether the PASRR screening is positive or negative (including specified exemptions); and

   (iii) the level of NF reimbursement requested.

2. If the Level I screen indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness and/or mental retardation, the Applicant must undergo the PASRR Level II evaluation prior to admission to the NF.

(j) Medicaid payment will not be available for any dates of NF services rendered prior to the date the PASRR process is complete and the Applicant has been determined appropriate for nursing home placement. The PASRR process is complete when either:

1. TennCare has received a negative Level I PASRR screen form and no contradictory information is subsequently received; or

2. For Applicants with a positive Level I PASRR screen (as submitted or upon review and determination by the Bureau), the Bureau has received a certified exemption or advance categorical determination signed by the physician; or a determination by DMH and/or DIDD, as applicable, that the Applicant is appropriate for NF placement. Determination by the Bureau that a Level II PASRR evaluation must be performed may be made:

   (i) Upon receipt of a positive PASRR screen from the NF or other submitting entity;

   (ii) Based on TennCare review of a negative PASRR screening form or history and physical submitted by a NF or other entity; or

   (iii) Upon review of any contradictory information submitted in the PAE application or supporting documentation at any time prior to disposition of the PAE.

(k) A NF that has entered into a provider agreement with a TennCare MCO shall assist a NF resident or

Applicant as follows:

1. The NF shall assist a NF resident or an Applicant for admission in applying for Medicaid eligibility and in applying for Medicaid-reimbursed NF care. This shall include assistance in properly completing all necessary paperwork and in providing relevant NF documentation to support the PAE. For Applicants not currently eligible for Medicaid, the NF may request assistance from the AAAD in completing the Medicaid application process in order to expedite the eligibility determination by DHS. Reasonable accommodations shall be made for an Applicant with disabilities or, alternatively, for a Designated Correspondent with disabilities when assistance is needed with the proper completion and submission of a PAE.

2. The NF shall request a Notice of Disposition or Change from the Department of Human Services upon learning that a resident or Applicant has, or is likely to have, applied for Medicaid eligibility.

(l) The Bureau shall process PAEs independently of determinations of Medicaid eligibility by DHS; however, Medicaid reimbursement for NF care shall not be available until the PASRR process has been completed, and both the PAE and financial eligibility have been approved.

(3) Medicaid Reimbursement.

(a) A NF that has entered into a provider agreement with a TennCare MCO is entitled to receive Medicaid reimbursement for covered services provided to a NF Eligible if:

1. The NF has completed the PASRR process as described in 1200-13-01-.10(2)(i) above and pursuant to 1200-13-01-.23.

2. The Bureau has received an approvable PAE for the person within ten (10) calendar days of the PAE Request Date or the physician certification date, whichever is earlier. The PAE Approval Date shall not be more than ten (10) days prior to date of submission of an approvable PAE. An approvable PAE is one in which any deficiencies in the submitted application are cured prior to disposition of the PAE.

3. The NF has entered into the TennCare PreAdmission Evaluation System (TPAES) a Medicaid Only Payer Date.

4. The person has been enrolled into CHOICES Group 1.

5. For a retroactive eligibility determination, the Bureau has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired PAE within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change, so long as the person has remained in a NF since the PAE was completed, (except for short-term hospitalization). The effective date of payment for NF services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE that has been updated.

6. If the NF participates in the Enrollee's MCO, reimbursement will be made by the MCO to the NF as a Network Provider. If the NF does not participate in the Enrollee's MCO, reimbursement will be made by the MCO to the NF as a non-participating provider, in accordance with Rule 1200-13-01-.05(10).

(b) Any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.

1. Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no more than ten (10) days prior to the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application.

2. Once a PAE has been denied, the original denied PAE application must be resubmitted along

with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for NF services.

(c) The earliest date of Medicaid reimbursement for care provided in a NF shall be the date that all of the following criteria are met:

1. Completion of the PASRR process, as described in 1200-13-01-.10(2)(i) above and pursuant to 1200-13-01-.23;

2. The effective date of level of care eligibility as reflected by the PAE Approval Date;

3. The effective date of Medicaid eligibility;

4. The date of admission to the NF; and

5. The effective date of enrollment into CHOICES Group 1.

(d) PAE Effective Dates pertaining to Advance Determinations for persons not enrolled in TennCare when the PAE is submitted:

1. An Advance Determination by TennCare that an Applicant not enrolled in TennCare at the time the PAE is submitted cannot be safely supported within the array of services and supports that would be available if the Applicant were enrolled in CHOICES Group 3, and approval of NF LOC, shall be effective for no more than thirty (30) days, pending a comprehensive assessment and POC developed by the MCO Care Coordinator once the Applicant is eligible for TennCare and enrolled in CHOICES Group 1 or 2.

2. If TennCare determines that an Advance Determination cannot be approved for an Applicant already admitted to a NF who is not enrolled in TennCare at the time the PAE is submitted, but upon enrollment into CHOICES Group 3 and receipt of comprehensive documentation submitted by the MCO, determines that the Applicant's needs cannot be safely and appropriately met in the community with the array of services and supports available in CHOICES Group 3, enrollment in CHOICES Group 3 will be terminated pursuant to 1200-13-01-.05(5)(b), and NF LOC will be approved. In such case, the effective date of NF LOC and, subject to requirements set forth in TennCare Rule 1200-13-01-.05(4)(a), enrollment into CHOICES Group 1 will be the date that NF LOC would have been effective had an Advance Determination been approved.

(e) Application of new LOC criteria. The new LOC criteria set forth in 1200-13-01-.10(4) shall be applied to all Applicants enrolled into CHOICES on or after July 1, 2012, based on their effective date of enrollment into the CHOICES program.

1. It is the date of enrollment into CHOICES and not the date of PAE submission, approval, or the PAE effective date which determines the LOC criteria that must be applied.

2. TennCare may review a PAE that had been reviewed and approved based on the NF LOC criteria in place as of June 30, 2012, to determine whether an Applicant who will be enrolled into CHOICES on or after July 1, 2012, meets the new LOC criteria. However, all Applicants enrolled into CHOICES with an effective date of enrollment on or after July 1, 2012, shall meet the criteria in place at the time of enrollment, and in accordance with these rules.

(f) A NF that has entered into a provider agreement with a TennCare MCO and that admits a TennCare Eligible without completion of the PASRR process and without an approved PAE does so without the assurance of Medicaid reimbursement.

(g) TennCare reimbursement will only be made to a NF on behalf of the NF Eligible and not directly to the NF Eligible.

(h) A NF that has entered into a provider agreement with a TennCare MCO shall admit persons on a first come, first served basis, except as otherwise permitted by State and federal laws and regulations.

(4) Level of Care Criteria for Medicaid Level 1 Reimbursement of Care in a Nursing Facility, CHOICES HCBS and PACE.

(a) The NF must have completed the PASRR process, as applicable and as described in 1200-13-01-.10(2)(i) above and pursuant to 1200-13-01-.23.

(b) An Applicant must meet both of the following LOC criteria in order to be approved for TennCare-reimbursed care in a NF, CHOICES HCBS or PACE, as applicable:

1. Medical Necessity of Care:

(i) Applicants requesting TennCare-reimbursed NF care. Care in a NF must be expected to improve or ameliorate the Applicant's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.

(ii) Applicants requesting HCBS in CHOICES or PACE. HCBS must be required in order to allow the Applicant to continue living safely in the home or community-based setting and to prevent or delay placement in a NF, and such HCBS must be specified in an approved plan of care and needed on an ongoing basis.

(I) The need for one-time CHOICES HCBS is not sufficient to meet medical necessity of care for HCBS.

(II) If a Member's ongoing need for assistance with activities of daily living and/or instrumental activities of daily living can be met, as determined through the needs assessment and care planning processes, through the provision of assistance by family members and/or other caregivers, or through the receipt of services available to the Member through community resources (e.g., Meals on Wheels) or other payer sources (e.g., Medicare), the Member does not require HCBS in order to continue living safely in the home and community-based setting and to prevent or delay placement in a NF.

2. Need for Inpatient Nursing Care:

(i) Applicants requesting TennCare-reimbursed NF care.

The Applicant must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The Applicant must be unable to self-perform needed nursing care and must meet one (1) or more of the following criteria on an ongoing basis:

(I) Have a total score of at least nine (9) on the TennCare NF LOC Acuity Scale; or

(II) Meet one or more of the ADL or related criteria specified in 1200-13-01-.10(4)(b)(2)(iii) on an ongoing basis and be determined by TennCare to not qualify for enrollment in CHOICES Group 3 (see TennCare Rule 1200-13-01-.05).

(ii) Applicants eligible to receive care in a NF, but requesting HCBS in CHOICES Group 2 or PACE.

The Applicant must have a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. In the absence of ongoing CHOICES HCBS or PACE, the Applicant would require and must qualify to receive NF services in order to remain eligible for HCBS. The Applicant must be unable to self-perform needed nursing care and must meet one (1) or more of the following criteria on an ongoing basis:

(I) Have a total score of at least nine (9) on the TennCare NF LOC Acuity Scale; or

(II) Meet one (1) or more of the ADL or related criteria specified in 1200-13-01-

.10(4)(b)(2)(iii) on an ongoing basis and be determined by TennCare to not qualify for enrollment in CHOICES Group 3 (see TennCare Rule 1200-13-01-.05).

(iii) Applicants not eligible to receive care in a NF, but at risk of NF placement and requesting HCBS in CHOICES Group 3, including Interim CHOICES Group 3.The Applicant must have a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. In the absence of ongoing CHOICES HCBS, the Applicant would not be able to live safely in the community and would be at risk of NF placement. The following criteria shall reflect the individual's Applicant's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent person who is able to function with minimal supervision or assistance. The Applicant must be unable to self-perform needed nursing care and must meet one (1) or more of the following criteria on an ongoing basis:

(I) Transfer. The Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or at least four days per week).

(II) Mobility. The Applicant requires physical assistance from another person for mobility on an ongoing basis (daily or at least four days per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

(III) Eating. The Applicant requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth (daily or at least four days per week). Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.

(IV) Toileting. The Applicant requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or at least four days per week).

(V) Expressive and Receptive Communication. The Applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the Applicant is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual intervention (daily or at least four days per week).

(VI) Orientation. The Applicant is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a NF) daily or at least four days per week.

(VII) Medication Administration. The Applicant is not mentally or physically capable of self-administering prescribed medications (daily or at least four days per week) despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to Applicant, and reassurance of the correct dose.

(VIII) Behavior. The Applicant requires persistent intervention (daily or at least four days per week) due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement).

(IX) Skilled Nursing or Rehabilitative Services. The Applicant requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

(c) For continued TennCare reimbursement of care in a NF, a Member must continue to be financially eligible for TennCare reimbursement for NF care and must continue to meet NF LOC (including medical necessity of care and the need for inpatient care) in place at the time of enrollment into CHOICES Group 1.

(d) A NF Eligible admitted to a NF and enrolled in CHOICES Group 1 prior to July 1, 2012, who continues to meet the LOC criteria in place at the time of enrollment into CHOICES Group 1 shall continue to meet NF LOC for purposes of enrolling in CHOICES Group 2, subject to requirements set forth in 1200-13-01-.05(3) and 1200-13-01-.05(4).

(e) A NF Eligible receiving HCBS in CHOICES Group 2 prior to July 1, 2012, shall be required to meet the NF LOC in place as of July 1, 2012, in order to qualify for Medicaid-reimbursed NF care unless TennCare determines that the Member's needs can no longer be safely and cost-effectively met in CHOICES Group 2.

(5) Criteria for Medicaid Level 2 and Enhanced Respiratory Care Reimbursement of Care in a NF.

(a) The NF must have completed the PASRR process as described in 1200-13-01-.10(2)(i) above and pursuant to 1200-13-01-.23.

(b) An Applicant must meet both of the following criteria in order to be approved for Medicaid Level 2 reimbursement of care in a NF:

1. The Applicant must meet NF LOC as defined in 1200-13-01-.10(4) above.

2. Need for Inpatient Skilled Nursing or Rehabilitative Services on a Daily Basis: The Applicant must have a physical or mental condition, disability, or impairment that requires skilled nursing or rehabilitative services on a daily basis or skilled rehabilitative services at least five days per week when skilled rehabilitative services constitute the primary basis for the approval of the PAE. The Applicant must require such services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit. In addition, the Applicant must be mentally or physically unable to perform the needed skilled services or the Applicant must require skilled services which, in accordance with accepted medical practice, are not usually and customarily self-performed. For interpretation of this rule, the following shall apply:

(i) Administration of oral medications, ophthalmics, otics, inhalers, subcutaneous injections (e.g., fixed-dose insulin, subtherapeutic heparin, and calcitonin), topicals, suppositories, nebulizer treatments, oxygen administration, shall not, in and of itself, be considered sufficient to meet the requirement of (5)(b)2.

(ii) Nursing observation and assessment, in and of itself, shall not be considered sufficient to meet the requirement of (5)(b)2. Examples of nursing services for which Level 2 reimbursement might be provided include, but are not limited to, the following:

(I) Gastrostomy tube feeding

(II) Sterile dressings for Stage 3 or 4 pressure sores

(III) Total parenteral nutrition

(IV) Intravenous fluid administration

(V) Nasopharyngeal and tracheostomy suctioning

(VI) Ventilator services

(iii) A skilled rehabilitative service must be expected to improve the Applicant's condition. Restorative and maintenance nursing procedures (e.g., routine range of motion exercises; stand-by assistance during ambulation; applications of splints/braces by nurses and nurses aides) shall not be considered sufficient to fulfill the requirement of (5)(b)2. Factors to be

considered in the decision as to whether a rehabilitative service meets, or continues to meet, the requirement of (5)(b)2. shall include, but not be limited to, an assessment of the type of therapy and its frequency, the remoteness of the injury or impairment, and the reasonable potential for improvement in the Applicant's functional capabilities or medical condition.

(iv) Effective July 1, 2012, level 2 NF reimbursement for sliding scale insulin may be authorized for an initial period of no more than two (2) weeks for Applicants with unstable blood glucose levels that require daily monitoring and administration of sliding scale insulin. Approval of such reimbursement will require a physician's order and supporting documentation including a plan of care for stabilizing the Applicant's blood sugar and transitioning to fixed dosing during the approval period. Additional periods of no more than two (2) weeks per period, not to exceed a maximum total of sixty (60) days, may be authorized upon submission of a new PAE and only with a physician's order and detailed explanation regarding why previous efforts to stabilize and transition to fixed dosing were not successful.

(c) In order to be approved for TennCare-reimbursed care in a NF at the Chronic Ventilator rate of reimbursement, an Applicant must be ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula).

(d) In order to be approved by the Bureau for TennCare-reimbursed care in a NF at the Tracheal Suctioning rate of reimbursement, an Applicant must have a functioning tracheostomy and require suctioning through the tracheostomy, at a minimum, multiple times per eight (8) hour shift. The suctioning must be required to remove excess secretions and/or aspirate from the trachea, which cannot be removed by the Applicant's spontaneous effort. Suctioning of the nasal or oral cavity does not qualify for this higher level of reimbursement. An MCO may authorize, based on medical necessity, short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention during the post-weaning period.

(e) Determination of medical necessity and authorization for TennCare reimbursement of Ventilator Weaning services, or short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention shall be managed by the Enrollee's MCO.

(6) TennCare Nursing Facility Level of Care Acuity Scale.

(a) Effective July 1, 2012, for all new enrollments into CHOICES Groups 1 and 2, level of care (LOC) eligibility for TennCare-reimbursement of NF services shall be based on an assessment of the following measures:

1. The Applicant's need for assistance with the following Activities of Daily Living (ADLs):

(i) Transfer;

(ii) Mobility;

(iii) Eating; and

(iv) Toileting.

2. The Applicant's level of independence (or deficiency) in the following ADL-related functions:

(i) Communication (expressive and receptive);

(ii) Orientation (to person and place);

(iii) Dementia-related behaviors; and

(iv) Self-administration of medications.

3. The Applicant's need for certain skilled and/or rehabilitative services.

(b) One or more questions on the PAE for NF LOC shall be used to assess each of the ADL or related measures specified above. There are four (4) possible responses to each question.

(c) Weighted Values.

1. Interpretation of possible responses for all measures except behavior:

(i) "Always" shall mean that the Applicant is always independent with that ADL or related activity.

(ii) "Usually" shall mean that the Applicant is usually independent (requiring assistance fewer than 4 days per week).

(iii) "Usually not" shall mean that the Applicant is usually not independent (requiring assistance 4 or more days per week).

(iv) "Never" means that the Applicant is never independent with that ADL or related activity.

2. Interpretation of possible responses for the behavior measure:

(i) "Always" shall mean that the Applicant always requires intervention for dementia-related behaviors.

(ii) "Usually" shall mean that the Applicant requires intervention for dementia-related behaviors 4 or more days per week.

(iii) "Usually not" shall mean that the Applicant requires intervention for dementia-related behaviors, but fewer than 4 days per week.

(iv) "Never" shall mean that the Applicant does not have dementia-related behaviors that require intervention.

3. The weighted value of each of the potential responses to a question regarding the ADL or related functions specified above when supported by the medical evidence submitted with the PAE shall be as follows:

ADL (or related) question	Condition	Always	Usually	Usually not	Never	Maximum Individual Acuity Score	Maximum Acuity Score for the Measure(s)
Transfer	Highest value of two measures	0	1	3	4	4	4
Mobility		0	1	2	3	3	
Eating		0	1	3	4	4	4
Toileting	Highest value of three questions for the toileting measure	0	0	1	2	2	3
Incontinence care		0	1	2	3	3	
Catheter/ ostomy care		0	1	2	3	3	
Orientation		0	1	3	4	4	4
Expressive communication	Highest value of two questions for the communication measure	0	0	0	1	1	1
Receptive communication		0	0	0	1	1	
Self-administration of medication	First question only; excludes SS insulin	0	0	1	2	2	2

Behavior		3	2	1	0	3	3
Maximum possible ADL (or related) Acuity Score							21

4. The weighted value for each of the skilled and/or rehabilitative services for which level 2 or enhanced respiratory care NF reimbursement could be authorized when determined by TennCare to be needed by the Applicant on a daily basis or at least five days per week for rehabilitative services, based on the medical evidence submitted with the PAE shall be as follows:

Skilled or rehabilitative service	Maximum Individual Acuity Score
Ventilator	5
Frequent tracheal suctioning	4
New tracheostomy or old tracheostomy requiring suctioning through the tracheostomy multiple times per day at less frequent intervals, i.e., < every 4 hours	3
Total Perenteral Nutrition (TPN)	3
Complex wound care (i.e., infected or dehisced wounds)	3
Wound care for stage 3 or 4 decubitus	2
Peritoneal dialysis	2
Tube feeding, enteral	2
Intravenous fluid administration	1
Injections, sliding scale insulin	1
Injections, other IV, IM	1
Isolation precautions	1
PCA pump	1
Occupational Therapy by OT or OT assistant	1
Physical Therapy by PT or PT assistant	1
Teaching catheter/ostomy care	0
Teaching self-injection	0
Other	0
Maximum Possible Skilled Services Acuity Score	5

5. Conditions.

(i) Maximum Acuity Score for Transfer and Mobility:

(I) Assessment of the need for assistance with transfer and the need for assistance with mobility are separate but overlapping measures of an Applicant's physical independence (or dependence) with movement.

(II) The maximum individual acuity score for transfer shall be four (4).

(III) The maximum individual acuity score for mobility shall be three (3).

(IV) The highest individual acuity score among the transfer and mobility measures shall be the Applicant's total acuity score across both measures.

(V) The maximum acuity score across both of the transfer and mobility measures shall be four (4).

(ii) Maximum Acuity Score for Toileting:

(I) Assessment of the need for assistance with toileting shall include the following:

I. An assessment of the Applicant's need for assistance with toileting;

II. Whether the Applicant is incontinent, and if so, the degree to which the Applicant is independent in incontinence care; and

III. Whether the Applicant requires a catheter and/or ostomy, and if so, the degree to which the Applicant is independent with catheter and/or ostomy care.

(II) The highest individual acuity score among each of the three (3) toileting questions shall be the Applicant's total acuity score for the toileting measure.

(III) The maximum acuity score for toileting shall be two (2).

(iii) Maximum Acuity Score for Communication:

(I) Assessment of the Applicant's level of independence (or deficiency) with communication shall include an assessment of expressive as well as receptive communication.

(II) The highest individual acuity score across each of the two (2) communication questions shall be the Applicant's total score for the communication measure.

(III) The maximum possible acuity score for communication shall be one (1).

(iv) Maximum Acuity Score for Self-Administration of Medication:

(I) Assessment of the Applicant's level of independence (or deficiency) with self-administration of medications as an ADL-related function shall not take into consideration whether the Applicant requires sliding scale insulin and the Applicant's level of independence in self-administering sliding scale insulin.

(II) Sliding scale insulin shall be considered along with other skilled and/or rehabilitative services for which TennCare could authorize level 2 NF reimbursement .

(III) The maximum individual acuity score for self-administration of medication shall be two (2).

(IV) The maximum individual acuity score for sliding scale insulin shall be one (1).

(v) Maximum Skilled Services Acuity Score

(I) The highest individual acuity score across all of the skilled and/or rehabilitative services shall be the Applicant's total acuity score for skilled and/or rehabilitative services.

(II) The maximum possible acuity score for skilled and/or rehabilitative services shall be five (5).

(d) Maximum Acuity Score

1. The maximum possible acuity score for Activities of Daily Living (ADL) or related deficiencies shall be twenty-one (21).

2. The maximum possible acuity score for skilled and/or rehabilitative services shall be five (5).

3. The maximum possible total NF LOC acuity score shall be twenty-six (26).

(e) Calculating an Applicant's Total Acuity Score.

1. Subject to the conditions set forth in 1200-13-01-.10(6)(c)5., an Applicant's acuity score for each functional measure (i.e., eating, toileting, orientation, communication, self-administration of

medication, or behavior), or in the case of transfer and mobility, the Applicant's acuity score across both measures shall be added in order to determine the Applicant's total ADL or related acuity score (up to a maximum of 21).

2. The Applicant's total ADL or related acuity score shall then be added to the Applicant's skilled services acuity score (up to a maximum of 5) in order to determine the Applicant's total acuity score (up to a maximum of 26).

(7) PreAdmission Evaluation Denials and Appeal Rights.

(a) A TennCare Eligible or the legal representative of the TennCare Eligible has the right to appeal the denial of a PAE and to request an Administrative Hearing by submitting a written letter of appeal to the Bureau of TennCare, Division of Long-Term Services and Supports, within thirty (30) calendar days of receipt of the notice of denial.

(b) If the Bureau denies a PAE, the Applicant will be notified in the following manner:

1. A written Notice of denial shall be sent to the Applicant and, where applicable, to the Designated Correspondent. A Notice of denial shall also be provided to the NF. This notice shall advise the Applicant of the right to appeal the denial decision within thirty (30) calendar days. The notice shall also advise the Applicant of the right to submit within thirty (30) calendar days either the original PAE with additional information for review or a new PAE. The Notice shall be mailed to the Applicant's address as it appears upon the PAE. If no address appears on the PAE and supporting documentation, the Notice will be mailed to the NF for forwarding to the Applicant.

2. If the PAE is resubmitted with additional information for review or if a new PAE is submitted, and the Bureau continues to deny the PAE, another written notice of denial shall be sent as described in (7)(b)1.

(c) The Applicant has the right to be represented at the hearing by anyone of his/her choice. The hearing will be conducted according to the provisions of the Tennessee Uniform Administrative Procedures Act.

(d) Reasonable accommodations shall be made for Applicants with disabilities who require assistance with an appeal.

(e) Any Notice required pursuant to this section shall be a plain language written Notice.

(f) When a PAE is approved for a fixed period of time with an Expiration Date determined by the Bureau, the Applicant shall be provided with a Notice of appeal rights, including the opportunity to submit an appeal within thirty (30) calendar days of receipt of the notice of denial. Nothing in this section shall preclude the right of the Applicant to submit a new PAE establishing medical necessity of care when the Expiration Date has been reached.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Dept. of Finance and Administration (board/commission/ other authority) on 9/14/12 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 07/16/12

Rulemaking Hearing(s) Conducted on: (add more dates). 09/07/12

Date: 9/14/12

Signature: Patti Killingsworth

Name of Officer: Patti Killingsworth

Title of Officer: Chief, Long-Term Services and Support, Bureau of TennCare, Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: 9/14/2012

Notary Public Signature: Patricia Ryan

My commission expires on: 9/20/2015

PATRICIA RYAN NOTARY PUBLIC STATE OF TENNESSEE RUTHERFORD COUNTY

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

RE Cooper

Robert E. Cooper, Jr.
Attorney General and Reporter

9-25-12
Date

Department of State Use Only

Filed with the Department of State on: 9/26/12

Effective on: 12/25/12

Tre Hargett
Secretary of State

RECEIVED
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SECRETARY OF STATE
PUBLICATIONS

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Copy of response to comment is included with filing.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

(If applicable, insert Regulatory Flexibility Addendum here)

The rules are not anticipated to have an effect on small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

The rules are not anticipated to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The rules replace Emergency Rules that allowed for changes to the Nursing Facility Level of Care requirements for entry into CHOICES, TennCare's program of long-term services and supports for individuals who are elderly or physically disabled. There are also other rules that are being updated.

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The rules are lawfully adopted by the Bureau of TennCare in accordance with §§ 4-5-202, 71-5-105 and 71-5-109.

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons and entities most directly affected by these Rules are the TennCare enrollees, providers and the managed care contractors. The governmental entity most directly affected by these Rules is the Bureau of TennCare, Tennessee Department of Finance and Administration.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The Rules were approved by the Tennessee Attorney General. No additional opinion was given or requested.

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars ($500,000), whichever is less;

The promulgation of these rules is anticipated to decrease state FY2013 expenditures by $17,930,000

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Darin J. Gordon
Director, Bureau of TennCare

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Darin J. Gordon
Director, Bureau of TennCare

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

310 Great Circle Road
Nashville, TN 37243
(615) 507-6443
Darin.J.Gordon@tn.gov

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

September 20, 2012

Mr. Jesse Samples, Executive Director
Tennessee Health Care Association
2809 Foster Avenue
Nashville, TN 37210

Dear Mr. Samples:

Thank you for your comments regarding the Permanent Rule implementing changes in TennCare's level of care (LOC) criteria for Medicaid reimbursement of nursing facility (NF) services. This letter responds to your specific recommendations, and also addresses several of the comments made in your letter.

TennCare has consistently supported the move away from a purely cost-based reimbursement methodology for NF services and toward a system of payment that better takes into account the acuity of residents served. As you are aware, this was part of the Long-Term Care Community Choices Act (LTC CCA) of 2008. It is important to note that THCA and the industry did not want to move forward with implementing that new methodology at the same time that the State was integrating NF services into the managed care program. Accordingly, we agreed to allow time for the system to stabilize before changing the reimbursement methodology.

We further agreed to delay moving forward with changing reimbursement methodologies when it was decided that the State would have to implement a reduction in provider rates (including NFs) during Fiscal Year 2012.

Moreover, shortly after the LTC CCA was passed, we learned that the State would not be able to implement LOC changes that would ultimately help to better target NF services to higher acuity residents due to Maintenance of Effort (MOE) requirements of the American Recovery and Reinvestment Act of 2009 and subsequently the Affordable Care Act of 2010. It was only in late 2011 that we reached agreement in principle with CMS on a strategy to revise LOC criteria while maintaining compliance with MOE provisions, and in mid-2012 that we received formal approval of an amendment that would allow us to begin implementing these changes on July 1, 2012. To that end, as you note, an additional $8 million state ($23.6 million total) in non-recurring funds was recommended by the Governor and approved by the General Assembly to help compensate facilities for the increase in the

acuity mix of residents in FY 2013, while we are working with you and with LTSS stakeholders broadly to determine how best to implement a new reimbursement methodology that better reflects acuity, while also aligning incentives in order to promote the highest quality of care for NF residents.

We are happy to work with THCA and with other industry representatives, as well as members of the LTSS stakeholder community broadly in the development of a new reimbursement methodology. In fact, based on your recommendations, we have already begun the process of working with Meyers and Stauffer to analyze MDS data and to then assist us in modeling various types of reimbursement options. We are happy to work with THCA to request any analyses you believe should be conducted as we explore options for acuity-based reimbursement and share that information along with other alternative models in our broader stakeholder discussions. I feel confident that, working together, we can develop a new methodology that will accomplish our shared goals of better matching payment to the acuity of residents served, while also promoting the highest quality of care for our members.

We respectfully disagree with your characterization that CHOICES Group 3 is a "low level of service benefit," and particularly that it is "becoming the primary service group for people needing long-term services and supports." As has been explained, this is the level of service typically received by a significant percentage of persons receiving HCBS prior to implementation of these changes, based on an individualized assessment of their needs. Bear in mind that these individuals also have access to other Medicaid benefits, including home health, as well as services available through Medicare (if the person is dual eligible as 90 percent of CHOICES members are), private insurance or other funding sources, and unpaid supports provided by family members and other caregivers.

Further, as you know, the LOC process has been specifically designed to allow persons with an acuity score of less than nine (9) whose needs cannot be safely met within the array of benefits available if enrolled in Group 3 to meet NF LOC and to have access to NF services or alternatively, a more comprehensive package of HCBS.

With respect to the primary LTSS service group, we monitor CHOICES enrollment, including how people come into the program, on a monthly basis. Since the beginning of Statewide implementation, Group 1 (persons receiving NF services) has consistently been the "primary" LTSS Service group, both in terms of total enrollment and in terms of how people are coming into the program.

At the outset of LOC changes, we said our intent was that roughly 20-25% of applicants for NF care would be diverted to more cost-effective home and community-based alternatives that would help to delay the need for NF placement. Upon analyzing data from the TennCare PAE System (TPAES) beginning with implementation of LOC changes on July 1, the rate of diversion from NFs we are seeing is at the low end of the anticipated range. With more than two months of data, the percentage of people applying for NF services that have been diverted to CHOICES Group 3 for HCBS has been just over 21% (21.04). Of course, as their needs change, level of care will be re-evaluated, and at the point that NF LOC is met, more comprehensive HCBS or NF care will be available.

Our denial rate (applicants that do not qualify for *any* LTSS) among persons applying to receive NF services remains flat at 9% (it typically runs around 9-10%), which we would expect, since people that would have qualified in the past would still qualify for services--HCBS (rather than NF services) when they have lesser needs. The remaining roughly 70% of NF applicants are in fact qualifying for NF LOC.

NF services thus continue as the "primary" CHOICES group at 20,809 members and 64.58% of the total CHOICES population as of September 1, 2012.

With respect to re-submission of PAEs, the TennCare Rules are very clear that a PAE may always be resubmitted. However, any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes. In fact, as I shared with you in an earlier email, one of the most significant issues we have seen is that providers are not always submitting an accurate assessment of the member's level of functioning in the PAE and supporting documentation. It is likely that providers became accustomed to the very low threshold that existed prior to July 1, and have not yet adjusted to the need for a more thorough assessment along with supporting documentation of the person's functional needs. In several cases where concerns have been raised about a person's ability to be safely served in Group 3, we have found that in fact the person has an acuity score of nine (9) and meets NF LOC; however, comprehensive, accurate information was not submitted in the initial application. In many such instances, staff here have assisted NFs in getting the right information in order to ensure that the person's actual level of functioning was accurately represented, and NF LOC was approved.

Regarding the timeliness of processing PAEs, this too is something that we monitor on an ongoing basis, ever-vigilant of the eight working day processing time line. Our managers receive a daily report of aged PAEs, so that we always know how many days remain for timely determination. Between July 1 and August 31, 2012, we received a total of 6,937 PAEs (5,210 Nursing Facility and 1,727 HCBS). Of those nearly 7,000 PAEs, a total of three (3) PAEs (.0004) were not adjudicated within the eight day timeframe. In each case, the decision was one day late (on the 9th day). In addition, there were four (4) PAEs adjudicated timely for which the decision was subsequently revised upon audit. I cannot express how hard the staff of the PAE unit have worked to process between 700 and in some cases nearly a thousand PAEs each week in a timely manner, reviewing not just one, but in many cases, two levels of care. It is therefore incredibly disheartening when unfounded allegations are made regarding the timeliness of their work. I would ask that in the future, if facilities make such allegations, you provide specific examples to TennCare, allowing us the opportunity to research and respond.

With respect to the MCOs' role in the LOC process, this has been very clearly defined in their contracts and other documents, with training and ongoing monitoring to ensure that they are fulfilling their contracted functions. It does appear, however, that NFs may have some confusion regarding the MCOs' role—particularly in instances in which a member is not yet Medicaid eligible, and therefore does not have an MCO. We will provide additional information to NFs via a memo and training bulletin very soon.

Finally, regarding your specific comments, you requested that we reconsider the 30-day period for which we will allow a member's previous LOC determination to stand once he has elected hospice and then subsequently chooses to withdraw his hospice election and re-enroll in CHOICES. The purpose of this period is to simplify the administrative process for persons who change their minds. In any other case, when a person is withdrawing their hospice election, we believe the reasonable likelihood is that the person's condition has improved such that hospice is no longer appropriate, in which case, re-evaluation of LOC is appropriate. In considering your recommendation, we reviewed 25 hospice re-enrollment requests. Of those 25, 6 were within 30 days of the hospice election, all indicating that the patient or family opted to disenroll from hospice services. The remaining 19 were more than 30 days from the hospice election, ranging from 3 months (only 1) to 8 months, but most were 6-8 months. In each of those 19 instances, there was an indication that the patient improved such that the physician was no longer ordering hospice services, in which case, re-evaluation of LOC was necessary to determine whether placement in a NF was appropriate. Upon review of this data, we have elected to stay with the 30-day period in effect in the Emergency Rule.

With respect to LOC, there is no "exception process." Rather, there are specific LOC criteria—both for persons to qualify for NF placement, and for persons "at risk" of NF placement. One of the components of the State's LOC criteria for NF placement (required for enrollment into CHOICES Group 1 or 2) is meeting the "at-risk" criteria, but being determined by TennCare to not qualify for enrollment into CHOICES Group 3. This is described in TennCare Rule 1200-13-01-.10(4). In instances where TennCare has determined that the person's needs cannot be safely met in CHOICES Group 3 (see the *NF LOC Guide* pp. 14-16, and TennCare Rule Sections 1200-13-01-.05(4), 1200-13-01-.05(5), and 1200-13-01-.05(6)), but the person satisfies the criteria set forth at 1200-13-01-.10(4)(c)1.(i) and (c)2.(iii) on an ongoing basis, the person will meet NF LOC.

Applicants that are denied NF LOC are always notified of the opportunity to appeal the denial of the PAE. They are not notified of an "exception" (as noted above, there is no "exception"); rather they are notified of the specific reasons they did not meet NF LOC, and afforded the opportunity to request a fair hearing regarding the State's decision.

Thank you again for your comments and recommendations. We will continue to carefully monitor these processes going forward to make sure that they are working as we intended, and to ensure that people are able to receive an appropriate level of services and supports.

Respectfully,

Patti Killingsworth

C: Darin Gordon, Deputy Commissioner

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For Department of State Use Only

Sequence Number: 09-10-12
Rule ID(s): 5310
File Date: 9/26/12
Effective Date: 12/25/12

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. T.C.A. § 4-5-205

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Bureau of TennCare
Contact Person:	George Woods
Address:	310 Great Circle Road
Zip:	37243
Phone:	(615) 507-6446
Email:	George.woods@tn.gov

Revision Type (check all that apply):

X Amendments
___ New
___ Repeal

Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1200-13-01	TennCare Long-Term Care Program
Rule Number	**Rule Title**
1200-13-01-.01	Purpose
1200-13-01-.02	Definitions
1200-13-01-.05	TennCare CHOICES Program
1200-13-01-.08	Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC
1200-13-01-.10	Medical (Level of Care) Eligibility Criteria for Medicaid Reimbursement of Care in Nursing Facilities

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Rule title 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC in the Table of Contents is amended by replacing "LTC" with "LTSS" so as amended Rule title 1200-13-01-.08 shall read as follows:

Rule 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving ~~LTC~~ LTSS

Rule title 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for Medicaid Reimbursement of Care in Nursing Facilities in the Table of Contents is deleted its entirety and replaced with a new Rule title 1200-13-01-.10 which shall read as follows:

Rule 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for ~~Medicaid~~ TennCare Reimbursement of Care in Nursing Facilities, CHOICES HCBS and PACE

Paragraph (1) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and replaced with a new Paragraph (1) which shall read as follows:

(1) The purpose of this Chapter is to set forth requirements pertaining to the Long-Term ~~Care (LTC)~~ Services and Supports (LTSS; formerly and also known as the Long-Term Care or LTC) delivery system.

The introductory language to Subparagraph (2) of Rule 1200-13-01-.01 Purpose is amended by deleting "LTC" and replacing it with "LTSS" so as amended the introductory language shall read as follows:

(2) The Bureau of TennCare (Bureau) offers the following ~~LTC~~ LTSS programs and services:

Subparagraphs (a) and (b) of Paragraph (2) of Rule 1200-13-01-.01 Purpose are deleted in their entirety and subsequent Subparagraphs re-lettered accordingly.

~~(a) Nursing Facility (NF) services.~~

~~1. Until such time as the TennCare CHOICES in Long-Term Care Program (CHOICES) is implemented in a particular Grand Division, NF services shall be administered by the Bureau under a Fee-for-Service (FFS) system and in accordance with this Chapter.~~

~~2. At the time that CHOICES is implemented in a particular Grand Division, NF services for eligible residents of that Grand Division shall be administered by the Managed Care Organizations (MCOs) under the Managed Care System and in accordance with this Chapter.~~

~~3. At the time that CHOICES is fully implemented statewide, all NF services shall be administered by the MCOs under the Managed Care System and in accordance with this Chapter.~~

~~(b) Statewide Home and Community Based Services Waiver for the Elderly and Disabled (Statewide E/D Waiver). (See Rule 1200-13-01-.17.)~~

~~1. Until such time that CHOICES is implemented in a particular Grand Division, the Statewide E/D Waiver shall offer home and community based services (HCBS) to eligible residents of that Grand Division under a FFS system and in accordance with this Chapter.~~

~~2. At the time that CHOICES is implemented in a particular Grand Division, the Statewide E/D Waiver shall terminate in that Grand Division and HCBS for eligible residents of that Grand Division shall be administered by the MCOs under the Managed Care System and in accordance with this Chapter. The HCBS waivers for persons with mental retardation (MR) are not affected by the implementation of CHOICES.~~

~~3. At the time that CHOICES is fully implemented statewide, the Statewide E/D Waiver shall terminate and all HCBS other than those offered under the HCBS waivers for individuals with MR or the Program of All-Inclusive Care for the Elderly (PACE) shall be administered by the MCOs under the Managed Care System and in accordance with this Chapter.~~

Part 2. of Subparagraph (c) re-lettered as (a) of Paragraph (2) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and replaced with a new Part 2. which shall read as follows:

2. HCBS for the elderly and adults who have Physical Disabilities.

~~2. HCBS for adults who are elderly or physically disabled.~~

Paragraph (3) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and replaced with a new Paragraph (3) which shall read as follows:

(3) Individuals receiving ~~LTC services~~ LTSS shall be enrolled in Managed Care Contractors (MCCs) as follows:

(a) Individuals receiving TennCare-reimbursed ~~LTC services~~ LTSS, other than those enrolled in the PACE Program or persons approved for immediate Eligibility pursuant to these rules, are also enrolled in a TennCare MCO for primary care, behavioral health services, and acute care services.

(b) In addition to enrollment in an MCO, the following ~~LTC recipients~~ LTSS Enrollees, other than those enrolled in the PACE Program or persons approved for Immediate Eligibility pursuant to these rules, are enrolled with the TennCare Pharmacy Benefits Manager for coverage of prescription drugs:

1. Children under the age of twenty-one (21); and

2. Adults aged twenty-one (21) and older who are not Medicare beneficiaries.

(c) Children under the age of twenty-one (21) who are ~~LTC recipients~~ LTSS Enrollees are also enrolled with the TennCare Dental Benefits Manager (DBM) for coverage of dental services.

Subparagraph (d) ALA – Administrative Lead Agency of Paragraph (4) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and subsequent Subparagraphs re-lettered accordingly.

~~(d) ALA – Administrative Lead Agency~~

Subparagraphs (k) and (l) re-lettered as (j) and (k) of Paragraph (4) of Rule 1200-13-01-.01 Purpose are deleted in their entirety and replaced with new Subparagraphs (j) and (k) which shall read as follows:

(j) DIDD – Tennessee Department of Intellectual and Developmental Disabilities (formerly known as Tennessee Department of Finance and Administration's Division of Intellectual Disabilities Services or DIDS)

(k) DMH – Tennessee Department of Mental Health and Substance Abuse Services (formerly known as the Tennessee Department of Mental Health and Developmental Disabilities)

~~(k) DIDS – Tennessee Department of Finance and Administration's Division of Intellectual Disabilities Services~~

~~(l) DMHDD – Tennessee Department of Mental Health and Developmental Disabilities~~

Subparagraph (m) E/D-Elderly and/or Disabled re-lettered as (l) of Paragraph (4) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and subsequent Subparagraphs re-lettered accordingly.

~~(ml) E/D – Elderly and/or Disabled~~

Subparagraph (u) ICF/MR re-lettered as (s) of Paragraph (4) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and subsequent Subparagraphs re-lettered accordingly.

~~(us) ICF/MR – Intermediate Care Facility for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded)~~

Paragraph (4) of Rule 1200-13-01-.01 Purpose is amended by adding new Subparagraphs (t) and (u) and re-lettering the current re-lettered Subparagraphs (t) and (u) as (v) and (w) with subsequent Subparagraphs re-lettered accordingly so as amended the new Subparagraphs (t) and (u) shall read as follows:

(t) ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities (formerly and also known as Intermediate Care Facility for persons with Mental Retardation or ICF/MR.

(u) ID – Intellectual Disability(ies) (formerly and also known as MR).

Subparagraph (x) re-lettered as (w) of Paragraph (4) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and replaced with a new Subparagraph (w) which shall read as follows:

(w~~x~~) LTC – Long-Term Care (also known as LTSS)

Paragraph (4) of Rule 1200-13-01-.01 Purpose is amended by adding a new Subparagraph (x) and re-lettering the current re-lettered Subparagraph (x) as (y) with subsequent Subparagraphs re-lettered accordingly so as amended the new Subparagraph (x) shall read as follows:

(x) LTSS – Long-Term Services and Supports (formerly and also known as LTC)

Subparagraph (bb) of Paragraph (4) of Rule 1200-13-01-.01 Purpose is deleted in its entirety and replaced with a new Subparagraph (bb) which shall read as follows:

(bb) MR – Mental Retardation (also known as ID)

Paragraph (4) of Rule 1200-13-01-.01 Purpose is amended by adding a new Subparagraph (tt) and re-lettering the current Subparagraph (tt) as (uu) so as amended the new Subparagraph (tt) shall read as follows:

(tt) TPAES – TennCare Pre-Admission Evaluation System

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Rule 1200-13-01-.02 Definitions is deleted in its entirety and replaced with a new Rule 1200-13-01-.02 which shall read as follows:

1200-13-01-.02 Definitions.

(1) Activities of Daily Living (ADLs). ~~(a)~~ Routine self-care tasks that people typically perform independently on a daily basis. One of the components of Level of Care eligibility for ~~LTC~~ LTSS is a person's ability to independently perform (or the amount of assistance needed to perform) certain ADLs, such as:

(a)~~1.~~ Personal hygiene and grooming;

(b)~~2.~~ Dressing and undressing;

(c)~~3.~~ Self feeding;

(d)4. Functional transfers (getting into and out of bed or wheelchair, getting onto or off toilet, etc.);

(e)5. Bowel and bladder management; and

(f)6. Ambulation (walking with or without use of an assistive device, e.g., walker, cane or crutches; or using a wheelchair).

~~(2) Administrative Lead Agency (ALA). The approved agency or agencies with which the Bureau contracts for the provision of covered services through the Statewide E/D Waiver.~~

(2) Adult Care Home. For purposes of CHOICES:

(a) A ~~State-licensed~~ CBRA ~~that offers~~ licensed by the DOH (see Rule 1200-08-36) that offers twenty-four (24) hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet NF LOC, but who prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-day basis is living in the home with the individuals for whom he is providing care.

(b) Coverage shall not include the costs of Room and Board.

(c) Pursuant to State law, licensure is currently limited to Critical Adult Care Homes for persons who are ventilator dependent or adults with traumatic brain injury.

(3) Adult Day Care.

(a) Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day and delivered in an Adult Day Care facility permanently licensed by DHS or a Mental Retardation Adult Habilitation Day Facility licensed by DMH, or as of July 1, 2012, by DIDD.

(b) Services shall be provided pursuant to an individualized POC by a licensed provider not related to the participating adult.

(c) The provider shall be responsible for the provision of all assistance and supervision required by program participants. Such assistance is a component of the Adult Day Care benefit and shall not be billed as a separate HCBS.

(4) Advance Determination. A decision made by the Bureau in accordance with the process and requirements described in Rule 1200-13-01-.05(6) that an Applicant would not qualify to enroll in CHOICES Group 3 (including Interim CHOICES Group 3) when enrollment into CHOICES Group 3 has not actually been denied or terminated, and which may impact the person's NF LOC eligibility (see Rule 1200-13-01-.10(4)(b)(2)(i)(II) and 1200-13-01-.10(4)(b)(2)(ii)(II)).

(5) Applicant. A person applying for TennCare-reimbursed LTSS, for whom a PAE has been submitted to TennCare, and/or by or on behalf of whom a Medicaid application has been submitted to DHS. For purposes of compliance with the Linton Order, the term shall include all individuals who have affirmatively expressed an intent to be considered for current or future admission to a NF or requested that their name be entered on any "wait list." All individuals who contact a NF to casually inquire about the facility's services or admissions policies shall be informed by the facility of that individual's right to apply for admission and be considered for admission on a nondiscriminatory basis and in conformance with Rule 1200-13-01-.06.

~~(5) Applicant. For purposes of compliance with the Linton Order, an individual who seeks admission to a NF and is not limited to those individuals who have completed an official application or have complied with the NF's preadmission requirements. The term shall include all individuals who have affirmatively expressed an intent to be considered for current or future admission to the NF or requested that their name be entered on any "wait list." Individuals who only make casual inquiry concerning the NF or its admission practices, who request information on these subjects, or who do not express any intention that they wish to be actively considered for admission shall not be considered Applicants. All individuals, whether Applicants or Non-Applicants, who contact a NF to casually inquire about the facility's services or admissions policies shall be informed by the facility of that individual's right to apply for admission and be considered for admission on a nondiscriminatory basis and in conformance with Rule 1200-13-01-.06.~~

(6) Area Agencies on Aging and Disability (AAAD). Agencies designated by the Commission on Aging and Disability or its successor organization to plan for and provide services to the elderly and disabled within a defined geographic area as provided by T.C.A. Title 71, Chapter 2.

(7) Arlington IDMR Waiver. HCBS Waiver for persons with IDMR under Section 1915(c) of the Social Security Act (limited to members of the Arlington class certified in United States v. Tennessee, et al.).

(8) Assisted Care Living Facility (ACLF) Services.

~~(a) For purposes of CHOICES:~~

(a) CBRA to NF care in an ACLF licensed by the DOH pursuant to Rule 1200-08-25 that provides and/or arranges for daily meals, personal care, homemaker and other supportive services or health care including medication oversight (to the extent permitted under State law), in a home-like environment to persons who need assistance with ADLs.

~~1. CBRA to NF care that provides and/or arranges for Personal Care, Homemaker and other supportive services or health care including medication oversight (to the extent permitted under State law), in a home-like environment to persons who need assistance with ADLs.~~

2.(b) Coverage shall not include the costs of Room and Board.

~~(b) For purposes of the Statewide E/D Waiver:~~

~~1. Personal Care Services, Homemaker Services, and medication oversight (to the extent permitted under State law) provided in a home-like environment in a licensed ACLF.~~

~~2. Coverage shall not include the costs of Room and Board.~~

(9) Assistive Technology. Assistive devices, adaptive aids, controls or appliances that enable an Enrollee to increase his ability to perform ADLs or to perceive or control his environment. Examples include, but are not limited to, "grabbers" to pick objects off the floor, a strobe light to signify the smoke alarm has been activated, etc.

(10) At Risk for Institutionalization. A requirement for eligibility to enroll in CHOICES Group 3 (including Interim CHOICES Group 3), whereby an individual does not meet the NF LOC criteria in place as of July 1, 2012, but meets the NF LOC criteria in place as of June 30, 2012, as defined in TennCare Rule 1200-13-01-.10(4) such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement.

(11) Attendant Care. For purposes of CHOICES, services to a Member who, due to age and/or ~~p~~Physical Disablities ~~disability~~, needs more extensive assistance than can be provided through intermittent Personal Care Visits (i.e., more than four (4) hours per occurrence or visits at intervals of less than four (4) hours between visits) to provide hands-on assistance and related tasks as specified below, and that may also include safety monitoring and/or supervision.

(a) Attendant Care may include assistance with the following:

1. ADLs such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation.

2. Continuous safety monitoring and supervision during the period of service delivery.

(b) For Members who require hands-on assistance with ADLs, ~~a~~Attendant ~~c~~Care may also include the following homemaker services that are essential, although secondary, to the hands-on assistance with ADLs needed by the Member in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:

1. Picking up the Member's medications or shopping for the Member's groceries.

2. Preparing the Member's meals and/or educating caregivers about preparation of nutritious meals for the Member.

3. Household tasks such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, and doing the Member's personal laundry, ironing and mending.

(c) Attendant Care shall not be provided for Members who do not require hands-on assistance with ADLs.

(d) Attendant Care shall be primarily provided in the Member's place of residence, except as permitted by rule and within the scope of service (e.g., picking up medications or shopping for groceries) when accompanying or transporting the Member into the community pursuant to Rule 1200-13-01-.05(8)(~~m~~n), or under exceptional circumstances as authorized by an MCO in the POC to accommodate the needs of the Member.

(e) A single Contract Provider staff person or Consumer-Directed Worker may provide Attendant Care services to multiple CHOICES Members in the same home and during the same hours, as long as he can provide the services safely and appropriately to each Member. Such arrangements shall be documented in each Member's POC. In such instances, the total units of service provided by the staff person shall be allocated among the CHOICES Members, based on the percentage of total service units required by each Member on average. The Provider shall bill the MCO only once for each of the service units provided, and shall not bill an MCO or multiple MCOs separately to provide services to multiple Members at the same time.

~~(f) Attendant Care shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services, or while a Member is receiving Adult Day Care services.~~

(f) Regardless of payer, Attendant Care shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services, or while a Member is receiving Adult Day Care services.

(g) Attendant Care shall not include:

1. Care or assistance including meal preparation or household tasks for other residents of the same household;

2. Yard work; or

3. Care of non-service related pets and animals.

(12) Back-up Plan.

(a) A written plan that is a required component of the POC for all CHOICES Members receiving Companion Care or non-residential CHOICES HCBS in their own homes and that specifies unpaid persons ~~as~~ and in the case of services provided through Consumer Direction, ~~well as~~ paid Consumer-Directed Workers and/or Contract Providers (as applicable and in accordance with 1200-13-01-.05(9)(h)(8)) who are available, and have agreed to serve as back-up, and who will be contacted to deliver needed care in situations when regularly scheduled CHOICES HCBS providers or Workers are unavailable or do not arrive as scheduled.

(b) A CHOICES Member or his Representative may not elect, as part of the Back-up Plan, to go without services.

(c) The Back-up Plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The Member and his Representative (as applicable) shall have primary responsibility for the development and implementation of the Back-up Plan for consumer-directed services with assistance from the FEA as needed.

(13) Bed Hold. The policy by which NFs ~~providing~~ receiving Level 1 reimbursement for NF care and ICFs/IID~~MR~~ are reimbursed for holding a resident's bed while he is away from the facility, in accordance with this Chapter.

(14) Bureau of TennCare (Bureau). The division of ~~F&A~~ the Department of Finance and Administration, the single state Medicaid agency that administers the TennCare Program. For the purposes of this Chapter, the Bureau shall represent the State of Tennessee.

(15) Care Coordinator. For purposes of CHOICES, a person who is employed or contracted by an MCO to perform the continuous process of care coordination:

(a) Assessing a Member's physical, behavioral, functional, and psychosocial needs;

(b) Identifying the physical health, behavioral health, and ~~LTC services~~ LTSS and other social support services and assistance (e.g., housing or income assistance) necessary to meet identified needs;

(c) Ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and ~~LTC services~~ LTSS needed to help the Member maintain or improve his physical or behavioral health status or functional abilities and maximize independence; and

(d) Facilitating access to other social support services and assistance needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.

~~(16) Caregiver. For purposes of the Statewide E/D Waiver, one or more adult individuals who sign an agreement with the ALA to provide services to an Enrollee participating in the Waiver to meet the needs of the Enrollee during the hours when Waiver services are not being provided by the ALA~~

~~(17) Case Management. For purposes of the Statewide E/D Waiver, services that will assist individuals who receive Waiver services in gaining access to needed Waiver and other Medicaid State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services.~~

~~(18) Case Manager. For purposes of the Statewide E/D Waiver:~~

~~(a) The individual who is responsible for development of the POC and for ongoing monitoring of the provision of services included in the Enrollee's POC. Case Managers shall initiate and oversee the process of assessment and reassessment of the Enrollee's LOC and the review of POCs at such intervals as are specified in the Waiver rules and policies.~~

~~(b) A Case Manager is prohibited from providing any other services to an Enrollee for whom he serves as Case Manager under the Waiver.~~

(16~~19~~)Centers for Medicare and Medicaid Services (CMS). The agency within the United States Department of Health and Human Services that is responsible for administering Titles XVIII, XIX, and XXI of the Social Security Act.

(17~~20~~)Certification.

(a) A process by which a Physician who is licensed as a doctor of medicine or doctor of osteopathy signs and dates a PAE signifying the following:

1. The person requires the requested level of institutional care or reimbursement (Level 1 NF, Level 2 NF, Enhanced Respiratory Care, or ICF/~~II~~DMR) or, in the case of a Section 1915(c) HCBS Waiver program or PACE, requires HCBS as an alternative to the applicable level of institutional care for which the individual would qualify; and

2. The requested ~~LTC services~~ LTSS are medically necessary for the individual.

(b) Consistent with requirements pertaining to certification of the need for SNF care set forth at 42 CFR § 424.20 and in Section 3108 of the Affordable Care Act, certification of the need for NF care may be performed by a nurse practitioner, ~~or~~ clinical nurse specialist, or physician assistant, ~~neither~~ none of

whom has a direct or indirect employment relationship with the facility but who is working in collaboration with a ~~p~~Physician.

(c) Physician certification is not required for CHOICES HCBS.

(18~~24~~)CHOICES. See "TennCare CHOICES in Long-Term ~~Care~~ Services and Supports."

(19) CHOICES 1 and 2 Carryover Group.

(a) Individuals who were enrolled in CHOICES Group 1 or CHOICES Group 2 as of June 30, 2012, but who, upon redetermination, no longer qualify for enrollment due solely to the State's modification of its NF LOC criteria.

(b) Subject to the requirements set forth in 1200-13-01-.05(3)(b)6., Members eligible for TennCare in the CHOICES 1 and 2 Carryover Group 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 as of June 30, 2012, and remain continuously enrolled in the CHOICES 1 and 2 Carryover Group and in CHOICES Group 1 or CHOICES Group 2.

(20~~23~~)CHOICES 217-Like Group. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with Pphysical D~~d~~isabilities who meet the NF LOC criteria, who could have been eligible for HCBS under 42 C.F.R. § 435.217 had the State continued its Section 1915(c) Statewide E/D Waiver and who need and are receiving CHOICES HCBS as an alternative to NF care. This group ~~exists only in the Grand divisions of Tennessee where CHOICES has been implemented, and participation~~ is subject to the Enrollment Target for CHOICES Group 2.

(21~~22~~)CHOICES At-Risk Demonstration Group.

(a) Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with Pphysical D~~d~~isabilities who meet NF financial eligibility requirements for TennCare-reimbursed LTSS, meet the NF LOC in place on June 30, 2012, but not the NF LOC in place on July 1, 2012, and who, in the absence of CHOICES HCBS available through CHOICES Group 3, are At Risk for Institutionalization as defined in these rules.

(b) Members eligible for TennCare in the CHOICES At-Risk Demonstration Group 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, continue to be At Risk for Institutionalization as defined in these rules, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES Group 3.

(22~~24~~)CHOICES Group 1. Individuals of all ages who are receiving TennCare-reimbursed care in a NF.

(23~~25~~)CHOICES Group 2. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with Pphysical D~~d~~isabilities who meet the NF LOC criteria and who qualify for TennCare either as SSI recipients or in an institutional category (i.e., as Members of the CHOICES 217-Like demonstration population), and who need and are receiving CHOICES HCBS as an alternative to NF care. The Bureau has the discretion to apply an Enrollment Target to this group, as described in this Chapter.

(24~~26~~)CHOICES Group 3. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with Pphysical D~~d~~isabilities who qualify for TennCare as SSI recipients, who do not meet the NF LOC, but who, in the absence of CHOICES HCBS, are At Risk for Institutionalization, as defined by the State. The Bureau has the discretion to apply an Enrollment Target to this group, as described in this Chapter.

(25~~27~~)CHOICES Home and Community Based Services (HCBS). Services specified in Rule 1200-13-01-.05(8)(~~l~~k) that are available only to eligible persons enrolled in CHOICES Group 2 or CHOICES Group 3 as an alternative to long-term care institutional services in a ~~n~~Nursing ~~f~~Facility or to delay or prevent placement in a ~~n~~Nursing ~~f~~Facility. Only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include Home Health or Private Duty Nursing services or any other HCBS that are covered by Tennessee's Title XIX State Plan or under the TennCare demonstration for all eligible Enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES ~~m~~Member's needs can be safely met in the community within his or her Individual ~~c~~Cost ~~n~~Neutrality ~~c~~Cap.

(2628)CHOICES Member. An individual who has been enrolled by the Bureau into CHOICES.

(2729)Chronic Ventilator Care Reimbursement. The rate of ~~Medicaid~~ reimbursement provided for NF services, including enhanced respiratory care assistance, delivered by a NF that meets the requirements in Rule 1200-13-01-.03(5) to residents determined by the Bureau to meet the medical eligibility criteria in Rule 1200-13-01-.10(5)(d).

(2830)Community Personal Needs Allowance. See "Personal Needs Allowance (PNA)."

(2931 Community-Based Residential Alternatives (CBRA) to institutional care. For purposes of CHOICES:

(a) Residential services that offer a cost-effective, community-based alternative to NF care for individuals who are elderly and/or adults with Pphysical Ddisabilities, and meet NF LOC.

(b) CBRAs include, but are not limited to:

1. CBRA facilities such as ACLFs and Adult Care Homes; and

2. Companion Care.

(3032)Companion Care. For purposes of CHOICES:

(a) A consumer-directed residential model in which a CHOICES Member may choose to select, employ, supervise and pay, using the services of an FEA, ~~on a monthly basis~~ a live-in companion who will be present in the Member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration.

(b) Such model shall be available only for a CHOICES Member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with ADLs or supervision and monitoring for extended periods of time that cannot be accomplished more cost-effectively with other non-residential services.

(c) A CHOICES Member who requires assistance in order to direct his Companion Care may designate a Representative to assume CD of Companion Care services on his behalf, pursuant to requirements for Representatives otherwise applicable to CD.

~~(d) Companion Care shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services, or while a Member is receiving Adult Day Care services.~~

(d) Regardless of payer, Companion Care shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving Short-Term NF services or Adult Day Care services.

(e) Companion Care is only available through CD.

(3133)Competent Adult. For purposes of Self-Direction of Health Care Tasks in CD, a person age twenty-one (21) or older who has the capability and capacity to evaluate knowledgeably the options available and the risks attendant upon each and to make an informed decision acting in accordance with his own preferences and values. A person is presumed competent unless a decision to the contrary is made.

(3234)Consumer Direction (CD) of Eligible CHOICES HCBS. For purposes of CHOICES, the opportunity for a Member assessed to need Eligible CHOICES HCBS (limited to Attendant Care, Personal Care Visits, In-Home Respite Care, or Companion Care) to elect to direct and manage (or to have a Representative direct and manage) certain aspects of the provision of such services, primarily the hiring, firing, and day-to-day supervision of Consumer-Directed Workers delivering the needed service(s).

(3335)Consumer-Directed Worker (Worker).

(a) An individual who has been hired by a CHOICES Member participating in CD of Eligible CHOICES HCBS or by his Representative to provide one or more Eligible CHOICES HCBS to the Member.

(b) Does not include an employee of an agency that is being paid by an MCO to provide CHOICES HCBS to the Member.

~~(36) Continuity of Care Period. For purposes of CHOICES:~~

~~(a) The period of time immediately following implementation of CHOICES in a Grand Division during which a Member shall continue to receive the same LTC services, as specified in the POC in place prior to CHOICES implementation, from the same LTC providers, regardless of whether such providers have elected to participate in the MCO's network.~~

~~(b) Such period shall be at least thirty (30) days following implementation, but in the case of CHOICES Group 2 Members, shall continue for up to ninety (90) days or until a comprehensive needs assessment has been performed and a new POC has been developed.~~

(34~~37~~)Contract Provider. A provider who is under contract with an Enrollee's MCO. Also called "Network Provider" or "In-Network ~~p~~Provider."

(35) Cost-Effective Alternative (CEA) Service.

(a) A service that is not a covered service but that is approved by TennCare and CMS and provided at an MCO's discretion. There is no entitlement to receive these services.

(b) CEA services may be provided because they are:

1. Alternatives to covered TennCare services that, in the MCO's judgment, are cost effective; or

2. Preventive in nature and offered to avoid the development of conditions that, in the MCO's judgment, would require more costly treatment in the future.

(c) CEA services need not be determined medically necessary except to the extent that they are provided as an alternative to covered ~~Medicaid~~ TennCare services. Even if medically necessary, CEA services are not covered services and are provided only at an MCO's discretion.

(d) For purposes of CHOICES, CEA services may include the provision of CHOICES HCBS as an alternative to NF care when the Enrollment Target for CHOICES Group 2 has been reached as described in Rule 1200-13-01-.05.

(36~~39~~)Cost Neutrality Cap. For purposes of CHOICES Group 2, the average cost of the level of NF reimbursement that would be paid if the Member were institutionalized. The Cost Neutrality Cap functions as a limit on the total cost of HCBS that can be provided to the individual in the home or community setting, including CHOICES HCBS, HH Services and PDN Services. The Cost Neutrality Cap shall be individually applied.

(37~~40~~)Dental Benefits Manager (DBM). See "Dental Benefits Manager" in Rule 1200-13-13-.01.

(38) Department of Intellectual and Developmental Disabilities (DIDD). The State entity contracted by TennCare to serve as the OAA for day-to-day operation of the HCBS waivers for persons with ID. Formerly known as the Division of Intellectual Disabilities Services (DIDS).

(39~~41~~)Designated Correspondent. A person or agency authorized by an individual on the PAE form to receive correspondence related to NF or ICF/IID~~MR~~ services on his behalf.

(40~~42~~) Disenrollment. The voluntary or involuntary termination of an individual's enrollment in an ~~LTC~~ LTSS Program.

~~(43) Division of Intellectual Disabilities Services (DIDS). The division of F&A that serves as the OAA for day-to-day operations of the HCBS Waivers for persons with MR. Formerly the Division of Mental Retardation Services.~~

(4144)Electronic Visit Verification (EVV) system. An electronic system that paid caregivers use to check-in at the beginning and check-out at the end of each period of service delivery. The system is used to monitor Member receipt of specified CHOICES HCBS and also to generate claims for submission by the provider.

(4245)Eligible CHOICES HCBS. For purposes of CD, CHOICES HCBS that may be consumer-directed are limited to Attendant Care, Personal Care Visits, In-Home Respite Care, or Companion Care. Eligible CHOICES HCBS do not include ~~h~~Home ~~h~~Health or ~~p~~Private ~~d~~Duty ~~n~~Nursing services.

(4346)Employer of Record. The Member participating in CD of Eligible CHOICES HCBS or a Representative designated by the Member to assume the CD of Eligible CHOICES HCBS functions on the Member's behalf.

(4447)Enhanced Respiratory Care Reimbursement. Specified levels of reimbursement (i.e., Chronic Ventilator Care, Tracheal Suctioning and Ventilator Weaning) provided for NF services ~~, including enhanced respiratory care assistance, or ventilator weaning services and care during the post weaning period,~~ delivered by a SNF ~~NF~~ that meets the requirements set forth in Rule 1200-13-01-.03(5) to persons determined by the Bureau or an MCO, as applicable, to meet specified medical eligibility criteria for such level of ~~Medicaid~~ reimbursement.

(4548)Enrollee. A ~~Medicaid~~ TennCare-eligible individual who is enrolled in a TennCare ~~LTC~~ LTSS Program.

(4649)Enrollment Target.

(a) The maximum number of individuals who can be enrolled in CHOICES Group 2 or CHOICES Group 3 at any given time, subject to the exceptions provided in this Chapter.

(b) The Enrollment Target is not calculated on the basis of "unduplicated participants." Vacated slots in CHOICES Group 2 or CHOICES Group 3 may be refilled immediately, rather than being held until the next program year, as is required in the HCBS Waiver programs.

(c) Persons enrolled in CHOICES Group 2 prior to July 1, 2012, who remain enrolled in CHOICES Group 2 and continue to qualify for TennCare in the CHOICES 1 and 2 Carryover Group shall be counted against the Enrollment Target for CHOICES Group 2.

(4750)Expenditure Cap. For purposes of CHOICES Group 3, the annual limit on expenditures for CHOICES HCBS, excluding Minor Home Modifications, that a CHOICES Group 3 Member can receive. The Expenditure Cap shall be $15,000 (fifteen thousand dollars) per Member per calendar year.

(4851)Expiration Date.

(a) A date assigned by the Bureau at the time of approval of a PAE after which TennCare reimbursement will not be made unless a new PAE is submitted and approved, or 365 days after the PAE Approval Date when the PAE has not been used.

(b) A PAE is "used" when the individual has begun receiving ~~LTC services~~ LTSS based on the LOC approved in the PAE.

(c) A PAE is "expired" when the individual has not begun receiving ~~LTC services~~ LTSS on or before the 365th day or when an assigned approval end date is reached or as specified in 1200-13-01-.10(2)(e).

(d) The first claim for reimbursement may be submitted after the 365th day, so long as the first date of service is on or before the 365th day.

(4952)Federal Estate Recovery Program (FERP). A federal program set forth under Section 1917(b) of the Social Security Act that requires states offering Medicaid-reimbursed ~~LTC services~~ LTSS to seek adjustment or recovery for certain types of medical assistance from the estates of individuals who were age fifty-five (55) or older at the time such assistance was received, and from permanently institutionalized individuals of any age. For both mandatory populations, the State may elect to recover up to the total cost of all medical assistance provided.

(a) For persons age fifty-five (55) and older, the State is obligated to seek adjustment or recovery for NF (including ICF/IIDMR) services, HCBS, and related hospital and prescription drug services.

(b) For permanently institutionalized persons, states are obligated to seek adjustment or recovery for the institutional services.

(5053)Fee-for-Service (FFS) System. An arrangement whereby the Bureau, rather than the MCO, is responsible for arranging for covered ~~LTC services~~ LTSS and paying claims for these services.

(5154)Fiscal Employer Agent (FEA). An entity contracting with the Bureau and/or an MCO that helps CHOICES Members participating in CD of Eligible CHOICES HCBS. The FEA provides both financial administration and supports brokerage functions for CHOICES Members participating in CD of Eligible CHOICES HCBS. This term is used by the IRS to designate an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6, and Notice 2003-70 as the agent to Members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA, and FUTA taxes. The FEA also files state income tax withholding and unemployment insurance tax forms and pays the associated taxes and processes payroll based on the ~~e~~Eligible CHOICES HCBS authorized and provided.

(5255)Grand Divisions. See "Grand Divisions" in Rule 1200-13-13-.01.

(5356)Health Care Tasks. For CHOICES Members participating in CD, those medical, nursing, or HH Services, beyond ADLs, that:

(a) A person without a functional disability or a caregiver would customarily perform without the assistance of a licensed health care provider;

(b) The person is unable to perform for himself due to a functional or cognitive limitation;

(c) The treating physician, advanced practice nurse, or registered nurse determines can safely be performed in the home and community by an unlicensed Consumer-Directed Worker under the direction of a Competent Adult or caregiver; and

(d) Enable the person to maintain independence, personal hygiene, and safety in his own home.

~~(57) Home (of an Enrollee). For purposes of the Statewide E/D Waiver, the residence or dwelling in which the Enrollee resides in Tennessee, excluding hospitals, NFs, ICFs/MR, ACLFs, Homes for the Aged (Residential Homes for the Aged), and other CBRAs.~~

(5458)Home and Community Based Services (HCBS). Services that are provided under the authority of a Section 1915(c) HCBS waiver or (in the case of CHOICES) a Section 1115 waiver pursuant to a written POC as an alternative to ~~LTC institutional services~~ institutional LTSS in a NF or an ICF/IIDMR to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require the LOC provided in the institution to which the HCBS offer an alternative, or in the case of CHOICES Group 3, are At Risk for Institutionalization. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX State Plan or under the TennCare demonstration for all eligible enrollees, including ~~h~~Home ~~h~~Health or ~~p~~Private ~~d~~Duty ~~n~~Nursing.

(5559)Home and Community Based Services (HCBS) Waiver. A Waiver approved by CMS under the Section 1915(c) authority.

(5660)Home-Delivered Meals.

(a) Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the Enrollee's home. Special diets shall be provided in accordance with the individual POC when ordered by the Enrollee's physician.

~~(b) Home-Delivered Meals shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services.~~

(b) Regardless of payer, Home-Delivered Meals shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services.

(5761)Home Health (HH) Services. See "Home Health Services" in Rule 1200-13-13-.01.

(5862)Homemaker Services.

(a) General household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, doing the Member's personal laundry, ironing or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the Member, assistance with maintenance of a safe environment, and errands such as grocery shopping and having the Member's prescriptions filled.

(b) Provided only for the Member (and not for other household members) and only when the Member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the Member.

(c) Effective July 1, 2012, provided only as part of Personal Care Visits and Attendant Care services for Members who also require hands-on assistance with ADLs. Homemaker Services authorized in an approved POC ~~plan of care~~ on or before June 30, 2012, shall continue to be provided for no more than ninety (90) days after July 1, 2012, pending a reassessment of the Member's needs and modifications to the Member's POC ~~plan of care~~ to comport with the new benefit structure, as well as individual notice of action, when required. Homemaker Services shall not be continued pending resolution of any appeal filed on or after July 1, 2012, as Homemaker Services are no longer covered as a stand-alone benefit. Homemaker Services are not covered for anyone ~~that~~ who does not also require hands-on assistance with ADLs.

~~(d) Shall not be provided to Members living in a receiving CBRA facility or receiving Short-Term NF services.~~

(d) Regardless of payer, shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services.

(5963)ICF/IID~~MR~~ Eligible. An individual determined by DHS to qualify for Medicaid ICF/IID~~MR~~ services and determined by the Bureau to meet the ICF/IID~~MR~~ LOC.

(6064)ICF/IID~~MR~~ PAE ~~Approval~~ Effective Date. The beginning date of LOC eligibility for Medicaid-reimbursed care in an ICF/IID~~MR~~ or HCBS Waiver services offered as an alternative to care in an ICF/IID~~MR~~, for which the ICF/IID~~MR~~ PAE has been approved by the Bureau.

(6165)ICF/IID~~MR~~ PAE Form. The assessment form used by the Bureau to document the current medical and habilitative needs of an individual with MR and to document that the individual meets the Medicaid LOC eligibility criteria for care in an ICF/IID~~MR~~.

(6266)Identification Screen (Level I). See "PreAdmission Screening/Resident Review."

(6367)Immediate Eligibility.

(a) A mechanism by which the Bureau may elect, based on a preliminary determination of an individual's eligibility for the CHOICES 217-Like Group, to enroll the individual into CHOICES Group 2 and provide immediate access to a limited package of CHOICES HCBS pending a final determination of eligibility.

(b) To qualify an individual must:

1. Be applying to receive covered CHOICES HCBS;

2. Be determined by the Bureau to meet NF LOC;

3. Have submitted an application for financial eligibility determination to DHS;

4. Be expected to qualify in the CHOICES 217-Like Group based on review of the financial information provided by the applicant; and

5. Meet all other specified criteria for enrollment into CHOICES Group 2, subject to categorical and financial eligibility determination.

(c) Immediate Eligibility shall only be for Specified CHOICES HCBS (no other covered services) and for a maximum of forty-five (45) days.

(d) Immediate Eligibility is not available for individuals who are already enrolled in TennCare or for persons who may qualify in the CHOICES At-Risk Demonstration Group.

(6468)Immediate Family Member~~:~~. For purposes of employment as a ~~c~~Consumer-~~d~~Directed Worker in CHOICES~~:~~, a spouse, parent, grandparent, child, grandchild, sibling, mother-in-law, father-in-law, sister-in-law, brother in-law, daughter-in-law, and son-in-law. Adopted and step members are included in this definition.

(6569) Individual Acuity Score. The weighted value assigned by TennCare to:

(a) The response to a specific ADL or related question in the PAE for NF LOC that is supported by the medical evidence submitted with the PAE; or

(b) A specific skilled or rehabilitative service determined by TennCare to be needed by the applicant on a daily basis or at least five (5) days per week for rehabilitative services based on the medical evidence submitted with the PAE and for which TennCare would authorize level 2 or ~~e~~Enhanced ~~r~~Respiratory ~~c~~Care ~~r~~Reimbursement in a NF.

(6670)Individual Cost Neutrality Cap. See "Cost Neutrality Cap."

~~(71) Individual Plan of Care (POC). For purposes of the Statewide E/D Waiver, an individualized written POC that serves as the fundamental tool by which the Bureau ensures the health and welfare of Enrollees and that meets the requirements of this Chapter.~~

(6772)In-Home Respite Care. For purposes of CHOICES:

(a) Services provided to Members unable to care for themselves, furnished on a short-term basis in the Member's place of residence, because of the absence or need for relief of those family members or other unpaid caregivers normally providing the care; and

~~(b) Shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services.~~

(b) Regardless of payer, shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services.

(6873) Inpatient Respite Care. For purposes of CHOICES:

(a) Services provided to individuals unable to care for themselves, furnished on a short-term basis in a licensed NF or licensed CBRA facility, because of the absence or need for relief of those family members or other unpaid caregivers normally providing the care.

~~(b) Shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services.~~

(b) Regardless of payer, shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services.

(6974)Inpatient Nursing Care. Nursing services that are available twenty-four (24) hours per day by or under the supervision of a licensed practical nurse or registered nurse and which, in accordance with general medical practice, are usually and customarily provided on an inpatient basis in a NF. Inpatient Nursing Care includes, but is not limited to, routine nursing services such as observation and assessment of the individual's medical condition, administration of legend drugs, and supervision of nurse aides; and other skilled nursing therapies or services that are performed by a licensed practical nurse or registered nurse.

(7075)Institutional Personal Needs Allowance. See "Personal Needs Allowance (PNA)."

(7176)Interim CHOICES Group 3 (open only between July 1, 2012, and December 31, 2013).

(a) Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with Pphysical Ddisabilities who qualify for TennCare as SSI recipients or as mMembers of the CHOICES At-Risk Demonstration Group, and who are At Risk for Institutionalization as defined in these rules. There will be no Enrollment Target applied to Interim CHOICES Group 3.

(b) 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, continue to be At Risk for Institutionalization, can be safely served in Interim CHOICES Group 3, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES Group 3.

(7277)Intermediate Care Facility for Individuals ~~Persons~~ with Intellectual Disabilities ~~Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded)~~ (ICF/IIDMR) (formerly and also known as Intermediate Care Facility for persons with Mental Retardation or ICF/MR). A licensed facility approved for Medicaid reimbursement that provides specialized services for individuals with IDMR or related conditions and that complies with current federal standards and certification requirements set forth in 42 C.F.R., Part 483.

(7378)Involuntary Transfer or Discharge. Any transfer or discharge that is opposed by the resident or a Representative of the resident of a NF or ICF/IIDMR. For purposes of compliance with the requirements of this Chapter, a discharge or transfer is involuntary when the NF initiates the action to transfer or discharge.

(7479)Legally Appointed Representative. Any person appointed by a court of competent jurisdiction or authorized by legal process (e.g., power of attorney for health care treatment, declaration for mental health treatment) to determine the legal and/or health care interests of an individual and/or his estate.

(7580)Level of Care (LOC). Medical eligibility criteria for receipt of an institutional service, HCBS offered as an alternative to the institutional service, or in the case of persons At Risk for Institutionalization, to delay or prevent institutional placement. An individual who meets the LOC criteria for NF care is an individual who has been determined by the Bureau to meet the medical eligibility criteria established for that service.

(7681)Level 1 Nursing Facility (NF) Care Reimbursement. The level of ~~Medicaid~~ reimbursement provided for NF services delivered to residents eligible for TennCare ~~Medicaid~~-reimbursement of NF services determined by the Bureau to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(4) by a NF that meets the requirements set forth in Rule 1200-13-01-.03(3), and in accordance with the reimbursement methodology for Level 1 NF Care set forth in Rule 1200-13-01-.03(6).

(7782)Level 2 Nursing Facility (NF) Care Reimbursement. The level of ~~Medicaid~~ reimbursement provided for NF services delivered to residents eligible for TennCare ~~Medicaid~~-reimbursement of NF services determined by the Bureau to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(5) by a NF that meets the requirements set forth in Rule 1200-13-01-.03(4), and in accordance with the reimbursement methodology for Level 2 NF Care set forth in Rule 1200-13-01-.03(7).

(7883)Linton. The lawsuit known as Linton v. Tennessee Commissioner of Health and Environment resulting in a series of Orders issued by the United States District Court and the Sixth Circuit Court of Appeals regarding ~~LTC~~ NF services.

~~(84) Long-Term Care (LTC) Enrollee or Participant. An individual who is participating in a TennCare LTC Program.~~

(7985)Long-Term Care (LTC) Ombudsman. An individual with expertise and experience in the fields of ~~LTC~~ LTSS and advocacy, who assists in the identification, investigation, and resolution of complaints that are made by, or on behalf of, NF residents, and persons residing in CBRA settings, including ACLFs and Adult Care Homes. The Tennessee LTC Ombudsman Program is administered by the TCAD.

(80) Long-Term Services and Supports (LTSS) Enrollee or Participant. An individual who is participating in a TennCare LTSS Program.

(8186)Long-Term Services and Supports ~~(LTC)~~ (LTSS) Program. One of the programs offering ~~LTC services~~ LTSS to individuals enrolled in TennCare. ~~LTC~~ LTSS Programs include institutional programs (NFs and ICFs/IIDMR), ~~as well as~~ HCBS offered ~~either~~ through CHOICES or through a Section 1915(c) HCBS Waiver Program, and the PACE Program.

(8287)Managed Care Organization (MCO). See "Managed Care Organization" in Rule 1200-13-13-.01.

(8388)Managed Care System. A system under which the MCOs are responsible for arranging for services and paying claims for delivery of these services to ~~m~~Members enrolled in their plans.

~~(89) Medicaid Eligible. For purposes of this Chapter, an individual who has been determined by DHS to be financially eligible to have Medicaid reimbursement for covered LTC services.~~

(84) Medicaid. As used in this Chapter, the term Medicaid refers to:

(a) The Social Security Act Title XIX program administered by the Single State Agency through CMS and any of the waivers granted to the State of Tennessee; or,

(b) Specific categories of eligibility established by Title XIX. The eligibility category in which a person qualifies for TennCare may determine the benefits the person is eligible to receive, and his cost sharing obligations.

(8590)Medicaid Only Payer Date (MOPD). The date a NF certifies that Medicaid reimbursement for NF services will begin because the aApplicant has been admitted to the facility and all other primary sources of reimbursement (including Medicare and private pay) have been exhausted. (This does not preclude the aApplicant's responsibility for payment of pPatient lLiability as described in these rules.) The MOPD must be known (and not projected) as it will result in the determination of eligibility for Medicaid reimbursement of NF services and in many cases, eligibility for Medicaid, as well as a capitation payment and payments for Medicaid services ~~(including, but not limited to LTC)~~ received, including but not limited to LTSS. The PAE may be submitted without an MOPD date, in which case the MOPD shall be submitted by the facility when it is known. Enrollment into CHOICES Group 1 and eligibility for reimbursement of NF services shall be permitted only upon submission of a MOPD. The effective date of CHOICES enrollment and Medicaid reimbursement of NF services shall not be earlier than the MOPD.

(8691)Medicare Savings Program. The mechanisms by which low-income Medicare beneficiaries can get assistance from Medicaid in paying for their Medicare premiums, deductibles, and/or coinsurance. These programs include the Qualified Medicare Beneficiary (QMB) program, the Specified Low Income Medicare Beneficiary (SLMB) program, and the Qualified Individual (QI) program.

(8792) Member. See "CHOICES Member."

(8893)Mental Illness (MI). For the purposes of compliance with federal PASRR regulations, an individual who meets the following requirements on diagnosis, level of impairment and duration of illness:

(a) The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, which is a schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but is not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

(b) The level of impairment must result in functional limitations in major life activities within the past three (3) to six (6) months that would be appropriate for the individual's developmental stage; or

(c) The treatment history of the individual has at least one of the following: a psychiatric treatment more intensive than outpatient care more than once in the past two (2) years, or within the last two (2) years, due to a mental disorder, the individual has experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

(8994) Mental Retardation (MR) and Related Conditions. For the purposes of compliance with federal PASRR regulations, an individual is considered to have MR if he has a level of retardation (mild, moderate, severe and profound) as described in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation (1983).

(a) MR refers to significantly subaverage general intellectual functioning, indicated by an IQ test score of 70 or below, existing concurrently with deficits in adaptive behavior and manifested during the developmental period (i.e., prior to age eighteen).

(b) The provisions of this Paragraph also apply to persons with "related conditions", as defined by 42 C.F.R. § 435.1010, which states: "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

1. It is attributable to:

(i) Cerebral palsy or epilepsy, or

(ii) Any other condition, other than MI, found to be closely related to MR because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR, and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age twenty-two (22).

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

(i) Self-care;

(ii) Understanding and use of language;

(iii) Learning;

(iv) Mobility;

(v) Self-direction; and

(vi) Capacity for independent living.

(9095) Minor Home Modifications. ~~(a)~~ For purposes of CHOICES:

(a)~~1.~~ Included are the following:

1.~~(i)~~ The provision and installation of certain home mobility aids, including but not limited to:

(i)~~(I)~~ Wheelchair ramps and modifications directly related to and specifically required for the construction or installation of the ramps;

(ii)~~(II)~~ Hand rails for interior or exterior stairs or steps; or

(iii)~~(III)~~Grab bars and other devices.

2.~~(ii)~~ Minor physical adaptations to the interior of a Member's place of residence that are necessary to ensure his health, welfare and safety, or which increase his mobility and accessibility within the residence, including but not limited to:

(i)~~(I)~~ Widening of doorways; or

(ii)~~(II)~~ Modification of bathroom facilities.

(b)~~2.~~ Excluded are the following:

1.~~(i)~~ Installation of stairway lifts or elevators;

2.~~(ii)~~ Adaptations that are considered to be general maintenance of the residence;

3.~~(iii)~~ Adaptations that are considered improvements to the residence;

4.~~(iv)~~ Adaptations that are of general utility and not of direct medical or remedial benefit to the individual, including but not limited to:

(i)~~(I)~~ Installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring;

(ii)~~(II)~~ Installation, repair, or replacement of heating or cooling units or systems;

(iii)~~(III)~~Installation or purchase of air or water purifiers or humidifiers;

(iv)~~(IV)~~Installation or repair of driveways, sidewalks, fences, decks, and patios; and

(v)~~(V)~~ Adaptations that add to the total square footage of the home are excluded from this benefit.

(c)~~3.~~ All services shall be provided in accordance with applicable State or local building codes.

(d)4. ~~Minor Home Modifications shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services, except as provided in Rule 1200-13-01-.05 to facilitate transition to the community.~~

(d)4. Regardless of payer, Minor Home Modifications shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting. Minor Home Modifications shall not be provided to Members receiving Short-Term NF services, except as provided in Rule 1200-13-01-.05 to facilitate transition to the community.

~~(b) For purposes of the Statewide E/D Waiver:~~

~~1. Included are the following:~~

~~(i) The provision and installation of certain home mobility aids, including but not limited to:~~

~~(I) Ramps;~~

~~(II) Rails;~~

~~(III) Non-skid surfacing;~~

~~(IV) Grab bars;~~

~~(ii) Other devices and minor home modifications that facilitate mobility; and~~

~~(iii) Modifications to the home environment to enhance safety.~~

~~2. Excluded are those adaptations or improvements to the home that are of general utility and that are not of direct medical or remedial benefit to the individual, including but not limited to:~~

~~(i) Carpeting;~~

~~(ii) Roof repair; or~~

~~(iii) Central air conditioning.~~

~~3. Adaptations that add to the total square footage of the home are excluded from this benefit.~~

~~4. All services shall be provided in accordance with applicable State or local building codes.~~

(9196)Natural Supports. For purposes of CHOICES:

(a) Unpaid support and assistance critical to ensuring the health, safety, welfare and quality of life of a Member residing in the community delivered by family members, friends, neighbors, and other entities including clubs, churches and community organizations.

(b) May be supplemented, but not supplanted by paid HCBS in order to help sustain the Natural Supports over time, and to help insure the delivery of cost effective community based care.

(9297)Network Provider. See "Contract Provider."

(9398)Non-Contract Provider. A provider who does not have a contract with an Enrollee's MCO. Also called "Out-of-Network Provider."

(9499)Notice. When used in rules and regulations pertaining to NFs, information that must be provided by the facility to "residents" or "aApplicants," and shall also include notification to the person identified in a PAE application as the resident's or aApplicant's dDesignated ~~representative~~ Correspondent and any other individual who is authorized by law to act on the resident's or aApplicant's behalf or who is in fact acting on the resident's or aApplicant's behalf in dealing with the NF.

(95100)Notice of Disposition or Change. A notice issued by DHS of an individual's financial eligibility for ~~Medicaid~~ TennCare, including the effective date for which a person may qualify for ~~Medicaid~~ TennCare reimbursement of ~~LTC services~~ LTSS, subject to lLevel of eCare and other applicable eligibility/enrollment criteria as defined in this Chapter.

(96101)Nursing Facility (NF). A Medicaid-certified NF ~~approved by the Bureau~~.

(97102)Nursing Facility (NF) Eligible. An individual determined by DHS to qualify for ~~Medicaid~~ TennCare reimbursement of NF services and determined by the Bureau to meet NF lLevel of eCare.

(98) One-Time CHOICES HCBS. Certain CHOICES HCBS which occur as a distinct event or which may be episodic in nature (occurring at irregular intervals or on an as needed basis for a limited duration of time), including In-Home Respite Care, Inpatient Respite, Assistive Technology, Minor Modifications, and Pest Control.

(99) Ongoing CHOICES HCBS. Certain CHOICES HCBS which are delivered on a regular and ongoing basis, generally one or more times each week, or (in the case of Community-Based Residential Alternatives and PERS) on a continuous basis, including Community-Based Residential Alternatives, Personal Care Visits, Attendant Care, Home-Delivered Meals, Personal Emergency Response Systems, and Adult Day Care.

(100103)Out-of-Network Provider. See "Non-Contract Provider."

(101) PACE Carryover Group.

(a) Individuals who were enrolled in PACE as of June 30, 2012, but who, upon redetermination, no longer qualify for enrollment due solely to the State's modification of its NF LOC criteria.

(b) Members eligible for TennCare in the PACE Carryover Group may continue to qualify in this group after June 30, 2012, so long as they:

1. Continue to meet NF financial eligibility;

2. Continue to meet the NF LOC criteria in place as of June 30, 2012;

3. Meet all other eligibility requirements for PACE in the Medicaid State Plan; and

4. Remain continuously enrolled in PACE.

(102~~104~~)PAE ~~Approval~~ Effective Date. The beginning date of LOC eligibility for ~~Medicaid~~ TennCare-reimbursed ~~care in a NF~~ LTSS for which the PAE has been approved by the Bureau and which, for purposes of care in a NF, cannot precede completion of the PASRR process.

(103~~105~~)Patient Liability. The amount determined by DHS that a ~~Medicaid~~ TennCare Eligible is required to pay for covered services provided by a NF, an ICF/IID~~MR~~, an HCBS waiver program, or CHOICES.

~~(106) Personal Care Assistance/Attendant Services. For purposes of the Statewide E/D Waiver:~~

~~(a) Intermittent provision of direct assistance with activities such as toileting, bathing, dressing, personal hygiene, eating, meal preparation (excluding the cost of food), budget management, attending appointments, and interpersonal and social skill building to enable the Enrollee to live in a community setting.~~

~~(b) Personal Care Assistance/Attendant Services shall not be provided to Enrollees living in a CBRA facility or receiving Short-Term NF services, or while an Enrollee is receiving Adult Day Care services.~~

~~(107) Personal Care Services. For purposes of the Statewide E/D Waiver:~~

~~(a) Services provided to assist the Enrollee with ADLs and related essential household tasks (e.g., making the bed, washing soiled linens or bedclothes that require immediate attention), and other activities that enable the Enrollee to remain in the home, as an alternative to NF care, including the following:~~

~~1. Assistance with ADLs (e.g., bathing, grooming, personal hygiene, toileting, feeding, dressing, ambulation);~~

~~2. Assistance with cleaning that is an integral part of personal care and is essential to the health and welfare of the Enrollee; and/or~~

~~3. Assistance with maintenance of a safe environment.~~

~~(b) Personal Care Services shall be primarily provided in the Enrollee's place of residence, except under exceptional circumstances as authorized in the POC to accommodate the needs of the Enrollee.~~

~~(c) Personal Care Services shall not be provided to Enrollees living in a CBRA facility or receiving Short-Term NF services, or while an Enrollee is receiving Adult Day Care services.~~

(104~~108~~)Personal Care Visits. For purposes of CHOICES:

(a) Visits to a Member who, due to age and/or Physical Disabilities, needs assistance that can be provided through intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance and related tasks as specified below.

(b) Personal Care Visits may include assistance with ADLs such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation.

(c) For Members who require hands-on assistance with ADLs, Personal Care Visits may also include the following homemaker services that are essential, although secondary, to the hands-on assistance with ADLs needed by the Member in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:

1. Picking up the Member's medications or shopping for the Member's groceries.

2. Preparing the Member's meals and/or educating caregivers about the preparation of nutritious meals for the Member.

3. Household tasks such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, and doing the Member's personal laundry, ironing and mending.

(d) Personal Care Visits shall not be provided for ~~m~~Members who do not require hands-on assistance with ADLs.

(e) Personal Care Visits shall be primarily provided in the Member's place of residence, except as permitted within the scope of service (e.g., picking up medications or shopping for groceries), when accompanying or transporting the Member into the community pursuant to rule 1200-13-01-.05(8)(~~m~~n), or under exceptional circumstances as authorized by an MCO in the POC to accommodate the needs of the Member.

(f) A single Contract Provider staff person or Consumer-Directed Worker may provide Personal Care Visits to multiple CHOICES ~~m~~Members in the same home and during the same hours, as long as he can provide the services safely and appropriately to each ~~m~~Member. Such arrangements shall be documented in each ~~m~~Member's plan of care. In such instances, the total units of service provided by the staff person shall be allocated among the CHOICES ~~m~~Members, based on the percentage of total service units required by each ~~m~~Member on average. The Provider shall bill the MCO only once for each of the service units provided, and shall not bill an MCO or multiple MCOs separately to provide services to multiple ~~m~~Members at the same time.

~~(g) Personal Care Visits shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services, or while a Member is receiving Adult Day Care services.~~

(g) Regardless of payer, Personal Care Visits shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services, or while a Member is receiving Adult Day Care services.

(h) Personal care visits shall not include:

1. Companion or sitter services, including safety monitoring and supervision.

2. Care or assistance including meal preparation or household tasks for other residents of the same household.

3. Yard work.

4. Care of non-service related pets and animals.

(10~~5~~9)Personal Emergency Response System (PERS). ~~(a)~~ For purposes of CHOICES:

1.(a) An electronic device that enables certain Members at high risk of institutionalization to summon help in an emergency. The Member may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once the "help" button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed. PERS services are limited to those Members who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time, such that the Member's safety would be compromised without access to a PERS.

2.(b) ~~PERS shall not be provided to Members living in a receiving CBRA facility or receiving Short-Term NF services.~~

2.(b) Regardless of payer, PERS shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA (including Companion Care) or Short-Term NF services.

(106~~110~~)Personal Needs Allowance (PNA). A reasonable amount of money that is deducted by DHS from the individual's funds pursuant to federal and State law and the Medicaid State Plan in the application of post-eligibility provisions and the calculation of Patient Liability for ~~LTC services~~ LTSS. The PNA is set aside for clothing and other personal needs of the individual while in the institution (Institutional PNA), and to also pay room, board and other living expenses in the community (Community PNA).

(107~~111~~)Pest Control.

(a) The one-time or intermittent use of sprays, poisons and traps, as appropriate, in the ~~Enrollee's~~ Member's residence (excluding NFs or ACLFs) to regulate or eliminate the intrusion of cockroaches, wasps, mice, rats and other species of household pests into the household environment thereby removing an environmental issue that could be detrimental to a ~~frail elderly or disabled Enrollee's~~ Member's health and physical well-being.

~~(b) Pest control shall not be provided to Enrollees living in a CBRA facility or receiving Short-Term NF services.~~

(b) Regardless of payer, shall not be provided to Members living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving Short-Term NF services.

(c) A treatment visit for Pest Control is a visit by the Pest Control provider to the ~~Enrollee's~~ Member's residence during which the Pest Control treatment is applied.

(d) Shall not be provided solely as a preventive measure. There must be documentation of a need for this service either through Care Coordinator direct observation or determination through a needs assessment that a household pest is causing or is expected to cause more harm than is reasonable to accept.

(e) Shall not include treatment for termites, bed bug infestations or any pest infestation that cannot be addressed through intermittent visits as provided through the current benefit and reimbursement structure.

(108~~112~~)Pharmacy Benefits Manager (PBM). See "Pharmacy Benefits Manager" in Rule 1200-13-13-.01.

(109~~113~~)Physical Disabilities.

(a) One or more medically diagnosed chronic, physical impairments, either congenital or acquired, that limit independent, purposeful physical movement of the body or of one or more extremities, as evidenced by substantial functional limitations in one or more ADLs that require such movement—primarily mobility or transfer—and that are primarily attributable to the physical impairments and not to cognitive impairments or mental health conditions.

(b) An individual with cognitive impairments or mental health conditions who also has one or more Pphysical Ddisabilities as defined above may qualify as "Physically Disabled," and may be enrolled into ~~the Statewide E/D Waiver or~~ CHOICES Group 2 ~~(as applicable)~~ or CHOICES Group 3 so long as such individual can be safely served in the community and at a cost that does not exceed the individual's Cost Neutrality Cap or Expenditure Cap, as applicable. This includes consideration of whether or not the ~~statewide E/D Waiver~~ CHOICES Group 2 or CHOICES Group 3 benefit package, ~~(~~as applicable~~),~~ ~~can~~ adequately addresses any specialized service needs the applicant may have pertaining to the cognitive impairment or mental health condition, as applicable.

(110~~114~~)Physically Disabled. For purposes of enrollment into CHOICES Group 2 or CHOICES Group 3, an adult aged twenty-one (21) or older who has one or more Pphysical Ddisabilities.

(111~~115~~)Physician. A doctor of medicine or osteopathy who has received a degree from an accredited medical school and who is licensed to practice his profession in Tennessee.

~~(116) Physician's Plan of Care (POC). For purposes of the Statewide E/D Waiver, an individualized written POC developed by the Enrollee's Physician and included on the PAE and reviewed as needed or at least every ninety (90) days.~~

(112~~117~~)Plain Language. Any notice or explanation written at a level that does not exceed the sixth grade reading level as measured by the Flesch Index, Fog Index, or Flesch-Kincaid Index.

(113) Plan of Care. A written document that is developed through a person-centered planning process based on an individualized assessment of an Enrollee's needs that specifies the types and frequency of LTSS that the Enrollee receives.

(114~~118~~)PreAdmission Evaluation (PAE). A process of assessment by the Bureau used to determine an individual's medical (or LOC) eligibility for TennCare-reimbursed care in a NF or ICF/IIDMR, and in the case of NF services, the appropriate level of reimbursement for such care, as well as eligibility for HCBS as an alternative to institutional care, or in the case of persons At Risk for Institutionalization, in order to delay or prevent NF placement. For purposes of CHOICES, the PAE application shall be used for the purposes of determining LOC and for persons enrolled in CHOICES Group 2, calculating the Member's Individual Cost Neutrality Cap.

(115~~119~~)PreAdmission Screening/Resident Review (PASRR). The process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified NF has, or is suspected of having, MI or MR, and, if so, whether the individual requires specialized services and is appropriate for NF placement.

(a) Identification Screen (Level I). The initial screening conducted to determine which NF Applicants or residents have MI or MR and are subject to PASRR. Individuals with a supportable primary diagnosis of Alzheimer's disease or dementia will also be detected through the Identification Screen. NFs are responsible for ensuring that all Applicants receive a Level I identification screen prior to admission to the facility, and for submission of the Level I Identification Screen to the Bureau.

(b) PASRR Evaluation (Level II). The process whereby a determination is made about whether the individual identified in the Level I screen requires the level of services provided by a NF or another type of facility and, if so, whether the individual requires specialized services. These reviews shall be the responsibility of the DMH~~DD~~ and/or DIDS~~D~~, as applicable.

(116~~120~~)Private Duty Nursing (PDN) Services. See "Private Duty Nursing Services" in Rule 1200-13-13-.01.

(117~~121~~)Program of All-Inclusive Care for the Elderly (PACE). A program for dually eligible Enrollees in need of ~~LTC services~~ LTSS that is authorized under the Medicaid State Plan, Attachment 3.1-A, #26.

(118~~122~~)Provider. See "Provider" in Rule 1200-13-13-.01. Provider does not include Consumer-Directed Workers (see Consumer-Directed Worker); nor does Provider include the FEA (see Fiscal Employer Agent).

(119~~123~~)Qualified Assessor. A practicing professional who meets the qualifications established by TennCare to certify the accuracy of a level of care assessment as reflected in the PAE application. For the CHOICES program, Qualified Assessors shall include only the following: a licensed physician, nurse practitioner,

physician assistant, registered or licensed nurse, or licensed social worker.

(120~~124~~)Qualifying Income Trust (QIT). See "Qualified Income Trust" in DHS Rules Chapter 1240-03-03.

~~(125) Recertification. For purposes of the Statewide E/D Waiver, the process approved by the Bureau by which the Enrollee's Physician assesses the medical necessity of continuation of Waiver services and certifies in writing that the Enrollee continues to require Waiver services.~~

(121~~126~~)Related Conditions. See "Mental Retardation (MR) and Related Conditions."

(122~~127~~) Representative.

(a) In general, for CHOICES Members, a Representative is an individual who is at least eighteen (18) years of age and is authorized by the Member to participate in care planning and implementation and to speak and make decisions on the Member's behalf, including but not limited to identification of needs, preference regarding services and service delivery settings, and communication and resolution of complaints and concerns.

(b) As it relates to CD of Eligible CHOICES HCBS, a Representative is an individual who is authorized by the Member to direct and manage the Member's Worker(s), and signs a Representative Agreement. The Representative for CD of Eligible CHOICES HCBS must also:

1. Be at least eighteen (18) years of age;

2. Have a personal relationship with the Member and understand his support needs;

3. Know the Member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and

4. Be physically present in the Member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate workers.

(123~~128~~)Representative Agreement. The agreement between a CHOICES Member electing CD of Eligible CHOICES HCBS who has a Representative direct and manage the Member's Worker(s) and the Member's Representative that specifies the roles and responsibilities of the Member and the Member's Representative.

(124~~129~~)Reserve Capacity. The State's right to maintain some capacity within an established Enrollment Target to enroll individuals into CHOICES HCBS under certain circumstances. These circumstances could include, but are not limited to:

~~(a) Accommodation of a phased in implementation of CHOICES;~~

~~(b)~~(a) Discharge from a NF;

~~(c)~~(b) Discharge from an acute care setting where institutional placement is otherwise imminent; or

~~(d)~~(c) Other circumstances which the State may establish from time to time in accord with this Chapter.

~~(130) Respite Care. For purposes of the Statewide E/D Waiver, Respite Care services:~~

~~(a) Are provided to Enrollees unable to care for themselves.~~

~~(b) Are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.~~

~~(c) May be provided Inpatient or in-home.~~

~~(d) Shall not be provided to Enrollees living in a CBRA facility or receiving Short-Term NF services.~~

(125~~131~~)Risk Agreement.

(a) An agreement signed by a Member who will receive CHOICES ~~Group 2~~ HCBS (or his Representative) that includes, at a minimum:

1. Identified risks to the Member of residing in the community and receiving HCBS;

2. The possible consequences of such risks, strategies to mitigate the identified risks; and

3. The Member's decision regarding his acceptance of risk.

(b) For Members electing to participate in CD, the Risk Agreement must include any additional risks associated with the Member's decision to act as the Employer of Record, or to have a Representative act as the Employer of Record on his behalf.

(126~~132~~)Room and Board. Lodging, meals, and utilities that are the responsibility of the individual receiving HCBS in a CBRA facility. The kinds of items that are considered "Room and Board" and are therefore not reimbursable by ~~Medicaid~~ TennCare include:

(a) Rent, or, if the individual owns his home, mortgage payments, depreciation, or mortgage interest;

(b) Property taxes;

(c) Insurance (title, mortgage, property and casualty);

(d) Building and/or grounds maintenance costs;

(e) Resident "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included);

(f) Household supplies necessary for the room and board of the individual;

(g) Furnishings used by the resident;

(h) Utilities (electricity, water and sewer, gas);

(i) Resident telephone; or

(j) Resident cable or pay television.

~~(133) Safety Plan. For purposes of the Statewide E/D Waiver, an individualized plan by which the ALA ensures the health, safety, and welfare of Enrollees who do not have twenty-four (24) hour caregiver services and which meets the requirements of this Chapter.~~

(127~~134~~) Self-Determination ~~IDMR~~ Waiver. Tennessee's Self Determination Waiver under Section 1915(c) of the Social Security Act.

(128~~135~~)Self-Direction of Health Care Tasks.

(a) The decision by a CHOICES Member participating in CD to direct and supervise a paid Worker delivering Eligible CHOICES HCBS in the performance of Health Care Tasks that would otherwise be performed by a licensed nurse.

(b) The Self-Direction of Health Care Tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that a CHOICES Member participating in CD may elect to have performed by a Consumer-Directed Worker as part of the delivery of Eligible CHOICES HCBS he is authorized to receive.

(129~~136~~)Service Agreement. The agreement between a CHOICES Member electing CD of Eligible CHOICES HCBS (or the Member's Representative) and the Member's Consumer-Directed Worker that specifies the roles and responsibilities of the Member (or the Member's Representative) and the Worker.

(1230~~137~~)Short-Term Nursing Facility (NF) Care. For purposes of CHOICES:

(a) The provision of NF care for up to ninety (90) days to a CHOICES Group 2 or CHOICES Group 3 Member who was receiving HCBS upon admission and who meets NF LOC and requires temporary placement in a NF—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such Member is reasonably expected to be discharged and to resume HCBS participation within no more than ninety (90) days.

(b) Such CHOICES Group 2 or CHOICES Group 3 Member must meet the NF LOC upon admission and in such case, while receiving Short-Term NF Care may continue enrollment in CHOICES Group 2 or CHOICES Group 3, pending discharge from the NF within no more than ninety (90) days or until such time it is determined that discharge within ninety (90) days from admission is not likely to occur, at which time the Member shall be transitioned to CHOICES Group 1, as appropriate.

(c) The Community PNA shall continue to apply during the provision of Short-Term NF care, up to the ninetieth (90th) day, in order to allow sufficient resources for the Member to maintain his community residence for transition back to the community.

(d) The PASRR process is required for CHOICES Group 2 and CHOICES Group 3 Members entering Short-Term NF Care.

(e) Persons receiving Short-Term NF Care are not eligible to receive any other HCBS, except as permitted in 1200-13-01-.05 to facilitate transition to the community.

(131~~138~~)Single Point of Entry (SPOE). The agency charged with screening, intake, and facilitated enrollment processes for non-~~Medicaid~~TennCare eligible individuals seeking enrollment into CHOICES.

(132) Skilled Nursing Facility (SNF). A Medicare-certified SNF.

(133~~139~~)Skilled Nursing Service. A Physician-ordered nursing service the complexity of which is such that it can only be safely and effectively provided directly by a registered nurse or licensed practical nurse.

(134~~140~~)Skilled Rehabilitative Service. A Physician-ordered rehabilitative service the complexity of which is such that it can only be safely and effectively provided by qualified health care personnel (e.g., registered physical therapist, licensed physical therapist assistant, registered occupational therapist, certified occupational therapy assistance, licensed respiratory therapist, licensed respiratory therapist assistant).

(135~~141~~)Specialized Services for Individuals with MI.

(a) The implementation of an individualized POC developed under and supervised by a Physician, provided by a Physician and other qualified mental health professionals that accomplishes the following;

1. Prescribes specific therapies and activities for the treatment of individuals who are experiencing an acute episode of severe MI, which necessitates continuous supervision by trained mental health personnel; and

2. Is directed toward diagnosing and reducing the individual's behavioral symptoms that necessitated institutionalization, improving his level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible convenience.

(b) Services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program are not included in this definition.

(136~~142~~)Specialized Services for Individuals with MR and Related Conditions.

(a) The implementation of an individualized POC specifying a continuous program for each individual, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed towards the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.

(b) Services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program are not included.

(137~~143~~)Specified CHOICES HCBS. The CHOICES HCBS that are available to persons who qualify for and are granted Immediate Eligibility by the Bureau. Specified CHOICES HCBS are limited to Adult Day Care, Attendant Care, Home-Delivered Meals, Personal Care Visits, and PERS.

~~(144) Statewide E/D Waiver. The Section 1915(c) HCBS Waiver project approved for Tennessee by CMS to provide services to a specified number of Medicaid-eligible adults who reside in Tennessee, who are aged or have physical disabilities, and who meet the medical eligibility (or LOC) criteria for reimbursement of Level 1 NF services.~~

(138~~145~~)Statewide IDMR Waiver. Tennessee's HCBS Waiver for the Mentally Retarded and Developmentally Disabled under Section 1915(c) of the Social Security Act.

~~(146) Subcontractor. For purposes of the Statewide E/D Waiver, an individual, organized partnership, professional corporation, or other legal association or entity that enters into a written contract with the ALA to provide Waiver services to an Enrollee.~~

(139~~147~~)Supports Broker. For purposes of CD:

(a) An individual assigned by the FEA to each CHOICES Member participating in CD who assists the Member/Representative in performing the Employer of Record functions, including, but not limited to: developing job descriptions; locating, recruiting, interviewing, scheduling, monitoring, and evaluating Workers.

(b) The Supports Broker collaborates with, but does not duplicate, the functions of the Member's Care Coordinator.

(c) The Supports Broker does not have authority or responsibility for CD. The Member or Member's Representative must retain authority and responsibility for CD.

(140~~148~~)TennCare. The program administered by the Single State Agency as designated by the State and CMS pursuant to Title XIX of the Social Security Act and the Section 1115 Research and Demonstration Waiver granted to the State of Tennessee.

(141~~149~~)TennCare CHOICES in Long-Term ~~Care~~ Services and Supports Program (CHOICES). The program in which NF services for TennCare eligibles of any age and HCBS for individuals aged sixty-five (65) and older and/or adults aged twenty-one (21) and older with ~~p~~Physical ~~d~~Disabilities are integrated into TennCare's Managed Care System.

(142) TennCare Eligible. For purposes of this Chapter, an individual who has been determined by DHS to be financially eligible to have TennCare reimbursement for covered LTSS.

(143~~150~~)Tennessee Pre-Admission Evaluation System (TPAES). A component of the State's Medicaid Management Information System and the system of record for all PreAdmission Evaluation ~~(i.e., level of care)~~ (LOC) submissions and ~~level of care~~ LOC determinations, as well as enrollments into and transitions between ~~LTC~~ LTSS programs, including CHOICES and the State's Money Follows the Person Rebalancing Demonstration (MFP), and which shall also be used to gather data required to comply with tracking and reporting requirements pertaining to MFP.

(144~~151~~)Third Party Liability (TPL). See "Third Party Liability" in Rule 1200-13-13-.01.

(145~~152~~)Tracheal Suctioning Reimbursement. The rate of ~~Medicaid~~ reimbursement provided for NF services, including enhanced respiratory care assistance, delivered by a NF that meets the requirements set forth in Rule 1200-13-01-.03(5), to residents determined by the Bureau to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(5)(e) or determined by an MCO to require short-term intensive respiratory intervention during the post-weaning period.

(146~~153~~)Transfer Form. For purposes of ICF/~~IIDMR~~ services and HCBS ID waiver programs, a form approved by the Bureau which is used in lieu of a new PAE to document the transfer of an ICF/~~IIDMR~~ eligible individual having an approved unexpired ICF/~~IIDMR~~ PAE from one ICF/~~IIDMR~~ to another ICF/~~IIDMR~~, from an HCBS MR Waiver Program to an ICF/MR, from an ICF/~~IIDMR~~ to an HCBS ~~IDMR~~ Waiver Program, or from one HCBS ~~IDMR~~ Waiver Program to another HCBS ~~IDMR~~ Waiver Program.

~~(154) Transfer Form. For purposes of the NF program and Statewide E/D Waiver prior to implementation of CHOICES, a form which is used in lieu of a new PAE to document the transfer of a NF eligible individual having an approved unexpired PAE from Level 1 in one NF to Level 1 in another such facility or to the HCBS E/D Waiver, from Level 2 in one NF to Level 2 in another such facility, or from the HCBS E/D Waiver to Level 1 in a NF.~~

(147~~155~~)Transition Allowance. For purposes of CHOICES.

(a) A per Member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of an MCO, be provided as a CEA to continued institutional care for a CHOICES Member in order to facilitate transition from a NF to the community when such Member will, upon transition, receive more cost-effective non-residential HCBS or Companion Care.

(b) Items which may be purchased or reimbursed are only those items the Member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

(c) Transition Allowance cannot be provided to CHOICES Members transitioning to a CBRA facility.

(148~~156~~)Ventilator Weaning Reimbursement. The rate of ~~Medicaid~~ reimbursement provided for ventilator weaning services delivered by a NF that meets the requirements set forth in Rule 1200-13-01-.03(5) to residents determined by an MCO to require such services based on medical necessity criteria.

(149~~157~~)Wait List. The list maintained by NFs of all individuals who have affirmatively expressed an intent to be considered for current or future admission to the NF or requested that their name be entered on any "wait list."

(150~~158~~)Waiting List. For purposes of CHOICES, the list maintained by the Bureau of individuals who have applied for CHOICES ~~Group 2~~ HCBS but who cannot be served because an Enrollment Target has been reached.

~~(159) Waiver Eligible. For purposes of the Statewide E/D Waiver, a resident of Tennessee determined by the Bureau to meet the criteria specified in Rule 1200-13-01-.17(5), and determined by DHS to qualify for Medicaid upon enrollment into a Section 1915(c) HCBS Waiver and receipt of HCBS. A Waiver Eligible is not necessarily enrolled into the Waiver.~~

(151~~160~~)Worker. See "Consumer-Directed Worker."

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Rule 1200-13-01-.05 TennCare CHOICES Program

Paragraph (2) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Paragraph (2) which shall read as follows:

(2) Program components. The TennCare CHOICES Program is a managed ~~LTC~~ 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 ~~LTC services~~ LTSS for their ~~m~~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.

The introductory Emergency Rule Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a Rulemaking Hearing Rule introductory Subparagraph (a) which shall read as follows:

(a) There are three (3) groups in TennCare CHOICES:

Part 1. of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Part 1. which shall read as follows:

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.

~~1. CHOICES Group 1. Participation in CHOICES Group 1 is limited to Medicaid Enrollees of all ages who qualify for and are receiving Medicaid-reimbursed NF services. Medicaid eligibility for LTC services 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 and qualify for Medicaid reimbursement of LTC services.~~

Introductory Subpart (i) of Part 2. of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new introductory Subpart (i) which shall read as follows:

(i) Participation in CHOICES Group 2 is limited to TennCare ~~Enrollees~~ Members who qualify for and are receiving TennCare-reimbursed CHOICES HCBS. To be eligible for CHOICES Group 2, ~~Enrollees~~ Applicants must meet the following criteria:

Subpart (iii) of Part 2. of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "Enrollees" with the word "Members" so as amended Subpart (iii) shall read as follows:

(iii) Eligibility Categories Served in CHOICES Group 2. Participation in CHOICES Group 2 is limited to TennCare ~~Enrollees~~ Members who qualify in one of the following eligibility categories:

Subpart (iii) of Part 2. of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Item (III) which shall read as follows:

(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.

Emergency Rule Part 3. of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 3. which shall read as follows:

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 ~~the~~ their Expenditure Cap for CHOICES HCBS 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 Pphysical Ddisabilities 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.

Emergency Rule Subparagraph (b) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (b) which shall read as follows:

(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.

~~(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 meet At-Risk LOC 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 person shall meet the NF LOC criteria in place on June 30, 2012, to qualify for enrollment into CHOICES Group 1.~~

Part 1. of Subparagraph (c) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "Persons" with the word "Members" so as amended Part 1. shall read as follows:

1. ~~Persons~~ 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.

Emergency Rule Part 2. of Subparagraph (c) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 2. which shall read as follows:

2. ~~Persons~~ 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 ~~the~~ Short-Term NF ~~benefit~~ 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 ~~an~~ CHOICES HCBS.

Emergency Rule Subparagraph (d) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (d) which shall read as follows:

(d) All ~~Enrollees~~ Members in TennCare CHOICES must be admitted to a NF and require ~~Medicaid~~ TennCare reimbursement of NF services or be receiving CHOICES HCBS in CHOICES Group 2 or CHOICES Group 3.

Subparagraph (e) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subparagraph (e) which shall read as follows:

(e) All ~~Enrollees~~ 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 iIndividual eCost nNeutrality eCap, in accordance with this Rule. If a person can be served safely and appropriately in the community and within their iIndividual eCost-nNeutrality eCap 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 aApplicant 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.

~~2. The health, safety, and welfare of the individual cannot be assured due to the lack of a signed Risk Agreement, or the person'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~~, resulting in the inability to ensure the person's health, safety and welfare~~.

Emergency Rule Subparagraph (f) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (f) which shall read as follows:

(f) All ~~Enrollees~~ 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 eExpenditure cCap 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 aApplicant 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 aApplicant or his caregiver is unwilling to abide by the POC~~, resulting in the inability to ensure the person's health, safety and welfare~~.

Parts 2., 4., 5. and 6. of Subparagraph (g) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with new Parts 2., 4., 5. and 6. which shall read as follows:

2. ~~Individuals~~ Members admitted to CHOICES Group 2 under the Immediate Eligibility option are ~~individuals~~ persons who are not already eligible for TennCare.

4. If eligibility in the CHOICES 217-Like Group is denied by DHS, the ~~individual~~ 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.

~~5. During the period of Immediate Eligibility, individuals are eligible only for the limited package of HCBS identified in Paragraph (8)(I). They are not eligible for any other TennCare services, including other LTC services.~~

6. During a period of Immediate Eligibility, ~~individuals~~ 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.

Introductory Subparagraph (a) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "individual" with the word "Applicant" so as amended introductory Subparagraph (a) shall read as follows:

(a) Enrollment into CHOICES Group 1. To qualify for enrollment into CHOICES Group 1, an ~~individual~~ Applicant must:

Emergency Rule Part 2. of Subparagraph (a) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 2. which shall read as follows:

2. Have an approved unexpired ~~CHOICES~~ 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 ~~may~~ shall be established ~~only with a CHOICES PAE~~ in accordance with Rule 1200-13-01-.10.

Part 3. of Subparagraph (a) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "Medicaid" with the word "TennCare" so as amended Part 3. shall read as follows:

3. Be approved by DHS for ~~Medicaid~~ TennCare reimbursement of NF services.

Part 4. of Subparagraph (a) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the acronym and word "LTC Services" with the acronym "LTSS" so as amended Part 4. shall read as follows:

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 ~~LTC services~~ LTSS) cannot begin until the Bureau or the MCO will be responsible for payment of NF services.

Subparagraph (b) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Subparagraph (b) which shall read as follows:

(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.

~~(b) Enrollment into CHOICES Group 2.~~

~~To qualify for enrollment into CHOICES Group 2:~~

~~1. An individual must be in one of the target populations specified in this Rule;~~

~~2. An individual must have an approved unexpired CHOICES PAE for NF LOC;~~

~~3. An individual must be approved by DHS for reimbursement of LTC services as an SSI recipient or in the CHOICES 217-Like Group. To be eligible in the CHOICES 217-Like Group, an individual 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 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 Individual Cost Neutrality 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 2; and~~

~~5. There must be capacity within the established Enrollment Target to enroll the individual in accordance with this Rule which may include satisfaction of criteria for reserve capacity, as applicable; or the individual must meet specified exceptions to enroll even when the Enrollment Target has been reached.~~

Emergency Rule Subpart (iii) of Part 1. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (iii) which shall read as follows:

(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 ~~CHOICES~~ HCBS that~~, when combined with the cost of HH Services and PDN Services the Member will receive, can be provided by the Member in the home or community setting~~ can be provided to the Member in the home or community setting, including CHOICES HCBS, HH Services and PDN Services.

Part 2. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the phrase "cost neutrality cap" in the first sentence with the phrase "Cost Neutrality Cap" so as amended Part 2. shall read as follows:

2. A Member is not entitled to receive services up to the amount of his ~~c~~Cost ~~n~~Neutrality ~~c~~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.

Items (I), (II) and (III) of Subart (i) of Part 3. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with new Items (I), (II) and (III) which shall read as follows:

(I) A Member who would qualify only for Level 1 NF reimbursement shall have a ~~c~~Cost ~~n~~Neutrality ~~c~~Cap set at the average ~~cost of~~ Level 1 cost of NF care.

(II) A Member who would qualify for Level 2 NF reimbursement shall have a ~~c~~Cost ~~n~~Neutrality ~~c~~Cap set at the average ~~cost of~~ Level 2 ~~(or skilled)~~ 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 ~~c~~Cost ~~n~~Neutrality ~~c~~Cap that reflects the higher payment that would be made to the NF for such care. There is no ~~c~~Cost ~~n~~Neutrality ~~c~~Cap for Ventilator Weaning Reimbursement, as such service is available only on a short-term basis in a SNF or acute care setting.

Subart (iii) of Part 3. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subpart (iii) which shall read as follows:

(iii) A Member's Individual Cost Neutrality Cap shall be the average Level 1 cost of ~~Level 1~~ NF care unless a higher ~~c~~Cost ~~n~~Neutrality ~~c~~Cap is established based on information submitted in the PAE application.

Part 4. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Part 4. which shall read as follows:

4. Application of the Individual Cost Neutrality Cap.

(i) The annual ~~c~~Cost ~~n~~Neutrality ~~c~~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 ~~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, 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 ~~c~~Cost ~~n~~Neutrality ~~c~~Cap, then the person does not qualify to enroll in or to remain enrolled in CHOICES Group 2.

Subpart (i) and introductory Subpart (ii) of Part 5. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program are amended by replacing the word "applicant" with the word "Applicant" so as amended Subpart (i) and introductory Subpart (ii) shall read as follows:

(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 aApplicant 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 aApplicant 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.

Emergency Rule Item (I) of Subpart (ii) of Part 5. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Item (I) which shall read as follows:

(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) ~~(See Rules 1200-13-13-.01(4) and 1200-13-14-.01(4))~~, 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.

Subparagraph (d) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subparagraph (d) which shall read as follows:

(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.

~~(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 individuals who can be enrolled into CHOICES Group 2 at any given time.~~

~~(i) Effective March 1, 2010, the Enrollment Target for CHOICES Group 2 will be seven thousand five hundred (7,500).~~

~~(ii) Effective July 1, 2010, the Enrollment Target for CHOICES Group 2 will be nine thousand five hundred (9,500).~~

~~(iii) Effective September 30, 2011, the Enrollment Target for CHOICES Group 2 will be eleven thousand (11,000).~~

(iv) Effective July 1, 2012, the Enrollment Target for CHOICES Group 2 will be twelve thousand five hundred (12,500).

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) Individuals being discharged from a NF; and

(II) Individuals 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, individuals 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 person shall be placed on a Waiting List for CHOICES Group 2.

(iv) Once the Enrollment Target is reached, qualified persons 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 five (5) days of the Member's enrollment into CHOICES.

~~(v) 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 that become available. 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.~~

Emergency Rules Subparagraphs (e), (f), and (g) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with Rulemaking Hearing Rule Subparagraphs (e), (f), and (g) which shall read as follows:

(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;

~~2. An individual must have an approved unexpired PAE for At-Risk LOC;~~

3. An individual must be approved by DHS for reimbursement of ~~LTC services~~ 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 ~~a~~Applicant qualifies to enroll in CHOICES Group 3;

(ii) Whether or not a ~~m~~Member qualifies to remain enrolled in CHOICES Group 3; and

(iii) The total cost of CHOICES HCBS a ~~m~~Member can receive while enrolled in CHOICES Group 3, excluding the cost of ~~m~~Minor ~~h~~Home ~~m~~Modifications. The Expenditure Cap functions as a limit on the total cost of CHOICES HCBS, excluding ~~m~~Minor ~~h~~Home ~~m~~Modifications, that can be provided by the MCO to the ~~m~~Member in the home or community setting.

2. A Member is not entitled to receive services up to the amount of the ~~e~~Expenditure ~~c~~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~~, conducted by the Member's Care Coordinator, of the Member's needs and the availability of Natural Supports and other (non-TennCare reimbursed) services to meet identified needs~~ 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 ~~m~~Members shall be $15,000 (fifteen thousand dollars) annually, excluding the cost of ~~m~~Minor ~~h~~Home ~~m~~Modifications.

4. Application of the Expenditure Cap.

(i) The annual ~~e~~Expenditure ~~c~~Cap shall be applied on a calendar year basis. The Bureau and the MCOs will track utilization of CHOICES HCBS excluding ~~m~~Minor ~~h~~Home ~~m~~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 ~~m~~Minor ~~h~~Home ~~m~~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 ~~s~~Short-~~t~~Term NF ~~services~~ Care received by a ~~m~~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.

Paragraph (5) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Paragraph (5) which shall read as follows:

(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.

~~(5) Disenrollment from CHOICES.~~

~~A Member may be disenrolled from CHOICES voluntarily or involuntarily.~~

~~(a) Voluntary disenrollment shall proceed only upon receipt of a statement signed by the Member or his authorized Representative. 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 LTC services.~~

~~(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 when the Member no longer meets one or more criteria for eligibility and/or enrollment as specified in this Rule. Such reasons include but are not limited to:~~

~~1. 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, resulting in the inability to ensure the Member's health, safety and welfare.~~

~~(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 health, safety, and welfare of the Member cannot be assured due to the lack of a signed Risk Agreement, or the Member's decision to continue receiving services in the home or community poses an unacceptable level of risk.~~

~~2. 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 appropriate and as described in this Rule.~~

~~3. The Member no longer needs or is no longer receiving LTC services.~~

~~4. 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.~~

Emergency Rule Paragraph (6) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (6) which shall read as follows:

(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)(~~c~~b)(2)(i)(II) and 1200-13-01-.10(4)(~~c~~b)(2)(ii)(II), a<u>A</u>dvance ~~d~~<u>D</u>etermination by TennCare that a CHOICES a<u>A</u>pplicant would not qualify for enrollment into CHOICES Group 3 shall be made only if all of the following criteria are met:

1. The a<u>A</u>pplicant has a total acuity score of at least six (6) but no more than eight (8);

2. The a<u>A</u>pplicant has an individual acuity score of at least three (3) for the Orientation measure;

3. The a<u>A</u>pplicant 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 a<u>A</u>pplicant 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 a<u>A</u>pplicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the e<u>E</u>xpenditure c<u>C</u>ap 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 a<u>A</u>dvance ~~d~~<u>D</u>etermination for ~~Medicaid eligible members~~ <u>Applicants enrolled in TennCare</u> 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 ~~m~~<u>M</u>ember's physical, behavioral, functional, and psychosocial needs;

(ii) An assessment of the ~~m~~<u>M</u>ember'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 ~~m~~Member's ~~n~~Natural ~~s~~Supports, including care being provided by family members and/or other caregivers, and ~~long-term care services~~ LTSS the ~~m~~Member is currently receiving (regardless of payer), and whether there is any anticipated change in the ~~m~~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 ~~long-term care services~~ LTSS and other social support services and assistance (e.g., housing or income assistance) that are needed~~, as applicable,~~ to ensure the ~~m~~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 ~~m~~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 ~~within the $15,000 expenditure cap for CHOICES 3~~ 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) ~~t~~The ~~m~~Member's living arrangements and the services and supports the ~~m~~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) ~~a~~Any recent significant event(s) or circumstances that have impacted the ~~a~~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 ~~a~~Advance ~~d~~Determination for ~~a~~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 ~~a~~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.

Emergency Rule Paragraph (7) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Paragraph (7) which shall read as follows:

(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.

~~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. ~~1.~~ An MCO may request to transition a Member from Group 2 to Group 1 only under the following circumstances:

~~(i)~~1. Except as provided in TennCare Rule 1200-13-01-.05(3)(b)6.~~(6)~~, the ~~m~~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)~~(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)~~(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.

~~(ii)~~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 ~~CHOICES~~ Group 1 or ~~CHOICES~~ Group 2 to ~~CHOICES~~ Group 3.

1. The ~~State~~ 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 ~~m~~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.

~~2.~~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 ~~CHOICES~~ Group 3 to ~~CHOICES~~ Group 1 or ~~CHOICES~~ Group 2.

1. The ~~State~~ 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.

Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Paragraph (8) which shall read as follows:

(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.

(cd) 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.

(de) 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.

(ef) 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.

(fg) 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.

(gh) 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.

(hi) 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.

(ij) 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.

(jk) All ~~LTC services~~ 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.

(kl) 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 (jk) 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	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. For Members who do not require ~~h~~Homemaker ~~s~~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. 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. For Members who require ~~h~~Homemaker ~~s~~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. ~~Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.~~ 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.	Yes	Yes

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
4: CBRA	Companion Care. ~~Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.~~ 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.	Yes	No
	CBRA facility services (e.g., ACLFs, Adult Care Homes).	No	No
5. Home-Delivered Meals	Covered with a limit of 1 meal per day, per Member. ~~Not covered when the Member is receiving CBRA services or Short-Term NF Care.~~ 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.	No	Yes
6. Homemaker Services	*Covered only for ~~m~~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. Not covered as a stand-alone benefit. Not covered for persons who do not require hands-on assistance with ADLs. ~~Not covered when the Member is receiving CBRA services or Short-Term NF Care.~~ 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.	*	*

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
7. In-Home Respite Care	Covered with a limit of 216 hours per calendar year, per Member. ~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care~~. 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.	Yes	No
8. Inpatient Respite Care	Covered with a limit of 9 days per calendar year, per Member. ~~PAE and~~ PASRR approval not required. ~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.~~ 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.	No	No
9. Minor Home Modifications	Covered with a limit of $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime. ~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care, except when provided as a CEA to facilitate transition from a NF to the community. See Rule 1200-13-01-.05(8)(o).~~ 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).	No	~~N/A~~No

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
10. Personal Care Visits	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. ~~Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.~~ 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.	Yes	Yes
11. PERS	~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care~~. 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.	No	Yes
12. Pest Control	Covered with a limit of 9 treatment visits per calendar year, per Member. ~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.~~ 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.	No	No
13. Short-Term NF Care	Covered with a limit of 90 days per stay, per Member. Approved ~~PAE and~~ PASRR required. Members receiving Short-Term NF Care are not eligible to receive any other HCBS except when permitted ~~as a CEA~~ to facilitate transition to the community. See Rule 1200-13-01-.05(8)(~~e~~h).	No	~~N/A~~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	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. For Members who do not require ~~h~~Homemaker ~~s~~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. For Members who require ~~h~~Homemaker ~~s~~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. For Members who require ~~h~~Homemaker ~~s~~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. ~~Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.~~ 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.	Yes	N/A
4. Home-Delivered Meals	Covered with a limit of 1 meal per day, per Member. ~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care~~. 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.	No	N/A

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
5. Homemaker Services	*Covered only for ~~m~~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. Not covered as a stand-alone benefit. Not covered for persons who do not require hands-on assistance with ADLs. ~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.~~ 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.	*	*
6. In-Home Respite Care	Covered with a limit of 216 hours per calendar year, per Member. ~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.~~ 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.	Yes	N/A
7. Inpatient Respite Care	Covered with a limit of 9 days per calendar year, per Member. ~~PAE and~~ PASRR approval not required. NF LOC not required. ~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.~~ 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.	No	N/A

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
8. Minor Home Modifications	Covered with a limit of $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime. ~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care, except when provided as a CEA to facilitate transition from a NF to the community. See Rule 1200-13-01-.05(8)(e).~~ 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).	No	N/A
9. Personal Care Visits	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. ~~Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.~~ 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.	Yes	N/A
10. PERS	~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care~~. 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.	No	N/A

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
11. Pest Control	Covered with a limit of 9 treatment visits per calendar year, per Member. ~~Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.~~ 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.	No	N/A
12. Short-Term NF Care	Covered with a limit of 90 days per stay, per Member. Approved ~~PAE and~~ PASRR required. Member must meet NF LOC. Members receiving Short-Term NF Care are not eligible to receive any other HCBS except when permitted ~~as a CEA~~ to facilitate transition to the community. See Rule 1200-13-01-.05(8)(e~~h~~).	No	N/A

(l~~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.

~~Applicants who qualify as "Immediate Eligibles" are eligible only for certain HCBS covered under CHOICES. They are not eligible for any other TennCare benefits, including other CHOICES benefits. These HCBS, called Specified HCBS, are listed below. The limits are the same as those specified in Subparagraph (k) 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.~~

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

(~~m~~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~~, but not to personally transport the Member~~. 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 ~~and~~ , 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.

(~~n~~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.

(~~o~~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 ~~be~~ elect to purchased or reimbursed 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.

Subparagraph (a) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subparagraph (a) which shall read as follows:

(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 certain types of~~ 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 ~~a prior authorization model~~ 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.

Subparagraph (b) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Subparagraph (b) which shall read as follows:

(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.

Introductory Subparagraph (c) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "Members" with the word "Member" so as amended the introductory Subparagraph (c) shall read as follows:

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

Part 1. of Subparagraph (c) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 1. which shall read as follows:

1. Be a Member of CHOICES Group 2 or CHOICES Group 3.

Part 2. of Subparagraph (c) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Part 2. which shall read as follows:

2. Be determined by a Care Coordinator, based on a comprehensive needs assessment, to need one or more ~~of the HCBS eligible for CD~~ Eligible CHOICES HCBS.

Part 4. of Su0.bparagraph (c) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "as applicable" after the word and comma "Agreement," so as amended Part 4. shall read as follows:

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.

Emergency Rule Part 1. of Subparagraph (d) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 1. which shall read as follows:

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.

Emergency Rule Subpart (i) of Part 1. of Subparagraph (f) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (i) which shall read as follows:

(i) The person is not enrolled in TennCare or in CHOICES Group 2 or CHOICES Group 3.

Subpart (iv) of Part 1. of Subparagraph (f) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by replacing the word "members" with the word "Members" after the words "with the" in the third line so as amended Subpart (iv) shall read as follows:

(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 ~~m~~Member's decision to participate in CD pose too great a threat to the Member's health, safety and welfare.

Part 7. of Subparagraph (h) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "of eligible" so as amended Part 7. shall read as follows:

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.

Subparagraph (h) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Part 8. which shall read as follows:

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.

Subpart (ii) of Part 1. of Subparagraph (i) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subpart (ii) which shall read as follows:

(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 ~~m~~Member shall not be permitted to employ any person who resides with the ~~m~~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:

(I) An iImmediate Family Member as defined in Rule 1200-13-01-.02.

(II) Any person with whom the ~~m~~Member currently resides, or with whom the ~~m~~Member has resided in the last five (5) years.

Emergency Rule Part 1. of Subparagraph (j) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 1. which shall read as follows:

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.

Emergency Rule Part 3. of Subparagraph (j) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 3. which shall read as follows:

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.

Emergency Rule Part 7. of Subparagraph (j) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Part 7. which shall read as follows:

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 ~~e~~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.

Subpart (ii) of Part 1. of Subparagraph (k) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Subpart (ii) which shall read as follows:

(ii) Voluntary or involuntary withdrawal of a Member from CD of Eligible CHOICES HCBS shall not affect a Member's eligibility for ~~LTC services~~ LTSS or enrollment in CHOICES, provided the Member continues to meet all requirements for enrollment in CHOICES as defined in this Chapter.

Emergency Rule Subpart (iii) of Part 1. of Subparagraph (k) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subpart (iii) which shall read as follows:

(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.

Emergency Rule Item (II) of Subpart (i) of Part 2. of Subparagraph (k) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Item (II) which shall read as follows:

(II) The person is no longer enrolled in either CHOICES Group 2 or CHOICES Group 3.

Item (III) of Subpart (i) of Part 2. of Subparagraph (k) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Item (III) which shall read as follows:

(III) The Member no longer needs any of the Eligible CHOICES HCBS ~~eligible for CD~~, as specified in the POC.

Item (V) of Subpart (i) of Part 2. of Subparagraph (k) of Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding ",as applicable," after the word "Agreement" so as amended Item (V) shall read as follows:

(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.

Subparagraphs (b), (c) and (d) of Paragraph (10) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with new Subparagraphs (b), (c) and (d) which shall read as follows:

(b) ~~Reimbursement methodology for Level I care~~ Level 1 reimbursement methodology for NF care: See Rule 1200-13-01-.03(6).

(c) ~~Reimbursement methodology for Level 2 care~~ Level 2 reimbursement methodology for NF care: See Rule 1200-13-01-.03(7).

(d) ~~Reimbursement methodology for Level 2 care at an Enhanced Respiratory Care rate~~ Enhanced Respiratory Care reimbursement methodology for NF care: See Rule 1200-13-01-.03(8).

Part 3. of Subparagraph (e) of Paragraph (10) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with new Part 3. which shall read as follows:

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 ~~except that for the first thirty (30) days following CHOICES implementation in the Grand Division, reimbursement shall be made at the NF's rate as established by the Office of the Comptroller~~.

Subparagraph (b) of Paragraph (11) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and current Subparagraph (c) re-lettered as (b).

~~(b) During the Continuity of Care period, both participating and non-participating HCBS providers will be reimbursed by the Member's MCO in accordance with the contract rates for providers of similar services.~~

Subparagraph (c) re-lettered as (b) of Paragraph (11) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new re-lettered Subparagraph (b) which shall read as follows:

(cb) ~~After the Continuity of Care period has ended, n~~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.

Emergency Rule Subparagraph (c) of Paragraph (12) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with Rulemaking Hearing Rule Subparagraph (c) which shall read as follows:

(c) Appeals related to the PAE process (including decisions pertaining to the PASRR process) are processed by the Bureau's Division of Long-Term ~~Care~~ Services and Supports in accordance with Rule 1200-13-01-.10(7).

Introductory language of Subparagraph (d) of Paragraph (12) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the word "Care" after the phrase "Long-Term" and adding the words "Services and Supports" so as amended introductory language of Subparagraph (d) shall read as follows:

(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 ~~Care~~ Services and Supports in the Bureau, in accordance with the following procedures:

Part 3. of Subparagraph (d) of Paragraph (12) of rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the word "Care" after the phrase "Long-Term" in the first sentence and adding the words "Services and Supports" so as amended Part 3. shall read as follows:

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 ~~Care~~ 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.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

Emergency Rule 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC is deleted in its entirety and replaced with Rulemaking Hearing Rule 1200-13-01-.08 which shall read as follows:

1200-13-01-.08 PERSONAL NEEDS ALLOWANCE (PNA), PATIENT LIABILITY, THIRD PARTY INSURANCE AND ESTATE RECOVERY FOR PERSONS RECEIVING ~~LTC~~ LTSS.

(1) Personal Needs Allowance (PNA). The PNA is established for each Enrollee receiving ~~LTC services~~ LTSS in accordance with the Tennessee Medicaid State Plan, approved Section 1915(c) Waiver applications, and these rules. It is deducted from the Enrollee's monthly income in calculating Patient Liability for ~~LTC services~~ LTSS.

(a) The PNA for each person receiving ~~Medicaid-funded~~ TennCare-reimbursed services in a NF or an ICF/~~IID~~IDMR is $50. Persons with no income have no PNA. Persons with incomes that are less than $50 per month (including institutionalized persons receiving SSI payments) may keep the entire amount of their income as their PNA.

(b) The maximum PNA for persons participating in CHOICES Group 2 or CHOICES Group 3 is 300% of the SSI FBR.

(c) The maximum PNA for persons participating in one of the State's Section 1915(c) HCBS Waivers is as follows:

~~1. The Statewide HCBS E/D Waiver: 200% of the SSI FBR, as defined in Rule 1200-13-01-.02.~~

~~2.~~1. The Statewide I~~D~~IDMR ~~Waiver~~: 200% of the SSI FBR.

~~3.~~2. The Arlington I~~D~~IDMR ~~Waiver~~: 200% of the SSI FBR.

~~4.~~3. The Self-Determination I~~D~~IDMR ~~Waiver~~: 300% of the SSI FBR.

(2) Patient Liability.

(a) Enrollees receiving ~~LTC services~~ LTSS are required to contribute to the cost of their ~~LTC~~ LTSS if their incomes are at certain levels. They are subject to the post-eligibility treatment of income rules set forth in Section 1924 of the Social Security Act (42 U.S.C.A. § 1396r-5), and 42 C.F.R. § 435.725.

(b) For Enrollees being served in HCBS Waivers, the State must also use institutional eligibility and post-eligibility rules for determining Patient Liability.

(c) For Members of the CHOICES 217-Like Group and the CHOICES At-Risk Demonstration Group, the State uses institutional eligibility and post-eligibility rules for determining Patient Liability in the same manner as specified under 42 C.F.R. §§ 435.217, 435.236, and 435.726 and Section 1924 of the Social Security Act (42 U.S.C.A. § 1396r-5), if the HCBS were provided under a Section 1915(c) Waiver.

(d) For a Member of CHOICES Group 2 or CHOICES Group 3 receiving the Short-Term NF Care benefit (for up to 90 days) or an Enrollee in one of the State's Section 1915(c) Waiver programs who is temporarily placed in a medical institution, i.e., a hospital, NF or ICF/~~IID~~IDMR (for up to 90 days), the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. The purpose is to ensure that the individual can maintain a community residence for transition back to the community. After 90 days, or as soon as it appears that the inpatient stay will not be a short-term

stay, whichever comes first, a CHOICES Group 2 or CHOICES Group 3 Member will be transitioned to CHOICES Group 1, or a waiver participant must be disenrolled from the waiver, and the institutional post-eligibility calculation shall apply.

(e) Patient Liability shall be collected as follows:

1. If the Enrollee resides in a NF, ICF/IIDMR, or CBRA facility (i.e., an ACLF or Critical Adult Care Home), the Enrollee must pay his Patient Liability to the residential facility. The facility shall reduce the amount billed to the Bureau or the MCO, as applicable, by the amount of the Enrollee's Patient Liability obligation, regardless of whether such amount is actually collected by the facility.

2. If a CHOICES Group 2 Member does not reside in a CBRA facility, i.e., the Member is receiving HCBS (including Companion Care) in his own home, and for all CHOICES Group 3 members (who are not eligible to receive CBRA services), the Member must pay his Patient Liability to the MCO. The amount of Patient Liability collected will be used to offset the cost of CHOICES Group 2 or CHOICES Group 3 benefits or CEA services provided as an alternative to covered CHOICES Group 2 or CHOICES Group 3 benefits that were reimbursed by the MCO for that month. The amount of Patient Liability collected by the MCO cannot exceed the cost of CHOICES Group 2 or CHOICES Group 3 benefits (or CEA services provided as an alternative to CHOICES Group 2 or CHOICES Group 3 benefits) reimbursed by the MCO for that month.

(f) A CHOICES provider, including an MCO, may decline to continue to provide ~~LTC services~~ LTSS to a CHOICES Member who fails to pay his Patient Liability. If other Contract Providers or the other TennCare MCO(s) operating in the Grand Division are unwilling to provide ~~LTC services~~ LTSS to a CHOICES Member who has failed to pay his Patient Liability, the Member may be disenrolled from the CHOICES program in accordance with the procedures set out in this Chapter.

(3) TPL for ~~LTC~~ LTSS.

(a) LTC insurance policies are considered TPL and ~~are treated like all other TPL policies, as described in Rule 1200-13-01-.04~~ the Bureau is subrogated to all rights of recovery.

(b) Applicants for the CHOICES program who have LTC insurance policies must report these policies to DHS upon enrollment in the CHOICES program. Applicants may be subject to criminal prosecution for knowingly providing incorrect information.

(c) Obligations of CHOICES Members receiving NF or CBRA services (other than Companion Care) having insurance that will pay for care in a NF or other residential facility (including cash benefits to the Member for the cost of such services):

1. If the benefits are assignable, the Member must assign them to the NF or residential facility. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay the NF or the residential facility for ~~LTC services~~ LTSS.

2. If the benefits are not assignable, the Member must provide payment to the NF or the residential facility immediately upon receipt of the benefits. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay the NF or the residential facility for ~~LTC services~~ LTSS.

(d) Obligations of CHOICES Members receiving non-residential CHOICES HCBS or Companion Care services having insurance that will pay for CHOICES HCBS (including cash benefits to the Member for the cost of such services):

1. If the benefits are assignable, the Member must assign them to the MCO. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay for CHOICES HCBS for the Member.

2. If the benefits are not assignable, the Member must make payment to the MCO immediately upon receipt of the benefits. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay for CHOICES HCBS for the Member.

~~(e) TPL payments do not reduce the amount of Patient Liability a Member is obligated to contribute toward the cost of LTC Services.~~

(e) TPL payments do not reduce the amount of Patient Liability an Enrollee is obligated to contribute toward the cost of LTSS, except in instances where the total cost of LTSS for the month is less than the combined total of TPL payments and the member's Patient Liability amount, in which case, TPL shall be collected first. The NF shall then collect Patient Liability up to the total cost of LTSS provided for the month.

(f) If benefits received by the policyholder are not paid to the facility or MCO, as applicable, such benefits shall be considered income, and may render the person ineligible for TennCare (including ~~LTC~~ LTSS) benefits.

(4) Estate Recovery. Persons enrolled in TennCare ~~LTC~~ LTSS programs are subject to the requirements of the FERP as set forth under Section 1917(b) of the Social Security Act, 42 U.S.C.A. § 1396p(b).

(a) The State is required to seek adjustment or recovery for certain types of medical assistance from the estates of individuals as follows:

1. For persons age fifty-five (55) and older, the State is obligated to seek adjustment or recovery for NF (including ICF/IID~~MR~~) services, HCBS, and related hospital and prescription drug services.

2. For permanently institutionalized persons under age fifty-five (55), the State is obligated to seek adjustment or recovery for the institutional services.

(b) Estate recovery shall apply to the estates of individuals under age fifty-five (55) who are inpatients in a NF, ICF/IID~~MR~~, or other medical institution and who cannot reasonably be expected to be discharged home.

(c) A determination that an individual cannot reasonably be expected to be discharged to return home shall be made in accordance with the following.

1. The PAE for LOC that is certified by the physician shall specify whether discharge is expected and the anticipated length of stay in the institution.

2. The following shall be deemed sufficient evidence that a person cannot reasonably be expected to be discharged to return home and is thus permanently institutionalized:

(i) An approved PAE certified by the physician indicating that discharge is not expected; or,

(ii) The continued stay of a resident of a medical institution at the end of a temporary stay predicted by his physician at the time of admission to be no longer than six (6) months in duration.

(d) Written notice of the determination that the individual residing in a medical institution cannot reasonably be expected to be discharged to return home shall be issued to the individual or his Designated Correspondent. The notice shall explain the right to request a reconsideration review. Such request must be submitted in writing to the Bureau, Long-Term ~~Care~~ Services and Supports Division, within thirty (30) days of receipt of the written notice. The reconsideration review shall be conducted as a Commissioner's Administrative Hearing in the manner set out in Rule 1200-13-01-.10~~(6)(f)~~(7).

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Rule 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for Medicaid Reimbursement of Care in Nursing Facilities as amended by Emergency Rule 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for Medicaid Reimbursement of Care in Nursing Facilities is deleted in its entirety and replaced with Rulemaking Hearing Rule 1200-13-01-.10 which shall read as follows:

1200-13-01-.10 MEDICAL (LEVEL OF CARE) ELIGIBILITY CRITERIA FOR ~~MEDICAID~~ TENNCARE REIMBURSEMENT OF CARE IN NURSING FACILITIES, CHOICES HCBS AND PACE.

(1) Definitions. See Rule 1200-13-01-.02.

(2) PreAdmission Evaluations and Discharge/Transfer/Hospice Forms.

(a) A PAE is required in the following circumstances:

1. When a ~~Medicaid~~ TennCare Eligible is admitted to a NF for receipt of ~~Medicaid~~ TennCare-reimbursed NF Services.

2. When a private-paying resident of a NF attains ~~Medicaid~~ TennCare Eligible status.

3. When Medicare reimbursement for SNF services has ended and ~~Medicaid~~ TennCare Level 2 reimbursement for NF services is requested.

4. When a NF Eligible is changed from ~~Medicaid~~ TennCare Level 1 to ~~Medicaid~~ TennCare Level 2 reimbursement, or from ~~Medicaid~~ TennCare Level 1 or Level 2 reimbursement to a Chronic Ventilator or Tracheal Suctioning Enhanced Respiratory Care rate, except as specified in Rule 1200-13-01-.10(5)(f).

5. When a NF Eligible is changed from ~~Medicaid~~ TennCare Level 2 reimbursement or an Enhanced Respiratory Care rate to ~~Medicaid~~ TennCare Level 1 reimbursement, unless the ~~individual~~ person has an approved unexpired Level 1 PAE.

6. When a NF Eligible is changed from an Enhanced Respiratory Care rate to ~~Medicaid~~ TennCare Level 2 reimbursement, unless the ~~individual~~ person has an approved unexpired Level 2 PAE.

7. When a NF Eligible requires continuation of the same LOC beyond the expiration date assigned by the Bureau.

8. When a NF Eligible no longer requires the specific skilled nursing or rehabilitative services for which a Level 2 PAE was approved but requires other ~~Level 2 care in a NF~~ skilled nursing or rehabilitative services for which Level 2 reimbursement may be authorized in a NF.

9. When a Member enrolled in CHOICES Group 1 or Group 2 on or after July 1, 2012, no longer meets NF LOC and wants to enroll in CHOICES Group 3 for HCBS.

10. When a Member enrolled in CHOICES Group 3 (including Interim CHOICES Group 3) on or after July 1, 2012, wants to enroll in CHOICES Group 1 or 2.

(b) NFs are required to complete and submit to the ~~m~~Member's MCO a Discharge/Transfer/Hospice Form any time a Member discharges from the facility or stops receiving NF services in the facility, which shall include but is not limited to the following circumstances:

1. When a CHOICES ~~m~~Member transfers from one ~~Nursing Facility~~ NF to another such facility.

2. When a CHOICES ~~m~~Member discharges to the hospital (even when readmission to the NF is expected following the hospital stay).

3. When a CHOICES ~~m~~Member elects to receive hospice services (even if Medicare will be responsible for payment of the hospice benefit).

4. When a CHOICES ~~m~~Member discharges home, with or without HCBS. In this case, the NF is obligated to notify the MCO before the ~~m~~Member is discharged from the facility and to coordinate with the MCO in discharge planning in order to ensure that any home and community based

services needed by the ~~m~~Member will be available upon discharge, and to avoid a lapse in CHOICES and/or TennCare eligibility.

5. Upon the death of a CHOICES ~~m~~Member.

(c) A PreAdmission Evaluation is not required in the following circumstances:

1. When a ~~Medicaid~~ NF Eligible with an approved unexpired Level 1 ~~PreAdmission Evaluation~~ PAE returns to the ~~Nursing Facility~~ NF after being hospitalized.

2. When a ~~Medicaid~~ NF Eligible with an approved unexpired Level 2 ~~PreAdmission Evaluation~~ PAE returns to the ~~Nursing Facility~~ NF after being hospitalized, if there has been no change in the skilled nursing or rehabilitative service for which the ~~PreAdmission Evaluation~~ PAE was approved.

3. When a ~~Medicaid~~ NF Eligible changes from Level 2 to Level 1 NF reimbursement and has an approved unexpired Level 1 ~~PreAdmission Evaluation~~ PAE.

4. To receive Medicaid co-payment when Medicare is the primary payer of ~~Skilled Nursing Facility~~ SNF care.

5. When a Discharge/Transfer/Hospice Form is appropriate in accordance with (2)(b).

6. For authorization by an MCO of Ventilator Weaning services or short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention. Medical necessity determinations and authorization of Ventilator Weaning services and short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate during the post-weaning period will be managed by the ~~Enrollee's~~ person's MCO.

7. When a person will be receiving hospice services in the NF.

(d) If a NF admits or allows continued stay of a TennCare Eligible without an approved PAE, it does so at its own risk and in such event the NF shall give the ~~individual~~ Applicant a plain language written notice, in a format approved by the Bureau, that Medicaid reimbursement will not be paid unless the PAE is approved and if it is not finally approved the ~~individual~~ Applicant can be held financially liable for services provided, including services delivered prior to the effective date of the PAE and enrollment in CHOICES Group 1, unless a third party is liable.

(e) Except as specified in 1200-13-01-.10(2)(e)2., an approved ~~PreAmission Evaluation~~ PAE is valid for ninety (90) calendar days beginning with the PAE Approval Date, unless an earlier expiration date has been established by TennCare (see 1200-13-01-.10(2)(h)). A valid approved ~~PreAmission Evaluation~~ PAE that has not been used within ninety (90) calendar days of the PAE Approval Date must be updated before it can be used. For purposes of Medicaid-reimbursed NF services, such update may be completed only upon submission of a confirmed Medicaid Only Payer Date. To update the PAE, the physician (in the case of NF services) or a Qualified Assessor (in the case of HCBS) shall certify that the ~~a~~Applicant's medical condition on the revised PAE Request Date is consistent with that described in the initial certification and/or assessment and that ~~Nursing Facility~~ NF services, or alternative HCBS, as applicable, are medically necessary for the ~~a~~Applicant. If the ~~individual's~~ Applicant's medical condition has significantly changed such that the previously approved ~~PreAdmission Evaluation~~ PAE does not reasonably reflect the ~~individual's~~ Applicant's current medical condition and functional capabilities, a new ~~PreAdmission Evaluation~~ PAE shall be required.

1. A PAE that is not used within 365 days of the PAE Approval Date shall expire and shall not be updated.

2. A PAE shall also expire upon the person's discharge from a NF, unless:

(i) The person transfers to another NF.

(ii) The person is discharged to the hospital and returns directly to the NF or to another NF.

(iii) The person is discharged home for therapeutic leave and returns to the NF within no more than ten (10) days.

(iv) The person is discharged home and a request to transition to CHOICES Group 2 is submitted by the MCO ~~to~~ and approved by TennCare prior to the person's discharge from the NF.

3. For persons electing hospice:

(i) If a person receiving NF services elects to receive hospice, is disenrolled from CHOICES Group 1, and subsequently withdraws the hospice election and wishes to re-enroll in CHOICES Group 1, the approved PAE may be used so long as:

(I) the person has remained in the NF;

(II) the person's condition has not changed;

(III) no more than thirty (30) days have lapsed since the person's disenrollment from CHOICES Group 1; and

(IV) NF LOC criteria have not changed.

(ii) If the person's condition has changed or if more than thirty (30) days have lapsed since the person's disenrollment from CHOICES Group 1, a new PAE shall be required.

(iii) If the PAE effective date was prior to July 1, 2012, a new PAE must be submitted and the person must qualify based on the new NF LOC criteria in place as of July 1, 2012.

(f) A PAE must include a recent history and physical or current medical records that support the ~~a~~Applicant's functional and/or skilled nursing or rehabilitative needs, as reflected in the PAE. A history and physical performed within 365 calendar days of the PAE Request Date may be used if the ~~patient's~~ Applicant's condition has not significantly changed. Medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed, or may be used in lieu of a history and physical, so long as the records provide medical evidence sufficient to support the functional and/or skilled or rehabilitative needs reflected in the PAE.

(g) A PAE must be certified as follows:

1. Physician certification shall be required for reimbursement of NF services and enrollment into CHOICES Group 1. Consistent with requirements pertaining to certification of the need for SNF care set forth at 42 CFR § 424.20 and in Section 3108 of the Affordable Care Act, certification of the need for NF care may be performed by a nurse practitioner, ~~or~~ clinical nurse specialist, or physician assistant, ~~neither~~ none of whom has a direct or indirect employment relationship with the facility but who is working in collaboration with a physician.

2. Certification of the level of care assessment by a Qualified Assessor shall be required for all PAEs.

(h) A PAE may be approved by the Bureau for a fixed period of time with an expiration date based on an assessment by the Bureau of the ~~individual's~~ Applicant's medical condition and anticipated continuing need for inpatient nursing care. Notice of appeal rights shall be provided when a PAE is approved with an expiration date.

(i) PASRR.

1. All ~~individuals~~ Applicants who reside in or seek admission to a Medicaid-certified ~~Nursing facility~~ NF must have a PASRR Level I screen for mental illness and mental retardation. The initial Level I screen must be completed prior to admission to the ~~Nursing Facility~~ NF and submitted to TennCare regardless of:

(i) payer source;

(ii) whether the PASRR screening is positive or negative (including specified exemptions); and

(iii) the level of ~~nursing facility~~ NF reimbursement requested.

2. If the Level I screen indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness and/or mental retardation, the ~~individual~~ Applicant must undergo the PASRR Level II evaluation prior to admission to the ~~Nursing Facility~~ NF.

(j) Medicaid payment will not be available for any dates of ~~Nursing Facility~~ NF services rendered prior to the date the PASRR process is complete and the ~~individual~~ Applicant has been determined appropriate for nursing home placement. The PASRR process is complete when either:

1. TennCare has received a negative Level I PASRR screen form and no contradictory information is subsequently received; or

2. For ~~persons~~ Applicants with a positive Level I PASRR screen (as submitted or upon review and determination by the Bureau), the Bureau has received a certified exemption or advance categorical determination signed by the physician; or a determination by DMH and/or DIDD, as applicable, that the ~~person~~ Applicant is appropriate for NF placement. Determination by the Bureau that a Level II PASRR evaluation must be performed may be made:

(i) Upon receipt of a positive PASRR screen from the NF or other submitting entity;

(ii) Based on TennCare review of a negative PASRR screening form or history and physical submitted by a NF or other entity; or

(iii) Upon review of any contradictory information submitted in the PAE application or supporting documentation at any time prior to disposition of the PAE.

(k) A NF that has entered into a provider agreement with a TennCare MCO shall assist a NF resident or aApplicant as follows:

1. The ~~Nursing Facility~~ NF shall assist a ~~Nursing Facility~~ NF resident or an aApplicant for admission in applying for Medicaid eligibility and in applying for Medicaid-reimbursed ~~Nursing Facility~~ NF care. This shall include assistance in properly completing all necessary paperwork and in providing relevant ~~Nursing Facility~~ NF documentation to support the ~~PreAdmission Evaluation~~ PAE. For Applicants not currently eligible for Medicaid, the NF may request assistance from the AAAD in completing the Medicaid application process in order to expedite the eligibility determination by DHS. Reasonable accommodations shall be made for an ~~individual~~ Applicant with disabilities or, alternatively, for a dDesignated Correspondent with disabilities when assistance is needed with the proper completion and submission of a ~~PreAdmission Evaluation~~ PAE.

2. The ~~Nursing Facility~~ NF shall request a Notice of Disposition or Change from the Department of Human Services upon learning that a resident or aApplicant has, or is likely to have, applied for Medicaid eligibility.

(l) The Bureau shall process PAEs independently of determinations of Medicaid eligibility by DHS; however, Medicaid reimbursement for NF care shall not be available until the PASRR process has been completed, and both the PAE and financial eligibility have been approved.

(3) Medicaid Reimbursement.

(a) A NF that has entered into a provider agreement with a TennCare MCO is entitled to receive Medicaid reimbursement for covered services provided to a NF Eligible if:

1. The NF has completed the PASRR process as ~~defined~~ described in 1200-13-01-.10(2)(i) above and pursuant to 1200-13-01-.23.

2. The Bureau has received an approvable PAE for the ~~individual~~ person within ten (10) calendar days of the PAE Request Date or the physician certification date, whichever is earlier. The PAE Approval Date shall not be more than ten (10) days prior to date of submission of an approvable PAE. An approvable PAE is one in which any deficiencies in the submitted application are cured prior to disposition of the PAE.

3. The NF has entered into the TennCare PreAdmission Evaluation System (TPAES) a Medicaid Only Payer Date.

4. The person has been enrolled into CHOICES Group 1.

5. For a retroactive eligibility determination, the Bureau has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired PAE within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change, so long as the person has remained in a NF since the PAE was completed (except for short-term hospitalization). The effective date of payment for NF services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE that has been updated.

6. If the NF participates in the Enrollee's MCO, reimbursement will be made by the MCO to the NF as a Network Provider. If the NF does not participate in the Enrollee's MCO, reimbursement will be made by the MCO to the NF as a non-participating provider, in accordance with Rule 1200-13-01-.05(10).

(b) Any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.

1. Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no more than ten (10) days prior to the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application.

2. Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for ~~nursing facility~~ NF services.

(c) The earliest date of Medicaid reimbursement for care provided in a ~~Nursing Facility~~ NF shall be the date that all of the following criteria are met:

1. Completion of the PASRR process, as ~~defined~~ described in 1200-13-01-.10(2)(i) above and pursuant to 1200-13-01-.23;

2. The effective date of level of care eligibility as reflected by the PAE Approval Date;

3. The effective date of Medicaid eligibility;

4. The date of admission to the ~~Nursing Facility~~ NF; and

5. The effective date of enrollment into CHOICES Group 1.

(d) PAE Effective Dates ~~P~~pertaining to Advance Determinations for ~~P~~persons ~~N~~not ~~E~~enrolled in TennCare when the PAE is ~~S~~submitted:

1. An Advance dDetermination by TennCare that an ~~person~~ Applicant not enrolled in TennCare at the time the PAE is submitted cannot be safely supported within the array of services and supports that would be available if the ~~person~~ Applicant were enrolled in CHOICES Group 3, and approval of NF LOC, shall be effective for no more than thirty (30) days, pending a

comprehensive assessment and ~~plan of care~~ POC developed by the MCO Care Coordinator once the ~~person~~ Applicant is eligible for TennCare and enrolled in CHOICES Group 1 or 2.

2. If TennCare determines that an ~~a~~Advance ~~d~~Determination cannot be approved for an ~~a~~Applicant already admitted to a NF who is not enrolled in TennCare at the time the PAE is submitted, but ~~subsequently~~ upon enrollment into CHOICES Group 3 and receipt of comprehensive documentation submitted by the MCO, determines that the ~~a~~Applicant's needs cannot be safely and appropriately met in the community with the array of services and supports available in CHOICES Group 3, enrollment in CHOICES Group 3 will be terminated pursuant to 1200-13-01-.05(5)(b), and NF LOC will be approved. In such case, the effective date of NF LOC and, subject to requirements set forth in TennCare Rule 1200-13-01-.05(4)(a), enrollment into CHOICES Group 1 will be the date that NF LOC would have been effective had an ~~a~~Advance ~~d~~Determination been ~~made~~ approved.

(e) Application of new LOC criteria. The new LOC criteria set forth in 1200-13-01-.10(4) shall be applied to all ~~persons~~ Applicants enrolled into CHOICES on or after July 1, 2012, based on their effective date of enrollment into the CHOICES program.

1. It is the date of enrollment into CHOICES and not the date of PAE submission, approval, or the PAE effective date which determines the LOC criteria that must be applied.

2. TennCare may~~, at its discretion,~~ review a PAE that had been reviewed and approved based on the NF LOC criteria in place as of June 30, 2012, to determine whether an ~~person~~ Applicant who will be enrolled into CHOICES on or after July 1, 2012, meets the new LOC criteria. However, all ~~persons~~ Applicants enrolled into CHOICES with an effective date of enrollment on or after July 1, 2012, shall meet the criteria in place at the time of enrollment, and in accordance with these rules.

(f) A NF that has entered into a provider agreement with a TennCare MCO and that admits a ~~Medicaid~~ TennCare Eligible without completion of the PASRR process~~,~~ and without an approved PAE does so without the assurance of Medicaid reimbursement.

(g) ~~Medicaid~~ TennCare reimbursement will only be made to a ~~Nursing Facility~~ NF on behalf of the ~~Nursing Facility~~ NF Eligible and not directly to the ~~Nursing Facility~~ NF Eligible.

(h) A NF that has entered into a provider agreement with a TennCare MCO shall admit ~~individuals~~ persons on a first come, first served basis, except as otherwise permitted by State and federal laws and regulations.

(4) ~~Criteria for Reimbursement of Medicaid Level 1~~ Level of Care Criteria for Medicaid Level 1 Reimbursement of Care in a Nursing Facility, CHOICES HCBS and PACE.

(a) The NF must have completed the PASRR process, as applicable and as described in 1200-13-01-.10(2)(i) above and pursuant to 1200-13-01-.23.

~~(a) The Nursing Facility must have completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.~~

~~(b) The individual must be determined by DHS to be eligible for Medicaid reimbursement for NF care.~~

(c~~b~~) An ~~individual~~ Applicant must meet both of the following LOC criteria in order to be approved for TennCare-reimbursed care in a NF, CHOICES HCBS or PACE, as applicable:

1. Medical Necessity of Care:

(i) ~~Persons~~ Applicants requesting ~~Medicaid~~ TennCare-reimbursed NF care. Care in a ~~Nursing Facility~~ NF must be expected to improve or ameliorate the ~~individual's~~ Applicant's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.

(ii) ~~Persons~~ Applicants requesting HCBS in CHOICES or PACE. HCBS must be required in order to allow the ~~person~~ Applicant to continue living safely in the home or community-based setting and to prevent or delay placement in a ~~nursing facility~~ NF, and such HCBS must be specified in an approved plan of care and needed on an ongoing basis.

(I) The need for one-time CHOICES HCBS is not sufficient to meet medical necessity of care for HCBS.

(II) If a ~~m~~Member's ongoing need for assistance with activities of daily living and/or instrumental activities of daily living can be met, as determined through the needs assessment and care planning processes, through the provision of assistance by family members and/or other caregivers, or through the receipt of services available to the ~~m~~Member through community resources (e.g., Meals on Wheels) or other payer sources (e.g., Medicare), the ~~m~~Member does not require HCBS in order to continue living safely in the home and community-based setting and to prevent or delay placement in a ~~nursing facility~~ NF.

2. Need for Inpatient Nursing Care:

(i) ~~Persons requesting care in a Nursing Facility~~ Applicants requesting TennCare-reimbursed NF care.

The ~~individual~~ Applicant must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The ~~individual~~ Applicant must be unable to self-perform needed nursing care and must meet one (1) or more of the following criteria on an ongoing basis:

(I) Have a total score of at least nine (9) on the TennCare NF LOC Acuity Scale; or

(II) Meet one or more of the ADL or related criteria specified in 1200-13-01-.10(4)(~~c~~b)(2)(iii) on an ongoing basis and be determined by TennCare to not qualify for enrollment in CHOICES Group 3 (see TennCare Rule 1200-13-01-.05).

(ii) ~~Persons~~ Applicants eligible to receive care in a NF, but requesting HCBS in CHOICES Group 2 or PACE.

The ~~individual~~ Applicant must have a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. In the absence of ongoing CHOICES HCBS or PACE, the ~~person~~ Applicant would require and must qualify to receive NF services in order to remain eligible for HCBS. The ~~individual~~ Applicant must be unable to self-perform needed nursing care and must meet one (1) or more of the following criteria on an ongoing basis:

(I) Have a total score of at least nine (9) on the TennCare NF LOC Acuity Scale; or

(II) Meet one (1) or more of the ADL or related criteria specified in 1200-13-01-.10(4)(~~c~~b)(2)(iii) on an ongoing basis and be determined by TennCare to not qualify for enrollment in CHOICES Group 3 (see TennCare Rule 1200-13-01-.05).

(iii) ~~Persons~~ Applicants not eligible to receive care in a NF, but at risk of NF placement and requesting HCBS in CHOICES Group 3, including Interim CHOICES Group 3. The ~~individual~~ Applicant must have a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. In the absence of ongoing CHOICES HCBS, the ~~person~~ Applicant would not be able to live safely in the community and would be at risk of NF placement. The following criteria shall reflect the ~~individual's~~ Applicant's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent ~~individual~~ person who is able to function with minimal supervision or assistance. The Applicant must be unable to self-perform needed nursing care and must

meet one (1) or more of the following criteria on an ongoing basis:

(I) Transfer. The ~~individual~~ Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or at least four days per week).

(II) Mobility. The ~~individual~~ Applicant requires physical assistance from another person for mobility on an ongoing basis (daily or at least four days per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

(III) Eating. The ~~individual~~ Applicant requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth (daily or at least four days per week). Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.

(IV) Toileting. The ~~individual~~ Applicant requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or at least four days per week).

(V) Expressive and Receptive Communication. The ~~individual~~ Applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the ~~individual~~ Applicant is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual intervention (daily or at least four days per week).

(VI) Orientation. The ~~individual~~ Applicant is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a ~~Nursing Facility~~ NF) daily or at least four days per week.

(VII) Medication Administration. The ~~individual~~ Applicant is not mentally or physically capable of self-administering prescribed medications (daily or at least four days per week) despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to ~~individual~~ Applicant, and reassurance of the correct dose.

(VIII) Behavior. The ~~individual~~ Applicant requires persistent intervention (daily or at least four days per week) due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement).

(IX) Skilled Nursing or Rehabilitative Services. The ~~individual~~ Applicant requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

(dc) For continued ~~Medicaid~~ TennCare reimbursement of care in a ~~Nursing Facility~~ NF, ~~an individual~~ Member must continue to be financially eligible for ~~Medicaid~~ TennCare reimbursement for ~~Nursing Facility~~ NF ~~C~~care and must continue to meet NF LOC (including medical necessity of care and the need for inpatient care) in place at the time of enrollment into CHOICES Group 1.

(ed) A ~~Nursing Facility~~ NF Eligible admitted to a ~~Nursing Facility~~ NF and ~~to~~ enrolled in CHOICES Group 1 prior to July 1, 2012, who continues to meet the LOC criteria in place at the time of enrollment into CHOICES Group 1 shall continue to meet NF LOC for purposes of enrolling in CHOICES Group 2, subject to requirements set forth in 1200-13-01-.05(3) and 1200-13-01-.05(4).

(fe) A ~~Nursing Facility~~ NF Eligible receiving HCBS in CHOICES Group 2 prior to July 1, 2012, shall be required to meet the NF LOC in place as of July 1, 2012, in order to qualify for Medicaid-reimbursed NF care unless TennCare determines that the ~~person's~~ Member's needs can no longer be safely and cost-effectively met in CHOICES Group 2.

(5) Criteria for Medicaid Level 2 and Enhanced Respiratory Care Reimbursement of Care in a ~~Nursing Facility~~ NF.

(a) The ~~Nursing Facility~~ NF must have completed the PASRR process as ~~defined~~ described in 1200-13-01-.10(2)(i) above and pursuant to 1200-13-01-.23.

~~(b) The individual must be determined by DHS to be eligible for Medicaid reimbursement for NF care.~~

(cb) An ~~individual~~ Applicant must meet both of the following criteria in order to be approved for Medicaid Level 2 reimbursement of care in a ~~Nursing Facility~~ NF:

1. The ~~individual~~ Applicant must meet NF LOC as defined in 1200-13-01-.10(4) above.

2. Need for Inpatient Skilled Nursing or Rehabilitative Services on a Daily Basis: The ~~individual~~ Applicant must have a physical or mental condition, disability, or impairment that requires skilled nursing or rehabilitative services on a daily basis or skilled rehabilitative services at least five days per week when skilled rehabilitative services constitute the primary basis for the approval of the ~~PreAdmission Evaluation~~ PAE. The ~~individual~~ Applicant must require such services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit. In addition, the ~~individual~~ Applicant must be mentally or physically unable to perform the needed skilled services or the ~~individual~~ Applicant must require skilled services which, in accordance with accepted medical practice, are not usually and customarily self-performed. For interpretation of this rule, the following shall apply:

(i) Administration of oral medications, ophthalmics, otics, inhalers, subcutaneous injections (e.g., fixed-dose insulin, subtherapeutic heparin, and calcitonin), topicals, suppositories, nebulizer treatments, oxygen administration, shall not, in and of itself, be considered sufficient to meet the requirement of (5)(cb)2.

(ii) Nursing observation and assessment, in and of itself, shall not be considered sufficient to meet the requirement of (5)(cb)2. Examples of nursing services for which Level 2 reimbursement might be provided include, but are not limited to, the following:

(I) Gastrostomy tube feeding

(II) Sterile dressings for Stage 3 or 4 pressure sores

(III) Total parenteral nutrition

(IV) Intravenous fluid administration

(V) Nasopharyngeal and tracheostomy suctioning

(VI) Ventilator services

(iii) A skilled rehabilitative service must be expected to improve the ~~individual's~~ Applicant's condition. Restorative and maintenance nursing procedures (e.g., routine range of motion exercises; stand-by assistance during ambulation; applications of splints/braces by nurses and nurses aides) shall not be considered sufficient to fulfill the requirement of (5)(b)2. Factors to be considered in the decision as to whether a rehabilitative service meets, or continues to meet, the requirement of (5)(cb)2. shall include, but not be limited to, an assessment of the type of therapy and its frequency, the remoteness of the injury or impairment, and the reasonable potential for improvement in the ~~individual's~~ Applicant's functional capabilities or medical condition.

(iv) Effective July 1, 2012, level 2 NF reimbursement for sliding scale insulin may be authorized for an initial period of no more than two (2) weeks for ~~residents~~ Applicants with unstable blood glucose levels that require daily monitoring and administration of sliding scale insulin. Approval of such reimbursement will require a physician's order and supporting documentation including a plan of care for stabilizing the aApplicant's blood sugar and transitioning to fixed dosing during the approval period. Additional periods of no more than two (2) weeks per period, not to exceed a maximum total of sixty (60) days, may be authorized upon submission of a new PAE and only with a physician's order and detailed explanation regarding why previous efforts to stabilize and transition to fixed dosing were not successful.

(c) In order to be approved for ~~Medicaid~~ TennCare-reimbursed care in a NF at the Chronic Ventilator rate of reimbursement, an ~~individual~~ Applicant must be ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula).

(d) In order to be approved by the Bureau for ~~Medicaid~~ TennCare-reimbursed care in a NF at the Tracheal Suctioning rate of reimbursement, an ~~individual~~ Applicant must have a functioning tracheostomy and require suctioning through the tracheostomy, at a minimum, multiple times per eight (8) hour shift. The suctioning must be required to remove excess secretions and/or aspirate from the trachea, which cannot be removed by the ~~patient's~~ Applicant's spontaneous effort. Suctioning of the nasal or oral cavity does not qualify for this higher level of reimbursement. An MCO may authorize, based on medical necessity, short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention during the post-weaning period.

(e) Determination of medical necessity and authorization for ~~Medicaid~~ TennCare reimbursement of Ventilator Weaning services, or short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention shall be managed by the Enrollee's MCO.

(6) TennCare Nursing Facility Level of Care Acuity Scale.

(a) Effective July 1, 2012, for all new enrollments into CHOICES Groups 1 and 2, level of care (LOC) eligibility for TennCare-reimbursement of NF services shall be based on an assessment of the following measures:

1. The aApplicant's need for assistance with the following Activities of Daily Living (ADLs):

   (i) Transfer;

   (ii) Mobility;

   (iii) Eating; and

   (iv) Toileting.

2. The aApplicant's level of independence (or deficiency) in the following ADL-related functions:

   (i) Communication (expressive and receptive);

   (ii) Orientation (to person and place);

   (iii) Dementia-related behaviors; and

   (iv) Self-administration of medications~~; and~~.

3. The aApplicant's need for certain skilled and/or rehabilitative services.

(b) One or more questions on the PAE for NF LOC shall be used to assess each of the ADL or related measures specified above. There are four (4) possible responses to each question.

(c) Weighted Values.

1. Interpretation of possible responses for all measures except behavior:

   (i) "Always" shall mean that the aApplicant is always independent with that ADL or related activity.

   (ii) "Usually" shall mean that the ~~person~~ Applicant is usually independent (requiring assistance fewer than 4 days per week).

   (iii) "Usually not" shall mean that the aApplicant is usually not independent (requiring assistance 4 or more days per week).

   (iv) "Never" means that the aApplicant is never independent with that ADL or related activity.

2. Interpretation of possible responses for the behavior measure:

   (i) "Always" shall mean that the aApplicant always requires intervention for dementia-related behaviors.

   (ii) "Usually" shall mean that the aApplicant requires intervention for dementia-related behaviors 4 or more days per week.

   (iii) "Usually not" shall mean that the aApplicant requires intervention for dementia-related behaviors, but fewer than 4 days per week.

   (iv) "Never" shall mean that the aApplicant does not have dementia-related behaviors that require intervention.

3. The weighted value of each of the potential responses to a question regarding the ADL or related functions specified above when supported by the medical evidence submitted with the PAE shall be as follows:

ADL (or related) question	Condition	Always	Usually	Usually not	Never	Maximum Individual Acuity Score	Maximum Acuity Score for the Measure(s)
Transfer	Highest value of two measures	0	1	3	4	4	4
Mobility		0	1	2	3	3	
Eating		0	1	3	4	4	4
Toileting	Highest value of three questions for the toileting measure	0	0	1	2	2	3
Incontinence care		0	1	2	3	3	
Catheter/ ostomy care		0	1	2	3	3	
Orientation		0	1	3	4	4	4
Expressive communication	Highest value of two questions for the communication measure	0	0	0	1	1	1
Receptive communication		0	0	0	1	1	
Self-administration of medication	First question only; excludes SS insulin	0	0	1	2	2	2
Behavior		3	2	1	0	3	3
Maximum possible ADL (or related) Acuity Score							21

4. The weighted value for each of the skilled and/or rehabilitative services for which level 2 or enhanced respiratory care NF reimbursement could be authorized when determined by TennCare to be needed by the aApplicant on a daily basis or at least five days per week for rehabilitative

services, based on the medical evidence submitted with the PAE shall be as follows:

Skilled or rehabilitative service	Maximum Individual Acuity Score
Ventilator	5
Frequent tracheal suctioning	4
New tracheostomy or old tracheostomy requiring suctioning through the tracheostomy multiple times per day at less frequent intervals, i.e., < every 4 hours	3
Total Perenteral Nutrition (TPN)	3
Complex wound care (i.e., infected or dehisced wounds)	3
Wound care for stage 3 or 4 decubitus	2
Peritoneal dialysis	2
Tube feeding, enteral	2
Intravenous fluid administration	1
Injections, sliding scale insulin	1
Injections, other IV, IM	1
Isolation precautions	1
PCA pump	1
Occupational Therapy by OT or OT assistant	1
Physical Therapy by PT or PT assistant	1
Teaching catheter/ostomy care	0
Teaching self-injection	0
Other	0
Maximum Possible Skilled Services Acuity Score	5

5. Conditions.

(i) Maximum Acuity Score for Transfer and Mobility:

(I) Assessment of the need for assistance with transfer and the need for assistance with mobility are separate but overlapping measures of an aApplicant's physical independence (or dependence) with movement.

(II) The maximum individual acuity score for transfer shall be four (4).

(III) The maximum individual acuity score for mobility shall be three (3).

(IV) The highest individual acuity score among the transfer and mobility measures shall be the aApplicant's total acuity score across both measures.

(V) The maximum acuity score across both of the transfer and mobility measures shall be four (4).

(ii) Maximum Acuity Score for Toileting:

(I) Assessment of the need for assistance with toileting shall include the following:

I. An assessment of the aApplicant's need for assistance with toileting;

II. Whether the aApplicant is incontinent, and if so, the degree to which the aApplicant is independent in incontinence care; and

III. Whether the aApplicant requires a catheter and/or ostomy, and if so, the degree

to which the aApplicant is independent with catheter and/or ostomy care.

(II) The highest individual acuity score among each of the three (3) toileting questions shall be the aApplicant's total acuity score for the toileting measure.

(III) The maximum acuity score for toileting shall be two (2).

(iii) Maximum Acuity Score for Communication:

(I) Assessment of the aApplicant's level of independence (or deficiency) with communication shall include an assessment of expressive as well as receptive communication.

(II) The highest individual acuity score across each of the two (2) communication questions shall be the aApplicant's total score for the communication measure.

(III) The maximum possible acuity score for communication shall be one (1).

(iv) Maximum Acuity Score for Self-Administration of Medication:

(I) Assessment of the aApplicant's level of independence (or deficiency) with self-administration of medications as an ADL-related function shall not take into consideration whether the aApplicant requires sliding scale insulin and the aApplicant's level of independence in self-administering sliding scale insulin.

(II) Sliding scale insulin shall be considered along with other skilled and/or rehabilitative services for which TennCare could authorize level 2 NF reimbursement .

(III) The maximum individual acuity score for self-administration of medication shall be two (2).

(IV) The maximum individual acuity score for sliding scale insulin shall be one (1).

(v) Maximum Skilled Services Acuity Score

(I) The highest individual acuity score across all of the skilled and/or rehabilitative services shall be the Applicant's total acuity score for skilled and/or rehabilitative services.

(II) The maximum possible acuity score for skilled and/or rehabilitative services shall be five (5).

(d) Maximum Acuity Score

1. The maximum possible acuity score for Activities of Daily Living (ADL) or related deficiencies shall be twenty-one (21).

2. The maximum possible acuity score for skilled and/or rehabilitative services shall be five (5).

3. The maximum possible total NF LOC acuity score shall be twenty-six (26).

(e) Calculating an Applicant's Total Acuity Score

1. Subject to the conditions set forth in 1200-13-01-.10(6)(c)5.~~(5)~~, an aApplicant's acuity score for each functional measure (i.e., eating, toileting, orientation, communication, self-administration of medication, or behavior), or in the case of transfer and mobility, the aApplicant's acuity score across both measures shall be added in order to determine the aApplicant's total ADL or related acuity score (up to a maximum of 21).

2. The aApplicant's total ADL or related acuity score shall then be added to the aApplicant's skilled services acuity score (up to a maximum of 5) in order to determine the aApplicant's total acuity

score (up to a maximum of 26).

(7) PreAdmission Evaluation Denials and Appeal Rights.

(a) A ~~Medicaid~~ TennCare Eligible or the legal representative of the ~~Medicaid~~ TennCare Eligible has the right to appeal the denial of a ~~PreAdmission Evaluation~~ PAE and to request an Administrative Hearing by submitting a written letter of appeal to the Bureau of TennCare, Division of Long-Term ~~Care~~ Services and Supports, within thirty (30) calendar days of receipt of the notice of denial.

(b) If the Bureau denies a PAE, the ~~individual~~ Applicant will be notified in the following manner:

1. A written ~~n~~Notice of denial shall be sent to the ~~individual~~ Applicant and, where applicable, to the ~~d~~Designated ~~c~~Correspondent. A ~~n~~Notice of denial shall also be provided to the ~~Nursing Facility~~ NF. This notice shall advise the ~~individual~~ Applicant of the right to appeal the denial decision within thirty (30) calendar days. The notice shall also advise the ~~individual~~ Applicant of the right to submit within thirty (30) calendar days either the original ~~PreAdmission Evaluation~~ PAE with additional information for review or a new ~~PreAdmission Evaluation~~ PAE. The ~~n~~Notice shall be mailed to the ~~Individual's~~ Applicant's address as it appears upon the ~~PreAdmission Evaluation~~ PAE. If no address appears on the ~~PreAdmission Evaluation~~ PAE and supporting documentation, the ~~n~~Notice will be mailed to the ~~Nursing Facility~~ NF for forwarding to the ~~individual~~ Applicant.

2. If the PAE is resubmitted with additional information for review or if a new PAE is submitted, and the Bureau continues to deny the PAE, another written notice of denial shall be sent as described in (7)(b)1.

(c) The ~~individual~~ Applicant has the right to be represented at the hearing by anyone of his/her choice. The hearing will be conducted according to the provisions of the Tennessee Uniform Administrative Procedures Act.

(d) Reasonable accommodations shall be made for ~~individuals~~ Applicants with disabilities who require assistance with an appeal.

(e) Any ~~n~~Notice required pursuant to this section shall be a plain language written ~~n~~Notice.

(f) When a PAE is approved for a fixed period of time with an Expiration Date determined by the Bureau, the ~~individual~~ Applicant shall be provided with a ~~n~~Notice of appeal rights, including the opportunity to submit an appeal within thirty (30) calendar days of receipt of the notice of denial. Nothing in this section shall preclude the right of the ~~individual~~ Applicant to submit a new PAE establishing medical necessity of care when the Expiration Date has been reached.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the _____ (board/commission/ other authority) on _____ (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: *07/16/12*

Rulemaking Hearing(s) Conducted on: (add more dates). *09/07/12*

Date: _____

Signature: _____

Name of Officer: Patti Killingsworth

Title of Officer: Chief, Long-Term Services and Support, Bureau of TennCare, Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: _____

Notary Public Signature: _____

My commission expires on: _____

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

_____
Robert E. Cooper, Jr.
Attorney General and Reporter

_____
Date

Department of State Use Only

Filed with the Department of State on: _____

Effective on: _____

_____
Tre Hargett
Secretary of State

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Copy of response to comment included with filing.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

(If applicable, insert Regulatory Flexibility Addendum here)

The rules are not anticipated to have an effect on small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

The rules are not anticipated to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The rules replace Emergency Rules that allowed for changes to the Nursing Facility Level of Care requirements for entry into CHOICES, TennCare's program of long-term services and supports for individuals who are elderly or physically disabled. There are also other rules that are being updated.

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The rules are lawfully adopted by the Bureau of TennCare in accordance with §§ 4-5-202, 71-5-105 and 71-5-109.

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons and entities most directly affected by these Rules are the TennCare enrollees, providers and the managed care contractors. The governmental entity most directly affected by these Rules is the Bureau of TennCare, Tennessee Department of Finance and Administration.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The Rules were approved by the Tennessee Attorney General. No additional opinion was given or requested.

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars ($500,000), whichever is less;

The promulgation of these rules is anticipated to decrease state FY2013 expenditures by $17,930,000

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Darin J. Gordon
Director, Bureau of TennCare

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Darin J. Gordon
Director, Bureau of TennCare

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

310 Great Circle Road
Nashville, TN 37243
(615) 507-6443
Darin.J.Gordon@tn.gov

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

GW10212226redline

12-22-12

STATE OF TENNESSEE

Office of the Attorney General

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ATTORNEY GENERAL AND REPORTER

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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
PUBLICATIONS

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	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. 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. 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. 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. 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.	Yes	Yes
4. CBRA	Companion Care. 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.	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	Covered with a limit of 1 meal per day, per Member. 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.	No	Yes
6. Homemaker Services	*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. Not covered as a stand-alone benefit. Not covered for persons who do not require hands-on assistance with ADLs. 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.	*	*
7. In-Home Respite Care	Covered with a limit of 216 hours per calendar year, per Member. 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.	Yes	No
8. Inpatient Respite Care	Covered with a limit of 9 days per calendar year, per Member. PASRR approval not required. 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.	No	No

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
9. Minor Home Modifications	Covered with a limit of $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime. 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).	No	No
10. Personal Care Visits	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. 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.	Yes	Yes
11. PERS	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.	No	Yes
12. Pest Control	Covered with a limit of 9 treatment visits per calendar year, per Member. 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.	No	No
13. Short-Term NF Care	Covered with a limit of 90 days per stay, per Member. Approved PASRR required. Members receiving Short-Term NF Care are not eligible to receive any other HBCS except when permitted to facilitate transition to the community. See Rule 1200-13-01-.05(8)(h).	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	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. 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. 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. 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. 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.	Yes	N/A
4. Home-Delivered Meals	Covered with a limit of 1 meal per day, per Member. 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.	No	N/A

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
5. Homemaker Services	*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. Not covered as a stand-alone benefit. Not covered for persons who do not require hands-on assistance with ADLs. 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.	*	*
6. In-Home Respite Care	Covered with a limit of 216 hours per calendar year, per Member. 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.	Yes	N/A
7. Inpatient Respite Care	Covered with a limit of 9 days per calendar year, per Member. PASRR approval not required. NF LOC not required. 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.	No	N/A
8. Minor Home Modifications	Covered with a limit of $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime. 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).	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	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. 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.	Yes	N/A
10. PERS	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.	No	N/A
11. Pest Control	Covered with a limit of 9 treatment visits per calendar year, per Member. 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.	No	N/A
12. Short-Term NF Care	Covered with a limit of 90 days per stay, per Member. Approved PASRR required. Member must meet NF LOC. 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).	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:

(I) 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.