RULES
OF
TENNESSEE DEPARTMENT OF FINANCE
AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-01
TENNCARE LONG-TERM CARE PROGRAMS

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1200-13-01-.01 PURPOSE.

(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.

(2) The Bureau of TennCare (Bureau) offers the following LTSS programs and services. Each of these programs is operated in accordance with the authority granted under the Medicaid State Plan or the applicable Waiver authority granted by CMS, and these rules.

(a) TennCare CHOICES Program (CHOICES). (See Rule 1200-13-01-.05.) This program has two components:

1. NF services.

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

(b) Employment and Community First (ECF) CHOICES (See Rule 1200-13-01-.31.)

(c) Intermediate Care Facility services for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility services for the Mentally Retarded) (ICFs/MR). (See Rule 1200-13-01-.30.)

(d) HCBS waivers for individuals with MR.

(Rule 1200-13-01-.01, continued)

1. Statewide MR Waiver. (See Rule 1200-13-01-.25.)

2. Arlington MR Waiver. (See Rule 1200-13-01-.28.)

3. Self-Determination MR Waiver. (See Rule 1200-13-01-.29.)

(e) PACE. This is a program for certain dually eligible Medicare and Medicaid beneficiaries that is offered through the Tennessee Medicaid State Plan, Attachment 3.1-A, #26.

(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, 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, 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.

(4) Acronyms. The following are acronyms used throughout this Chapter and the terms they represent:

(a) AAAD – Area Agencies on Aging and Disability

(b) ACLF – Assisted Care Living Facility

(c) ADL – Activity of Daily Living

(d) CBRA – Community-Based Residential Alternative

(e) CD – Consumer Direction

(f) CEA – Cost Effective Alternative

(g) CMS – Centers for Medicare and Medicaid Services

(h) DBM – Dental Benefits Manager

(i) DD – Developmental Disability(ies)

(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)

(Rule 1200-13-01-.01, continued)

(l) ECF CHOICES – Employment and Community First CHOICES

(m) EVV – Electronic Visit Verification

(n) F&A – Tennessee Department of Finance and Administration

(o) FEA – Fiscal Employer Agent

(p) FERP – Federal Estate Recovery Program

(q) FFS – Fee-for-Service

(r) FPL – Federal Poverty Level

(s) HCBS – Home and Community Based Services

(t) HH – Home Health

(u) I/DD – Intellectual or Developmental Disability(ies)

(v) IADL – Instrumental Activity of Daily Living

(w) 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).

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

(y) LOC – Level of Care

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

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

(bb) MCC – Managed Care Contractor

(cc) MCO – Managed Care Organization

(dd) MI – Mental Illness

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

(ff) NF – Nursing Facility

(gg) OAA – Operational Administrative Agency

(hh) PACE – Program of All-Inclusive Care for the Elderly

(ii) PAE – PreAdmission Evaluation

(jj) PASRR – PreAdmission Screening and Resident Review

(kk) PBM – Pharmacy Benefits Manager

(ll) PCSP – Person-Centered Support Plan

(Rule 1200-13-01-.01, continued)

(mm) PDN – Private Duty Nursing

(nn) PERS – Personal Emergency Response System

(oo) POC – Plan of Care

(pp) PNA – Personal Needs Allowance

(qq) QIT – Qualifying Income Trust

(rr) QMRP – Qualified Mental Retardation Professional

(ss) SNF – Skilled Nursing Facility (as defined under Medicare)

(tt) SPOE – Single Point of Entry

(uu) SSI – Supplemental Security Income

(vv) SSI FBR – Supplemental Security Income Federal Benefit Rate

(ww) TCAD – Tennessee Commission on Aging and Disability

(xx) TPAES – TennCare Pre-Admission Evaluation System

(yy) TPL – Third Party Liability

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-109, Executive Order No. 11.* ***Administrative History:*** *Original rule filed September 10, 1975; effective October 10, 1975. Repealed and refiled July 13, 1977; effective August 12, 1977. Repealed and refiled November 17, 1977; effective December 19, 1977. Amendment filed August 31, 1981; effective October 15. 1981. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed February 9, 1987; effective April 9, 1987. Amendment filed May 30, 1989; effective July 14, 1989. Amendment filed November 28, 1990; effective January 12, 1991. Amendment filed February 22, 1991; effective April 9, 1991. Amendment filed September 16, 1991; effective October 31, 1991. Amendment filed September 19, 1991; effective November 3, 1991. Amendment filed January 10, 1992; effective February 24, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed October 20, 1999; effective January 3, 2000. Amendment filed June 29, 2000; effective September 12, 2000. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Amendments filed September 26, 2012; effective December 25, 2012. Amendment filed September 26, 2013; effective December 25, 2013. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.*

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;

(Rule 1200-13-01-.02, continued)

(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) Adult Dental Services. For purposes of ECF CHOICES only and limited to adults age 21 or older:

(a) Preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments to relieve pain and infection which have dental procedure codes listed in the current TennCare Maximum Reimbursement Rate Schedule for Dental Services that is used specifically for adult dental services provided under the State's Section 1915(c) Waivers for individuals with intellectual disabilities; and intravenous sedation or other anesthesia services provided in the dentist's office by, and billed by, the dentist or by a nurse anesthetist or anesthesiologist who meets the Waiver provider qualifications. Orthodontic services are excluded from coverage.

(b) Dental services for adults age 21 or older enrolled in the ECF CHOICES program shall be reimbursed only for dates of services when the ECF CHOICES Member was enrolled in ECF CHOICES at the time the service was delivered, and subject to the amount approved for such services in the ECF CHOICES Member's PCSP.

(c) All Dental Services for children enrolled in the Waiver are provided through the TennCare EPSDT program. Dental Services shall not be covered through ECF

(Rule 1200-13-01-.02, continued)

CHOICES for children under age 21 years enrolled in ECF CHOICES (since it would duplicate TennCare/EPSDT benefits).

(d) Adult Dental Services for adults age 21 or older enrolled in ECF CHOICES shall be limited to a maximum of $5,000 per member per calendar year, and a maximum of $7,500 per member across three (3) consecutive calendar years.

(5) Aging Caregiver. Pursuant to T.C.A § 33-5-112 as amended, the older custodial parent or custodial caregiver of an individual who has an intellectual disability and who is at least 75 years of age. A Potential Applicant for ECF CHOICES who has an Aging Caregiver shall, subject to all applicable eligibility and enrollment criteria, be enrolled into ECF CHOICES Group 5, unless the Applicant qualifies and elects to enroll in an available ECF CHOICES Group 4 slot, or cannot be safely served in ECF CHOICES Group 5 and meets eligibility criteria, including NF LOC, to enroll in an available ECF CHOICES Group 6 slot. Reserve capacity shall be established in ECF CHOICES Group 5 based on the number of persons with an intellectual disability who have an Aging Caregiver that are expected to be served in each program year.

(6) 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 TennCare. An Applicant is entitled to a determination regarding his or her eligibility to enroll in the program for which the PAE has been submitted, and to due process, including notice and the right to request a fair hearing, if the application is denied. 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 NF "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.

(7) 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.

(8) 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.).

(9) 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.

(10) Assistive Technology.

(a) For purposes of CHOICES:

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.

(Rule 1200-13-01-.02, continued)

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.

(b) For purposes of ECF CHOICES:

An item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities and to support the individual’s increased independence in the home, community living and participation, and individualized integrated employment or self-employment. The service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required by the person to increase, maintain or improve his/her functional capacity to perform daily tasks in the community and in employment that would not be possible otherwise. All items must meet applicable standards of manufacture, design and installation. The person-centered support plan must include strategies for training the individual and any others who the individual will or may rely on in effectively using the assistive technology or adaptive equipment (e.g. his/her support staff; co-workers and supervisors in the place of employment; natural supports).

1. Assistive Technology Equipment and Supplies also covers the following:

(i) Evaluation and assessment of the assistive technology and adaptive equipment needs of the individual by an appropriate professional, including a functional evaluation of the impact of the provision of appropriate assistive technology and adaptive equipment through equipment trials and appropriate services to him/her in all environments with which the person interacts over the course of any 24 hour day, including the home, integrated employment setting(s) and community integration locations;

(ii) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, updating, repairing, or replacing assistive technology devices and adaptive equipment;

(iii) Adaptive equipment to enable the individual to feed him/herself and/or complete oral hygiene as indicated while at home, work or in the community (e.g. utensils, gripping aid for utensils, adjustable universal utensil cuff, utensil holder, scooper trays, cups, bowls, plates, plate guards, non-skid pads for plates/bowls, wheelchair cup holders, adaptive cups that are specifically designed to allow a person to feed him/herself or for someone to safely assist a person to eat and drink, and adaptive toothbrushes);

(iv) Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the person-centered support plan;

(v) Training, programming, demonstrations or technical assistance for the individual and for his/her providers of support (whether paid or unpaid) to facilitate the person’s use of the assistive technology and adaptive equipment;

(vi) Adaptive switches and attachments;

(vii) Adaptive toileting equipment;

(Rule 1200-13-01-.02, continued)

(viii) Communication devices and aids that enable the person to perceive, control or communicate with the environment, including a variety of devices for augmentative communication;

(ix) Assistive devices for persons with hearing and vision loss (e.g. assistive listening devices, TDD, large visual display services, Braille screen communicators, FM systems, volume control telephones, large print telephones and teletouch systems and long white canes with appropriate tips to identify footpath information for people with visual impairment;

(x) Computer equipment, adaptive peripherals and adaptive workstations to accommodate active participation in the workplace and in the community;

(xi) Software also is approved when required to operate accessories included for environmental control;

(xii) Pre-paid, pre-programmed cellular phones that allow an individual who is participating in employment or community integration activities without paid or natural supports and who may need assistance due to an accident, injury or inability to find the way home. The person's PCSP outlines a protocol that is followed if the individual has an urgent need to request help while in the community;

(xiii) Such other durable and non-durable medical equipment not available under the State Plan that is necessary to address functional limitations in the community, in the workplace, and in the home;

(xiv) Repair of equipment is covered for items purchased through this Waiver or purchased prior to Waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The individual must own any piece of equipment that is repaired.

2. A written recommendation by an appropriate professional must be obtained to ensure that the equipment will meet the needs of the person. The recommendation of the Job Accommodation Networks (JAN) will meet this requirement for worksite technology. Depending upon the financial size of the employer or the public entity, those settings may be required to provide some of these items as part of their legal obligations under Title I or Title III of the ADA. Federal financial participation is not claimed for accommodations that are the legal responsibility of an employer or public entity, pursuant to Title I or Title III of the ADA.

3. ECF CHOICES will not cover Assistive Technology or Adaptive Equipment and services which are otherwise available to the individual under Section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. §§ 1401, et seq.). If this service is authorized, documentation is maintained that the service is not available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. §§ 1401, et seq.).

4. Assistive Technology, Adaptive Equipment and Supplies shall be limited to $5,000 per person per calendar year.

(11) At Risk for Institutionalization.

(a) For purposes of CHOICES.

(Rule 1200-13-01-.02, continued)

1. 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.

2. As it relates to CHOICES Group 3, includes only SSI eligible adults age sixty-five (65) or older or age twenty-one (21) or older with physical disabilities. As it relates to Interim CHOICES Group 3, open for enrollment only between July 1, 2012 and June 30, 2015, includes only adults age sixty-five (65) or older or age twenty-one (21) or older with physical disabilities who receive SSI or meet Nursing Facility Financial eligibility criteria.

(b) For purposes of ECF CHOICES:

The minimum medical eligibility (i.e., level of care) requirement to enroll in ECF CHOICES Group 4 or 5, whereby an Applicant does not meet NF LOC criteria, but has an intellectual or developmental disability as defined under T.C.A. § 33-1-101, as amended, including for an Applicant with ID, limitations in two (2) or more adaptive skill areas (i.e., communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work); and for an Applicant age five (5) or older with DD, substantial functional limitations in three (3) or more major life activities (i.e., self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency); such that, in the absence of the provision of a moderate level of ECF CHOICES 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.

(12) 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.

(Rule 1200-13-01-.02, continued)

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.

(13) Back-up Plan. A written plan that is a required component of the plan of care for all CHOICES members receiving companion care or the plan of care or person-centered support plan, as appropriate, for CHOICES or ECF CHOICES members receiving non-residential CHOICES or ECF CHOICES HCBS in their own homes and which specifies unpaid persons as well as paid consumer-directed workers and/or contract providers (as applicable) who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care or support in situations when regularly scheduled CHOICES or ECF CHOICES HCBS providers or workers are unavailable or do not arrive as scheduled. A CHOICES or ECF CHOICES member or his/her representative may not elect, as part of the back-up plan, to go without services. 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/her representative (as applicable) shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services. The FEA will assist as needed with the development and verification of the initial back-up plan for consumer direction. The care coordinator or support coordinator shall be responsible for

(Rule 1200-13-01-.02, continued)

assistance as needed with implementing the back-up plan and for updating and verifying the back-up plan on an ongoing basis.

(14) 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.

(15) Benefits Counseling. For purposes of ECF CHOICES only and limited to persons age 16 or older:

(a) A service designed to inform the individual (and guardian, conservator and/or family, if applicable) of the multiple pathways to ensuring individualized integrated employment or self-employment that results in increased economic self-sufficiency (net financial benefit) through the use of various work incentives. This service should also repudiate myths and alleviate fears and concerns related to seeking and working in individualized integrated employment or self-employment through an accurate, individualized assessment. The service provides information to the individual (and guardian, conservator and/or family, if applicable) regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, ECF, housing subsidies, food stamps, etc.

(b) The service also will provide information and education to the person (and guardian, conservator and/or family, if applicable) regarding income reporting requirements for public benefit programs, including the Social Security Administration.

(c) Benefits counseling provides work incentives counseling and planning services to persons actively considering or seeking individualized integrated employment or self-employment, or career advancement in either of these types of employment.

(d) This service is provided by a certified Community Work Incentives Coordinator (CWIC). In addition to ensuring this service is not otherwise available to the individual under Section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. §§ 1401, et seq.), ECF CHOICES may not fund this service if CWIC Benefits Counseling services funded through the Federal Work Incentives Planning and Assistance (WIPA) program are available to the individual.

(e) Service must be provided in a manner that supports the person's communication style and needs, including, but not limited to, age appropriate communications, translation/interpretation services for persons of limited English-proficiency or who have other communication needs requiring translation including sign language interpretation, and ability to communicate with a person who uses an assistive communication device.

(f) Benefits Counseling services are paid for on an hourly basis and limited in the following ways:

1. Initial Benefits Counseling for someone actively considering or seeking individualized integrated employment or self-employment, or career advancement in these types of employment: up to twenty (20) hours. This service may be authorized no more than once every two (2) years (with a minimum of two 365-day intervals between services).

2. Supplementary Benefits Counseling for someone evaluating an individualized integrated job offer/promotion or self-employment opportunity: up to an additional six (6) hours. This service may be authorized up to three (3) times per year if needed.

(Rule 1200-13-01-.02, continued)

3. PRN Problem-Solving services for someone to maintain individualized integrated employment or self-employment: up to eight (8) hours per situation requiring PRN assistance. This service may be authorized up to four (4) times per year if necessary for the individual to maintain individualized integrated employment or self-employment.

(16) 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.

(17) 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.

(18) Career Advancement. For purposes of ECF CHOICES only and limited to persons age 16 or older:

(a) This is a time-limited career planning and advancement support service for persons currently engaged in individualized integrated employment or self-employment who wish to obtain a promotion and/or a second individualized integrated employment or self-employment opportunity. The service is time-limited and focuses on developing and successfully implementing a plan for achieving increased income and economic self-sufficiency through promotion to a higher paying position or through a second individualized integrated employment or self-employment opportunity.

(b) The outcomes of this service are:

1. The identification of the person's specific career advancement objective;

2. Development of a viable plan to achieve this objective; and

3. Implementation of the plan which results in the person successfully achieving his/her specific career advancement objective.

(c) Career Advancement is paid on an outcome basis, after key milestones are accomplished:

1. Outcome payment number one is paid after the written plan to achieve the person's specific career advancement objective is reviewed and approved. Note: The written plan must follow the template prescribed by TennCare.

(Rule 1200-13-01-.02, continued)

2. Outcome payment number two is paid after the person has achieved his/her specific career advancement objective and has been in the new position or second job for a minimum of two (2) weeks.

(d) This service may not be included on a Person-Centered Support Plan if the PCSP also includes any of the following services: Integrated Employment Path Services, Exploration, Discovery, Situational Observation and Assessment, Job Development or Self-Employment Plan, or Job Development or Self-Employment Start-Up. This service may not be authorized retroactive to a promotion or second job being made available to a person. Supports for Career Advancement may be authorized and paid once every three (3) years (with a minimum of three 365-day intervals between services), if evidence exists that the individual is eligible for promotion or able to present as a strong candidate for employment in a second job (e.g. has strong reference, performance reviews and attendance record from current employer). The only exception is in situations where the provider previously authorized and paid for outcome payment number one but did not also earn outcome payment number two (because they did not successfully obtain a promotion or second job for the person). In this situation, reauthorization for outcome payments number one and two may occur a maximum of once per year (with a minimum 365-day interval between services), so long as the reauthorization involves the use of a new/different provider.

(19) Caregiver. For purposes of CHOICES or ECF CHOICES, a person who:

(a) Is a family member or is unrelated to the member but has a close, personal relationship with the member; and

(b) Is routinely involved in providing unpaid support and assistance to the member.

(c) A person who satisfies the criteria for caregiver in (a) and (b) above may also be designated by the member as a representative for CHOICES or ECF CHOICES or for consumer direction of eligible CHOICES or ECF CHOICES HCBS.

(20) 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.

(21) 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.

(Rule 1200-13-01-.02, continued)

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

(23) 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.

(24) 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.

(25) 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 June 30, 2015, may continue to qualify in this group after June 30, 2015, 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.

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

(27) 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.

(28) 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.

(29) CHOICES Home and Community-Based Services (HCBS). Services that are available only to eligible persons enrolled in CHOICES Group 2 or 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 certain CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not

(Rule 1200-13-01-.02, continued)

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 Group 2 member's needs can be safely met in the community within his or her individual cost neutrality cap.

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

(31) 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).

(32) Community-Based Residential Alternatives (CBRA) to institutional care. For purposes of CHOICES and ECF 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 for individuals with I/DD.

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

1. Services provided in a licensed facility such as an ACLF or Critical Adult Care Home, and residential services provided in a licensed home or in the person's home by an appropriately licensed provider such as Community Living Supports and Community Living Supports-Family Model; and

2. Companion Care.

(33) Community Integration Support Services. For purposes of ECF CHOICES only:

(a) Services which coordinate and provide supports for valued and active participation in integrated daytime and nighttime activities that build on the person's interests, preferences, gifts, and strengths while reflecting the person's goals with regard to community involvement and membership. This service involves participation in one or more integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers. Community Integration Support Services are designed to promote maximum participation in integrated community life while facilitating meaningful relationships, friendships and social networks with persons without disabilities who share similar interests and goals for community involvement and participation.

(b) Community Integration Support Services shall support and enhance, rather than supplant, an individual's involvement in public education, post-secondary education/training and individualized integrated employment or self-employment (or services designed to lead to these types of employment).

(c) Community Integration Support Services enable the person to increase or maintain his/her capacity for independent participation in community life and to develop age-appropriate social roles valued by the community by learning, practicing and applying skills necessary for full inclusion in the person's community, including skills in arranging and using public transportation for individuals aged 16 or older.

(d) Community Integration Support Services provide assistance for active and positive participation in a broad range of integrated community settings that allow the person to engage with people who do not have disabilities who are not paid or unpaid caregivers.

(Rule 1200-13-01-.02, continued)

The service is expected to result in the person developing and sustaining a range of valued, age-appropriate social roles and relationships; building natural supports; increasing independence; and experiencing meaningful community integration and inclusion. Activities are expected to increase the individual's opportunity to build connections within his/her local community and include (but are not limited to) the following:

1. Supports to participate in age-appropriate community activities, groups, associations or clubs to develop social networks with community organizations and clubs;

2. Supports to participate in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness (e.g. yoga class, walking group, etc.);

3. Supports to participate in adult education and postsecondary education classes;

4. Supports to participate in formal/informal associations or community/neighborhood groups;

5. Supports to participate in volunteer opportunities;

6. Supports to participate in opportunities focused on training and education for self-determination and self-advocacy;

7. Supports for learning to navigate the local community, including learning to use public transportation and/or private transportation available in the local area; and

8. Supports to maintain relationships with members of the broader community (e.g., neighbors, co-workers and other community members who do not have disabilities and who are not paid or unpaid caregivers) through natural opportunities and invitations that may occur.

(e) This service includes a combination of training and supports as needed by the individual. The Community Integration Support Services provider shall be responsible for any personal assistance needs during the hours that Community Integration Support Services are provided; however, the personal assistance services may not comprise the entirety of the Community Integration Support Service. All providers of personal care under Community Integration Support Services meet the Personal Assistance provider qualifications.

(f) This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve his or her personally identified goals for community integration, involvement, exploration and for developing and sustaining a network of positive natural supports. All settings where Community Integration Support Services are provided must be non-disability specific and meet all federal standards for HCBS settings. This service is provided separate and apart from the person's place of residence. This service does not take place in licensed facilities, sheltered workshops or any type of facility owned, leased or operated by a provider of this service.

(g) This service is available only:

1. For children not yet old enough to work and/or not yet eligible for employment services who are enrolled in Essential Family Supports; or

(Rule 1200-13-01-.02, continued)

2. As “wrap-around” supports to employment or employment services (Supported Employment Individual or Small Group services and/or Integrated Employment Path Services) for individuals not receiving Community Living Supports or Community Living Supports-Family Model; or

3. For individuals who are of legal working age (16+) not receiving Community Living Supports or Community Living Supports-Family Model who, after an Employment Informed Choice Process as defined by TennCare, have decided not to pursue employment; or

4. For individuals of retirement age not receiving Community Living Supports or Community Living Supports-Family Model who have made a choice not to pursue further employment opportunities.

(h) For individuals receiving Community Integration Support Services who are of legal working age (16+), and not participating in employment or employment services, the option to pursue employment should be discussed at least semi-annually, unless the person is age 65 or older and has declined further interest in employment.

(i) For individuals receiving Community Living Supports or Community Living Supports-Family Model, all services necessary to support community integration and participation are part of the scope of benefits provided under the CLS or CLS-FM benefit and shall not be authorized, provided or reimbursed as a separate service.

(j) For individuals of appropriate age (18+), fading of the service and less dependence on paid support for ongoing participation in community activities and relationships is expected. Fading strategies, similar to those used in Supported Employment Job Coaching, should be utilized. Milestones for the reduction/fading of paid supports and the enhancement of natural supports must be established and monitored for this service.

(k) Payment for registration, materials and supplies for participation in classes, conferences and similar types of activities, or club/association dues can be covered, but cannot exceed $500 per year for children under age 21 or $1,000 per year for adults age 21 or older. These costs are not included in the rates paid to the providers of Community Integration Support Services and must be prior approved before being incurred.

(l) Transportation to and from the service is not included in the rate paid for the service; but transportation during the service (when no-cost forms of transportation are not available or not being accessed) is included in the rate paid for the service.

(m) Community Integration Support Services shall be limited as follows:

1. For persons not working in Individualized Integrated Employment, Individualized Integrated Self-Employment, or Small Group Employment in the community or receiving at least one employment service, no more than 20 hours per week of Community Integration Support Services and Independent Living Skills Training combined after completing an Employment Informed Choice process.

2. For persons who are working in Individualized Integrated Employment, Individualized Integrated Self-Employment, or Small Group Employment in the community (not a sheltered workshop) or receiving at least one employment service, no more than 30 hours per week of Community Integration Support Services, Independent Living Skills Training, and Individual or Small Group Employment Supports combined.

3. For persons who are working in Individualized Integrated Employment or Individualized Integrated Self-Employment (not in a small group or in a sheltered workshop), no more than 40 hours per week of Community Integration Support Services, Independent Living Skills Training, Job Coaching, Co-Worker Supports, and the hours worked without paid supports combined.

4. For persons who are working in Individualized Integrated Employment or Individualized Integrated Self-Employment (not in a small group or in a sheltered workshop) at least 30 hours per week, no more than 50 hours per week of Community Integration Support Services, Independent Living Skills Training, Job Coaching, Co-Worker Supports, and the hours worked without paid supports combined.

(34) Community Living Supports (CLS). For the purposes of CHOICES and ECF CHOICES, this service is available only to CHOICES Group 2 and 3 Members and ECF CHOICES Group 5 and 6 Members as appropriate:

(a) A CBRA licensed by the DIDD in accordance with T.C.A. Title 33 and TDMHSAS Rules 0940-05-24, 0940-05-28 or 0940-05-32, as applicable, that encompasses a continuum of residential support options for up to four individuals living in a home that:

1. Supports each resident's independence and full integration into the community;

2. Ensures each resident's choice and rights; and

3. Comports fully with standards applicable to HCBS settings detailed in 42 C.F.R. § 441.301(c)(4) and (5), including those requirements applicable to provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need and set forth in the person-centered plan of care.

(b) CLS services are individualized based on the needs of each resident and specified in the person-centered plan of care. Services may include hands-on assistance, supervision, transportation, and other supports intended to help the individual exercise choices such as:

1. Selecting and moving into a home.

2. Locating and choosing suitable housemates.

3. Acquiring and maintaining household furnishings.

4. Acquiring, retaining, or improving skills needed for activities of daily living or assistance with activities of daily living as needed, such as bathing, dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility.

5. Acquiring, retaining, or improving skills needed for instrumental activities of daily living or assistance with instrumental activities of daily living as needed, such as household chores, meal planning, shopping, preparation and storage of food, and managing personal finances.

6. Building and maintaining interpersonal relationships with family and friends.

7. Pursuing educational goals and employment opportunities.

(Rule 1200-13-01-.02, continued)

8. Participating fully in community life, including faith-based, social, and leisure activities selected by the individual.

9. Scheduling and attending appropriate medical services.

10. Self-administering medications, including assistance with administration of medications as permitted pursuant to T.C.A. §§ 68-1-904 and 71-5-1414.

11. Managing acute or chronic health conditions, including nurse oversight and monitoring, and skilled nursing services as needed for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.

12. Becoming aware of, and effectively using, transportation, police, fire, and emergency help available in the community to the general public.

13. Asserting civil and statutory rights through self-advocacy.

(35) Community Living Supports Family Model (CLS-FM). For the purposes of CHOICES and ECF CHOICES, this service is available to CHOICES Group 2 and 3 Members and ECF CHOICES Group 5 and Group 6 Members as appropriate:

(a) A CBRA licensed by the DIDD in accordance with T.C.A. Title 33 and TDMHSAS Rule 0940-05-26 that encompasses a continuum of residential support options for up to three individuals living in the home oftrained family caregivers (other than the individual's own family) in an "adult foster care" arrangement. In this type of shared living arrangement, the provider allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and a family and provide the individualized services that:

1. Support each resident's independence and full integration into the community;

2. Ensure each resident's choice and rights; and

3. Support each resident in a manner that comports fully with standards applicable to HCBS settings detailed in 42 C.F.R. § 441.301(c)(4)-(5), including those requirements applicable to provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need and set forth in the person-centered plan of care.

(b) CLS-FM services are individualized based on the needs of each resident and specified in the person-centered plan of care. Services may include hands-on assistance, supervision, transportation, and other supports intended to help the individual exercise choices such as:

1. Selecting and moving into a home.

2. Locating and choosing suitable housemates.

3. Acquiring and maintaining household furnishings.

(Rule 1200-13-01-.02, continued)

4. Acquiring, retaining, or improving skills needed for activities of daily living or assistance with activities of daily living as needed, such as bathing, dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility.

5. Acquiring, retaining, or improving skills needed for instrumental activities of daily living or assistance with instrumental activities of daily living as needed, such as household chores, meal planning, shopping, preparation and storage of food, and managing personal finances.

6. Building and maintaining interpersonal relationships with family and friends.

7. Pursuing educational goals and employment opportunities.

8. Participating fully in community life, including faith-based, social, and leisure activities selected by the individual.

9. Scheduling and attending appropriate medical services.

10. Self-administering medications, including assistance with administration of medications as permitted pursuant to T.C.A. §§ 68-1-904 and 71-5-1414.

11. Managing acute or chronic health conditions, including nurse oversight and monitoring, and skilled nursing services as needed for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.

12. Becoming aware of, and effectively using, transportation, police, fire, and emergency help available in the community to the general public.

13. Asserting civil and statutory rights through self-advocacy.

(36) Community Personal Needs Allowance. See “Personal Needs Allowance (PNA).”

(37) Community Support Development, Organization and Navigation. For purposes of ECF CHOICES only and limited to members enrolled in ECF CHOICES Group 4 (Essential Family Supports):

(a) Assists individuals and families in:

1. Promoting a spirit of personal reliance and contribution, mutual support and community connection;

2. Developing social networks and connections within local communities; and

3. Emphasizing, promoting and coordinating the use of unpaid supports to address individual and family needs in addition to paid services.

(b) Supports provided include:

1. Helping individuals and family caregivers to develop a network for information and mutual support from others who receive services or family caregivers of individuals with disabilities;

(Rule 1200-13-01-.02, continued)

2. Assisting individuals with disabilities and family caregivers with identifying and utilizing supports available from community service organizations, such as churches, schools, colleges, libraries, neighborhood associations, clubs, recreational entities, businesses and community organizations focused on exchange of services (e.g. time banks); and

3. Assisting individuals with disabilities and family caregivers with providing mutual support to one another (through service/support exchange), and contributions offered to others in the community.

(c) These services are provided by a Community Navigator and reimbursed on a per person (or family) per month basis, based on specific goals and objectives as specified in the person-centered support plan.

(38) Community Transportation. For purposes of ECF CHOICES only:

(a) Community Transportation services are non-medical transportation services offered in order to enable individuals, and their personal assistants as needed, to gain access to employment, community life, activities and resources that are identified in the person-centered support plan. These services allow individuals to get to and from typical day-to-day, non-medical activities such as individualized integrated employment or self-employment (if not home-based), the grocery store or bank, social events, clubs and associations and other civic activities, or attending a worship service. This service is made available when public or other no-cost community-based transportation services are not available and the person does not have access to transportation through any other means (including natural supports).

(b) Whenever possible, family, neighbors, co-workers, carpools or friends are utilized to provide transportation assistance without charge. When this service is authorized, the most cost-effective option should be considered first. This service is in addition to the medical transportation service offered under the Medicaid State Plan, which includes transportation to medical appointments as well as emergency medical transportation.

(c) Community Transportation shall be limited to no more than $225 per month for persons electing to receive this service through Consumer Direction.

(39) 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.

(40) 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.

(41) Conservatorship and Alternatives to Conservatorship Counseling and Assistance. For purposes of ECF CHOICES only:

(a) This service offers up to $500 in one-time consultation, education and assistance to family caregivers in understanding conservatorship and alternatives to conservatorship. These services shall be provided in a manner that seeks to preserve the rights and freedoms of the individual to the maximum extent possible and appropriate. This service may include assistance with completing necessary paperwork and processes to establish an alternative to conservatorship or conservatorship, if appropriate. Reimbursable services may include payment of legal or court fees necessary to formalize an alternative to conservatorship or conservatorship, but only upon completion of education and consultation to help preserve the person's rights and freedoms to the maximum extent possible and appropriate.

(b) Conservatorship and Alternatives to Conservatorship Counseling and Assistance shall be limited to $500 per lifetime.

(42) Consumer. Except when used regarding consumer direction of eligible CHOICES or ECF CHOICES HCBS, an individual who uses a mental health or substance abuse service.

(43) Consumer-Directed Worker (Worker). An individual who has been hired by a CHOICES or ECF CHOICES member participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS or his/her representative to provide one or more eligible CHOICES or ECF CHOICES HCBS to the member. Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the member.

(44) Consumer Direction of Eligible CHOICES or ECF CHOICES HCBS. The opportunity for a CHOICES or ECF CHOICES member assessed to need specified types of CHOICES or ECF CHOICES HCBS including for purposes of CHOICES, attendant care, personal care, in-home respite, companion care; and for purposes of ECF CHOICES, personal assistance, supportive home care, hourly respite, and community transportation; and/or any other service specified in TennCare rules as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s) and for ECF CHOICES, the delivery of each eligible ECF CHOICES HCBS within the authorized budget for that service.

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

(46) 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:

(Rule 1200-13-01-.02, continued)

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.

(e) For purposes of ECF CHOICES, CEA services may include the provision of ECF CHOICES HCBS as an alternative to NF care when the Enrollment Target for the benefit group in which the Member will be enrolled has been reached as described in Rule 1200-13-01-.31.

(47) 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.

(48) Co-Worker Supports. For purposes of ECF CHOICES only and limited to persons age 16 or older:

(a) This service involves a provider of Job Coaching for Individualized Integrated Employment entering into an agreement with an individual's employer to reimburse the employer for supports provided by one or more supervisors and/or co-workers, acceptable to the individual, to enable the person to maintain individualized integrated employment with the employer. This service cannot include payment for the supervisory and co-worker supports rendered as a normal part of the business setting and that would otherwise be provided to an employee without a disability. Additional natural supports for the individual, already negotiated with the employer, and provided through supervisors and co-workers, are not eligible for reimbursement under Co-Worker Supports. Only supports that must otherwise be provided by a Job Coach may be reimbursed under this service category. Co-Worker Supports would be authorized in situations where any of the following is true:

1. From the start of employment or at any point during employment, if the employer prefers (or the individual prefers and the employer agrees) to provide needed Job Coach supports, rather than having a Job Coach, either employed by a third party agency or self-employed, present in the business. Fading expectations should still be in place to maximize independence of the employed individual.

2. At any point in the individual's employment where needed Job Coaching supports can be most cost effectively provided by Co-Worker Supports and both the employer and individual agree to the use of Co-Worker Supports. Fading of Job Coaching supports may or may not still be occurring, but Co-Worker Supports should always be considered when ongoing fading of Job Coaching has stopped occurring.

(Rule 1200-13-01-.02, continued)

3. For individuals who are expected to be able to transition to working only with employer supports available to any employee and additional negotiated natural supports if applicable. In this situation, Co-Worker Supports are authorized as a temporary (maximum twelve months) bridge to relying only on employer supports, and additional negotiated natural (unpaid) supports if applicable, to maintain employment. The supervisor(s) and/or co-worker(s) identified to provide the support to the individual must meet the qualifications for a legally responsible individual as provider of this service. The provider is responsible for ensuring these qualifications are met and also for oversight and monitoring of paid co-worker supports.

(b) The amount of time authorized for this service is negotiated with the employer and reflective of the specific needs the individual has for Co-Worker Supports above and beyond negotiated natural supports and supervisory/co-worker supports otherwise available to employees without disabilities. A 10% add-on to the 15 minute unit rate for the employer is applied to cover the service provider's role in administering Co-Worker Supports.

(c) Co-Worker Supports shall be limited as follows:

1. For persons who are working in Individualized Integrated Employment or Individualized Integrated Self-Employment (not in a small group or in a sheltered workshop), no more than 40 hours per week of Co-Worker Supports, Job Coaching, Community Integration Support Services, Independent Living Skills Training, and the hours worked without paid supports combined.

2. For persons who are working in Individualized Integrated Employment or Individualized Integrated Self-Employment (not in a small group or in a sheltered workshop) at least 30 hours per week, no more than 50 hours per week of Co-Worker Supports, Job Coaching, Community Integration Support Services, Independent Living Skills Training, and the hours worked without paid supports combined.

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

(50) Department of Intellectual and Developmental Disabilities (DIDD). The State entity contracted by TennCare to serve as the OAA for day-to-day operation of Section 1915(c) HCBS Waivers for persons with ID. Formerly known as the Division of Intellectual Disabilities Services (DIDS), DIDD is responsible for the performance of contracted functions for ECF CHOICES as specified in an interagency agreement.

(51) 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.

(52) Developmental Disability(ies) (DD).

(a) Pursuant to T.C.A § 33-1-101, as amended, a developmental disability in a person over five (5) years of age means a condition that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;

2. Manifested before twenty-two (22) years of age;

3 Is likely to continue indefinitely;

(Rule 1200-13-01-.02, continued)

4. Results in substantial functional limitations in three (3) or more of the following major life activities:

(i) Self-care;

(ii) Receptive and expressive language;

(iii) Learning;

(iv) Mobility;

(v) Self-direction;

(vi) Capacity for independent living; or

(vii) Economic self-sufficiency; and

5. Reflects the person's need for a combination and sequence of special interdisciplinary or generic services, supports, or other assistance that is likely to continue indefinitely and need to be individually planned and coordinated.

(b) Developmental disability in a person up to five (5) years of age means a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disability as defined for persons over five (5) years of age if services and supports are not provided.

(c) For purposes of ECF CHOICES, the determination that an Applicant has substantial functional limitations in three (3) or more major life activities shall be made by TennCare using an adaptive behavior (or life skills) assessment tool, and review of supporting medical evidence. Information gathered through such adaptive behavior (or life skills) assessment may be used by an Applicant for purposes of supporting functional deficits described in 1200-13-01-.10, or an Individual Acuity Score or an Applicant's total score on the NF LOC Acuity Scale, in accordance with criteria specified in Rule 1200-13-01-.10.

(53) Discovery. For purposes of ECF CHOICES only and limited to persons age 14 or older:

(a) This is a time-limited and targeted service for an individual who wishes to pursue individualized integrated employment or self-employment but for whom more information is needed to determine the following prior to pursuing individualized integrated employment or self-employment:

1. Strongest interests toward one or more specific aspects of the labor market;

2. Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment;

3. Conditions necessary for successful employment or self-employment.

(b) Discovery involves a comprehensive analysis of the person in relation to Parts 1., 2., and 3. above. Activities include observation of the person in familiar places and activities, interviews with family, friends and others who know the person well, observation of the person in an unfamiliar place and activity, and identification of the person's strong interests and existing strengths and skills that are transferable to individualized integrated employment or self-employment. Discovery also involves identification of conditions for success based on experience shared by the person and

(Rule 1200-13-01-.02, continued)

others who know the person well, and observation of the person during the Discovery process. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized integrated employment or self-employment.

(c) Discovery results in the production of a detailed written Profile, using a standard template prescribed by TennCare, which summarizes the process, learning and recommendations to inform identification of the person's individualized integrated employment or self-employment goal(s) and strategies to be used in securing this employment or self-employment for the person.

(d) If Discovery is paid for through ECF CHOICES, the person should be assisted to apply to Vocational Rehabilitation (VR) for services to obtain individualized integrated employment or self-employment.

(e) The Discovery Profile should be shared with VR staff to facilitate the expeditious development of an Individual Plan for Employment (IPE).

(f) Discovery shall be limited to no more than ninety (90) calendar days from the date of service initiation. This service is expected, on average, to involve fifty (50) hours of service.

(g) The provider shall document each date of service, the activities performed that day, and the duration of each activity. The written Profile is due no later than fourteen (14) days after the last date of service is concluded. Discovery is paid on an outcome basis, after the written Profile is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

(h) After an individual has received the service for the first time, re-authorization may occur a maximum of once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within twelve (12) months.

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

(55) ECF CHOICES 217-Like Group. Individuals with I/DD of all ages who meet the NF LOC criteria who need and are receiving HCBS, and who would be eligible in the same manner as specified under 42 C.F.R. § 435.217, 42 C.F.R. § 435.726, and Section 1902(a) of the Social Security Act, if the HCBS were provided under a Section 1915(c) Waiver. Enrollment in this group shall be subject to the enrollment targets established for each applicable ECF CHOICES benefit group. An Applicant may qualify in the ECF CHOICES 217-Like Group only when there is an available slot for enrollment into an ECF CHOICES benefit group for which the Applicant meets all eligibility and enrollment criteria, including prioritization criteria for enrollment into ECF CHOICES as established in these Rules, and when the Applicant upon approval of financial eligibility, will be enrolled by TennCare into such ECF CHOICES group.

(56) ECF CHOICES Group (Group). One of the three groups of TennCare enrollees who are enrolled in ECF CHOICES, and for which a particular package of ECF CHOICES HCBS benefits and limitations pertaining thereto is available. All groups in ECF CHOICES receive services in the community. These Groups are:

(Rule 1200-13-01-.02, continued)

(a) Group 4 (Essential Family Supports). Children under age twenty one (21) with I/DD living at home with family who meet the NF LOC and need and are receiving HCBS as an alternative to NF Care, or who, in the absence of HCBS, are "At Risk for Institutionalization," as defined in these rules, and adults age 21 or older with I/DD living at home with family who meet the NF LOC and need and are receiving HCBS as an alternative to NF care, or who, in the absence of HCBS, are "At Risk for Institutionalization," as defined in these rules, and elect to be in this group. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Group, Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups. "Family" shall be interpreted to mean individual(s) to whom the child or adult with I/DD is legally related, whether the relationship is by blood, by marriage, or by adoption. "Family" shall not include a foster care or paid living arrangement.

(b) Group 5 (Essential Supports for Employment and Independent Living). Adults age twenty-one (21) or older with I/DD who do not meet nursing facility level of care, but who, in the absence of HCBS are "At Risk for Institutionalization," as defined in these rules. To qualify in this group, the adult must be SSI eligible or qualify in the Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

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

(57) ECF CHOICES Home and Community-Based Services (HCBS). Services that are available only to eligible persons enrolled in ECF CHOICES Groups 4, 5 or 6 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only certain ECF CHOICES HCBS are eligible for Consumer Direction. ECF 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, for members enrolled in ECF CHOICES Group 6 who are granted an exception to the expenditure cap based on exceptional medical and/or behavioral needs, be counted for purposes of determining whether an ECF CHOICES member's needs can be safely met in the community within his or her individual expenditure cap.

(58) ECF CHOICES Member. A member who has been enrolled by TennCare into ECF CHOICES.

(59) ECF CHOICES Referral List. The listing of Potential Applicants that have completed a screening process to express their interest in applying for enrollment into the ECF CHOICES program.

(60) Electronic Visit Verification (EVV) System. An electronic system into which provider staff and consumer-directed workers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of specified CHOICES and ECF CHOICES HCBS and which may also be utilized for submission of claims.

(61) Eligible. Any person certified by TennCare as eligible to receive services and benefits under the TennCare program. As it relates to CHOICES and ECF CHOICES a person is eligible to

(Rule 1200-13-01-.02, continued)

receive CHOICES or ECF CHOICES benefits only if he/she has been enrolled in CHOICES or ECF CHOICES by TennCare.

(62) 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.

(63) Eligible ECF CHOICES HCBS. Personal assistance, supportive home care, hourly respite, community transportation, and/or any other ECF CHOICES HCBS specified in TennCare rules as eligible for consumer direction which an ECF CHOICES member is determined to need and elects to direct and manage (or 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) and the delivery of each eligible ECF CHOICES HCBS within the authorized budget for that service. Eligible ECF CHOICES HCBS do not include home health or private duty nursing services.

(64) Emergent Circumstances. For purposes of reserve capacity in ECF CHOICES, a limited number of individuals who meet one or more emergent circumstances criteria as specified in these Rules and for which enrollment into ECF CHOICES is the most appropriate way to provide needed supports, as determined by an Interagency Review Committee, including both TennCare and DIDD.

(65) Employer of Record. The member participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS or a representative designated by the member to assume the consumer direction of eligible CHOICES or ECF CHOICES HCBS functions on the member's behalf.

(66) Employment and Community First CHOICES (ECF CHOICES). A managed long-term services and supports program that offers home and community-based services to eligible individuals with intellectual and developmental disabilities enrolled in the program in order to promote competitive employment and integrated community living as the first and preferred option.

(67) Employment Informed Choice. The process the MCOs must complete for working age members (ages 16 to 62) enrolled in ECF CHOICES who are eligible for, and want to receive, Community Integration Support Services and/or Independent Living Skills Training services when the member is not engaged in or pursuing integrated employment (with or without Supported Employment Individual or Small Group services, Integrated Employment Path Services or comparable Vocational Rehabilitation/Special Education services). Members who receive Community Living Supports or Community Living Supports-Family Model services are not eligible to receive Community Integration Support Services and/or Independent Living Skills Training services. The Employment Informed Choice process includes, but is not limited to, an orientation to employment, self-employment, employment supports and work incentives provided by the member's support coordinator; the authorization and completion of Exploration services in order to experience various employment settings that are aligned with the member's interests, aptitudes, experiences and/or skills and ensure an informed choice regarding employment; and signed acknowledgment from the member/representative if the member elects not to pursue employment *before* Community Integration Support Services and/or Independent Living Skills Training may be authorized.

(68) Enhanced Respiratory Care (ERC). Specialized types of assistance provided to individuals with certain significant respiratory care needs as part of the medically necessary services delivered in an appropriately licensed and dual certified NF/SNF, consisting of Ventilator Weaning, Chronic Ventilator Care, or Tracheal Suctioning including Sub-Acute and Secretion

(Rule 1200-13-01-.02, continued)

Management, and for which a NF may, pursuant to these rules, be eligible to receive Enhanced Respiratory Care Reimbursement.

(69) Enhanced Respiratory Care Reimbursement. Specified levels of reimbursement (i.e., Ventilator Weaning, Chronic Ventilator Care, and Tracheal Suctioning, including Sub-Acute and Secretion Management) provided for ERC delivered by a dual certified NF/SNF that meets the requirements set forth in Rule 1200-13-01-.03(5) to persons determined by the Bureau or an MCO to meet specified medical eligibility or medical necessity criteria for such level of reimbursement.

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

(71) Enrollment. One of three (3) components of the referral list management process for ECF CHOICES that occurs only when a Potential Applicant has been determined to meet criteria for an available reserve capacity slot or for one of the categories for which enrollment into ECF CHOICES is currently open, and when there is an appropriate slot available for the person to enroll, subject to all applicable eligibility and enrollment criteria. Enrollment into ECF CHOICES may be approved only by TennCare, and subject to the availability of an appropriate slot for the person to enroll if all applicable eligibility and enrollment criteria are met.

(72) 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.

(73) Expenditure Cap. The annual limit on expenditures for CHOICES or ECF CHOICES that a member enrolled in CHOICES Group 3 or ECF CHOICES, as applicable, can receive. For purposes of the Expenditure Cap for members in CHOICES Group 3 and ECF CHOICES Group 4, the cost of minor home modifications is not counted in calculating annual expenditures for CHOICES HCBS or ECF CHOICES HCBS. For purposes of the Expenditure Cap for members in ECF CHOICES Group 6 who are granted an exception to the Expenditure Cap based on exceptional medical and/or behavioral needs, the cost of home health and private duty nursing shall be counted against the member’s Expenditure Cap.

(74) 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.

(Rule 1200-13-01-.02, continued)

(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.

(75) Exploration. For purposes of ECF CHOICES only and limited to persons age 14 or older:

(a) This is a time-limited and targeted service designed to help a person make an informed choice about whether s/he wishes to pursue individualized integrated employment or self-employment, as defined above. The Exploration service shall be completed no more than thirty (30) calendar days from the date of service initiation. This service is not appropriate for ECF CHOICES members who already know they want to pursue individualized integrated employment or self-employment.

(b) This service includes career exploration activities to identify a person's specific interests and aptitudes for paid work, including experience and skills transferable to individualized integrated employment or self-employment. This service also includes exploration of individualized integrated employment or self-employment opportunities in the local area that are specifically related to the person's identified interests, experiences and/or skills through four to five uniquely arranged business tours, informational interviews and/or job shadows. (Each person receiving this service should participate in business tours, informational interviews and/or job shadows uniquely selected based on his or her individual interests, aptitudes, experiences, and skills most transferable to employment. All persons should not participate in the same experiences.) Each business tour, informational interview and/or job shadow shall include time for set-up, prepping the person for participation, and debriefing with the person after each opportunity.

(c) This service also includes introductory education on the numerous work incentives for individuals receiving publicly funded benefits (e.g. SSI, SSDI, Medicaid, Medicare, etc.). This service further includes introductory education on how Supported Employment services work (including Vocational Rehabilitation services). Educational information is provided to the person and the legal guardian/conservator and/or most involved family member(s), if applicable, to ensure legal guardian/conservator and/or family support for the person's choice to pursue individualized integrated employment or self-employment. The educational aspects of this service shall include addressing any concerns, hesitations or objections of the person and the legal guardian/conservator and/or most involved family member(s), if applicable.

(d) This service is expected to involve, on average, forty (40) hours of service. The provider shall document each date of service, the activities performed that day, and the duration of each activity. This service culminates in a written report summarizing the process and outcomes, using a standard template prescribed by TennCare. The written report is due no later than fourteen (14) calendar days after the last date of service is concluded. Exploration is paid on an outcome basis, after the written report is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

(e) After an individual has received the service for the first time, re-authorization may occur a maximum of once per year (with a minimum 365-day interval between services) and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment.

(Rule 1200-13-01-.02, continued)

(76) Family Caregiver Education and Training. For purposes of ECF CHOICES only and limited to members enrolled in ECF CHOICES Group 4 (Essential Family Supports):

(a) This service provides reimbursement up to $500 per year to offset the costs of educational materials, training programs, workshops and conferences that help the family caregiver to:

1. Understand the disability of the person supported;

2. Achieve greater competence and confidence in providing supports;

3. Develop and access community and other resources and supports;

4. Develop advocacy skills; and

5. Support the person in developing self-advocacy skills.

(b) Other types of education and training shall not be reimbursed.

(c) Family Caregiver Education and Training is offered only for a family caregiver who is providing unpaid support, training, companionship, or supervision for a person participating in ECF CHOICES who is living in the family home. The intent of the service is to provide education and support to the caregiver that preserves the family unit and increases confidence, stamina and empowerment. Education and training activities are based on the family/caregiver's unique needs and are specifically identified in the person-centered support plan prior to authorization.

(d) In order to be reimbursed by the MCO, Family Caregiver Education and Training must be approved by the member's MCO before such education or training activities commence and shall be limited to no more than $500 per calendar year.

(e) "Family" shall be interpreted to mean individual(s) to whom the child or adult with I/DD is legally related, whether the relationship is by blood, by marriage, or by adoption. "Family" shall not include a foster care or paid living arrangement. Caregiver shall be interpreted as defined in these rules.

(77) Family Caregiver Stipend in lieu of Supportive Home Care. For purposes of ECF CHOICES only and limited to members enrolled in ECF CHOICES Group 4 (Essential Family Supports):

(a) A monthly payment to the primary family caregiver of a person supported when the person lives with the family in the family home and the family is providing daily services and supports that would otherwise be defined within the scope of Supportive Home Care services. This service is available only in lieu of Supportive Home Care (including Personal Assistance) services and shall not be authorized for a person receiving Supportive Home Care (including Personal Assistance) services. The funds may be used to compensate lost wage earning opportunities that are entailed in providing support to a family member with a disability and to help offset the cost of other services and supports the person needs that are not covered under this program.

(b) For a child under age 18, the Family Caregiver Stipend shall be limited to $500 per month. For an adult age 18 or older, the Family Caregiver Stipend shall be no more than $1,000 per month. The amount of Family Caregiver Stipend approved shall be based on the needs of the individual taking into account the supports necessary for employment and community integration and participation, and shall ensure that supports necessary for employment and community integration and participation are provided first, or available to the person through other sources (whether paid or unpaid)

(Rule 1200-13-01-.02, continued)

or as part of the supports provided by the family caregiver in order for a Stipend to be approved.

(c) "Family" shall be interpreted to mean individual(s) to whom the child or adult with I/DD is legally related, whether the relationship is by blood, by marriage, or by adoption. "Family" shall not include a foster care or paid living arrangement. Caregiver shall be interpreted as defined in these rules.

(78) Family-to-Family Support. For purposes of ECF CHOICES only and limited to members enrolled in ECF CHOICES Group 4 (Essential Family Supports):

(a) These services provide information, resources, guidance, and support from an experienced and trained parent or other family member to another parent or family caregiver who is the primary unpaid support to a child with intellectual or developmental disabilities enrolled in ECF CHOICES. The service shall include facilitation of parent or family member "matches" and follow-up support to assure the matched relationship meets peer expectations.

(b) Family-to-Family Support shall be reimbursed on a per member per month basis for each Member enrolled in ECF CHOICES Group 4. The per member per month reimbursement of Family-to-Family Support shall not be counted against the member's expenditure cap.

(79) 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.

(80) 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.

(81) Fiscal Employer Agent (FEA). An entity contracting with the State and/or one of the State's contracted MCOs that helps CHOICES and ECF CHOICES members participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS. The FEA provides both financial administration and supports brokerage functions for CHOICES and ECF CHOICES members participating in consumer direction of eligible CHOICES or ECF 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 or ECF CHOICES HCBS authorized and provided.

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

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

(Rule 1200-13-01-.02, continued)

(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.

(84) Health Insurance Counseling/Forms Assistance. For purposes of ECF CHOICES only and limited to members enrolled in ECF CHOICES Group 4 (Essential Family Supports):

(a) Health Insurance Counseling/Forms Assistance services offers training and assistance to individuals enrolled in ECF CHOICES and/or their family caregiver and policy holder in understanding the benefits offered through their private or public insurance program, completing necessary forms, accessing covered benefits, and navigating member appeal processes regarding covered benefits. An insurance company or its affiliate shall not be reimbursed for providing this service.

(b) This is a time-limited service intended to develop the person and/or family caregiver's understanding and capacity to self-manage insurance benefits. Reimbursement shall be limited to 15 hours per person per year.

(c) Persons choosing to receive this service must agree to complete an online assessment of its efficacy following the conclusion of counseling and/or forms assistance.

(85) Home and Community-Based Services (HCBS). Services that are provided pursuant to a Section 1915(c) Waiver or the CHOICES or ECF CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. 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. However, only CHOICES and ECF CHOICES HCBS are eligible for Consumer Direction. CHOICES and ECF 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 Group 2 member's needs can be safely met in the community within his or her individual cost neutrality cap. The cost of home health and private duty nursing shall also be counted against the member's Expenditure Cap for members in ECF CHOICES Group 6 who are granted an exception to the Expenditure Cap based on exceptional medical and/or behavioral needs.

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

(87) 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

(Rule 1200-13-01-.02, continued)

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, provided however, that an MCO may authorize Home-Delivered Meals for a CHOICES member receiving Companion Care or Community Living Supports (not Community Living Supports-Family Model) in their own home (not a provider-controlled residence) when such service is medically necessary in order to 1) address health risks related to food insecurity; 2) support improved management of chronic health conditions; 3) reduce risk of hospital readmissions related to such chronic health conditions; 4) improve physical or mental health outcomes; or 5) delay or prevent nursing home placement.

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

(89) 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.

(90) 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.

(91) 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.

(92) 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.

(Rule 1200-13-01-.02, continued)

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

(94) Immediate Family Member. For purposes of employment as a Consumer-Directed Worker in CHOICES and in CHOICES Community Living Supports-Family Model, 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.

(95) Independent Living Skills Training. For purposes of ECF CHOICES only:

(a) Independent Living Skills Training services provide education and skill development or training to improve the person's ability to independently perform routine daily activities and utilize community resources as specified in the person's person-centered support plan. Services are instructional, focused on development of skills identified in the person-centered support plan and are not intended to provide substitute task performance. Daily living skills training may include only education and skill development related to:

1. Personal hygiene;

2. Food and meal preparation;

3. Home upkeep/maintenance;

4. Money management;

5. Accessing and using community resources;

6. Community mobility;

7. Parenting;

8. Computer use; and

9. Driving evaluation and lessons.

(b) Independent Living Skills Training is intended as a short-term service designed to allow a person not receiving Community Living Supports or Community Living Supports-Family Model to acquire specific additional skills that will support his/her transition to or sustained independent community living. Individuals receiving Independent Living Skills Training must have specific independent-living goals in their person-centered support plan that Independent Living Skills Training is specifically designed to support.

(c) The provider must prepare and follow a specific plan and strategy for teaching specific skills for the independent living goals identified in the person-centered support plan. Systematic instruction and other strategies used in Supported Employment Job Coaching should also be employed in this service. The provider must document monthly progress toward achieving each independent living skill identified in the person-centered support plan.

(d) This service will typically originate from the person's home and take place in the person's home and home community. Providers of this service should meet people in these natural environments to provide this service rather than maintaining a separate service location.

(Rule 1200-13-01-.02, continued)

(e) Transportation during the service (when no-cost forms of transportation are not available or not being accessed) is included in the rate paid for the service.

(f) Individuals receiving Community Living Supports or Community Living Supports-Family Model are not eligible to receive this service, since the scope of benefits provided to a person under the CLS and CLS-FM benefits include habilitation training and supports to help the person achieve maximum independence and sustained community living.

(g) Independent Living Skills Training shall be limited as follows:

1. For persons not working in Individualized Integrated Employment, Individualized Integrated Self-Employment, or Small Group Employment in the community or receiving at least one employment service, no more than 20 hours per week of Independent Living Skills Training and Community Integration Support Services combined after completing an Employment Informed Choice process.

2. For persons who are working in Individualized Integrated Employment, Individualized Integrated Self-Employment, or Small Group Employment in the community (not a sheltered workshop) or receiving at least one employment service, no more than 30 hours per week of Independent Living Skills Training, Community Integration Support Services, and Individual or Small Group Employment Supports combined.

3. For persons who are working in Individualized Integrated Employment or Individualized Integrated Self-Employment (not in a small group or in a sheltered workshop), no more than 40 hours per week of Independent Living Skills Training, Community Integration Support Services, Job Coaching, Co-Worker Supports, and the hours worked without paid supports combined.

4. For persons who are working in Individualized Integrated Employment or Individualized Integrated Self-Employment (not in a small group or in a sheltered workshop) at least 30 hours per week, no more than 50 hours per week of Independent Living Skills Training, Community Integration Support Services, Job Coaching, Co-Worker Supports, and the hours worked without paid supports combined.

(96) 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.

(c) An Individual Acuity Score shall be based only on the response to the specific ADL or related question on the PAE, and the supporting medical evidence submitted with the PAE pertaining to such question on the PAE, and not by any other assessment instrument, including the adaptive behavior (or life skills) assessment used to determine whether a person has an intellectual or developmental disability; provided, however, that all available information, including the adaptive behavior (or life skills) assessment shall be taken into account in a Safety Determination (see Rule 1200-13-01-.02 and Rule 1200-13-01-.05(6)).

(97) Individual Cost Neutrality Cap. See “Cost Neutrality Cap.”

(Rule 1200-13-01-.02, continued)

(98) Individual Education and Training Services. For purposes of ECF CHOICES only and limited to members enrolled in ECF CHOICES Group 5 (Essential Supports for Employment and Independent Living) or Group 6 (Comprehensive Supports for Employment and Community Living):

Reimbursement up to $500 per year to offset the costs of training programs, workshops and conferences that help the person develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. Other types of education and training shall not be reimbursed. This service may include education and training for participants, their caregivers and/or legal representatives that is directly related to building or acquiring such skills. Managed care organizations assure that information about educational and/or training opportunities is available to participants and their caregivers and legal representatives. Covered expenses may include enrollment fees, books and other educational materials and transportation related to participation in training courses, conferences and other similar events. In order to be reimbursed by the MCO, Individual Education and Training Services must be approved by the member's MCO before such education or training activities commence and shall be limited to $500 per individual per calendar year.

(99) Individualized Integrated Employment. Sustained paid employment in a competitive or customized job with an employer for which an individual is compensated at or above the state's minimum wage, with the optimal goal being not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(100) Individualized Integrated Self-Employment. Sustained paid self-employment that is home-based or conducted in an integrated setting(s) where net income in relation to hours worked is equivalent to no less than the state's minimum wage, after a reasonable self-employment start-up period.

(101) 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.

(102) Initial Support Plan (SP). As it pertains to ECF CHOICES, the Initial SP is a written plan developed by the Support Coordinator in accordance with policies and protocols established by TennCare which identifies ECF CHOICES HCBS that are needed by the ECF CHOICES member immediately upon enrollment in ECF CHOICES while the Support Coordinator develops the comprehensive Person-Centered Support Plan. Needed ECF CHOICES HCBS specified in the Initial SP shall be authorized for no more than thirty (30) calendar days, by which point the MCO shall develop and implement the member's comprehensive Person-Centered Support Plan.

(103) 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,

(Rule 1200-13-01-.02, continued)

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.

(104) 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.

(105) Institutional Personal Needs Allowance. See “Personal Needs Allowance (PNA).”

(106) Intake. One of three (3) components of the referral list management process for ECF CHOICES during which basic documentation is gathered to confirm information self-reported in the screening process, including whether a person has an intellectual or developmental disability (i.e., is in the target population for ECF CHOICES) and other information that will be used to prioritize the person for enrollment into ECF CHOICES based on established prioritization and enrollment criteria. Intake is generally performed during a face-to-face interview with the Potential Applicant. The result of intake could be 1) a decision to proceed with enrollment because a person with ID qualifies for an available reserve capacity slot based on an aging caregiver or meets certain prioritization criteria for a category for which enrollment is open and there is an appropriate slot available for enrollment; 2) referral to the Interagency Review Committee because the person may meet criteria for a reserve capacity slot based on emergent circumstances or multiple complex health conditions; or 3) continued placement on the ECF CHOICES referral list in the appropriate category.

(107) Integrated Employment Path Services (Time-Limited, Community-Based Prevocational Training). For purposes of ECF CHOICES only and limited to members age 16 or older:

(a) The provision of time-limited learning and work experiences, including volunteering opportunities, where a person can develop general, non-job-task-specific strengths and skills that contribute to employability in individualized integrated employment or self-employment. Services are expected to specifically involve strategies that facilitate a participant's successful transition to individualized integrated employment or self-employment.

(b) Individuals receiving Integrated Employment Path Services must have a desire to obtain some type of individualized integrated employment or self-employment and this goal must be documented in the PCSP as the goal that Integrated Employment Path Services are specifically authorized to address.

(c) Services should be customized to provide opportunities for increased knowledge, skills and experiences specifically relevant to the person’s specific individualized integrated employment and/or self-employment goals and career goals. If such specific goals are not known, this service can also be used to assist a person with identifying his/her specific individualized integrated employment and/or self-employment goals and career goals.

(d) The expected outcome of this service is measurable gains in knowledge, skills and experiences that contribute to the individual achieving individualized integrated employment or self-employment. Integrated Employment Path Services are intended to develop and teach general skills that lead to individualized integrated employment or

(Rule 1200-13-01-.02, continued)

self-employment including but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; and general workplace safety and mobility training.

(e) Service limitations:

1. This service is limited to no more than twelve (12) months. One extension of up to twelve (12) months can be allowed only if the individual is actively pursuing individualized integrated employment or self-employment in an integrated setting and has documentation that a service(s) (i.e. Job Development or Self-Employment Start-Up funded by Tennessee Rehabilitation Services, ECF CHOICES or another similar source) is concurrently authorized for this purpose. The twelve (12) month authorization and one twelve (12) month reauthorization may be repeated only if a person loses individualized integrated employment or self-employment and is seeking replacement opportunities.

2. This service must be delivered in integrated, community settings and may not be provided in sheltered workshops or other segregated facility-based day, vocational or prevocational settings.

3. Integrated Employment Path Services shall not be provided or reimbursed if the person is receiving Job Coaching (for Individualized Integrated Employment or Self-Employment), Co-Worker Supports or is working in individualized integrated employment or self-employment without any paid supports. Integrated Employment Path Services are only appropriate for individuals who are not yet engaged in individualized integrated employment or self-employment.

4. Integrated Employment Path Services shall be limited to no more than 30 hours per week in combination with Supported Employment – Small Group, Community Integration Support Services, and Independent Living Skills Training.

(f) Transportation of the individual to and from this service is not included in the rate paid for this service but transportation during the service is included in the rate.

(g) ECF CHOICES will not cover services which are otherwise available to the individual under Section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. §§ 1401, *et seq.*). If this service is authorized, documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. §§ 1401, *et seq.*).

(h) This service will not duplicate other services provided through the Waiver or Medicaid State Plan services.

(108) Intellectual Disability(ies) (ID). Pursuant to T.C.A. § 33-1-101, an intellectual disability is defined as substantial limitations in functioning:

(a) As shown by significantly sub-average intellectual functioning that exists concurrently with related limitations in two (2) or more of the following adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work; and

(b) That are manifested before eighteen (18) years of age.

(Rule 1200-13-01-.02, continued)

For purposes of ECF CHOICES, the determination that an Applicant has limitations in two (2) or more adaptive skill areas shall be made by TennCare using an adaptive behavior (or life skills) assessment tool, and review of supporting medical evidence. Information gathered through such adaptive behavior (or life skills) assessment shall not be used for purposes of evaluating functional deficits described in Rule 1200-13-01-.10, or in determining an Individual Acuity Score or an Applicants total score on the NF LOC Acuity Scale.

(109) Interagency Review Committee. The committee composed of staff from TennCare and DIDD that reviews requests submitted on behalf of a Potential Applicant in order to determine whether the Potential Applicant meets emergent circumstances or multiple complex health conditions criteria as defined in these rules. A determination by the Interagency Review Committee that a Potential Applicant meets emergent circumstances or multiple chronic health conditions criteria shall be required before DIDD or an MCO proceeds with an enrollment visit to determine if the Potential Applicant qualifies to enroll in ECF CHOICES in a reserve capacity slot designated for such purpose.

(110) Interim CHOICES Group 3 (open only between July 1, 2012, and June 30, 2015).

(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 June 30, 2015, may continue to qualify in this group after June 30, 2015, 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.

(111) Interim ECF CHOICES At-Risk Group. Individuals with I/DD of all ages who: are not eligible for Medicaid or TennCare under any other category; meet the financial eligibility standards for the ECF CHOICES 217-Like Group; do not meet NF LOC criteria but in the absence of ECF CHOICES, are At Risk for Institutionalization. The Interim ECF CHOICES At Risk Demonstration Group will open to new enrollment only until such time that the Employment and Community First CHOICES At-Risk Demonstration Group (with income up to one hundred and fifty percent (150%) of the FPL) and the Employment and Community First CHOICES Working Disabled Demonstration Groups can be established. Persons enrolled in the Interim ECF CHOICES At-Risk Demonstration Group as of the date new enrollment into the group closes may continue to qualify in the group as long as they continue to meet nursing facility financial eligibility standards and the At-Risk LOC criteria, and remain continuously eligible and enrolled in the Interim ECF CHOICES At-Risk Demonstration Group. Enrollment in this group shall be subject to the enrollment targets established for each applicable ECF CHOICES benefit group. An Applicant may qualify in the Interim ECF CHOICES At-Risk Group only when there is an available slot for enrollment into an ECF CHOICES benefit group for which the Applicant meets all eligibility and enrollment criteria, including prioritization criteria for enrollment into ECF CHOICES as established in these Rules, and when the Applicant, upon approval of financial eligibility, will be enrolled by TennCare into such ECF CHOICES group.

(112) 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.

(Rule 1200-13-01-.02, continued)

(113) 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.

(114) Job Coaching. For purposes of ECF CHOICES only and limited to members age 16 or older:

(a) Job Coaching for Individualized, Integrated Employment includes identifying, through job analysis, and providing services and supports that assist the individual in maintaining individualized integrated employment that pays at least minimum wage but ideally not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Job coaching includes supports provided to the individual and his/her supervisor and/or co-workers, either remotely (via technology) or face-to-face. Supports during each phase of employment must be guided by a Job Coaching Fading Plan which incorporates an appropriate mix of best practices for the individual to achieve fading goals as identified in the Plan (e.g. systematic instruction utilizing task analysis to teach the individual to independently complete as much of his/her job duties as possible; high or low tech assistive technology; and effective engagement of natural supports including co-workers and supervisor(s) as needed). If progress on fading ceases at some point, adaptations to job duties, negotiated with the supervisor/employer, or transition to Co-Worker Supports may be utilized if no reduction in hours or hourly pay results.

1. The amount of time authorized for this service is a percentage of the individual's hours worked and is tiered based on the individual's level of disability and the length of time the person has been employed on the job. An exception policy applies for individuals with exceptional circumstances.

2. Transportation of the supported employee to and from the job site is not included in the rate paid for the service. Transportation of the supported employee, if necessary, during the provision of job coaching is included in the rate paid for the service.

(b) Job Coaching for Individualized, Integrated Self-Employment includes identification and provision of services and supports that assist the individual in maintaining self-employment. Job coaching for self-employment includes supports provided to the individual, either remotely (via technology) or face-to-face. Supports must enable the individual to successfully operate the business (with assistance from other sources of professional services or suppliers of goods necessary for the type of business). Job Coaching supports should never supplant the individual's role or responsibility in all aspects of the business. Supports during each phase of self-employment must be guided by a Job Coaching Fading Plan which incorporates an appropriate mix of best practices for the individual to achieve fading goals as identified in the Plan (e.g., systematic instruction utilizing task analysis to teach the individual to independently complete as much of his/her roles and responsibilities as possible; high or low tech assistive technology; and effective engagement of any business partners and/or associates and/or suppliers of goods or services. If progress on fading ceases at some point, business plan adaptations may be utilized if no reduction in paid hours or net hourly pay results.

1. The amount of time authorized for this service is a percentage of the individual's hours engaged in self-employment and is tiered based on the individual's level of disability and the length of time the person has been self-employed in the current business. An exception policy applies for individuals with exceptional circumstances.

(Rule 1200-13-01-.02, continued)

2. Transportation of the supported self-employed person to and from the place of work is not included in the rate paid for the service. Transportation of the supported self-employed person, if necessary, during the provision of job coaching is included in the rate paid for the service.

(c) Job Coaching (for Individualized, Integrated Employment or Individualized, Integrated Self-Employment) shall be limited as follows:

1. No more than 40 hours per week of Job Coaching, Co-Worker Supports, Community Integration Support Services, Independent Living Skills Training, and the hours worked without paid supports combined.

2. For persons who are working in Individualized Integrated Employment or Individualized Integrated Self-Employment (not in a small group or in a sheltered workshop) at least 30 hours per week, no more than 50 hours per week of Job Coaching, Co-Worker Supports, Community Integration Support Services, Independent Living Skills Training, and the hours worked without paid supports combined.

(115) Job Development or Self-Employment Start Up. For purposes of ECF CHOICES only and limited to members age 16 or older:

(a) This is a time-limited service designed to implement a Job Development or Self-Employment Plan as follows:

1. Job Development is support to obtain an individualized competitive or customized job in an integrated employment setting in the general workforce, for which an individual is compensated at or above the minimum wage, but ideally not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The Job Development strategy should reflect best practices and be adjusted based on whether the individual is seeking competitive or customized employment.

2. Self-Employment Start Up is support in implementing a self-employment business plan. The outcome of this service is expected to be the achievement of an individualized integrated employment or self-employment outcome consistent with the individual's personal and career goals, as determined through Exploration, Discovery and/or the Situational Observation and Assessment, if authorized, and as identified in the Job Development or Self-Employment Plan that guides the delivery of this service.

(b) This service will be paid on an outcome basis once the person has completed two calendar weeks of individualized integrated employment or self-employment. Outcome payment amounts are tiered based upon the assessed level of challenge anticipated to achieve the intended outcome of this service for the individual being served. Outcome payments are also paid over three phases to incentivize retention of the job or self-employment situation.

(c) After an individual has received the service for the first time, re-authorization may occur a maximum of once per year (with a minimum 365-day interval between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within nine (9) months.

(Rule 1200-13-01-.02, continued)

(116) Job Development Plan or Self-Employment Plan. For purposes of ECF CHOICES only and limited to members age 16 or older:

(a) This is a time-limited and targeted service designed to create a clear and detailed plan for Job Development or for the start-up phase of Self-Employment. This service is limited to thirty (30) calendar days from the date of service initiation. This service includes a planning meeting involving the individual and other key people who will be instrumental in supporting the individual to become employed in individualized integrated employment or self-employment.

(b) This service culminates in a written plan, using a template prescribed by TennCare, that incorporates the results of Exploration, Discovery, and/or Situational Observation and Assessment, if previously authorized. The written plan is due no later than thirty (30) calendar days after the service commences. For self-employment goals, this service results in the development of a self-employment business plan, including potential sources of business financing (such as VR, Small Business Administration loans, PASS plans), given that Medicaid funds may not be used to defray the capital expenses associated with starting a business. This service is paid on an outcome basis, after the written plan is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

(c) After an individual has received the service for the first time, re-authorization may occur a maximum of once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within twelve (12) months.

(117) 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.

(118) 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.

(119) Level of Need. The categorization of the intensity level of practical supports needed by a member enrolled in ECF CHOICES Group 6 based on an objective assessment utilizing the American Association of Intellectual and Developmental Disabilities Supports Intensity Scale®. The member's assessed level of need, including consideration of exceptional medical or behavioral needs as identified in the assessment, is used to establish the member's Expenditure Cap, required Support Coordinator-to-member ratios, and frequency of required Support Coordination contacts in the ECF CHOICES program.

(120) 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).

(Rule 1200-13-01-.02, continued)

(121) 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).

(122) 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.

(123) 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.

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

(125) 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.

(126) Managed Care Organization (MCO). See “Managed Care Organization” in Rule 1200-13-13-.01.

(127) 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.

(128) 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.

(129) 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.

(130) 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,

(Rule 1200-13-01-.02, continued)

the Specified Low Income Medicare Beneficiary (SLMB) program, and the Qualified Individual (QI) program.

(131) Member. See "CHOICES Member."

(132) 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.

(133) 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.

(Rule 1200-13-01-.02, continued)

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.

(134) Minor Home Modifications. For purposes of CHOICES and ECF 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;

(Rule 1200-13-01-.02, continued)

(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.

(e) Minor home modifications are subject to a limit of $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime.

(135) Multiple Complex Health Conditions. For purposes of reserve capacity in ECF CHOICES, a limited number of individuals who have multiple complex chronic or acquired health conditions that present significant barriers or challenges to employment and community integration, and who are in urgent need of supports in order to maintain the current living arrangement and delay or prevent the need for more expensive services, and for which enrollment into ECF CHOICES is the most appropriate way to provide needed supports, as determined through an Interagency Committee review process, including both TennCare and DIDD. Multiple Complex Health Conditions shall be applicable only to individuals of working age.

(136) 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.

(137) Network Provider. See “Contract Provider.”

(138) Non-Contract Provider. A provider who does not have a contract with an Enrollee’s MCO. Also called “Out-of-Network Provider.”

(139) 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.

(140) 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.

(Rule 1200-13-01-.02, continued)

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

(142) 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.

(143) 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.

(144) One-Time ECF CHOICES HCBS. Specified ECF CHOICES HCBS other than employment services and supports which occur as a distinct event or which may be episodic in nature (occurring at less frequent irregular intervals or on an as needed basis for a limited duration of time). One-time ECF CHOICES HCBS include: Conservatorship and Alternatives to Conservatorship Counseling and Assistance, Minor Home Modifications, Individual Education and Training Services, Specialized Consultation and Training, Adult Dental Services, Community Support Development, Organization and Navigation, Family Caregiver Education and Training, Assistive Technology, Adaptive Equipment and Supplies, Peer-to-Peer Support and Navigation for Person Centered Planning, Self-Direction, Integrated Employment/Self Employment, and Independent Community Living, Respite, Family-to-Family Support, and Health Insurance Counseling/Forms Assistance.

(145) 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.

(146) Ongoing ECF CHOICES HCBS. Specified ECF 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 on a continuous basis, or which may be one component of a continuum of services intended to achieve employment. Ongoing ECF CHOICES HCBS include: Supportive Home Care, Family Caregiver Stipend in lieu of Supportive Home Care, Independent Living Skills Training, Community Integration Support Services, Personal Assistance, Community Transportation, Community Living Supports (CLS), Community Living Supports Family Model (CLS-FM), Exploration, Discovery, Benefits Counseling, Situational Observation and Assessment, Job Development or Self-Employment Plan, Job Development or Self-Employment Start Up, Job Coaching (including Competitive, Integrated Employment and Self-Employment), Supported Employment – Small Group, Co-worker Supports, Career Advancement, and Integrated Employment Path Services (Time Limited Pre-Vocational Training).

(147) Out-of-Network Provider. See “Non-Contract Provider.”

(148) 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.

(149) 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.

(150) 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.

(151) Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living. For purposes of ECF CHOICES only and limited to members enrolled in ECF CHOICES Group 5 (Essential Supports for Employment and Independent Living) or Group 6 (Comprehensive Supports for Employment and Community Living):

(a) These services assist an individual and his/her family member(s) or conservator in one or more of the following areas:

1 Directing the person-centered planning process;

2. Understanding and considering self-direction;

3. Understanding and considering individualized integrated employment/self-employment; or

4. Understanding and considering independent community living options.

(b) The service involves addressing questions and concerns related to such options. Services are provided by a peer who has successfully directed his or her person-centered planning process, self-directed his or her own services, successfully obtained individualized integrated employment or self-employment and/or utilized independent living options.

(c) Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living services are provided by individuals with intellectual or developmental disabilities (with paid supports if needed) who have successfully directed their person-centered planning processes, and/or self-directed their own services, and/or successfully utilized independent living options. Individuals with intellectual or developmental disabilities qualified to provide these services will have also completed training in best practices for offering peer to peer supports in the areas covered by this service.

(d) Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living services are focused on mentoring and training others based upon their personal experience and success in one or more areas this service is focused on. A qualified service provider understands, empathizes with and can support three important areas important for enhancing self-esteem:

1. The human need for connections;

2. Overcoming the disabling power of learned helplessness, low expectations and the stigma of labels; and

3. Supporting self-advocacy, self-determination and informed choice in decision making.

(e) The Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living service provider offers:

1. One-on-one training and information to encourage the person to lead their person-centered planning process, pursue self-direction, seek integrated employment/self-employment and/or independent community living options;

2. Education on informed decision making, risk taking, and natural consequences;

3. Education on self-direction, including recruiting, hiring and supervising staff;

4. Planning support regarding integrated employment;

5. Planning support regarding independent community living opportunities, including selection of living arrangements and housemates; and

6. Assistance with identifying potential opportunities for community participation, the development of valued social relationships, and expanding unpaid supports to address individual needs in addition to paid services.

(f) These services are intended to support an individual in knowledge and skill acquisition and should not be provided on an ongoing basis, nor should these services be provided for companionship purposes. Reimbursement shall be limited to $1,500 per person per lifetime.

(152) Person-Centered Support Plan (PCSP) – As it pertains to CHOICES and ECF CHOICES, the PCSP is a written plan developed by the Support Coordinator or Care Coordinator in accordance with person-centered planning requirements set forth in federal regulation, and in TennCare policies and protocols, using a person-centered planning process that accurately documents the member's strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the member to help them achieve their preferred lifestyle and goals, and to meet their identified unmet needs (after considering the availability and role of unpaid supports provided by family members and other natural supports) through paid services provided by the member's MCO and other payor sources. The person-centered planning process is directed by the member with long-term support needs, and may include a representative whom the member has freely chosen to assist the member with decision-making, and others chosen by the member to contribute to the process. If the member has a guardian or conservator, the member shall lead the planning process to the maximum extent possible, and the guardian or conservator shall have a participatory role as needed and defined by the individual, except as explicitly defined under State law and the order of guardianship or conservatorship. Any decisions made on the member's behalf should be made using principles of substituted judgment and supported decision making. This planning process, and the resulting PCSP, will assist the member in achieving a personally defined lifestyle and outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health, welfare, and personal growth. Services in CHOICES and ECF CHOICES shall be authorized, provided, and reimbursed only as specified in the PCSP.

(153) Personal Assistance. For purposes of ECF CHOICES only and limited to adults age 21 or older enrolled in ECF CHOICES Group 5 (Essential Supports for Employment and

(Rule 1200-13-01-.02, continued)

Independent Living) or Group 6 (Comprehensive Supports for Employment and Community Living):

(a) A range of services and supports designed to assist an individual with a disability to perform activities and instrumental activities of daily living at the person's own home, on the job or in the community that the individual would typically do for themselves if he/she did not have a disability. Personal Assistance services may be provided outside of the person's home as long as the outcomes are consistent with the supports defined in the person-centered support plan with the goal of ensuring full participation and inclusion.

(b) Personal Assistance services may be used to:

1. Support the person at home in getting ready for work and/or community participation;

2. Support the person in getting to work and/or community participation opportunities; and

3. Support the person in the workplace and/or in the broader community.

(c) The only exception is if Supported Employment Services or Community Integration Support Services are being provided, in which case the provider of Supported Employment and/or Community Integration Support Services shall be responsible for personal assistance needs during the hours that Supported Employment services are provided as long as the Personal Assistance Services do not comprise the entirety of the Supported Employment or Community Integration Support Service. If a person only needs personal assistance to participate in employment or community opportunities, then this service should be authorized rather than Supported Employment or Community Integration Support Services.

(d) Personal Assistance services that are covered also include the following:

1. Support, supervision and engaging participation with eating, toileting, personal hygiene and grooming, and other activities of daily living as appropriate and needed to sustain community living, except when provided as a component of another covered service the person is receiving at that time; and

2. Direction and training to individuals in the person's social network or to his/her coworkers who choose to learn how to provide some of the Personal Assistance services.

(e) In ECF CHOICES Group 6 (Comprehensive Supports for Employment and Community Living), Personal Assistance services shall be limited to 215 hours per month. An MCO may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered benefits.

(154) 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.

(155) 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

(Rule 1200-13-01-.02, continued)

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, provided however, that an MCO may authorize PERS for a CHOICES member receiving Companion Care, Community Living Supports, or Community Living Supports-Family Model services when such service provides less than 24-hour staff support and PERS is medically necessary in order to help sustain or increase the member's independence in the home, reduce risk of safety concerns, and delay or prevent nursing home placement.

(156) 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).

(157) 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.

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

(159) 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

(Rule 1200-13-01-.02, continued)

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. For purposes of eligibility for enrollment in CHOICES Group 2, includes any adult age 21 or older who meets level of care criteria for Medicaid Level 1 reimbursement of care in a nursing facility, CHOICES HCBS and PACE, including requirements set forth in TennCare Rule 1200-13-01-.10(4)(b)2.(ii) and, based upon review of evidence by TennCare, will be institutionalized but for the availability of these services.

(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.

(160) 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.

(161) 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.

(162) 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.

(163) 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.

(164) Potential Applicant. Individuals for whom TennCare or its designee shall perform referral and intake functions as specified in these rules. A Potential Applicant is entitled to a determination regarding his or her eligibility to enroll in the ECF CHOICES program and, if the application is denied, to due process, including notice and the right to request a fair hearing only when the Potential Applicant is determined to meet criteria for an available reserve capacity slot or meets prioritization criteria for an available program slot for which enrollment is currently open and will be enrolled into the program if all applicable eligibility and enrollment criteria are met.

(165) 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.

(166) 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.

(Rule 1200-13-01-.02, continued)

(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.

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

(168) 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.

(169) 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).

(170) 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, licensed social worker, or an individual who has a bachelor's degree in social work, nursing, education or other human service (e.g., psychology or sociology) and is also prior approved by TennCare on a case-by-case basis. For the ECF CHOICES program, Qualified Assessors shall include the preceding individuals and shall also include individuals who meet the federal requirements for a Qualified Intellectual Disabilities Professional or Qualified Developmental Disabilities Professional or individuals who have five (5) or more years' experience as an independent support coordinator or case manager for service recipients in a 1915(c) HCBS Waiver and have completed Personal Outcome Measures Introduction and Assessment Workshop trainings as established by the Council on Quality and Leadership and are prior approved by TennCare on a case-by-case basis.

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

(172) Referral. An expression of interest in applying for the ECF CHOICES program.

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

(174) Representative.

(a) In general, for CHOICES and ECF CHOICES members, a person who is at least eighteen (18) years of age and is authorized by the member to participate in care or support planning and implementation and to speak and/or 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, provided that any decision making authority not specifically delegated to a legal representative (e.g., a guardian or conservator) is retained by the member unless he or she chooses to allow a (non-legal) representative whom he or she has freely chosen to make such decisions.

(b) As it relates to consumer direction of eligible CHOICES or ECF CHOICES HCBS, a person who is authorized by the member to direct and manage the member's worker(s), and signs a representative agreement. The representative for consumer direction of eligible CHOICES or ECF CHOICES HCBS must also: be at least eighteen (18) years of age; have a personal relationship with the member and understand his/her support needs; know the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses; and be physically present in the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate workers.

(175) Representative Agreement. The agreement between a CHOICES or ECF CHOICES member electing consumer direction of eligible CHOICES or ECF CHOICES HCBS who has a representative direct and manage the consumer's worker(s) and the member's representative that specifies the roles and responsibilities of the member and the member's representative.

(176) 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.

(177) Reserve capacity slot**.** For the purposes of ECF CHOICES, the state's authority to reserve a finite number of program slots in a particular ECF CHOICES Group for persons in specified circumstances; such as an Aging Caregiver of a person with ID, Emergent Circumstances, and Multiple Complex Health Conditions as defined.

(178) Respite. For purposes of ECF CHOICES only:

(a) Respite shall mean services provided to a person supported when unpaid caregivers are absent or need relief from routine caregiving responsibilities.

(b) Respite shall be limited to 30 days of service per person per calendar year or to 216 hours per person per calendar year, depending on the needs and preferences of the individual as reflected in the PCSP.

1. A member shall choose to receive Respite as either a daily or hourly service. The 2 limits cannot be combined in a calendar year.

2. If a member chooses to receive Respite as a daily service, each 24 hour time period within which Respite is provided and reimbursed shall count as one day regardless of the number of hours of Respite services reimbursed during that 24 hour period.

3. Only hourly Respite shall be available through Consumer Direction. Daily Respite shall not be available through Consumer Direction.

(c) Respite services shall be provided in settings that meet the federal HCBS regulatory standards, which promote community involvement and inclusion and which allow

(Rule 1200-13-01-.02, continued)

individuals to sustain their lifestyle and routines when an unpaid caregiver is absent for a period of time.

(d) Respite shall be provided only for persons living with unpaid family caregivers, or living independently (not in a CBRA setting), but having unpaid caregivers who routinely (i.e., daily or almost daily) have responsibilities to provide support to the member, and relief from such support is needed.

(179) 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.

(180) 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.

(181) Safety Determination.

(a) A decision made by the Bureau in accordance with the process and requirements described in Rule 1200-13-01-.05(6) regarding whether:

(Rule 1200-13-01-.02, continued)

1. An Applicant age 65 and older and is At Risk for Institutionalization as defined in Rule 1200-13-01-.02 or an Applicant age 21 and older who has a physical disability and is At Risk for Institutionalization as defined in Rule 1200-13-01-.02 would qualify to enroll in CHOICES Group 3 (including Interim CHOICES Group 3) or if there is sufficient evidence, as required and determined by the Bureau, to demonstrate that the necessary intervention and supervision needed by the Applicant 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); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care, and which may impact the Applicant'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)).

2. An Applicant, age 21 and older who has an intellectual or developmental disability and is At Risk for Institutionalization as defined in Rule 1200-13-01-.02 would qualify to enroll in ECF CHOICES Group 5, or if there is sufficient evidence, as required and determined by the Bureau, to demonstrate that the necessary intervention and supervision needed by the Applicant cannot be safely provided within the array of services and supports that would be available if the Applicant was enrolled in ECF CHOICES Group 5, including ECF CHOICES HCBS up to the Expenditure Cap of $30,000; one-time emergency assistance up to $6,000; non-ECF CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care, and which may impact the Applicant's NF LOC eligibility (see Rule 1200-13-01-.10(4)(b)2.(ii)(III)).

3. An Applicant under age 18 who has an intellectual or developmental disability and is At Risk for Institutionalization as defined in Rule 1200-13-01-.02 would not qualify financially for TennCare unless the deeming of the parent's income to the child is waived, and absent the availability of benefits in ECF CHOICES Group 4, including ECF CHOICES HCBS up to the Expenditure Cap of $15,000, non-ECF CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care, the child is at imminent risk of placement outside the home, and which may impact the Applicant's NF LOC eligibility (see Rule 1200-13-01-.10(4)(b)2.(ii)(IV)).

(b) Such determination shall include review of information submitted to the Bureau as part of the Safety Determination request, including, but not limited to:

1. Ongoing skilled and/or rehabilitative interventions and treatment by licensed professional staff;

2. A pattern of recent falls resulting in injury or with significant potential for injury;

3. An established pattern of recent emergent hospital admissions or emergency department utilization for emergent conditions;

4. Recent nursing facility admissions, including precipitating factors and length of stay;

(Rule 1200-13-01-.02, continued)

5. An established pattern of self-neglect that increases risk to personal health, safety and/or welfare requiring involvement by law enforcement or Adult Protective Services;

6. A determination by a community-based residential alternative provider that the Applicant's needs can no longer be safely met in a community setting;

7. The need for and availability of regular, reliable natural supports, including changes in the physical or behavioral health or functional status of family or unpaid caregivers; and

8. For Applicants who have an intellectual or developmental disability, the Applicant's adaptive and maladaptive behaviors as determined by the life skills assessment tool developed or selected by TennCare and the Maladaptive Behavior Index (MBI or problem behavior) portion of the Inventory for Client and Agency Planning (ICAP) Assessment to capture behaviors requiring extraordinary support to ensure the safety of the individual.

(182) Screening. One of three (3) components of the ECF CHOICES referral list management process which includes providing basic education about the program, including eligibility criteria and enrollment processes, and helps to gather basic information that can be used to determine if a Potential Applicant is likely to qualify for the program, and that allows the Potential Applicant to be prioritized for intake based on established prioritization and enrollment criteria.

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

(184) 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.

(185) Service Agreement. The agreement between a CHOICES or ECF CHOICES member (or the member's representative) electing consumer direction of HCBS and the member's consumer-directed worker that specifies the roles and responsibilities of the member (or the member's representative) and the member's worker.

(186) 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

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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.

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

(188) Situational Observation and Assessment. For purposes of ECF CHOICES only and limited to members age 14 or older:

(a) This is a time-limited service that involves observation and assessment of an individual's interpersonal skills, work habits and vocational skills through practical experiential, community integrated volunteer experiences and/or paid individualized, integrated work experiences that are uniquely arranged and specifically related to the interests, preferences and transferable skills of the job seeker as established through Discovery or a similar process. This service involves a comparison of the actual performance of the individual being assessed with core job competencies and duties required of a skilled worker in order to further determine the work competencies and skills needed by the individual to be successful in environments similar to where the Assessment is taking place. The individual shall be reimbursed at least the minimum wage and all applicable overtime for work performed, except as permitted pursuant to the Fair Labor Standards Act for unpaid internships.

(b) Situational Observation and Assessment shall be limited to no more than thirty (30) calendar days from the date of service initiation. Each job seeker may be authorized for up to four (4) such experiences within the thirty (30) calendar day period. A summary report, using a standard template prescribed by TennCare, is due within ten (10) days after the last date of service is concluded. Reimbursement is paid on an outcome basis for each individual experience, which is expected to involve an average of twelve (12) hours of service per individual experience. The Situational Observation and Assessment outcome payment is made after the written summary report is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

(c) The learning from this service described in the summary report is to be used to help inform the job development plan or self-employment plan.

(d) After an individual has received the service for the first time, re-authorization may occur a maximum of once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within twelve (12) months.

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

(190) 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.

(191) 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).

(192) Specialized Consultation and Training. For purposes of ECF CHOICES only, and limited to adults age 21 or older enrolled in ECF CHOICES Group 5 (Essential Supports for Employment and Independent Living) or Group 6 (Comprehensive Supports for Employment and Community Living):

(a) Expertise, training and technical assistance in one or more specialty areas (behavior services, occupational therapy, physical therapy, speech language pathology, nutrition, orientation and mobility, or nurse education, training and delegation) to assist paid or natural or co-worker supports in supporting individuals who have long-term intervention needs, consistent with the person-centered support plan, therefore increasing the effectiveness of the specialized therapy or service. This service also is used to allow the specialists listed above to be an integral part of the person-centered planning team, as needed, to participate in team meetings and provide additional intensive consultation for individuals whose functional, medical or behavioral needs are determined to be complex. The consultation staff and the paid support staff are able to bill for their service time concurrently. Specialized Consultation and Training shall not include the ongoing provision of direct services. Activities that are covered include:

1. Observing the individual to determine and assess functional, medical or behavioral needs;

2. Assessing any current interventions for effectiveness;

3. Developing a written, easy-to-understand intervention plan, which may include recommendations for assistive technology/equipment, workplace and community integration site modifications; the intervention plan will clearly define the interventions, activities and expected timeline for completion of activities;

4. Identification of activities and outcomes to be carried out by paid and natural supports and co-workers;

5. Training of family caregivers or paid support personnel on how to implement the specific interventions/supports detailed in the intervention plan; in the case of nurse education, training and delegation, shall include specific training, assessment of competency, and delegation of skilled nursing tasks to be performed as permitted under state law;

6. Development of and training on how to observe, record data and monitor implementation of therapeutic interventions/support strategies;

7. Monitoring the individual, family caregivers and/or the supports personnel during the implementation of the plan;

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8. Reviewing documentation and evaluating the activities conducted by relevant persons as detailed in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes or revision of the plan as needed;

9. Participating in team meetings; and/or,

10. Tele-Consulting, as permitted under state law, through the use of two-way, real time interactive audio and video between places of greater and lesser clinical expertise to provide clinical consultation services when distance separates the clinical expert from the individual.

(b) Specialized Consultation Services are provided by a certified, licensed, and/or registered professional or qualified assistive technology professional appropriate to carry out the relevant therapeutic interventions for purposes of teaching and training, and not for the ongoing provision of direct services.

(c) Specialized Consultation Services are limited to $5,000 per person per calendar year, except for adults in ECF CHOICES Group 6 (Comprehensive Supports for Employment and Community Living) determined by TennCare to have exceptional medical and/or behavioral support needs.

(d) Only for adults age 21 or older in ECF CHOICES Group 6 (Comprehensive Supports for Employment and Community Living) determined by TennCare to have exceptional medical and/or behavioral support needs, Specialized Consultation Services shall be limited to $10,000 per person per calendar year.

(e) An MCO may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered benefits.

(193) 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.

(194) 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

(Rule 1200-13-01-.02, continued)

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.

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

(196) Supported Employment – Small Group Supports. For purposes of ECF CHOICES only and limited to members age 16 or older:

(a) This service provides employment services and training activities to support successful transition to individualized integrated employment or self-employment, or to supplement such employment and/or self-employment when it is only part-time. Service may involve small group career planning and exploration, small group Discovery classes/activities, other educational opportunities related to successful job acquisition and working successfully in individualized integrated employment. Service may also include employment in integrated business, industry and community settings. Examples include mobile crews, small enclaves and other small groups participating in integrated employment that is specifically related to the identified interests, experiences and/or skills of each of the persons in the small group and that results in acquisition of knowledge, skills and experiences that facilitate transition to individualized integrated employment or self-employment, or that supplement such employment or self-employment when it is only part-time. Minimum staffing ratio is 1:3 for this service.

1. Career planning and exploration activities, Discovery classes/activities, other educational opportunities related to successful job acquisition and working successfully in individualized integrated employment or self-employment must be conducted in appropriate non-disability-specific settings (e.g. Job Centers, businesses, post-secondary education campuses, libraries, etc.) All settings must meet all HCBS setting standards and must not isolate participants from others who do not have disabilities.

2. In the enclave model, a small group of people with disabilities (no more than three people) is trained and supervised to work among employees who are not disabled at the host company's work site. Persons in the enclave may work as a team at a single work area or may work in multiple areas throughout the company. The Supported Employment—Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in integrated business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others in the setting who do not have disabilities. The experience should allow opportunities for routine interactions with others without disabilities in the setting and involvement from supervisors and co-workers without disabilities (not paid to deliver this service) in the supervision and support of individuals receiving this service.

3. In the mobile work crew model, a small crew of workers (including no more than three persons with disabilities and ideally also including workers without disabilities) work as a distinct unit and operate as a self-contained business that generates employment for their crew members by selling a service. The crew typically works at several locations within the community. The Supported Employment—Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in

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integrated business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. The experience should allow opportunities for routine interactions with people without disabilities (including fellow crew members, customers, etc.) in the course of performing services.

(b) Paid work under Supported Employment—Small Group must be compensated at minimum wage or higher.

(c) Supported Employment—Small Group does not include vocational or prevocational services, employment or training provided in facility based work settings. Supported Employment—Small Group service settings cannot be provider-owned, leased or operated settings. The settings must be integrated in, and support full access of participants to the greater community, including opportunities to learn about and seek individualized integrated employment or self-employment, engage in community life, and control their earned income.

(d) The expected outcome of this service is the acquisition of knowledge, skills and experiences that facilitate career development and transition to individualized integrated employment or self-employment, or that supplement such employment and/or self-employment when it is only part-time. The individualized integrated employment or self-employment shall be consistent with the individual's personal and career goals.

(e) Supported Employment—Small Group services shall be provided in a way that presumes all participants are capable of working in individualized integrated employment and/or self-employment. Participants in this service shall be encouraged, on an ongoing basis, to explore and develop their interests, strengths, and abilities relating to individualized integrated employment and/or self-employment. In order to reauthorize this service, the Person-Centered Support Plan (PCSP) must document that such opportunities are being provided through this service, to the individual, on an on-going basis. The PCSP shall also document and address any barriers to the individual transitioning to individualized integrated employment or self-employment if the person is not already participating in individualized integrated employment or self-employment. Any individual using this service to supplement part-time individualized integrated employment or self-employment shall be offered assistance to increase hours in individualized integrated employment and/or self-employment as an alternative or partial alternative to continuing this service.

(f) As a component part of this service, Supported Employment—Small Group service providers shall support individuals in identifying and pursuing opportunities that will move them into individualized integrated employment or self-employment. A one-time incentive payment for full transition of a person from Supported Employment—Small Group services to individualized integrated employment or self-employment shall be paid to the Supported Employment—Small Group provider upon successful transition (defined as successfully completing at least four weeks in the individualized integrated employment or self-employment situation) out of Supported Employment—Small Group services to individualized integrated employment or self-employment.

(g) Transportation of participants to and from the service is not included in the rate paid for the service; however transportation provided during the course of Supported Employment—Small Group services is considered a component part of the service and the cost of this transportation is included in the rate paid to providers of this service.

(h) The Supported Employment—Small Group provider shall be responsible for any personal assistance needs during the hours that Supported Employment—Small Group

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services are provided; however, the personal assistance services may not comprise the entirety of the Supported Employment—Small Group service. All providers of personal care under Supported Employment—Small Group shall meet the Personal Assistance service provider qualifications, except that a separate PSSA license shall not be required.

(i) Supported Employment—Small Group services exclude services available to an individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. §§ 1401, et seq.).

(j) Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;

2. Payments that are passed through to users of supported employment services; or

3. Payments for training that is not directly related to an individual’s supported employment program.

(k) Supported Employment—Small Group does not include supports provided in facility based (sheltered, prevocational, vocational or habilitation) work settings and does not include supports for volunteering.

(l) Supported Employment—Small Group services shall be limited to no more than 30 hours per week of Supported Employment—Small Group, Integrated Employment Path Services, Community Integration Support Services, and Independent Living Skills training combined.

(197) Supportive Home Care (SHC). For purposes of ECF CHOICES only, and limited to members enrolled in ECF CHOICES Group 4 (Essential Family Supports):

(a) This service involves the provision of services and supports in the home and community by a paid caregiver who does not live in the family home to an individual living with his or her family that directly assist the individual with activities of daily living and personal needs to insure adequate functioning in their home and maintain community living. Supportive Home Care services may be provided outside of the person’s home as long as the outcomes are consistent with the supports defined in the person-centered support plan with the goal of ensuring full participation and inclusion.

(b) Services include:

1. Hands-on assistance with activities of daily living such as dressing/undressing, bathing, feeding, toileting, assistance with ambulation (including the use of a walker, cane, etc.), care of hair and care of teeth or dentures. This can also include preparation and cleaning of areas used during personal care activities such as the bathroom and kitchen.

2. Observation of the person supported to assure safety, oversight direction of the person to complete activities of daily living or instrumental activities of daily living.

3. Routine housecleaning and housekeeping activities performed for the person supported (and not other family members or persons living in the home, as applicable), consisting of tasks that take place on a daily, weekly or other regular

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basis, including: washing dishes, laundry, dusting, vacuuming, meal preparation and shopping for food and similar activities that do not involve hands-on care of the person.

4. Necessary cleaning of vehicles, wheelchairs and other adaptive equipment and home modifications such as ramps.

(198) Supports Broker. An individual assigned by the FEA to each CHOICES or ECF CHOICES member participating in consumer direction who assists the member/representative as needed in performing certain employer of record functions as follows: developing job descriptions; recruiting, interviewing, and hiring workers; member and worker enrollment in consumer direction and consumer direction training; and developing (as part of the onboarding process for new workers) a schedule for the member's workers that comports with the schedule at which services are needed by the member as reflected in the plan of care or PCSP, as applicable. The supports broker shall also assist the member as needed with developing and verifying the initial back-up plan for consumer direction. The supports broker collaborates with the member's care coordinator or support coordinator, as appropriate. The supports broker does not have authority or responsibility for consumer direction. The member or member's representative must retain authority and responsibility for consumer direction.

(199) 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.

(200) 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.

(201) 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.

(202) TennCare Pre-Admission Evaluation Tracking System (PAE Tracking System). A component of the State's Medicaid Management Information System and the system of record for all Pre-Admission Evaluation (i.e., level of care) submissions and level of care determinations, as well as enrollments into and transitions between LTSS programs, including CHOICES, ECF CHOICES, and the State's MFP Rebalancing Demonstration (MFP), as a tracking mechanism for referral list management in ECF CHOICES, and which shall also be used to gather data required to comply with tracking and reporting requirements pertaining to MFP.

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

(204) Tracheal Suctioning Reimbursement. The rate of reimbursement provided for NF services, including enhanced respiratory care assistance, delivered by a dual certified NF/SNF 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)(d) or determined by their TennCare MCO to require short-term intensive respiratory intervention during the post-weaning period, which shall include documented progress in weaning from the tracheostomy. Tracheal Suctioning Reimbursement shall include two (2) distinct levels of reimbursement as follows:

(a) Secretion Management Tracheal Suctioning Reimbursement for services delivered by a dual certified NF/SNF to persons who meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(5)(d) and have an approved PAE for such level of reimbursement; and

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(b) Sub-Acute Tracheal Suctioning Reimbursement for short-term intensive respiratory intervention delivered by a dual certified NF/SNF and determined by the person's TennCare MCO to be medically necessary during the post-weaning period, which shall include documented progress in weaning from the tracheostomy. Because Sub-Acute Tracheal Suctioning Reimbursement provides for intensive respiratory intervention during the period immediately following a person's liberation from the ventilator, Sub-Acute Tracheal Suctioning Reimbursement shall be provided only in a bed specifically licensed for ventilator care.

(205) 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.

(206) 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.

(207) 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.

(208) 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."

(209) 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.

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

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed December 31, 1979; effective February 14, 1980. Amendment filed May 26, 1983; effective June 27, 1983. Amendment filed September 16, 1987; effective October 31, 1987. Amendment filed November 10, 1988; effective December 25, 1988. Public necessity rule filed January 30, 2006; effective through July 14, 2006. Public necessity rule filed January 30, 2006, expired on July 14, 2006. On July 15, 2006, rule reverted to status*

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in effect on January 29, 2006. Amendment filed May 3, 2006; effective July 17, 2006. Amendment filed January 30, 2007; effective April 15, 2007. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rules filed June 29, 2012; effective through December 26, 2012. Repeal and new rule filed September 26, 2012; effective December 25, 2012. Amendment filed September 26, 2013; effective December 25, 2013. Amendments filed July 28, 2014; effective October 26, 2014. Emergency rule filed June 30, 2015; effective through December 27, 2015. Amendment filed April 14, 2015; effective July 13, 2015. Emergency rule filed July 27, 2015; effective through January 23, 2016. Amendment filed September 23, 2015; effective December 22, 2015. Amendment filed October 22, 2015; effective January 21, 2016. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.

1200-13-01-.03 NURSING FACILITY (NF) PROVIDER REIMBURSEMENT.

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

(2) Level 1, Level 2, and Enhanced Respiratory Care NF Reimbursement.

(a) Reimbursement for NF services provided to a Medicaid Eligible member enrolled in the TennCare Program shall be categorized according to the needs of the individual and the level of skilled and/or rehabilitative services required as specified in Rule 1200-13-01-.10.

(b) Level 2 or Enhanced Respiratory Care NF Reimbursement shall be provided only for beds that are certified by both Medicaid and Medicare for the provision of NF/SNF care.

(c) Effective July 1, 2016, each level of Enhanced Respiratory Care Reimbursement shall be an add-on payment to the NF's established Level 2 per diem rate or the NF's blended per diem rate, when established. The amount of the NF's add-on payment for each of the specified levels of reimbursement shall be based on the facility's performance on quality outcome and technology measures pursuant to a methodology established by TennCare. Quality outcome and technology measures, performance benchmarks, and the methodology to apply such measures and benchmarks to each of the specified levels of Enhanced Respiratory Care Reimbursement may be adjusted during FY 2016-2017 to ensure compliance with the Appropriations Act, Public Chapter 758, and no more frequently than annually thereafter in order to continuously improve the quality of care and quality of life outcomes experienced by individuals receiving Enhanced Respiratory Care in a NF.

(d) Enhanced Respiratory Care Reimbursement shall be provided only for services authorized and delivered in a facility operating in compliance with conditions of reimbursement for Enhanced Respiratory Care specified in this rule, and in a bed specifically licensed for such purpose, as applicable. A NF shall not be eligible for Enhanced Respiratory Care Reimbursement if it does not meet the conditions for reimbursement, or for any Enhanced Respiratory Care services provided in excess of the facility's licensed capacity to provide such services, regardless of payer source. Because Sub-Acute Tracheal Suctioning Reimbursement provides for intensive respiratory intervention during the period immediately following a person's liberation from the ventilator, Sub-Acute Tracheal Suctioning Reimbursement shall be provided only in a bed specifically licensed for ventilator care.

(e) A NF shall be eligible for Enhanced Respiratory Care Reimbursement only if the facility has submitted complete, accurate and timely quality measurement data as required by TennCare in order to determine the NF's quality performance.

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1. Quality measurement data shall be submitted by the NF on a monthly basis.

2. A NF's add-on per diem payment for each specified level of Enhanced Respiratory Care Reimbursement provided for NF services shall be adjusted based on the NF's quality performance no more frequently than semi-annually.

3. A NF shall not be entitled to Enhanced Respiratory Care Reimbursement for any NF services provided if the facility has not complied with quality performance reporting requirements, or if any such data is determined (including upon post-payment audit or review) to be inaccurate or incomplete.

4. Any facility submitting false (including inaccurate or incomplete) quality performance data for purposes of Medicaid payment shall be subject to all applicable federal and state laws pertaining to the submission of false claims.

(3) Conditions for Reimbursement of Level 1 NF Care.

(a) A Level 1 NF must enter into a provider agreement with the Bureau or, upon implementation of CHOICES in the Grand Division, one or more TennCare MCOs, for reimbursement of Level 1 NF services.

(b) A Level 1 NF must be certified by the Tennessee Department of Health, showing that it has met the standards set out in 42 C.F.R., Part 442.

(c) NFs reimbursed for Level 1 NF services participating in TennCare shall be terminated as a TennCare provider if certification or licensure is canceled by CMS or the State.

(d) If the resident has resources to apply toward payment, including Patient Liability as determined by DHS, or TPL, which may include LTC insurance benefits, the payment for NF services shall be the NF's per diem rate for the applicable level of NF reimbursement authorized minus the resident's available resources.

(e) Payments for residents requiring reimbursement for Level 1 NF Services shall not exceed per diem costs or charges, whichever is less.

(f) Regardless of the reimbursement rate established for a Level 1 NF, no Level 1 NF may charge TennCare Enrollees an amount greater than the amount per day charge to private paying patients for equivalent accommodations and services.

(g) Personal laundry services in a Level 1 NF shall be considered a covered service and included in the per diem rate. TennCare Enrollees may not be charged for personal laundry services.

(4) Conditions for Reimbursement of Level 2 NF Care.

(a) A Level 2 NF must enter into a provider agreement with the Bureau, or, upon implementation of CHOICES in the Grand Division, one or more TennCare MCOs, for reimbursement of Level 2 NF services.

(b) Level 2 NFs (Medicare SNFs and TennCare NFs receiving reimbursement for Level 2 NF care) must be certified by Medicare, showing they have met the federal certification standards. Any of these NFs participating in TennCare shall be terminated as a TennCare provider if certification or licensure is canceled by CMS or the State.

(c) If the resident has available resources to apply toward payment, including Patient Liability as determined by DHS, or TPL, which may include LTC insurance benefits, the

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payment for NF services shall be the NF's per diem rate for the applicable level of NF reimbursement authorized minus the resident's available resources.

(d) If the Level 2 NF (upon submission of a cost report and a desk review or examination of its cost), has collected on a per diem basis during the period covered by the cost report and examination, more than cost reimbursement allowed, the Level 2 NF shall be required to reimburse the State for that portion of the reimbursement collected in excess of the actual recorded and examined cost.

(e) Regardless of the reimbursement rate established for a Level 2 NF, no Level 2 NF may charge TennCare Enrollees an amount greater than the amount per day charged to private paying patients for equivalent accommodations and services.

(5) Conditions for Enhanced Respiratory Care Reimbursement.

(a) The Level 2 NF must enter into a provider agreement with one or more TennCare MCOs for the provision and reimbursement of ERC in a dual certified and licensed NF/SNF.

1. A TennCare MCO shall, pursuant to T.C.A. § 71-5-1412, as amended, contract with any nursing facility for the provision of Medicaid NF services, but shall not be obligated to reimburse any NF for Enhanced Respiratory Care.

2. Unless an exception is granted, a TennCare MCO shall not reimburse any NF for Enhanced Respiratory Care unless such NF was contracted by the MCO for Enhanced Respiratory Care Reimbursement as of July 1, 2016. An MCO may request an exception from TennCare to the moratorium on reimbursement for Enhanced Respiratory Care upon the MCO's demonstration of the need for additional capacity or improved quality in the geographic area in which the NF is located, and the NF's compliance with all applicable conditions of Enhanced Respiratory Care Reimbursement specified in this paragraph.

(b) NFs providing Enhanced Respiratory Care services must be dual certified for the provision of Medicare SNF and Medicaid NF services, showing they have met the federal certification standards. Any NF participating in the TennCare Program shall be terminated by all TennCare MCOs as a TennCare provider if certification or licensure is terminated by CMS or the State.

(c) NFs providing Ventilator Weaning or Chronic Ventilator Care services and NFs receiving short-term reimbursement at the Sub-Acute Tracheal Suctioning rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention, shall meet or exceed the following minimum standards:

1. The NF shall ensure that medical direction of all Ventilator Weaning, Chronic Ventilator Care, and Sub-Acute Tracheal Suctioning services is provided by a physician licensed to practice in the State of Tennessee and board certified in pulmonary disease or critical care medicine as recognized by either the American Board of Medical Specialties or American Osteopathic Association, as applicable.

2. A licensed respiratory care practitioner as defined by T.C.A. § 63-27-102, shall be on site in the ventilator care unit twenty four (24) hours per day, seven (7) days per week to provide:

(i) Ventilator care;

(ii) Administration of medical gases;

(iii) Administration of aerosol medications; and

(iv) Diagnostic testing and monitoring of life support systems.

3. The NF shall ensure that an appropriate individualized POC is prepared for each resident receiving Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute Tracheal Suctioning. The POC shall be developed with input and participation from the medical director of the NF's Enhanced Respiratory Care program as described in Part 1.

4. The NF shall establish admissions criteria to ensure the medical stability of ventilator-dependent residents prior to transfer from an acute care setting. The NF shall maintain documentation regarding the clinical evaluation of each resident who will receive Enhanced Respiratory Care for appropriateness of placement in the facility prior to admission.

5. End tidal carbon dioxide (etCO2) or transcutaneous monitoring of carbon dioxide and oxygen (tcCO2) and continuous pulse oximetry measurements shall be available for all residents receiving Chronic Ventilator Care and provided based on the needs of each resident. For residents receiving Ventilator Weaning or Sub-Acute Tracheal Suctioning, continuous pulse oximetry shall be provided, and end tidal Carbon Dioxide (etCO2) measurements shall be provided no less than every four (4) hours, and within one (1) hour following all vent parameter changes, or for residents receiving Sub-Acute Tracheal Suctioning, after all tracheostomy tube changes, tracheostomy capping trials, or the use of speaking devices.

6. An audible, redundant external alarm system shall be connected to emergency power and/or battery back-up and located outside the room of each resident who is ventilator-dependent for the purpose of alerting staff of resident ventilator circuit disconnection or ventilator failure.

7. Ventilator equipment (and ideally physiologic monitoring equipment) shall be connected to back-up generator power via clearly marked wall outlets.

8. Ventilators shall be equipped with adequate back-up provisions, including:

(i) Internal and/or external battery back-up systems to provide a minimum of eight (8) hours of power;

(ii) Sufficient emergency oxygen delivery devices (i.e., compressed gas or battery operated concentrators);

(iii) At least one (1) battery operated suction device available per every eight (8) residents on mechanical ventilator or with a tracheostomy; and

(iv) A minimum of one (1) patient-ready back-up ventilator which shall be available in the facility at all times.

9. The NF shall be equipped with current ventilator technology to encourage and enable maximum mobility and comfort, ideally weighing less than fifteen (15) pounds with various mounting options for portability (e.g., wheelchair, bedside table, or backpack).

10. The facility shall have an emergency preparedness plan specific to residents receiving Enhanced Respiratory Care (i.e., Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute Tracheal Suctioning) which shall specifically address total power failures (loss of power and generator), as well as other emergency circumstances.

11. The facility shall have a written training program, including an annual demonstration of competencies, for all staff caring for residents receiving Enhanced Respiratory Care (i.e., Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute Tracheal Suctioning), which shall include alarm response, positioning and transfers, care within licensure scope, and rescue breathing.

(d) A NF contracted with one or more TennCare MCOs to receive Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute Tracheal Suctioning Reimbursement must be operating in compliance with Department of Health Rule 1200-08-06-.06(12) in order to be eligible for Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute Tracheal Suctioning Reimbursement. In addition, the NF shall provide attestation of its compliance with each of the requirements specified in Subparagraph (c) or shall submit a plan of correction regarding how it will achieve compliance with any condition not currently specified in Rule 1200-08-06-.06(12) no later than January 1, 2017, and shall maintain compliance on a continuous basis thereafter. As of January 1, 2017, a NF must be operating in compliance with all of the conditions specified in Subparagraph (c) in order to be eligible for Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute Tracheal Suctioning Reimbursement.

(e) The standards set forth in Subparagraph (c) are not applicable for Secretion Management Tracheal Suctioning Reimbursement; however, the NF must meet standards specified in Subparagraph (f) below for Secretion Management Tracheal Suctioning Reimbursement.

(f) A NF contracted with one or more TennCare MCOs to receive only Secretion Management Tracheal Suctioning Reimbursement shall meet or exceed the following minimum standards:

1. A licensed respiratory care practitioner as defined by T.C.A. § 63-27-102, shall be on site a minimum of weekly to provide:

   (i) Clinical Assessment of each resident receiving Secretion Management Tracheal Suctioning (including Pulse Oximetry measurements);

   (ii) Evaluation of appropriate humidification;

   (iii) Tracheostomy site and neck skin assessment;

   (iv) Care plan updates; and

   (v) Ongoing education and training on patient assessment, equipment and treatment.

2. The NF shall ensure that an appropriate individualized POC is prepared for each resident receiving Secretion Management Tracheal Suctioning. The POC shall be developed with input and participation from a licensed respiratory care practitioner as defined by T.C.A. § 63-27-102. Medical direction, including POC development and oversight for persons receiving Sub-Acute Tracheal Suctioning shall be conducted in accordance with Subparagraph (c).

3. The NF shall establish admissions criteria which meet the standard of care to ensure the medical stability of residents who will receive Secretion Management Tracheal Suctioning prior to transfer from an acute care setting. The NF shall maintain pre-admission documentation regarding the clinical evaluation of each resident who will receive Secretion Management Tracheal Suctioning for appropriateness of placement in the facility.

4. Pulse oximetry measurements shall be provided at least daily with continuous monitoring available, based on the needs of each resident. For any resident being weaned from the tracheostomy, the following shall be provided:

   (i) Continuous pulse oximetry monitoring; and

   (ii) End tidal Carbon Dioxide (etCO2) measurements at least every four (4) hours and within one (1) hour following tracheostomy tube changes, tracheostomy capping trials, or the use of speaking devices. Transcutaneous (tcCO2) shall not be appropriate for intermittent monitoring.

5. Mechanical airway clearance devices and/or heated high flow molecular humidification via the tracheostomy shall also be available for secretion management, as appropriate for the needs of each resident.

6. Oxygen equipment shall be connected to back-up generator power via clearly marked wall outlets.

7. Adequate back-up provisions shall be in place including:

   (i) Sufficient emergency oxygen delivery devices (i.e. compressed gas or battery operated concentrators); and

   (ii) At least one (1) battery operated suction device available per every eight (8) residents on mechanical ventilation or with a tracheostomy.

8. The facility shall have an emergency preparedness plan specific to residents receiving Secretion Management Tracheal Suctioning which shall specifically address total power failures (loss of power and generator), as well as other emergency circumstances.

9. The facility shall have a written training program, including an annual demonstration of competencies, for all staff caring for residents receiving Secretion Management Tracheal Suctioning which shall include alarm response, positioning and transfers, care within licensure scope, and rescue breathing.

(g) When a NF establishes a “Tracheostomy Unit” by accepting Tracheal Suctioning Reimbursement, including Sub-Acute and Secretion Management, for more than three (3) residents on the same day the licensed respiratory care practitioner described in Part (f)1 shall be on site a minimum of daily for assessment, care management, and care planning of residents receiving Tracheal Suctioning.

(h) A NF contracted with one or more TennCare MCOs to receive Secretion Management Tracheal Suctioning Reimbursement shall provide attestation of its compliance with each of the requirements specified in Subparagraph (f) or shall submit a plan of correction regarding how it will achieve compliance no later than January 1, 2017, and shall maintain compliance on a continuous basis thereafter. As of January 1, 2017, a

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NF must be operating in compliance with all of the conditions specified in Subparagraph (f) in order to be eligible for Secretion Management Tracheal Suctioning Reimbursement.

(i) Eligibility for and access to ERC services by individuals from out of state is governed by 42 C.F.R. § 435.403. A NF shall not recruit individuals from other states to receive Enhanced Respiratory Care in Tennessee. A NF shall not be eligible to receive TennCare reimbursement for Enhanced Respiratory Care services for a resident placed by another state or any agency acting on behalf of another state in making the placement because such services are not available in the individual's current state of residence, including residents admitted to the NF/SNF under the Medicare Skilled Nursing Facility care benefit when such benefit has been exhausted. The NF shall be responsible for arranging, prior to the resident's admission to the facility, Medicaid reimbursement for Enhanced Respiratory Care services from the Medicaid Agency of the state which placed the resident and which will commence when other payment sources (e.g., Medicare, private pay, but not TennCare) have been exhausted.

(6) Reimbursement methodology for Level 1 Care.

(a) A Level 1 NF shall be reimbursed on the lowest of the following:

1. Allowable cost;

2. Allowable charges;

3. An amount representing the sixty-fifth (65th) percentile of all such NFs or beds, whichever is lower, participating in the Level 1 Medicaid NF Program. In determining the sixty-fifth (65th) percentile for purposes of this part, each provider's most recently filed and reviewed cost report shall be inflated from the mid-point of the provider's cost reporting period to the mid-point of the State's payment period. The trending factor shall be computed for NFs that have submitted cost reports covering at least six (6) months of program operations. For NFs that have submitted cost reports covering at least three (3) full years of program participation, the trending factor shall be the average cost increase over the three (3) year period, limited to the seventy-fifth (75th) percentile trending factor of NFs participating for at least three (3) years. Negative averages shall be considered zero (0). For NFs that have not completed three (3) full years in the program, the one (1) year trending factor shall be the fiftieth (50th) percentile trending factor of NFs participating in the program for at least three (3) years. For NFs that have failed to file timely cost reports, the trending factor shall be zero (0);

4. An amount representing the reimbursable cost of the sixty-fifth (65th) percentile of NFs or beds, whichever is lower, participating in the NF Level 1 Program. In determining the sixty-fifth (65th) percentile ceiling for purposes of this part, operating costs from each provider's most recently filed and reviewed cost report will be inflated from the mid-point of the provider's cost reporting period to the mid-point of the state's payment period. The inflation factor shall be as described in Part 3. above. Capital-related costs are not subject to indexing. Capital-related costs are property, depreciation, and amortization expenses included in Section F.18 and F.19 of the NF Cost Report Form. All other costs, including home office costs and management fees, are operating costs. No inflation factor will be allowed for providers not filing timely cost reports. For providers in the program less than three (3) years, the inflation factor shall be the fiftieth (50th) percentile of allowable inflation factors for providers participating in

(Rule 1200-13-01-.03, continued)

the program for at least three (3) years. Budgeted cost reports receive no inflation allowance; or

5. For State Fiscal Year 1997-98, the budgeted amount for Level 1 and Level 2 care of $672,040,000. For State Fiscal Year 1998-99, the budgeted amount for Level 1 and Level 2 care of $705,642,000. For State Fiscal Year 1999-2000 and subsequent years, a proportional share of expenditures not to exceed the amount budgeted by the State for NF reimbursement. Expenditures shall be monitored throughout each year to determine if rate adjustments are necessary to assure that each LOC is within the budgeted amount.

6. To assure the proper application of Part 5. above, the Comptroller's Office shall be authorized to adjust per-diem rates up or down as necessary during the year.

7. The annual NF tax shall be passed through as an allowable cost, but shall be excluded for purposes of computing the inflation allowance and cost-containment incentive. The NF tax shall not be subject to the sixty-fifth (65th) percentile limits but is subject to the limit specified in Rule 1200-13-01-.03(6)(a)5.

8. If the resident has no available resources to apply toward payment, the Medicaid payment is the lower of per-diem cost, charges, or the sixty-fifth (65th) percentile of all such NFs or beds participating in the Medicaid Program, whichever is less. Cost is determined on a facility-by-facility basis.

9. The cost report closing date for determination of the Level 1 sixty-fifth (65th) percentile shall be the first working day of the month preceding the month in which the recomputed sixty-fifth (65th) percentile is effective. All clean cost reports received by the Comptroller's Office on or before the closing date shall be included in the determination of the sixty-fifth (65th) percentile ceiling. A clean cost report is one upon which rates may be set without additional communication from the provider. Home office cost reports must be filed before any individual NF cost reports included in a chain can be processed.

(b) Costs for supplies and other items billed, including any NF staff required to deliver the service, which are billed to Medicare Part B on behalf of all patients must be included as a reduction to reimbursable expenses in Section G of the NF cost report.

(c) Once a per-diem rate is determined from a clean cost report, the rate will not be changed until the next ceiling redetermination except for audit adjustments, correction of errors, or termination of a budgeted rate, or as necessary to comply with Rule 1200-13-01-.03(6)(a)5.

(7) Reimbursement Methodology for Level 2 Care.

(a) A Level 2 NF shall be reimbursed on the lowest of the following:

1. Allowable costs;

2. Allowable charges;

3. An amount representing the reimbursable cost of the sixty-fifth (65th) percentile of all such NFs or beds, whichever is lower, participating in the Level 2 Medicaid NF Program. In determining the sixty-fifth (65th) percentile for purposes of this part, each provider's most recently filed and reviewed cost report shall be inflated from the mid-point of the provider's cost reporting period to the mid-point of the Bureau's payment period. The trending factor shall be computed for NFs that

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have submitted cost reports covering at least six (6) months of program operations. For NFs that have submitted cost reports covering at least three (3) full years of program participation, the trending factor shall be the average cost increase over the three (3) year period, limited to the seventy-fifth (75th) percentile trending factor of NFs participating for at least three (3) years. Negative averages shall be considered zero (0). For NFs that have not completed three (3) full years in the program, the one (1) year trending factor shall be the fiftieth (50th) percentile trending factor of NFs participating in the program for at least three (3) years. For NFs that have failed to file timely cost reports, the trending factor shall be zero (0);

4. A prospective amount representing the reimbursable cost of the sixty-fifth (65th) percentile of NFs or beds, whichever is lower, participating in the NF Level 2 Program. In determining the sixty-fifth (65th) percentile ceiling for purposes of this part, operating costs from each provider's most recently filed and reviewed cost report will be inflated from the midpoint of the provider's cost reporting period to the mid-point of the Bureau's payment period. The inflation factor shall be as described in Part 3. above. Capital-related costs are not subject to indexing. Operating and capital-related costs are as specified on Worksheet B of the Medicare SNF cost report form. Budgeted cost reports receive no inflation allowance; or

5. For State Fiscal Year 1997-98, the budgeted amount for Level 1 and Level 2 care of $672,040,000. For State Fiscal Year 1998-99, the budgeted amount for Level 1 and Level 2 care of $705,642,000. For State Fiscal Year 1999-2000 and subsequent years, a proportional share of expenditures not to exceed the amount budgeted by the State for NF reimbursement. Expenditures shall be monitored throughout each year to determine if rate adjustments are necessary to assure that each LOC is within the budgeted amount.

6. To assure the proper application of Part 5. above, the Comptroller's Office shall be authorized to adjust per-diem rates up or down as necessary during the year.

7. The cost report closing date for determination of the Level 2 sixty-fifth (65th) percentile shall be the first working day of the month preceding the month in which the recomputed sixty-fifth (65th) percentile is effective. All clean cost reports received by the Comptroller's Office on or before the closing date shall be included in the determination of the sixty-fifth (65th) percentile. A clean cost report is one upon which rates may be set without additional communication from the provider. Home office cost reports must be filed before any individual NF cost reports included in a chain can be processed.

8. The annual NF tax shall be passed through as an allowable cost, but shall be excluded for purposes of computing the inflation allowance and cost-containment incentive. The NF tax shall not be subject to the sixty-fifth (65th) percentile limits but is subject to the limit specified in Rule 1200-13-01-.03(7)(a)5.

9. Once a per-diem rate is determined from a clean cost report, the rate shall not be changed until the next ceiling redetermination except for audit adjustments, correction of errors, or termination of a budgeted rate, or as necessary to comply with Rule 1200-13-01-.03(7)(a)5.

10. If the resident has no available resources to apply toward payment, the Medicaid payment is the lower of per-diem cost, charges, or the sixty-fifth (65th) percentile of beds or NFs, whichever is lower, participating in the Medicaid Program. Cost is determined on a facility by facility basis.

(b) Medicare Part B charges, including any facility staff required to deliver the service, are non-allowable in calculating Medicaid Level 2 NF reimbursement.

(8) Enhanced Respiratory Care Reimbursement in a dual certified and licensed NF/SNF shall be made only by TennCare MCOs in accordance with this Chapter and rates established by the Bureau. Effective July 1, 2016, each level of Enhanced Respiratory Care Reimbursement shall be an add-on payment to the NF's established Level 2 per diem rate or the NF's blended per diem rate, when established. The amount of the NF's add-on payment for each of the specified levels of reimbursement shall be based on the facility's performance on quality outcome and technology measures pursuant to a methodology established by TennCare. Quality outcome and technology measures, performance benchmarks, and the methodology to apply such measures and benchmarks to each of the specified levels of Enhanced Respiratory Care Reimbursement may be adjusted during FY 2016-2017 to ensure compliance with the Appropriations Act, Public Chapter 758, and no more frequently than annually thereafter in order to continuously improve the quality of care and quality of life outcomes experienced by individuals receiving Enhanced Respiratory Care in a NF.

(9) Bed holds. A Level 1 NF shall be reimbursed for a resident's bed in the NF during the resident's temporary absence from the NF as follows:

(a) Reimbursement shall be made for up to a total of ten (10) days per State fiscal year while the resident is hospitalized or absent from the NF on therapeutic leave. The following conditions must be met in order for a bed hold reimbursement to be made:

1. The resident intends to return to the NF.

2. For hospital leave days:

(i) Each period of hospitalization is physician ordered and so documented in the resident's medical record in the NF; and

(ii) The hospital provides a discharge plan for the resident.

3. Therapeutic leave days, when the resident is absent from the NF on a therapeutic home visit or other therapeutic absence, are provided pursuant to a physician's order.

4. At least eighty-five percent (85%) of all other beds in the NF are occupied at the time of the hospital admission or therapeutic absence. An occupied bed is one that is actually being used by a resident. Beds being held for other residents while they are hospitalized or otherwise absent from the facility are not considered to be occupied beds for purposes of this calculation. Computations of occupancy percentages will be rounded to the nearest percentage point.

(b) NFs shall not be reimbursed for holding a bed for a person receiving Level 2 NF or Enhanced Respiratory Care reimbursement during his temporary absence from the NF.

(10) Other Reimbursement Issues.

(a) No change of ownership or controlling interest of an existing Medicaid provider, including NFs, can occur until monies as may be owed to the Bureau or its contractors are provided for. The purchaser shall notify the Bureau of the purchase at the time of ownership change and is financially liable for the outstanding liabilities to the Bureau or its contractors for one (1) year from the date of purchase or for one (1) year following the Bureau's receipt of the provider's Medicare final notice of program reimbursement,

(Rule 1200-13-01-.03, continued)

whichever is later. The purchaser shall be entitled to use any means available to it by law to secure and recoup these funds from the selling entity. In addition, purchasers of NFs are responsible for obtaining an accurate accounting and transfer of funds held in trust for Medicaid residents at the time of the change of ownership or controlling interest.

(b) If the Bureau or an MCO has not reimbursed a business for TennCare services provided under the TennCare Program at the time the business is sold, when such an amount is determined, the Bureau or the MCO shall be required to reimburse the person owning the business provided such sale included the sale of such assets.

(c) When a provider was originally paid within a retrospective payment system that is subject to regular adjustments and the provider disputes the proposed adjustment action, the provider must file with the State not later than thirty (30) days after receipt of the notice informing the provider of the proposed adjustment action, a request for hearing. The provider's right to a hearing shall be deemed waived if a hearing is not requested within thirty (30) days after receipt of the notice.

Authority: *T.C.A. §§ 4-5-202, 4-5-205, 4-5-208, 71-5-105, 71-5-109, Executive Order No. 23, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 3l, 1979; effective March 16, 1979. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed November 4, 1981; effective December 21, 1981. Amendment filed September 27, 1982; effective October 27, 1982. Amendment filed February 11, 1983; effective March 14, 1983. Amendment filed May 27, 1983; effective June 27, 1983. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed February 14, 1984; effective March 15, 1984. Amendment filed March 12, 1984; effective April 11, 1984. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed June 25, 1984; effective September 11, 1984. Amendment filed September 10, 1985; effective October 10, 1985. Amendment filed November 4, 1985; effective December 4, 1985. Amendment filed November 4, 1985; effective February 12, 1986. Amendment filed April 29, 1986; effective May 29, 1986. Original rule filed July 30, 1987; effective September 13, 1987. Amendment filed September 30, 1987; effective November 14, 1987. Amendment filed January 22, 1988; effective March 7, 1988. Amendment filed September 30, 1988; effective November 14, 1988. Amendment filed October 27, 1988; effective December 11, 1988. Amendment filed November 10, 1988; effective December 25, 1988. Amendment filed December 15, 1988; effective January 29, 1989. Amendment filed May 30, 1989; effective July 14, 1989. Amendment filed July 22, 1989; effective August 4, 1989. Amendment filed August 31, 1989; effective October 15, 1989. Amendment filed November 27, 1989; effective January 11, 1990. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed March 1, 1990; effective April 15, 1990. Amendment filed November 5, 1990; effective December 20, 1990. Amendment filed January 17, 1991; effective March 3, 1991. Amendment filed January 31, 1991; effective March 17, 1991. Amendment filed February 12, 1991; effective March 29, 1991. Amendment filed February 21, 1991; effective April 7, 1991. Amendment filed February 27, 1991; effective April 13, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed September 11, 1991; effective October 26, 1991. Amendment filed September 17, 1991; effective November 1. 1991. Amendment filed October 25, 1991; effective December 9, 1991. Amendment filed November 27, 1991; effective January 11, 1992. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 10, 1992; effective April 24, 1992. Amendment filed March 17, 1992; effective May 1, 1992. Amendment filed April 14, 1992; effective May 29, 1992. Amendment filed April 30, 1992; effective June 14, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed November 17, 1993; effective January 31, 1994. Amendment filed December 7, 1993; effective February 20, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Public necessity rule filed September 26, 2005; effective through March 10, 2006. Amendment filed December 20, 2005; effective March 5, 2006. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.*

1200-13-01-.04 REPEALED.

Authority: *T.C.A. §§ 4-5-202 and 71-5-105.* ***Administrative History:*** *Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendments filed May 29, 1987; effective July 13, 1987. Amendment filed June 22, 1989; effective August 4, 1989. Amendment filed August 31, 1989; effective October 15, 1989. Repeal filed February 1, 2013; effective July 29, 2013.*

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.

(Rule 1200-13-01-.05, continued)

(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.

(Rule 1200-13-01-.05, continued)

(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 the State. 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 June 30, 2015. Members enrolled in Interim CHOICES Group 3 on June 30, 2015, may continue to qualify in this group after June 30, 2015, 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. Should such Member subsequently require transition back to CHOICES Group 1, TennCare may grant an exception to the current NF LOC criteria, so long as the person continues to meet the NF LOC criteria in place on June 30, 2012, and has remained continuously enrolled in CHOICES Group 1 and/or Group 2 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:

(Rule 1200-13-01-.05, continued)

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.

(Rule 1200-13-01-.05, continued)

2. The Applicant or his caregiver is unwilling to abide by the POC.

(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;

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;

(Rule 1200-13-01-.05, continued)

(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 determined by TennCare to meet the medical eligibility criteria in Rule 1200-13-01-.10(5)(c) who would qualify for Chronic Ventilator Care or a Member determined by the Bureau to meet the medical eligibility criteria in Rule 1200-13-01-.10(5)(d) who would qualify for Secretion Management Tracheal Suctioning will have a Cost Neutrality Cap that reflects the higher payment that would be made to a NF for such care. For at least FY 2016-2017, the Cost Neutrality Cap for such CHOICES Group 2 member shall be based on the annualized cost of the applicable Enhanced Respiratory Care rate in effect as of June 30, 2016. Beginning July 1, 2017, the Cost Neutrality Cap for such CHOICES Group 2 member may be established based on the average annualized cost of the applicable level of Enhanced Respiratory Care Reimbursement using payments for such level of reimbursement during the FY 2016-2017 year. The Cost Neutrality Cap for such CHOICES Group 2 member shall be adjusted no more frequently than annually thereafter. There is no Cost Neutrality Cap based on the cost of Ventilator Weaning Reimbursement or Sub-Acute Tracheal Suctioning Reimbursement, as such services are 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.

(Rule 1200-13-01-.05, continued)

(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;

(Rule 1200-13-01-.05, continued)

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

(Rule 1200-13-01-.05, continued)

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 June 30, 2015, 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:

(Rule 1200-13-01-.05, continued)

(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) Safety Determination Requests for CHOICES and ECF CHOICES.

(a) For purposes of the Need for Inpatient Nursing Care, as specified in TennCare Rule 1200-13-01-.10(4)(b)2.(i)(II) and 1200-13-01-.10(4)(b)2.(ii)(II)-(IV), a Safety Determination by TennCare shall be made upon request of the Applicant, the Applicant's Representative, or the entity submitting the PAE, including the AAAD, DIDD, MCO, NF, or PACE Organization if an Applicant for CHOICES is in the target population for CHOICES as specified in Rule 1200-13-01-.05 and is At Risk for Institutionalization as defined in Rule 1200-13-01-.02, or an Applicant for ECF CHOICES is in the target population for ECF CHOICES as specified in Rule 1200-13-01-.31 and is At Risk for Institutionalization as defined in Rule 1200-13-01-.02, and at least one of the following criteria are met.

1. The Applicant has an approved total acuity score of at least five (5) but no more than eight (8);

2. The Applicant has an approved individual acuity score of at least three (3) for the Orientation measure and the absence of frequent intermittent or continuous intervention and supervision would result in imminent and serious risk of harm to the Applicant and/or others (documentation of the impact of such deficits on the Applicant's safety, including information or examples that would support and describe the imminence and seriousness of risk shall be required);

3. The Applicant has an approved individual acuity score of at least two (2) for the Behavior measure; and the absence of intervention and supervision for behaviors at the frequency specified in the PAE would result in imminent and serious risk of harm to the Applicant and/or others (in addition to information submitted with the PAE, information or examples that would support and describe the imminence and seriousness of risk resulting from the behaviors shall be required);

(Rule 1200-13-01-.05, continued)

4. The Applicant has an approved individual acuity score of at least three (3) for the mobility or transfer measures or an approved individual acuity score of at least two (2) for the toileting measure, and the absence of frequent intermittent assistance for mobility and/or toileting needs would result in imminent and serious risk to the Applicant's health and safety (documentation of the mobility/transfer or toileting deficits and the lack of availability of assistance for mobility/transfer and toileting needs shall be required);

5. The Applicant has experienced a significant change in physical or behavioral health or functional needs or the Applicant's caregiver has experienced a significant change in physical or behavioral health or functional needs which impacts the availability of needed assistance for the Applicant;

6. The Applicant has a pattern of recent falls resulting in injury or with significant potential for injury or a recent fall under circumstances indicating a significant potential risk for further falls;

7. The Applicant has an established pattern of recent emergent hospital admissions or emergency department utilization for emergent conditions or a recent hospital or NF admission or episode of treatment in a hospital emergency department under circumstances sufficient to indicate that the person may not be capable of being safely maintained in the community (not every hospital or NF admission or emergency department episode will be sufficient to indicate such).

8. The Applicant's behaviors or a pattern of self-neglect has created a risk to personal health, safety and/or welfare that has prompted intervention by law enforcement or Adult Protective Services (APS). A report of APS or law enforcement involvement shall be sufficient by itself to require the conduct of a Safety Determination (but not necessarily the approval of a Safety Determination).

9. The Applicant has recently been discharged from a community-based residential alternative setting (or such discharge is pending) because the Applicant's needs can no longer be safely met in that setting.

10. The Applicant is a CHOICES Group 1 or Group 2 member or PACE member enrolled on or after July 1, 2012 (pursuant to level of care rules specified in 1200-13-01-.10(4)(b)2.(i) and (ii)) and has been determined upon review to no longer meet nursing facility level of care based on a total acuity score of 9 or above.

11. The applicant has diagnosed complex acute or chronic medical conditions which require frequent, ongoing skilled and/or rehabilitative interventions and treatment by licensed professional staff.

12. The Applicant's MCO has determined, upon enrollment into Group 3 based on a PAE submitted by another entity, that the Applicant's needs cannot be safely met within the array of services and supports available if enrolled in Group 3 (see 1200-13-01-.02), such that a higher level of care is needed.

13. An Applicant who has an intellectual or developmental disability has a General Maladaptive Index value of -21 or lower, as determined on the Maladaptive Behavior Index (MBI) portion of the Inventory for Client and Agency Planning (ICAP).

(Rule 1200-13-01-.05, continued)

14. An Applicant under age 18 who has an intellectual or developmental disability will not qualify financially for TennCare unless the deeming of the parent's income to the child is waived, and absent the availability of benefits in ECF CHOICES Group 4, the child is at imminent risk of placement outside the home.

(b) Any of these criteria shall be sufficient to warrant review of a Safety Determination request by the Bureau; however except as provided in Subpart (f)1.(i) below, no criterion shall necessarily be sufficient, in and of itself, to justify that such Safety Determination request (and NF LOC) will be approved. The Bureau may also, at its discretion, review a Safety Determination request when none of the criteria in (a) above have been met, but other safety concerns have been submitted which the Bureau determines may impact the person's ability to be safely served in CHOICES Group 3, or ECF CHOICES Group 5, as applicable, along with sufficient medical evidence to make a safety determination. The Bureau's Safety Determination shall be based on a review of the medical evidence in its entirety, including consideration of the Applicant's medical and functional needs, and the array of services and supports that would be available if the Applicant was enrolled in CHOICES Group 3 or ECF CHOICES Group 4 (for children under age 18) or Group 5 (for adults age 21 and older), as applicable for the target population in which the Applicant will be enrolled, if eligible, including CHOICES HCBS or ECF CHOICES HCBS up to the Expenditure Cap of $15,000 or $30,000, as applicable, and one-time emergency assistance up to $6,000, as applicable; non-CHOICES HCBS available through TennCare (e.g., home health); cost effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources and unpaid supports provided by family members and other caregivers who are willing and able to provide such care.

(c) PAEs may be submitted by more than one entity on behalf of an applicant. If Entity #1 (e.g., the MCO) believes that an applicant's needs can be safely met if enrolled in Group 3 and a Safety Determination is not needed for the applicant, but Entity #2 (e.g., the NF) believes that a Safety Determination is appropriate, then Entity #2 (e.g., the NF) may also submit a PAE on behalf of the applicant, along with a completed Safety Determination request, to the Bureau for review.

(d) If one or more of the criteria specified in (a) above are met and the medical evidence received by the Bureau is insufficient to make a Safety Determination, the Bureau may request a face-to-face assessment by the AAAD or DIDD (for non Medicaid-eligible Applicants), the MCO (for Medicaid-eligible Applicants), or other designee in order to gather additional information needed by the Bureau to make a final Safety Determination. In such instances, the PAE shall be deemed incomplete, and the time for disposition of the PAE shall be tolled for a reasonable period of time (not to exceed 10 business days, except when such delay is based on the reasonable needs or request of the Applicant, and only for a specific additional period not to exceed a total period of 30 calendar days, occasioned by the Applicant's needs or request) while such additional evidence is gathered.

(e) Except as specified in Subpart (f)1.(i) below, documentation required to support a Safety Determination request shall include all of the following:

1. A completed PAE, including detailed explanation of each ADL or related deficiency, as required by the Bureau, a completed Safety Determination request, and medical evidence sufficient to support the functional and related deficits identified in the PAE and the health and safety risks identified in the Safety Determination request;

2. A comprehensive needs assessment which shall include all of the following:

(Rule 1200-13-01-.05, continued)

(i) An assessment of the Applicant's physical, behavioral, and psychosocial needs not reflected in the PAE, including the specific tasks and functions for which assistance is needed by the Applicant, the frequency with which such tasks must be performed, and the Applicant's need for safety monitoring and supervision;

(ii) The Applicant's living arrangements and the services and supports the Applicant has received for the six (6) months prior to submission of the Safety Determination request, including unpaid care provided by family members and other caregivers, paid services and supports the Applicant has been receiving regardless of payer (e.g., non-CHOICES HCBS available through TennCare such as home health and services available through Medicare, private insurance or other funding sources); and any anticipated change in the availability of such care or services from the current caregiver or payer; and

(iii) Detailed explanation regarding 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 impact the Applicant's ability to be safely supported within the array of covered services and supports that would be available if the Applicant were enrolled in CHOICES Group 3 or ECF CHOICES Group 5, as applicable, or for a child under age 18 who has an intellectual or developmental disability, how such event(s) or circumstances would impact the Applicant's ability to remain in the family home.

3. A person-centered plan of care or support plan, as applicable, developed by the MCO Care Coordinator or Support Coordinator, NF, or PACE Organization (i.e., the entity submitting the Safety Determination request) which specifies the tasks and functions for which assistance is needed by the Applicant, the frequency with which such tasks must be performed, the Applicant's need for safety monitoring and supervision; and the amount (e.g., minutes, hours, etc.) of paid assistance that would be necessary to provide such assistance; and that would be provided by such entity upon approval of the Safety Determination. (A plan of care or support plan is not required for a Safety Determination submitted by the AAAD or DIDD.) In the case of a Safety Determination request submitted by an MCO or AAAD for a NF resident, the plan of care shall be developed in collaboration with the NF, as appropriate; and

4. An explanation regarding why an array of covered services and supports, including CHOICES HCBS up to the Expenditure Cap of $15,000, ECF CHOICES HCBS up to the Expenditure Cap of $30,000 and one-time emergency assistance up to $6,000; and non-CHOICES or non-ECF 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 Applicant's needs in the community, or for a child under age 18 who has an intellectual or developmental disability, why the availability of benefits in ECF CHOICES Group 4, including ECF CHOICES HCBS up to the Expenditure Cap of $15,000, non-ECF CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care, are necessary to prevent the child's imminent placement outside the home.

(f) Approval of a Safety Determination Request

(Rule 1200-13-01-.05, continued)

1. A Safety Determination request shall be approved if there is sufficient evidence, as required and determined by the Bureau, to demonstrate that the necessary intervention and supervision needed by the Applicant cannot be safely provided within the array of services and supports that would be available if the Applicant was enrolled in CHOICES Group 3 or ECF CHOICES Group 5, as applicable for the target population in which the Applicant will be enrolled, if eligible, including CHOICES HCBS or ECF CHOICES HCBS up to the Expenditure Cap of $15,000 or $30,000, as applicable, and one-time emergency assistance up to $6,000, as applicable; non-CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and unpaid supports provided by family members and other caregivers who are willing and able to provide such care; or for a child under age 18 who has an intellectual or developmental disability, that the Applicant will not qualify financially for TennCare unless the deeming of the parent's income to the child is waived, and absent the availability of benefits in ECF CHOICES Group 4, including ECF CHOICES HCBS up to the Expenditure Cap of $15,000; non-ECF CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care, the child is at imminent risk of placement outside the home:

   (i) An applicant with I/DD whose GMI score is at or below -31 (categorized as "Serious" or "Very Serious") shall qualify for NF LOC on the basis of the safety determination, regardless of their score on the PAE Acuity Scale. No minimum acuity score and no other information shall be required as part of the safety determination.

   (ii) A maladaptive behavior index value of -21 to -30 (categorized as "Moderately Serious") shall be sufficient to warrant a Safety Determination review upon request, but shall not automatically qualify for approval of NF LOC on the basis of safety. The decision shall be based on a review of the entirety of the person's needs and circumstances and in accordance with documentation requirements specified herein.

   (iii) For applicants with I/DD who have a maladaptive behavior index value of -20 and above, the problem behavior assessment and the life skills assessment shall be taken into account along with other documentation requirements specified herein in determining whether any safety determination request submitted should be approved.

2. When a Safety Determination request is approved, the Applicant's NF LOC eligibility shall be approved (see Rule 1200-13-01-.10(4)(b)2.(i)(II) and 1200-13-01-.10(4)(b)2.(ii)(II)-(IV)).

3. If enrolled in CHOICES Group 1 or 2, PACE, or in ECF CHOICES, based upon approval of a Safety Determination request, the NF, MCO, or PACE Organization, respectively, shall implement any plan of care or initial support plan developed by such entity and submitted as part of the Safety Determination request to demonstrate the services needed by the Applicant, subject to changes in the Applicant's needs which shall be reflected in a revised plan of care or person-centered support plan and signed by the Applicant (or authorized representative).

(Rule 1200-13-01-.05, continued)

4. The lack of availability of suitable community housing, the need for assistance with routine medication management, discharge from another service system (e.g., state custody or a mental health institute), or release from incarceration shall not be sufficient by itself to justify approval of a Safety Determination request.

(g) Denial of a Safety Determination Request for CHOICES or ECF CHOICES.

1 Pursuant to Rule 1200-13-01-.10(7)(b), when a PAE is denied, including instances where a Safety Determination has been requested and denied, a written Notice of denial shall be sent to the Applicant and, where applicable, to the Designated Correspondent. In instances where such denial is based in part on a Safety Determination that has been requested and denied, such Notice shall advise the Applicant of the Bureau's LOC decision, including denial of the Safety Determination request. This notice shall advise the Applicant of the right to appeal the PAE denial decision, which includes the Safety Determination, as applicable, within 30 calendar days,

2. If enrolled in CHOICES Group 3 or in ECF CHOICES Group 5 based upon denial of a Safety Determination Request, the MCO shall implement any plan of care or initial support plan, as applicable, developed by the MCO and submitted as part of the Safety Determination process to demonstrate that the Applicant's needs can be safely met in CHOICES Group 3 or ECF CHOICES Group 5, as applicable, including covered medically necessary CHOICES HCBS or ECF CHOICES HCBS, and non-CHOICES or non-ECF CHOICES HCBS available through TennCare and cost-effective alternative services upon which denial of the Safety Determination was based, subject to changes in the Applicant's needs which shall be reflected in a revised plan of care or person-centered support plan and signed by the Applicant (or authorized representative).

(h) Duration of Nursing Facility Level of Care Based on an Approved Safety Determination Request.

1. Pursuant to 1200-13-01-.10(2)(h), Nursing Facility level of care based on an approved Safety Determination request may be approved by the Bureau for an open ended period of time or 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, and how long it is reasonably anticipated that the Applicant's needs cannot be safely and appropriately met in the community within the array of services and supports available if enrolled in CHOICES Group 3 or ECF CHOICES Group 5, as applicable, or for a child under age 18, when the child turns age 18 and the parent's income is no longer deemed to the child. This may include periods of less than 30 days as appropriate, including instances in which it is determined that additional post-acute inpatient treatment of no more than 30 days is needed for stabilization, rehabilitation, or intensive teaching as specified in the plan of care following an acute event, newly diagnosed complex medical condition, or significant progression of a previously diagnosed complex medical condition in order to facilitate the Applicant's safe transition back to the community.

2. Pursuant to Rule 1200-13-01-.10(7)(f), when a PAE for NF LOC is approved 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, and how long it is reasonably anticipated that the Applicant's needs cannot be safely and appropriately met in the community within the array of services and supports available if enrolled in CHOICES Group

(Rule 1200-13-01-.05, continued)

3 or ECF CHOICES Group 5, or for a child under age 18, when the child turns age 18 and the parent's income is no longer deemed to the child, the Applicant shall be provided with a Notice of appeal rights, including the opportunity to submit an appeal within 30 calendar days of receipt of this notice. Nothing in this section shall preclude the right of the Applicant to submit a new PAE (including a new Safety Determination request) establishing medical necessity of care before the Expiration Date has been reached or anytime thereafter.

(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

(Rule 1200-13-01-.05, continued)

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

(Rule 1200-13-01-.05, continued)

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")
1. Adult Day Care	Covered with a limit of 2080 hours per calendar year, per CHOICES Member.	No
2. Assistive Technology	Covered with a limit of $900 per calendar year, per Member.	No

(Rule 1200-13-01-.05, continued)

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible 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
4. CBRA	Companion Care. Not covered (regardless of payer), when the Member is living in an ACLF, Critical 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, or Short-Term NF Care.	Yes
	CBRA services (e.g., ACLFs, Critical Adult Care Homes, CLS, and CLS-FM).	No

(Rule 1200-13-01-.05, continued)

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")
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, provided however, that an MCO may authorize Home-Delivered Meals for a CHOICES Member receiving Companion Care or Community Living Supports (not Community Living Supports-Family Model) in their own home (not a provider-controlled residence) when such service is medically necessary in order to 1) address health risks related to food insecurity; 2) support improved management of chronic health conditions; 3) reduce risk of hospital readmissions related to such chronic health conditions; 4) improve physical or mental health outcomes; or 5) delay or prevent nursing home placement.	No
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

(Rule 1200-13-01-.05, continued)

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")
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
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
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

(Rule 1200-13-01-.05, continued)

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")
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, provided however, that an MCO may authorize PERS for a CHOICES Member receiving Companion Care, Community Living Supports, or Community Living Supports-Family Model services when such service provides less than 24-hour staff support and PERS is medically necessary in order help sustain or increase the Member's independence in the home, reduce risk of safety concerns, and delay or prevent nursing home placement.	No
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
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

(Rule 1200-13-01-.05, continued)

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")
1. Adult Day Care	Covered with a limit of 2080 hours per calendar year, per CHOICES Member.	No
2. Assistive Technology	Covered with a limit of $900 per calendar year, per Member.	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

(Rule 1200-13-01-.05, continued)

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")
4. CBRA	CBRA services (e.g., ACLFs, CLS, and CLS-FM as specified below). CBRAs available to individuals in Group 3 include only Assisted Care Living Facility services, CLS, and CLS-FM that can be provided within the limitations set forth in the expenditure cap as defined in Rule 1200-13-01-.02 and further specified in Rule 1200-13-01-.05(4)(f), when the cost of such services will not exceed the cost of CHOICES HCBS that would otherwise be needed by the Member to 1) safely transition from a nursing facility to the community; or 2) continue being safely served in the community and to delay or prevent nursing facility placement.	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, provided however, that an MCO may authorize Home-Delivered Meals for a CHOICES Member receiving Companion Care or Community Living Supports (not Community Living Supports-Family Model) in their own home (not a provider-controlled residence) when such service is medically necessary in order to 1) address health risks related to food insecurity; 2) support improved management of chronic health conditions; 3) reduce risk of hospital readmissions related to such chronic health conditions; 4) improve physical or mental health outcomes; or 5) delay or prevent nursing home placement.	No

(Rule 1200-13-01-.05, continued)

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible 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
8. 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
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

(Rule 1200-13-01-.05, continued)

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible 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
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, provided however, that an MCO may authorize PERS for a CHOICES Member receiving Companion Care, Community Living Supports, or Community Living Supports-Family Model services when such service provides less than 24-hour staff support and PERS is medically necessary in order help sustain or increase the Member's independence in the home, reduce risk of safety concerns, and delay or prevent nursing home placement.	No
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
13. 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

(m) Transportation.

(Rule 1200-13-01-.05, continued)

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.

(n) 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) 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:

(Rule 1200-13-01-.05, continued)

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.

(p) Community Based Residential Alternatives (CBRAs).

1. Intent. This subparagraph describes requirements for CBRAs in the CHOICES program necessary to ensure compliance with federal HCBS obligations, including those set forth in 42 C.F.R. §§ 441.301, et seq. These requirements supplement requirements set forth in the licensure rules applicable to the specific CBRA provider, requirements for Managed Care Organizations who administer CBRAs in the CHOICES program, requirements set forth in MCO provider agreements with CBRA providers, and other applicable state laws and regulations, and program policies and protocols applicable to these services and/or providers of these services.

2. Requirements for CBRAs.

(i) Member Choice. A Member shall transition into a specific CBRA setting and receive CBRA services only when such services and setting:

(I) Have been selected by the Member;

(II) The Member has been given the opportunity to meet and to choose to reside with any housemates who will also live in the CBRA setting, as applicable; and

(III) The setting has been determined to be appropriate for the Member based on the Member's needs, interests, and preferences, including (as applicable) the member's preferred community and/or proximity to family and other natural supports. A CLS or CLS-FM provider shall not admit a Member and CLS or CLS-FM services shall not be authorized for a CHOICES Member unless the CLS or CLS-FM provider is able to safely meet the Member's needs and ensure the Member's health, safety and well-being.

(ii) A Member may choose to stop receiving services in a CBRA setting or from a particular CBRA provider at any time, and shall be supported in choosing and transitioning within a reasonable period to a different service, setting, or provider as applicable, that is appropriate based on the Member's needs and preferences.

(iii) Member Rights. Providers of CBRA services shall ensure that services are delivered in a manner that safeguards the following rights of persons receiving CBRA services:

(I) To be treated with respect and dignity;

(II) To have the same legal rights and responsibilities as any other person unless otherwise limited by law;

(III) To receive services regardless of gender, race, creed, marital status, national origin, disability, sexual orientation, ethnicity or age;

(IV) To be free from abuse, neglect and exploitation;

(V) To receive appropriate, quality services and supports in accordance with a comprehensive, person-centered written plan of care;

(VI) To receive services and supports in the most integrated and least restrictive setting that is appropriate based on the individualized needs of the Member;

(VII) To have access to personal records and to have services, supports and personal records explained so that they are easily understood;

(VIII) To have personal records maintained confidentially;

(IX) To own and have control over personal property, including personal funds, as specified in the plan of care;

(X) To have access to information and records pertaining to expenditures of funds for services provided;

(XI) To have choices and make decisions, and to be supported by family members, an advocate or others, as appropriate, to exercise their legal capacity;

(XII) To have privacy;

(XIII) To be able to associate, publicly or privately, with friends, family and others;

(XIV) To practice the religion or faith of one's choosing;

(XV) To be free from inappropriate use of physical or chemical restraint;

(XVI) To have access to transportation and environments used by the general public; and

(XVII) To seek resolution of rights violations or quality of care issues without retaliation.

(iv) The rights to be safeguarded by providers described in this rule do not limit any other statutory and constitutional rights afforded to all CHOICES Members or their legally authorized representatives, including those rights provided by the HCBS Settings Rule and Person-Centered Planning Rule in 42 C.F.R. § 441.301, and all other rights afforded to residents of CBRAs specific to the licensure authority for that CBRA.

(v) A Member who does not have a legally authorized representative may be supported by family members, an advocate or others as needed to exercise their legal capacity in a supported decision making model.

(vi) A Member may include family members and/or other representatives in the planning and decision-making processes.

(vii) A provider may serve as the Member's representative payee and assist the Member with personal funds management only as specified in the plan of care. Providers who assist the Member with personal funds management in accordance with the plan of care shall comply with all applicable policies and protocols pertaining to personal funds management, and shall ensure that the Member's bills have been paid timely and are not overdue, and that there are adequate funds remaining for food, utilities, and any other necessary expenses.

3. CLS Ombudsman.

(i) TennCare shall arrange for all Members choosing to receive CLS or CLS-FM services, including Members identified for transition to CLS or CLS-FM, to have access to a CLS Ombudsman. The CLS Ombudsman shall be employed and/or contracted with an agency that is separate and distinct from the TennCare Bureau.

(ii) The CLS Ombudsman will:

(I) Help to ensure Member choice in the selection of their CLS or CLS-FM benefit, provider, setting, and housemates;

(II) Provide Member education, including rights and responsibilities of Members receiving CLS or CLS-FM, how to handle quality and other concerns, identifying and reporting abuse and neglect, and the role of the CLS Ombudsman and how to contact the CLS Ombudsman;

(III) Provide Member advocacy for individuals receiving CLS or CLS-FM services, including assisting individuals in understanding and exercising personal rights, assisting Members in the resolution of problems and complaints regarding CLS or CLS-FM services, and referral to APS of potential instances of abuse, neglect or financial exploitation; and

(IV) Provide systems level advocacy, including recommendations regarding potential program changes or improvements regarding the CLS or CLS-FM benefit, and immediate notification to TennCare of significant quality concerns.

(iii) CLS and CLS-FM providers shall ensure that every CHOICES Member receiving CLS or CLS-FM services knows how to contact the CLS Ombudsman and that contact information for the CLS Ombudsman is available in the residence in a location of the Member's preference.

(iv) CLS and CLS-FM providers shall ensure access to telephones and/or computers for purposes of communication, and shall respect and safeguard the member's right to privacy, including the Member's ability to meet privately with the CLS Ombudsman in the residence.

4. Person-centered Delivery of CLS and CLS-FM Services. A CLS or CLS-FM provider shall be responsible for the following:

(i) A copy of the plan of care for any Member receiving CLS or CLS-FM services shall be accessible in the home to all paid staff;

(Rule 1200-13-01-.05, continued)

(ii) Staff shall meet all applicable training requirements as specified in applicable licensure regulations, TennCare regulations, contractor risk agreements with managed care organizations, provider agreements with managed care organizations, or in TennCare policy or protocol. Staff shall be trained on the delivery of person-centered service delivery, and on each Member's plan of care, including the risk assessment and risk agreement, as applicable, prior to being permitted to provide supports to that Member;

(iii) The CLS or CLS-FM provider shall implement the Member's plan of care and shall ensure that services are delivered in a manner that is consistent with the Member's preferences and which supports the Member in achieving his or her goals and desired outcomes;

(iv) The CLS or CLS-FM provider shall support the Member to make his or her own choices and to maintain control of his or her home and living environment;

(v) The Member shall have access to all common living areas within the home with due regard to privacy and personal possessions;

(vi) The Member shall be afforded the freedom to associate with persons of his/her choosing and have visitors at reasonable hours;

(vii) The CLS or CLS-FM provider shall support the Member to participate fully in community life, including faith-based, social, and leisure activities selected by the Member; and

(viii) There shall be an adequate food supply (at least 48 hours) for the Member that is consistent with the Member's dietary needs and preferences.

5. Requirements for Community Living Supports (CLS).

(i) Providers of CLS services in the CHOICES program shall:

(I) Be contracted with the Member's MCO for the provision of CLS services, and licensed by the DIDD in accordance with T.C.A. Title 33 and TDMHSAS Rules 0940-05-24, 0940-05-28 or 0940-05-32 as applicable;

(II) Maintain an adequate administrative structure necessary to support the provision of CLS services;

(III) Demonstrate financial solvency as it relates to daily operations, including sufficient resources and liquid assets to operate the facility;

(IV) Maintain adequate, trained staff to properly support each CLS resident; the provider must comply with minimum staffing standards specified in licensure regulations, and ensure an adequate number of trained staff to implement each resident's plan of care, and meet the needs and ensure the health and safety of each resident, including the availability of back-up and emergency staff when scheduled staff cannot report to work;

(V) Comply with all background check requirements specified in T.C.A Title 33;

(Rule 1200-13-01-.05, continued)

(VI) Comply with all critical incident reporting and investigation requirements set forth in state law, contractor risk agreements with managed care organizations, provider agreements with managed care organizations, or in TennCare policy or protocol; and

(VII) Cooperate with quality monitoring and oversight activities conducted by the DIDD under contract with TennCare to ensure compliance with requirements for the provision of CLS and to monitor the quality of CLS and CLS-FM services received.

(ii) A home where CLS services are provided shall have no more than four (4) residents, or fewer as permitted by the applicable licensure requirements.

(iii) The Member or the Member's representative (legally authorized or designated by Member) shall have a contributing voice in choosing other individuals who reside in the home where CLS services are provided, and the staff who provide the Member's services and supports.

(I) The CLS provider shall notify the Member and the Member's representative (as applicable) of changes of extended or permanent duration in the regularly assigned staff who will provide the Member's support. Such notification may be verbal or in writing. When practicable, such notification shall occur in advance of the staffing change.

(II) The CLS provider shall ensure that the Member and/or Member's representative has the opportunity to help choose new staff who will be regularly assigned to support the Member; however, this may not be possible in the short-term for situations where the change in staffing is of limited duration or is unexpected, e.g., due to illness, termination of employment, or abuse or neglect.

(iv) A CLS provider may deliver CLS services in a home where other CHOICES members receiving CLS reside. A CLS provider may also deliver CLS services in a home where CHOICES members receiving CLS reside along with individuals enrolled in a Section 1915(c) HCBS waiver program operated by the DIDD, when the provider is able and willing to provide supports in a blended residence, comply with all applicable program requirements, and meet the needs and ensure the health, safety and welfare of each resident.

(v) In instances when the CLS provider owns the Member's place of residence, the provider must sign a written lease/agreement pursuant to the Tennessee Uniform Landlord and Tenant Act (T.C.A. §§ 66-28-101, et seq.) as applicable per the county of residence. If the Tennessee Uniform Landlord and Tenant Act is not applicable to the county of residence, the provider must sign a written lease/agreement with the Member that provides the Member with the same protections as those afforded under the Tennessee Uniform Landlord and Tenant Act.

(vi) Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence shall be inspected, as required by TennCare, prior to the Member's transition to CLS services; the home where CLS services are provided

(Rule 1200-13-01-.05, continued)

must have an operable smoke detector and a second means of egress, and all utilities must be working and in proper order.

(vii) The provider shall be responsible for the provision of all assistance and supervision required by program participants. Services shall be provided pursuant to the Member's person-centered plan of care and may include assistance with the following:

(I) Hands-on assistance with ADLs such as bathing, dressing, personal hygiene, eating, toileting, transfers and ambulation;

(II) Assistance with instrumental activities of daily living necessary to support community living;

(III) Safety monitoring and supervision for Members requiring this type of support as outlined in their person-centered plan of care; and

(IV) Managing acute or chronic health conditions, including nurse oversight and monitoring, administration of medications, and skilled nursing services as needed for routine, ongoing health care tasks such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc., by appropriately licensed nurses practicing within the scope of their licenses, except as delegated in accordance with state law.

(viii) Medication administration shall be performed by appropriately licensed staff or by unlicensed staff who are currently certified in medication administration and employed by an HCBS waiver provider who is both licensed under T.C.A. Title 33 and contracted with DIDD to provide services through an HCBS waiver operated by DIDD, as permitted pursuant to T.C.A. §§ 68-1-904 and 71-5-1414.

(ix) Self-administration of medications is permitted for a person receiving CLS services who is capable of using prescription medication in a manner directed by the prescribing practitioner without assistance or direction. Staff intervention must be limited to verbal reminders as to the time the medication is due. The plan of care must document any training the person needs in order to self-administer medications and how it will be provided; storage, labeling and documentation of administration; oversight to ensure safe administration; and how medication will be administered during any time the person is incapable of self-administration.

(x) Services and supports for a Member receiving CLS shall be provided up to 24 hours per day based on the Member's assessed level of need as specified in the plan of care and approved level of CLS reimbursement. Members approved for 24 hours per day of CLS are not prohibited from engaging in independent activities.

(xi) Members approved for 24 hour support who are assessed to be capable of independent functioning may participate in activities of their choosing without the support of staff as specified in the plan of care and risk assessment and risk agreement.

(xii) Regardless of the level of CLS reimbursement a Member is authorized to receive, a Member may choose to be away from home without support of staff, e.g., for overnight visits, vacations, etc. with family or friends.

(xiii) The CLS provider shall be responsible for community transportation needed by the Member. The CLS provider shall transport the Member into the community or assist the Member in identifying and arranging transportation into the community to participate in activities of his choosing.

(xiv) The provider shall be responsible for assisting the Member in scheduling medical appointments and obtaining medical services, including accompanying the Member to medical appointments, as needed, and shall either provide transportation to medical services and appointments for the Member or assist the Member in arranging and utilizing NEMT, as covered under the TennCare program.

6. Requirements for Community Living Supports Family Model (CLS-FM) Services.

(i) Providers of CLS-FM services in the CHOICES program shall:

(I) Be contracted with the Member's MCO for the provision of CLS-FM services, and licensed by the DIDD in accordance with T.C.A. Title 33 and TDMHSAS Rule 0940-05-26;

(II) Maintain an adequate administrative structure necessary to support the provision of CLS-FM services;

(III) Demonstrate financial solvency as it relates to daily operations, including sufficient resources and liquid assets to operate the facility;

(IV) Ensure CLS-FM family caregivers are adequately trained to properly support each CLS resident; the provider must comply with minimum staffing standards specified in licensure regulations, and ensure an adequate number of family caregivers and trained staff as needed to implement each resident's plan of care, and meet the needs and ensure the health and safety of each resident, including the availability of back-up and emergency staff when scheduled staff cannot report to work;

(V) Comply with all background check requirements specified in T.C.A. Title 33;

(VI) Comply with all critical incident reporting and investigation requirements set forth in state law, contractor risk agreements with managed care organizations, provider agreements with managed care organizations, or in TennCare policy or protocol; and

(VII) Cooperate with quality monitoring and oversight activities conducted by the DIDD under contract with TennCare to ensure compliance with requirements for the provision of CLS and to monitor the quality of CLS and CLS-FM services received.

(ii) A home where CLS-FM services are provided shall serve no more than three (3) individuals, including individuals receiving CLS-FM services and individuals receiving Family Model Residential services, and must be physically adequate to allow each participant to have private bedroom and bathroom space unless otherwise agreed upon with residents to share, in which case each participant must have equal domain over shared spaces.

(iii) The Member or the Member's representative (legally authorized or designated by Member) shall have a contributing voice in choosing other individuals who reside in the home where CLS-FM services are provided, caregivers whose home the Member will move into, and any staff hired by the CLS-FM provider to assist in providing the Member's services and supports.

(iv) A CLS-FM provider may deliver CLS-FM services in a home where other CHOICES Members receiving CLS-FM reside. A CLS-FM provider may also deliver CLS services in a home where CHOICES Members receiving CLS-FM reside along with individuals enrolled in a Section 1915(c) HCBS waiver program operated by the DIDD, when the provider is able and willing to provide supports in a blended residence, comply with all applicable program requirements, and meet the needs and ensure the health, safety and welfare of each resident. In instances of blended homes, there shall be no more than three (3) service recipients residing in the home, regardless of the program or funding source.

(v) The family caregiver and Member must sign a written lease/agreement pursuant to the Tennessee Uniform Landlord and Tenant Act (T.C.A. §§ 66-28-101, et seq.) as applicable per the county of residence. If the Tennessee Uniform Landlord and Tenant Act is not applicable to the county of residence, the provider must sign a written lease/agreement with the Member that provides the Member with the same protections as those afforded under the Tennessee Uniform Landlord and Tenant Act.

(vi) Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence shall be inspected, as required by TennCare, prior to the Member's transition to CLS services; the home where CLS-FM services are provided must have an operable smoke detector and a second means of egress.

(vii) The CLS-FM provider shall be responsible for the provision of all assistance and supervision required by program participants. Services shall be provided pursuant to the Member's person-centered plan of care and may include assistance with the following:

(I) Hands-on assistance with ADLs such as bathing, dressing, personal hygiene, eating, toileting, transfers and ambulation;

(II) Assistance with instrumental activities of daily living necessary to support community living;

(III) Safety monitoring and supervision for Members requiring this type of support as outlined in their person-centered plan of care; and

(IV) Managing acute or chronic health conditions, including nurse oversight and monitoring, administration of medications, and skilled nursing services as needed for routine, ongoing health care tasks such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc., by appropriately licensed nurses practicing within the scope of their licenses, except as delegated in accordance with state law.

(Rule 1200-13-01-.05, continued)

(viii) Medication administration shall be performed by appropriately licensed staff or by unlicensed staff who are currently certified in medication administration and employed by an HCBS waiver provider who is both licensed under T.C.A. Title 33 and contracted with DIDD to provide services through an HCBS waiver operated by DIDD, as permitted pursuant to T.C.A. §§ 68-1-904 and 71-5-1414.

(ix) Self-administration of medications is permitted for a person receiving CLS-FM services who is capable of using prescription medication in a manner directed by the prescribing practitioner without assistance or direction. Staff intervention must be limited to verbal reminders as to the time the medication is due. The plan of care must document any training the person needs in order to self-administer medications and how it will be provided; storage, labeling and documentation of administration; oversight to ensure safe administration; and how medication will be administered during any time the person is incapable of self-administration.

(x) Services and supports for a Member receiving CLS-FM shall be provided up to 24 hours per day based on the Member's assessed level of need as specified in the plan of care and approved level of CLS reimbursement. Members approved for 24 hours per day of CLS-FM are not prohibited from engaging in independent activities.

(xi) Members approved for 24 hour support who are assessed to be capable of independent functioning may participate in activities of their choosing without the support of staff as specified in the plan of care and risk assessment and risk agreement.

(xii) Regardless of the level of CLS-FM reimbursement a Member is authorized to receive, a Member may choose to be away from home without support of staff, e.g., for overnight visits, vacations, etc. with family or friends.

(xiii) The CLS provider shall be responsible for community transportation needed by the Member. The CLS provider shall transport the Member into the community or assist the Member in identifying and arranging transportation into the community to participate in activities of his choosing.

(xiv) The provider shall be responsible for assisting the Member in scheduling medical appointments and obtaining medical services, including accompanying the Member to medical appointments, as needed, and shall either provide transportation to medical services and appointments for the Member or assist the Member in arranging and utilizing non-emergency transportation services (NEMT), as covered under the TennCare program.

7. Reimbursement of CLS and CLS-FM Services

(i) Reimbursement for CLS and CLS-FM services shall be made to a contracted CLS or CLS-FM provider by the Member's MCO in accordance with the Member's plan of care and service authorizations, and contingent upon the Member's eligibility for and enrollment in TennCare and CHOICES.

(ii) Reimbursement for CLS and CLS-FM services shall be made only for dates of service that the member actually receives CLS and CLS-FM services. CLS and CLS-FM services shall not be reimbursed for any date on which the member does not receive any CLS or CLS-FM services

(Rule 1200-13-01-.05, continued)

because the member is in a hospital or other inpatient setting, or for therapeutic leave, e.g., overnight visits, vacations, etc. with family or friends when the Member is not accompanied by staff.

(iii) Rates of reimbursement for CLS and CLS-FM services shall be established by TennCare.

(iv) Rates of reimbursement for CLS and CLS-FM services may take into account the level of care the person qualifies to receive (Nursing Facility or At-Risk as determined by TennCare), and the person's support needs, including skilled nursing needs for ongoing health care tasks.

(v) The rate of reimbursement for CLS or CLS-FM, as applicable, shall not vary based on the number of people receiving CLS, CLS-FM or HCBS Waiver services who live in the home.

(vi) A licensed and contracted CLS or CLS-FM provider selected by a person to provide CLS or CLS-FM services shall determine whether the provider is able to safely provide the requested service and meet the person's needs, and may take into consideration the rate of reimbursement authorized.

(vii) Neither a Member nor a CLS or CLS-FM provider may file a medical appeal or receive a fair hearing regarding the rate of reimbursement a provider will receive for CLS or CLS-FM services.

(viii) The rate of reimbursement for CLS or CLS-FM services is inclusive of all applicable transportation services needed by the Member, except for transportation authorized and obtained under the TennCare NEMT benefit.

(ix) Reimbursement for CLS or CLS-FM services shall not be made for room and board. Residential expenses (e.g., rent, utilities, phone, cable TV, food, etc.) shall be apportioned as appropriate between the Member and other residents in the home.

(x) Family members of the individual receiving services are not prohibited from helping pay a resident's Room and Board expenses.

(xi) Reimbursement for CLS or CLS-FM services shall not include the cost of maintenance of the dwelling.

(xii) Reimbursement for CLS or CLS-FM services shall not include payment made to the Member's immediate family member as defined in Rule 1200-13-01-.02 or to the Member's conservator.

(xiii) Except as permitted pursuant to Rule 1200-13-01-.05(8)(l), Personal Care Visits, Attendant Care, and Home-Delivered Meals shall not be authorized or reimbursed for a Member receiving CLS or CLS-FM services.

(xiv) In-home Respite shall not be authorized or reimbursed for a Member receiving CLS or CLS-FM services.

(xv) CLS and CLS-FM services shall not be provided or reimbursed in nursing facilities, ACLFs, hospitals or ICFs/IID.

(9) Consumer-Direction (CD).

(Rule 1200-13-01-.05, continued)

(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

(Rule 1200-13-01-.05, continued)

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.

(Rule 1200-13-01-.05, continued)

(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;

(Rule 1200-13-01-.05, continued)

(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

(Rule 1200-13-01-.05, continued)

(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.

(Rule 1200-13-01-.05, continued)

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) Complete 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) Verification that the person has not been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 128B(f) of the Social Security Act);

(vi) Complete all required training;

(vii) Complete all required applications to become a TennCare provider;

(viii) Sign an abbreviated Medicaid agreement;

(ix) Be assigned a Medicaid provider ID number;

(x) Sign a Service Agreement; and

(xi) 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 (or Representative for CD) cannot waive a background check for a potential Worker. A background check may reveal a potential Worker's past criminal conduct that may pose an unacceptable risk to the Member. Any of the following findings may place the Member at risk and may 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; and/or

(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.

4. Individualized Assessment of a Consumer-Directed Worker with a Criminal Background.

(i) If a potential Worker's background check includes past criminal conduct, the Member (or Representative for CD) must review the past criminal conduct with the help of the FEA. The Member (or Representative for CD), with the assistance of the FEA, will consider the following factors:

(I) Whether or not the evidence gathered during the potential Worker's individualized assessment shows the criminal conduct is related to the job in such a way that could place the Member at risk;

(II) The nature and gravity of the offense or conduct, such as whether the offense is related to physical or sexual or emotional abuse of another person, if the offense involves violence against another person, or the manufacture, sale, or distribution of drugs; and

(III) The time that has passed since the offense or conduct and/or completion of the sentence.

(ii) After considering the above factors and any other evidence submitted by the potential Worker, the Member (or Representative for CD) must decide whether to hire the potential Worker.

(iii) If a Member (or Representative for CD) decides to hire the Worker, the FEA shall assist the Member (or Representative for CD) in notifying the Member's MCO of this decision and shall collaborate with the Member's MCO to amend the Member's risk agreement to reflect the Member's (or CD Representative's) decision to voluntarily assume risk associated with hiring an individual with a criminal history and that the Member (or Representative for CD) is solely responsible for any negative consequences stemming from that decision.

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.

(Rule 1200-13-01-.05, continued)

(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. 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.

5. 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

(Rule 1200-13-01-.05, continued)

licensed health care provider incurs no additional liability when ordering a Health Care Task which is to be performed through self-directed care.

6. 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.

7. 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.

8. 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.

(Rule 1200-13-01-.05, continued)

(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.

(Rule 1200-13-01-.05, continued)

(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.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-109, and Executive Order Nos. 11 and 23.* ***Administrative History:*** *Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendment filed April 8, 1981; effective May 26, 1981. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed November 4, 1981; effective December 21, 1981. Amendment filed January 29, 1982; effective March 15, 1982. Amendment filed May 14, 1982; effective July 1, 1982. Amendment filed May 26, 1983; effective June 27, 1983. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed November 30, 1984; effective December 30, 1984. Amendment filed September 18, 1985; effective October 18, 1985. Amendment filed February 12, 1986; effective March 14, 1986. Amendment filed February 23, 1987; effective April 9, 1987. Amendment filed March 25, 1987; effective May 9, 1987. Amendment filed July 30, 1987; effective September 13, 1987. Amendment filed September 30, 1987; effective November 14, 1987. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed October 12, 1987; effective January 27, 1988. Amendment filed August 17, 1988; effective October 1, 1988. Amendment filed July 26, 1989; effective September 10, 1989. Amendment filed February 23, 1990; effective April 9. 1990. Amendment filed May 10, 1990; effective June 24, 1990. Amendment filed June 8, 1990; effective July 23, 1990. Amendment*

(Rule 1200-13-01-.05, continued)
filed August 17, 1990; effective October 1, 1990. Amendment filed September 28, 1990; effective November 12, 1990. Amendment filed November 5, 1990; effective December 20, 1990. Amendment filed November 27, 1990; effective January 11, 1991. Amendment filed January 9, 1991; effective February 23, 1991. Amendment filed February 12, 1991; effective March 29, 1991. Amendment filed February 21, 1991; effective April 7, 1991. Amendment filed February 1991; effective April 9, 1991. Amendment filed February 27, 1991; effective April 13, 1991. Amendment filed April 1, 1991; effective May 16, 1991. Amendment filed June 12, 1991; elective July 27, 1991. Amendment filed November 22, 1991; effective January 6, 1992. Amendment filed April 29, 1992; effective June 13, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed October 8, 1992; effective November 22, 1992. Amendment filed October 26, 1992; effective December 10, 1992. Amendment filed November 17, 1993; effective January 31, 1994. Amendment filed March 11, 1994; effective May 25, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed May 2, 1994; effective July 16, 1994. Amendment filed November 10, 1994; effective January 24, 1995. Amendment filed March 3, 1995; effective June 15, 1995. Amendment filed June 29, 2000; effective September 12, 2000. Amendment filed August 21, 2001; effective November 4, 2001. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rule filed September 23, 2011; effective through March 21, 2012. Amendment filed December 15, 2011; effective March 14, 2012. Emergency rules filed June 29, 2012; effective through December 26, 2012. Amendments filed September 26, 2012; effective December 25, 2012. Numbering errors were found with the rules for 1200-13-01-.05 by the Secretary of State's office. On December 20, 2012, the Attorney General's office approved the legality of the correctly renumbered rule 1200-13-01-.05 as presented by TennCare. Amendments filed September 26, 2013; effective December 25, 2013. Amendments filed July 28, 2014; effective October 26, 2014. Amendment filed April 14, 2015; effective July 13, 2015. Emergency rule filed July 27, 2015; effective through January 23, 2016. Amendment filed October 22, 2015; effective January 21, 2016. Amendment filed March 22, 2016; effective June 20, 2016. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.

1200-13-01-.06 SPECIAL FEDERAL REQUIREMENTS PERTAINING TO NURSING FACILITIES.

(1) Anti-discrimination.

No Medicaid-reimbursed resident of a NF shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination by any such facility.

(a) A NF may not directly or through contractual or other arrangements, on ground of race, color, or national origin:

1. Deny a Medicaid-reimbursed resident any service or benefit provided under the program.

2. Provide any service or benefit to a Medicaid-reimbursed resident which is different, or is provided in a different manner, from that provided to others under the program.

3. Subject a Medicaid-reimbursed resident to segregation or separate treatment in any matter related to the receipt of any service or benefit under the program.

4. Restrict a Medicaid-reimbursed resident in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit under the program.

5. Treat a Medicaid-reimbursed resident differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or

(Rule 1200-13-01-.06, continued)

other requirement or condition which the resident must meet in order to be provided any service or benefit provided under the program.

(b) A NF, in determining the types of services, or benefits which will be provided under any such program, or the Medicaid-reimbursed resident to whom, or the situations in which, such services or benefits will be provided under the program, or the Medicaid-reimbursed resident to be afforded an opportunity to participate in the program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting those residents to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishments of the objective of the program with respect to those residents of a particular race, color, or national origin.

(c) As used in this rule, the services or benefits provided by a NF shall be deemed to include any service, or benefit provided in or through a facility participating in this program.

(d) The enumeration of specific forms of prohibited discrimination in this rule does not limit the generality of the prohibition in this rule.

(e) When a NF has previously discriminated against persons on the ground of race, color, or national origin, the facility must take affirmative action to overcome the effects of prior discrimination.

(f) Even in the absence of such prior discrimination, a facility may take affirmative action to overcome the effects of conditions which resulted in limiting participation by persons of a particular race, color, or national origin.

(2) Admissions, transfers, and discharges from NFs.

(a) All NFs shall establish written policies and procedures addressing admission, transfer and discharge, consistent with these rules. These policies and procedures shall be available for inspection by the state.

(b) A NF that has entered into a provider agreement with the Bureau of TennCare or an MCO shall admit individuals on a first come, first served basis, except as otherwise permitted by state and federal laws and regulations.

(c) NFs participating in the Medicaid Program shall not as a condition of admission to or continued stay at the facility request or require:

1. Transfer or discharge of a Medicaid-eligible resident because Medicaid has been or becomes the resident's source of payment for long-term care.

2. Payment of an amount from a Medicaid-eligible resident in excess of the amount of Patient Liability determined by DHS.

3. Payment in excess of the amount of Patient Liability determined by DHS from any resident who is financially eligible for medical assistance but who has not submitted a PAE for consideration or whose appeal rights for a denied PAE have not been exhausted.

4. Any person to forego his or her right to Title XIX Medical Assistance benefits for any period of time.

(Rule 1200-13-01-.06, continued)

5. A third party (i.e. responsible party) signature, except as required of a court appointed legal guardian or conservator, or require payment of any kind by a third party on behalf of a Medicaid Eligible individual.

(d) NFs participating in the Medicaid Program must comply with the following guidelines regarding transfers, discharges and/or readmissions.

1. Transfer and Discharge Rights.

(i) A NF must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

(I) The transfer or discharge is necessary to meet the resident's welfare which cannot be met in the facility;

(II) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(III) The safety of individuals in the facility is endangered;

(IV) The health of individuals in the facility would otherwise be endangered;

(V) The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Title XIX or Title XVIII on the resident's behalf) for a stay at the facility; or

(VI) The facility ceases to operate.

(ii) In each of the cases described above, no resident shall be discharged or transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. Each NF shall establish a policy for handling residents who wish to leave the facility against medical advice. The basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in items (I) and (II) above, the documentation must be made by the resident's physician, and in the case described in item (IV) above, the documentation must be made by a physician. For purposes of item (V), in the case of a resident who becomes eligible for assistance under Title XIX after admission to the facility, only charges which may be imposed under Title XIX shall be considered to be allowable.

(iii) When a resident is transferred, a summary of treatment given at the facility, condition of resident at time of transfer and date and place to which transferred shall be entered in the record. If transfer is due to an emergency; this information will be recorded within forty-eight (48) hours; otherwise, it will precede the transfer of the resident.

(iv) When a resident is transferred, a copy of the clinical summary should, with consent of the resident, be sent to the NF that will continue the care of the resident.

(v) Where an involuntary transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

(I) The traumatic effect on the resident.

(II) The proximity of the proposed NF to the present facility and to the family and friends of the resident.

(III) The availability of necessary medical and social services at the proposed NF.

(IV) Compliance by the proposed NF with all applicable federal and State regulations.

2. Pre-Transfer and Pre-Discharge Notice. Before effecting a transfer or discharge of a resident, a NF must:

(i) Notify the resident (and, if known, a family member of the resident or legal Representative) of the transfer or discharge and the reasons therefore.

(ii) Record the reasons in the resident's clinical record (including any documentation required pursuant to Part 1. above) and include in the notice the items described in Part 4. below.

(iii) Notify the Department of Health and the LTC Ombudsman.

(iv) Not transfer or discharge a resident until the above agencies have designated their intention to intervene and until any appeal process is complete, should the resident request a fair hearing.

3. Timing of Notice. The notice under Part 2. above must be made at least thirty (30) days in advance of the resident's transfer or discharge except:

(i) In a case described in Items 1200-13-01-.06(2)(d)1.(i)(III) and (IV).

(ii) In a case described in Item 1200-13-01-.06(2)(d)1.(i)(II) where the resident's health improves sufficiently to allow a more immediate transfer or discharge.

(iii) In a case described in Item 1200-13-01-.06(2)(d)1.(i)(I) where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs.

(iv) In a case where a resident has not resided in the facility for thirty (30) days.

In the case of such exceptions, notice must be given as many days before the date of transfer or discharge as is practicable.

4. Items included in notice. Each pre-transfer and pre-discharge notice under Part 2. above must include:

(i) Notice of the resident's right to appeal the transfer or discharge.

(ii) The name, mailing address, and telephone number of the LTC Ombudsman.

(Rule 1200-13-01-.06, continued)

(iii) In the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.

(iv) In the case of mentally ill residents, the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

5. Orientation. A NF must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer discharge from the facility.

6. Notice of Bed-Hold Policy and Readmission. Before a resident of a NF is transferred for hospitalization or therapeutic leave, a NF must provide written information to the resident and a family member or legal representative concerning:

(i) The provisions of the State Plan under this Title XIX regarding the period (if any) during which the resident will be permitted under the State Plan to return and resume residence in the facility, and

(ii) The policies of the facility consistent with Part 7. below, regarding such a period.

7. Notice Upon Transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a NF must provide written notice to the resident and a family member or legal representative of the duration of any period under the State Plan allowed for the resumption of residence in the facility.

(e) NFs participating in the Medicaid Program must establish and follow a written policy under which an Enrollee, whose hospitalization or therapeutic leave exceeds the bed hold period, is readmitted to the NF immediately upon the first availability of a bed in a semi-private room if the Enrollee:

1. Requires the services provided by the NF; and

2. Is eligible for the level of NF care services.

(3) Single Wait List.

(a) Each NF participating in the TennCare must develop and consistently implement policies and procedures regarding its admissions, including the development and maintenance of a single Wait List of persons requesting admission to those facilities. This list must at a minimum contain the following information pertaining to each request for admission:

1. The name of the applicant.

2. The name of the contact person or designated representative other than the applicant (if any).

3. The address of the applicant and the contact person or designated representative (if any).

4. The telephone number of the applicant and the contact person or designated representative (if any).

5. The name of the person or agency referring the applicant to the NF.

6. The sex and race of the applicant.

7. The date and time of the request for admission.

8. Reason(s) for refusal/non-acceptance/other-action-taken pertaining to the request for admission.

9. The name and title of the NF staff person taking the application for admission.

10. A notation stating whether the applicant is anticipated to be Medicaid eligible at time of admission or within one year of admission.

(b) The Wait List should be updated and revised at least once each quarter to remove the names of previous applicants who are no longer interested in admission to the NF. Following three (3) contacts each separated by a period of at least ten (10) days, the NF shall, consistent with the written notice required in this section move an applicant to the end of the single admission list whenever an available bed is not accepted at the time of the vacancy, but the applicant wishes to remain on the admissions list. Applicants shall be advised of these policies at the time of their inquiry, and must be notified in writing, in a format approved by the Department of Health, when their name is removed from the list or moved to the end of the list. Such contacts shall be documented in the facility log containing the Wait List. The date, time and method of each contact shall be recorded along with the name of the facility staff person making the contact, and the identity of the applicant or contact person contacted. The log of such contacts shall also summarize the communication between the facility staff person and the applicant or contact person.

(c) Each facility shall send written confirmation that an applicant's name has been entered on the Wait List, their position on the wait list, and a notification of their right of access to the wait list as provided in Subparagraph (h) of this Rule. This confirmation shall include at a minimum the date and time of entry on the wait list and shall be mailed by first class postage to the applicant and their designated representative (if any) identified pursuant to the requirements in Subparagraph (a) of this Rule.

(d) Each NF participating in TennCare shall admit applicants in the chronological order in which the referral or request for admission was received by the facility, except as permitted in Subparagraph (e) of this Rule.

(e) Documentation justifying deviation from the order of the Wait List must be maintained for inspection by the State. Inspection shall include the right to review and/or make copies of these records. Deviation may be based upon:

1. Medical need, including, but not necessarily limited to, the expedited admission of patients being discharged from hospitals and patients who previously resided in a NF at a different level of care, but who, in both cases, continue to require institutional medical services;

2. The applicant's sex, if the available bed is in a room or a part of the facility that exclusively serves residents of the opposite sex;

3. Necessity to implement the provisions of a plan of affirmative action to admit racial minorities, if the plan has previously been approved by the Department of Health;

4. Emergency placements requested by the Department when evacuating another health care facility or by the Adult Protective Service of the Tennessee Department of Human Services;

5. Other reasons or policies, e.g., previous participation in a community based waiver or other alternative care program, when approved by the Medical Director of the Department of Health's Bureau of Health Licensure and Regulation, provided, however, that no such approval shall be granted if to do so would in any way impair the Department's or the facility's ability to comply with its obligations under federal and state civil rights laws, regulations or conditions of licensure or participation.

6. If a Medicaid-eligible recipient's hospitalization or therapeutic leave exceeds the period paid for under the Tennessee Medicaid program for the holding of a bed in the facility for the resident and if the resident continues to require the services provided by the NF, then the resident must be readmitted to the facility immediately upon the first availability of a bed in the facility, consistent with Part 2. above;

7. Where, with the participation and approval of the Department of Health, expedited admission is approved for residents who are being displaced from another facility or its waiting list as a result of that facility's withdrawal from the Medicaid program.

(f) Telephone requests to be placed on the Wait List shall be accepted. The information required in Subparagraph (a) of this Rule shall be documented.

(g) If an applicant, whether on his own behalf or acting through another, requests admission or to be placed on a list of applicants awaiting admission, the information on the waiting list must be recorded and preserved.

(h) Applicants or their representatives shall have the right to be informed by telephone of their position on the Wait List. Ombudsmen and appropriate State and federal personnel shall have access to the Wait List when requested, and such access shall include the right to review and/or copy the Wait List.

(i) Any referrals received from the DHS shall be handled in the following manner.

1. Applicants shall be placed on a Wait List without formal application until such facility is within sixty (60) days of admission to the facility based on experience.

2. When the applicant is within sixty (60) days of admission to the facility as estimated by the facility based on its experience, the facility shall notify the applicant and DHS in writing so that a formal application can be made prior to consideration for admittance.

3. If, after sixty (60) days from the date notification is issued, the facility has not received a completed application then the facility may remove the applicant's name from the Wait List.

(4) Physician visits.

(a) NFs are responsible for assuring that physician visits are made according to the schedule set out at 42 C.F.R. § 483.40. To meet the requirement for a physician visit, the physician must, at the time of the visit,

(Rule 1200-13-01-.06, continued)

1. See the resident;

2. Review the resident's total program of care, including treatments;

3. Verify that the resident continues to need the designated level of NF care and document it in the progress notes or orders;

4. Write, sign, and date progress notes; and

5. Sign all orders.

(b) At the option of the physician, required visits after the initial visit may alternate between visits by a physician and visits by a physician assistant or nurse practitioner working under the physician's delegation.

(c) A physician visit will be considered to be timely if it occurs not later than ten (10) days after the date of the required visit. Failure of the visit to be made timely will result in non-payment of claims, or a recoupment of all amounts paid by the Bureau or the MCO during the time that the physician visit has lapsed.

(d) NFs are responsible for assuring that the physician verify at the time of each physician's visit the Medicaid recipient's continued need for NF LOC and whether or not he is being served at the appropriate LOC.

1. Failure to obtain the verification at the time of the scheduled physician visit may result in a recoupment of all amounts paid by the Bureau or the MCO during the time that the verification/physician visit has lapsed.

2. If such a recoupment is made, the participating facility shall not:

(i) Attempt to recoup from the resident; or

(ii) Discharge the resident based on the recoupment.

3. In cases where the physician refused to make the required verification because the physician believes that the LOC is no longer appropriate, a new resident assessment must be completed by the NF.

(5) Termination of NF provider agreements.

(a) Facilities requesting voluntary termination of provider agreements shall comply with the following:

1. Facilities that choose to voluntarily terminate their provider agreements may do so by notifying the Bureau or the MCO(s) in writing of such intent. The effective date of the termination will be determined by the Bureau consistent with the terms of the TennCare Provider Agreement then in force between the Bureau or the MCO(s) and the facility.

2. The facility will not be entitled to payment for any additional or newly admitted TennCare eligible residents from the date of the facility's notice of withdrawal from the TennCare Program. The facility may, however, at its election, continue to receive TennCare payment for those individuals who resided in the facility, on the date of such notice, so long as they continue to reside in and receive services from the facility and provided that such individuals are TennCare-eligible

(Rule 1200-13-01-.06, continued)

during the period for which reimbursement is sought. The facility's right to continue to receive TennCare payments for such individuals following the date of its notice of intent to withdraw from the TennCare program is contingent upon:

(i) The facility's compliance with all requirements for TennCare participation; and

(ii) Its agreement to continue to serve, and accept TennCare payment for, on a non-discriminatory basis, all individuals residing in the facility on the date of notification of withdrawal, who are or become TennCare eligible.

3. The notification must provide the following information:

(i) The reason(s) for voluntary termination;

(ii) The names and TennCare identification numbers of all TennCare-eligible residents;

(iii) Name of the resident and name of the contact person for the resident (if any) for each resident with an application for TennCare eligibility pending;

(iv) A copy of the letter the facility will send to each resident informing him of the voluntary termination, and a copy of the letter to be sent to all TennCare-eligible residents regarding this action;

(v) A copy of the letter sent to all applicants on the Wait List informing them of the facility's voluntary termination;

(vi) Whether or not the facility intends to continue to provide services to non-TennCare residents who were residents of the facility on the date withdrawal was approved, in the event they convert to TennCare eligibility; and a copy of the notice to residents explaining that decision; and,

(vii) Other information determined by the Bureau or the MCOs as necessary to process the request for termination.

4. The termination of the provider's involvement in TennCare must be done in such a manner as to minimize the harm to current residents.

(i) Residents who are currently TennCare-eligible shall be informed, in a notice to be provided by the facility and approved by the Bureau, that the facility has elected to withdraw from the TennCare program. If the facility has elected under Subpart (ii) of the section to continue to receive TennCare payments for residents of the facility as of the date of notice of withdrawal from the TennCare Program, the notice shall inform the resident of the right to remain in the facility as a TennCare resident as long as he wishes to do so and remain otherwise eligible under the rules of the TennCare Program. The notice shall also inform the resident that, if he wishes to transfer to another facility, under the supervision of TennCare, the NF where he now resides will assist in locating a new placement and providing orientation and preparation for the transfer, in accordance with 42 U.S.C.A. §1396r(c)(2)(B) and implementing regulations and guidelines, if any.

(ii) All other residents of the facility shall receive a separate notice informing them of the facility's intention to withdraw from the TennCare program.

(Rule 1200-13-01-.06, continued)

The notice will be provided by the facility after having been first reviewed and approved by the Bureau. The notice shall inform such residents that, should they become eligible for TennCare coverage, they will be able to convert to TennCare from their current source of payment and remain in the facility only during a period that ends with the termination of the facility's provider agreement, a date to be determined in accordance with the terms of the provider agreement. They will not be eligible for TennCare coverage of their care in the facility thereafter. Transfer of these residents shall be considered an involuntary transfer and shall comply with federal and State regulations governing involuntary transfer or discharges.

The same notice will caution these residents that, if they require care as TennCare residents after the facility's provider agreement is terminated, they will have to transfer to another facility. The notice will also inform the residents that, when their present facility is no longer participating in the TennCare program, certain legal rights and protections that apply to all residents (regardless of source of payment) in TennCare facilities will no longer be available to those who remain in the NF. Readers of the notice will be informed that, if they wish to transfer, or to have their names placed on Wait Lists at other facilities, the facility that is withdrawing from the program will assist them by providing preparation and orientation under the supervision of the Bureau, as required by 42 U.S.C.A. § 1396r(c)(2)(B) and implementing regulations and guidelines, if any.

(iii) Applicants whose names are on the facility's Wait List will be notified by the facility on a form that has been reviewed and approved by the Bureau that the facility intends to withdraw from the TennCare Program. They will be cautioned that they will not be able to obtain TennCare coverage for any care that they receive in the facility. The notice shall also inform them that certain legal rights and protections that apply to all residents (regardless of source of payment) in TennCare participating facilities will not be available in the NF to which they have applied, once that facility has withdrawn from the TennCare program.

Applicants shall be informed in the notice that, if they wish to make application at other facilities, the withdrawing facility, under the supervision of TennCare, shall assist them in seeking placement elsewhere.

5. Following submission of a notice of withdrawal from the TennCare Program a facility cannot opt to receive continued TennCare payments for any resident unless it agrees to accept continual TennCare payment for all individuals who are residents on the date of the notice of withdrawal, and who are or become TennCare-eligible provided, however, that the Bureau or the Enrollee's MCO will pay the facility for all covered services actually provided to TennCare-eligible residents following notice of the facility's withdrawal and pending the resident's transfer or discharge. In instances where facilities elect to continue to receive such TennCare payments, their provider agreements will remain in effect until the last TennCare-eligible individual, who resided in the facility as of the date of notification of withdrawal, has been discharged or transferred from the facility in accordance with TennCare and State licensure requirements.

6. Facilities which terminate their provider agreement shall not be permitted to participate in TennCare for a period of at least two (2) years from the date the provider agreement is terminated.

(Rule 1200-13-01-.06, continued)

7. Unless the facility notifies the Bureau within thirty (30) days after giving a notice of termination, the facility may not stop the termination procedure consistent with this order without written approval from the Bureau.

(b) NFs may be involuntarily decertified by the Tennessee Department of Health's Division of Health Care Facilities because of their failure to comply with the provisions of these rules. Facilities that are involuntarily decertified shall not be permitted to participate in the Medicaid program for a minimum of five (5) years from the date of the decertification.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 12-4-301, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed September 16, 1981; effective November 2, 1981. Amendment filed November 6, 1981; effective December 21, 1981. Amendment filed August 18, 1982; effective September 17, 1982. Amendment filed September 2, 1982; effective October 4, 1982. Amendment filed September 27, 1982; effective October 27, 1982. Amendment filed November 12, 1982; effective December 13, 1982. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed August 31, 1983; effective September 30, 1983. Amendment filed March 12, 1984; effective April 11, 1984. Amendment filed June 27, 1984; effective July 27, 1984. Amendments filed March 27, 1985; effective April 26, 1985. Amendment filed June 4, 1985; effective July 4, 1985. Amendment filed September 18, 1985; effective October 18, 1985. Amendment filed April 29, 1986; effective May 29, 1986. Amendment filed June 30, 1986; effective July 30, 1986. Amendment filed July 17, 1986; effective August 31, 1986. Amendment filed September 2, 1986; effective October 17, 1986. Amendment filed July 30, 1987; effective September 13, 1987. Amendment filed September 30, 1987; effective November 14, 1987. Amendment filed February 19, 1988; effective April 4, 1988. Amendment filed June 2, 1988; effective July 17, 1988. Amendment filed September 6, 1988; effective October 21, 1988. Amendment filed November 10, 1988; effective December 25, 1988. Amendment filed March 22, 1989; effective May 8, 1989. Amendment filed June 22, 1989; effective August 4, 1989. Amendment filed June 29, 1989; effective August 14, 1989. Amendment filed July 26, 1989; effective September 10, 1989. Amendment filed August 31, 1989; effective October 15, 1989. Amendment filed October 11, 1989; effective November 25, 1989. Amendment filed November 30, 1989; effective January 14, 1990. Amendment filed December 8, 1989; effective January 22, 1990. Amendments filed January 29, 1990; effective March 15, 1990. Amendment filed July 5, 1990; effective August 19, 1990. Amendment filed August 17, 1990; effective October 1, 1990. Amendment filed November 27, 1990; effective January 11, 1991. Amendment filed December 14, 1990; effective January 28, 1991. Amendment filed January 16, 1991; effective March 2, 1991. Amendment filed February 19, 1991; effective April 5, 1991. Amendment filed February 26, 1991; effective April 12, 1991. Amendment filed May 7, 1991; effective June 21, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed June 14, 1991; effective July 29, 1991. Amendment filed September 16, 1991; effective October 31, 1991. Amendment filed September 17, 1991; effective November 1, 1991. Amendment filed September 30, 1991; effective November 14, 1991. Amendment filed October 14, 1991; effective November 28, 1991. Amendment filed October 21, 1991; effective December 5, 1991. Amendment filed October 23, 1991; effective December 7, 1991. Amendment filed March 10, 1992; effective April 24, 1992. Amendment filed March 26, 1992; effective May 10, 1992. Amendment filed April 29, 1992; effective June 13, 1992. Amendment filed September 29, 1992; effective November 13, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 7, 1993; effective February 20, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed May 25, 1994; effective August 9, 1994. Amendment filed November 10, 1994; effective January 24, 1995. Amendment filed August 1, 1995; effective October 14, 1995. Amendment filed October 20, 1995; effective January 3, 1996. Amendment filed July 15, 1996; effective September 28, 1996. Amendment filed April 20, 1998; effective July 4, 1998. Amendment filed October 14, 1998; effective December 28, 1998. Amendment filed January 3, 2000; effective March 18, 2000. Amendment filed June 22, 2000; effective September 5, 2000. Amendment filed January 9, 2002; effective March 25, 2002. Amendment filed July 24, 2003; effective October 7, 2003. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Public necessity rule filed September 26, 2005; effective through March 10, 2006. Amendments filed December 20, 2005;*

(Rule 1200-13-01-.06, continued)
effective March 5, 2006. Amendment filed January 16, 2006; effective April 1, 2006. Amendment filed July 17, 2007; effective September 30, 2007. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010.

1200-13-01-.07 REPEALED

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 197; effective March 16, 1979. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed May 8, 1985; effective August 13, 1985. Amendment filed April 29, 1986, effective May 29, 1986. Amendment filed January 22, 1988; effective March 7, 1988. Amendment filed January 30, 1989; effective March 16, 1989. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed February 23, 1990; effective April 9, 1990. Amendment filed July 5, 1990; effective August 19, 1990. Amendment filed August 30, 1990; effective October 14, 1990. Amendment filed October 30, 1990; effective December 14, 1990. Amendment filed January 9, 1991; effective February 23, 1991. Amendment filed February 27, 1991; effective April 13, 1991. Amendment filed April 29, 1991; effective June 13, 1991. Amendment filed May 8, 1991; effective June 22, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed September 19, 1991; effective November 3, 1991. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 26, 1992; effective May 10, 1992. Amendment filed March 27, 1992; effective May 11, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed August 4, 1992; effective September 18, 1992. Amendment filed September 29, 1992; effective November 13, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed December 30, 1992; effective February 16, 1993. Amendment filed December 10, 1993; effective February 23, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 28, 2007; effective April 11, 2007.*

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, CHOICES Group 3, or ECF CHOICES 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.

(Rule 1200-13-01-.08, continued)

(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, the CHOICES At-Risk Demonstration Group, the ECF CHOICES 217-Like Group, the Interim ECF CHOICES At-Risk Group, and upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES At-Risk and ECF CHOICES Working Disabled Demonstration Groups, 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, CHOICES Group 3, or ECF CHOICES 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, CHOICES Group 3, or ECF CHOICES Member will be transitioned to CHOICES Group 1 (see 1200-13-01-.31(6)(b) for requirements pertaining to ECF CHOICES Members), 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 receives CBRA services other than Companion Care (i.e., ACLF, Critical Adult Care Home, Community Living Supports, or Community Living Supports – Family Model), the Enrollee must pay his Patient Liability to the residential facility or provider. The residential facility or provider 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, CHOICES Group 3, or ECF CHOICES Member does not receive CBRA services other than Companion Care, i.e., the Member is receiving HCBS in his own home, 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, CHOICES Group 3, or ECF CHOICES benefits or CEA services provided as an alternative to covered CHOICES Group 2, CHOICES Group 3, or ECF CHOICES 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, CHOICES Group 3 or ECF CHOICES benefits (or CEA services provided as an alternative to CHOICES Group 2, CHOICES Group 3 or ECF CHOICES benefits) reimbursed by the MCO for that month.

(f) A CHOICES or ECF CHOICES provider, including an MCO, may decline to continue to provide LTSS to a CHOICES or ECF 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 or ECF CHOICES

(Rule 1200-13-01-.08, continued)

Member who has failed to pay his Patient Liability, the Member may be disenrolled from the CHOICES or ECF 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 or ECF CHOICES programs who have LTC insurance policies must report these policies to TennCare upon enrollment in the CHOICES or ECF CHOICES program. Applicants may be subject to criminal prosecution for knowingly providing incorrect information.

(c) Obligations of CHOICES or ECF 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 or provider. These benefits will be used to reduce the amounts that the MCO would otherwise be required to pay the NF or the residential facility or provider for LTSS.

2. If the benefits are not assignable, the Member must provide payment to the NF or the residential facility or provider 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 or provider for LTSS.

(d) Obligations of CHOICES or ECF CHOICES Members receiving non-residential CHOICES HCBS or Companion Care services, or non-residential ECF CHOICES services having insurance that will pay for CHOICES HCBS or ECF 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 or ECF 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 or ECF 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).

(Rule 1200-13-01-.08, continued)

(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).

Authority: *T.C.A. §§ 4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed May 15, 1980; effective June 29, 1980. Amendment filed May 27, 1983; effective June 27, 1983. Amendment filed February 22, 1991; effective April 9, 1991. Emergency rule filed March 1, 2009; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rules filed June 29, 2012; effective through December 26, 2012. Repeal and new rule filed September 26, 2012; effective December 25, 2012. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.*

1200-13-01-.09 THIRD PARTY SIGNATURE.

(1) No facility may require a third party signature for a Medicaid recipient as a condition of application or admission to, or continued stay in, the facility. However, any person appointed by a court of competent jurisdiction to act on behalf of a recipient may be required to perform all requirements normally required of an applicant.

(Rule 1200-13-01-.09, continued)

(2) If a facility has collected an advance payment or deposit from or on behalf of a person retroactively determined to be eligible for Medicaid, the amount collected less the amount determined by the Department of Human Services to be the patient's liability for that period of time shall be refunded within ten (10) days after receiving payment for retroactive period from the state of its agents.

(3) The facility must file for such retroactive reimbursement for the full period of retroactive eligibility on the next claim for reimbursement filed by the facility following the date of notification of eligibility.

Authority: *T.C.A. §§ 14-1945 and 14-23-109.* ***Administrative History:*** *Original rule filed May 15, 1980; effective June 29, 1980. Amendment filed October 8, 1985; effective November 7, 1985.*

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.

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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

(Rule 1200-13-01-.10, continued)

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:

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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

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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) 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.

(e) 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.

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

(g) 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, ECF 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, ECF 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, ECF 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 or one-time ECF 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

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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 (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 through approval of a Safety Determination Request to not be able to be safely served 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), cost-effective alternative services (as applicable), services available through Medicare, private insurance or other funding sources, and natural supports provided by family members and other caregivers who are willing and able to provide such care. An Applicant who cannot be safely served in CHOICES Group 3 does not qualify to enroll in CHOICES Group 3. An applicant who could be safely served in CHOICES Group 3 except that he does not meet Medicaid categorical and financial eligibility criteria for CHOICES Group 3 (i.e. is not an SSI recipient) shall not be eligible for CHOICES Group 1 as a result of a Safety Determination.

(ii) Applicants eligible to receive care in a NF, but requesting HCBS in CHOICES Group 2, ECF CHOICES 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, ECF 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) For a CHOICES Group 2 Applicant, 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 through approval of a Safety Determination Request to not be able to be safely served within the array of services and supports that would be available if the Applicant was enrolled in CHOICES Group 3, including

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CHOICES HCBS up to the Expenditure Cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), cost-effective alternative services (as applicable), services available through Medicare, private insurance or other funding sources, and natural supports provided by family members and other caregivers who are willing and able to provide such care. An Applicant who cannot be safely served in CHOICES Group 3 does not qualify to enroll in CHOICES Group 3. An applicant who could be safely served in CHOICES Group 3 except that he does not meet Medicaid categorical and financial eligibility criteria for CHOICES Group 3 (i.e. is not an SSI recipient) shall not be eligible for CHOICES Group 2 as a result of a Safety Determination; or

(III) For an ECF CHOICES Applicant age 21 or older, have an intellectual or developmental disability and be determined through approval of a Safety Determination Request to not be able to be safely served within the array of services and supports that would be available if the Applicant was enrolled in ECF CHOICES Group 5, including ECF CHOICES HCBS up to the Expenditure Cap of $30,000; one-time emergency assistance up to $6,000; non-ECF CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care; or

(IV) For an ECF CHOICES Applicant under age 18 with an intellectual or developmental disability, to not qualify financially for TennCare unless the deeming of the parent's income to the child is waived, and absent the availability of benefits in ECF CHOICES Group 4, including ECF CHOICES HCBS up to the Expenditure Cap of $15,000, non-ECF CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care, the child is at imminent risk of placement outside the home.

(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). Approval of this

deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of transfer assistance required.

(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 (manual or electric) 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. Approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of mobility assistance required.

(III) Eating. The Applicant requires physical assistance with gastrostomy tube feedings or physical assistance or constant one-on-one observation and verbal assistance (reminding, encouraging) 4 or more days per week to consume prepared food and drink (or self-administer tube feedings, as applicable) or must be fed part or all of each meal. Food preparation, tray set-up, assistance in cutting up foods, and general supervision of multiple residents shall not be considered to meet this requirement. Approval of this deficit shall require documentation which supports the need for such intervention, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task. For PAEs submitted by the AAAD (or entity other than an MCO, NF, or PACE Organization), an eating or feeding plan specifying the type, frequency and duration of supports required by the Applicant for feeding, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task shall be required.

(IV) Toileting. The Applicant requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or catheter care on an ongoing basis (daily or at least four days per week). Approval of this deficit shall require documentation of the specific type and frequency of toileting assistance required.

(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) in a manner that can be understood by others, including through the use of assistive devices; or the Applicant is incapable of understanding and following very simple instructions and commands without continual intervention (daily or at least four days per week). Approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of communication assistance required.

(VI) Orientation. The Applicant is disoriented to person (e.g., fails to remember own name, or recognize immediate family members), place (e.g., does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make decisions

that prevent risk of harm) daily or at least four days per week. Approval of this deficit shall require documentation of the specific orientation deficit(s), including the frequency of occurrence of such deficit(s), and the impact of such deficit(s) on the Applicant.

(VII) Medication Administration. The Applicant is not cognitively or physically capable (daily or at least four days per week) of self-administering prescribed medications at the prescribed schedule 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, reassurance of the correct dose, and the use of assistive devices including a prepared medication box. An occasional lapse in adherence to a medication schedule shall not be sufficient for approval of this deficit; the Applicant must have physical or cognitive impairments which persistently inhibit his or her ability to self-administer medications. Approval of this deficit shall require evidence that such interventions have been tried or would not be successful, and that in the absence of intervention, the Applicant's health would be at serious and imminent risk of harm.

(VIII) Behavior. The Applicant requires persistent staff or caregiver intervention and supervision (daily or at least four days per week) due to an established and persistent pattern of behavioral problems which are not primarily related to a mental health condition (for which mental health treatment would be the most appropriate course of treatment) or a substance abuse disorder (for which substance abuse treatment would be the most appropriate course of treatment), and which, absent such continual intervention and supervision, place the Applicant or others at imminent and serious risk of harm. Such behaviors may include physical aggression (including assaultive or self-injurious behavior, destruction of property, resistive or combative to personal and other care, intimidating/threatening, or sexual acting out or exploitation) or inappropriate or unsafe behavior (including disrobing in public, eating non-edible substances, fire setting, unsafe cooking or smoking, wandering, elopement, or getting lost). Approval of this deficit shall require documentation of the specific behaviors and the frequency of such behaviors.

(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 daily home health visits. Approval of such skilled nursing or rehabilitative services shall require a physician's order and other documentation as specified in the PAE. Level 2 reimbursement for rehabilitative services and acuity points for such rehabilitative services shall not be approved for chronic conditions, exacerbations of chronic conditions, weakness after hospitalization, or maintenance of functional status, although the NF shall be required to ensure that appropriate services and supports are provided based on the individualized needs of each resident.

(iv) Applicants not eligible to receive care in a NF, but at risk of NF placement and requesting HCBS in ECF CHOICES Group 4 or 5. The Applicant has an intellectual or developmental disability as defined under Tennessee

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state law, including for an Applicant with ID, limitations in two (2) or more adaptive skill areas (i.e., communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work); and for an Applicant age five (5) or older with DD, substantial functional limitations in three (3) or more major life activities (i.e., self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency); such that, in the absence of the provision of a moderate level of ECF CHOICES home and community based services and supports on an ongoing basis, 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.

(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). On a case-by-case basis, TennCare may, subject to additional medical review, authorize Chronic Ventilator Reimbursement for an Applicant who is ventilator dependent with a progressive neuromuscular disorder or spinal cord injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least 12 hours each day in order to avoid or delay tracheostomy.

(d) In order to be approved by the Bureau for TennCare-reimbursed care in a NF at the Secretion Management Tracheal Suctioning rate of reimbursement:

(Rule 1200-13-01-.10, continued)

1. An Applicant must have a functioning tracheostomy and a copious volume of secretions, and require either:

   (i) Invasive tracheal suctioning, at a minimum, once every three (3) hours with documented assessment pre- and post-suctioning; or

   (ii) The use of mechanical airway clearance devices and/or heated high flow molecular humidification via the tracheostomy, at a minimum, three (3) times per day with documented assessment pre-and post.

      (I) A copious volume of secretions shall be defined as 25 to 30 ml per day occurring over the course of the day, and not necessarily at every suctioning.

      (II) The requirement for invasive tracheal suctioning, at a minimum, once every three (3) hours shall be applied as a marker of the severity of the Applicant's respiratory care needs. Secretion Management Tracheal Suctioning is not a scheduled intervention and shall not be performed as a medication would be delivered, i.e., at scheduled intervals (except as prescribed by an appropriately licensed health care professional practicing within the scope of his or her license). Rather, tracheal suctioning should be provided as clinically indicated, based on the needs of each person requiring such care; evidence of the need should be clearly and accurately documented. This could mean a shorter or longer interval at any point, but with a clinical need for invasive tracheal suctioning an average of every three (3) hours or more often in order to qualify for Secretion Management Tracheal Suctioning Reimbursement, except when mechanical airway clearance devices and/or heated high flow molecular humidification via the tracheostomy are used to manage secretions.

      (III) When mechanical airway clearance devices and/or heated high flow molecular humidification via the tracheostomy are used to manage secretions, there must be documented evidence of the Applicant's copious secretions, but they are managed non-invasively using a cough assist device periodically or high flow molecular humidity continuously or at least three (3) times per day as ongoing treatment. The device is expected to provide ongoing relief of the copious volume of secretions, which shall not negate the need for intervention (and eligibility for Secretion Management Tracheal Suctioning Reimbursement), if absent the high flow device, the copious volume of secretions would require more invasive management.

2. The suctioning (or airway clearance, as applicable) 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 Sub-Acute 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 which shall include documented progress in weaning from the tracheostomy.

3. A PAE for Secretion Management Tracheal Suctioning Reimbursement shall be approved for no more than a period of thirty (30) days. Clinical review and

(Rule 1200-13-01-.10, continued)

approval of a new PAE shall be required for ongoing coverage, which shall include evaluation of clinical progress and the NF's efforts to improve secretion management through alternative methods. TennCare may, on a case-by-case basis, approve a PAE for Secretion Management Tracheal Suctioning Management Reimbursement for a period of more than thirty (30) days, e.g., if a person has ALS (amyotrophic lateral sclerosis) or another progressive neuromuscular disorder, spinal cord injury, or chronic respiratory failure, or is in a persistent vegetative state, and evidence clearly supports that ongoing secretion management tracheal suctioning is expected to continue.

4. A NF who has an approved PAE for Tracheal Suctioning Reimbursement for any resident as of July 1, 2016 shall be entitled to continue to receive such level of reimbursement no later than July 31, 2016 (or any earlier date that may be specified in the approved PAE). The NF shall submit a new PAE for such resident no later than July 19, 2016 in order to determine whether Secretion Management Tracheal Suctioning Reimbursement will be continued, or whether a different level of NF reimbursement is appropriate.

(e) Determination of medical necessity and authorization for Ventilator Weaning Reimbursement, or short-term payment at the Sub-Acute 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 and for approval of NF LOC for individuals applying for enrollment into ECF CHOICES, 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.

(Rule 1200-13-01-.10, continued)

(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	
Mobility		0	1	2	3	3	4
Eating		0	1	3	4	4	4
Toileting	Highest value of three questions for the toileting measure	0	0	1	2	2	
Incontinence care		0	1	2	3	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	0	0	0	1	1	
Receptive		0	0	0	1	1	1

(Rule 1200-13-01-.10, continued)

communication	measure						
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.

(Rule 1200-13-01-.10, continued)

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.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed October 22, 1981; effective December 7, 1981. Amendment filed March 1, 1982; effective April 15, 1982. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed May 24, 1985; effective June 23, 1985. Amendment filed November 9, 1988; effective December 24, 1988. Amendment filed March 30, 1995; effective June 15, 1995. Repeal and new rule filed June 29, 2000; effective September 12, 2000. Amendment filed July 24, 2003; effective October 7, 2003. Amendment filed September 30, 2005; effective December 14, 2005. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Emergency rules filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Emergency rule filed June 29, 2012; effective through December 26, 2012. Repeal and new rule filed September 26, 2012; effective December 25, 2012. Emergency rule filed June 30, 2015; effective through December 27, 2015. Amendment filed April 14, 2015; effective July 13, 2015. Amendment filed September 23, 2015; effective December 22, 2015. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016. Amendments filed July 3, 2017; effective October 1, 2017.*

1200-13-01-.11 REPEALED.

Authority: *T.C.A. §§ 4-5-202 and 71-5-105.* ***Administrative History:*** *Original rule filed June 7, 1982; effective July 22, 1982. Repeal and new rule filed February 23, 1987; effective April 9, 1987. Amendment filed March 22, 1989; effective Mayl6, 1989. Amendment filed June 8, 1990; effective July 23, 1990. Amendment filed March 18, 1994; effective June 1, 1994. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Repeal filed February 1, 2013; effective July 29, 2013.*

1200-13-01-.12 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 14-23-105, 14-23-109, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 2, 1983; effective April 4, 1983. Repeal and new rule filed February 4, 1985; effective March 6, 1985. Amendment filed July 5, 1990; effective August 19, 1990. Repeal filed March 18, 1994; effective June 1, 1994.*

1200-13-01-.13 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 11.* ***Administrative History:*** *Original rule filed June 23, 1983; effective July 25, 1983. Amendment filed March 30, 1995; effective June 15, 1995. Repeal filed June 29, 2000; effective September 12, 2000.*

1200-13-01-.14 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed February 14, 1984; effective March 15, 1984. Amendment filed August 21, 1984; effective September 20, 1984. Repeal filed March 18, 1994; effective June 1, 1994.*

1200-13-01-.15 MEDICAL (LOC) ELIGIBILITY CRITERIA FOR MEDICAID REIMBURSEMENT OF CARE IN AN ICF/MR.

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

(2) ICF/MR PreAdmission Evaluations and Transfer Forms

(a) An ICF/MR PreAdmission Evaluation is required to be submitted to the Bureau of TennCare for approval when

1. A Medicaid Eligible is admitted to an ICF/MR.

2. A private-paying resident of an ICF/MR attains Medicaid Eligible status or applies for Medicaid eligibility. A new ICF/MR PreAdmission Evaluation is not required when an individual's financial status changes from Medicaid Eligible to private pay and then back to Medicaid Eligible within a 90-day time period.

(b) A Transfer Form is required to be submitted to the Bureau of TennCare for approval when an ICF/MR Eligible having an approved unexpired ICF/MR PAE transfers from one ICF/MR to another ICF/MR or from the HCBS MR Waiver Program to an ICF/MR. A Transfer Form is required to be submitted to the Division of Intellectual Disabilities Services for approval when an ICF/MR Eligible having an approved unexpired ICF/MR PAE transfers from an ICF/MR to the HCBS MR Waiver Program.

(c) An approved ICF/MR PreAdmission Evaluation is valid for ninety (90) calendar days from the ICF/MR PAE Approval Date. An approved ICF/MR PreAdmission Evaluation that has not been used within ninety (90) calendar days of the ICF/MR PAE Approval Date can be updated within 365 calendar days of the ICF/MR PAE Approval Date if the physician certifies that the individual's current medical condition is consistent with that described in the approved ICF/MR PreAdmission Evaluation. A PAE that is not used within 365 days of the PAE Approval Date is expired and cannot be updated.

(d) An ICF/MR PreAdmission Evaluation must include a recent medical history and physical signed by a physician who is licensed as a doctor of medicine or doctor of osteopathy, or by a licensed nurse practitioner or physician's assistant. A medical history and physical performed within 365 calendar days of the ICF/MR PAE Request Date may be used if the individual's condition has not significantly changed. Additional 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.

(Rule 1200-13-01-.15, continued)

(e) An ICF/MR PAE must include a psychological evaluation of need for care. Pursuant to 42 C.F.R. § 456.370(b), such evaluation must be performed before admission to the ICF/MR or authorization of payment, but not more than three months before admission.

(3) Medicaid Reimbursement

(a) An ICF/MR which has entered into a provider agreement with the Bureau of TennCare is entitled to receive Medicaid reimbursement for covered services provided to an ICF/MR Eligible if:

1. The Bureau of TennCare has received an approvable ICF/MR PreAdmission Evaluation for the individual within ten (10) calendar days of the ICF/MR 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.

2. For the transfer to an ICF/MR of an individual having an approved unexpired ICF/MR PreAdmission Evaluation, the Bureau of TennCare has received an approvable Transfer Form within ten (10) calendar days after the date of the transfer. For transfer from ICF/MR services to an HCBS MR Waiver program, the transfer form must be submitted and approved prior to enrollment in the HCBS MR Waiver program.

3. For a retroactive eligibility determination, the Bureau of TennCare has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired ICF/MR PreAdmission Evaluation within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change. The effective date of payment for ICF/MR services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE which has been updated.

(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 earlier than 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 ICF/MR services.

(c) An ICF/MR that admits a Medicaid Eligible without an approved ICF/MR PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement from the Bureau of TennCare.

(4) Criteria for Medicaid-reimbursed Care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)

(Rule 1200-13-01-.15, continued)

(a) Medicaid Eligible Status: The individual must be determined by the Tennessee Department of Human Services to be financially eligible for Medicaid-reimbursed care in an Intermediate Care Facility for the Mentally Retarded.

(b) An individual must meet all of the following criteria in order to be approved for Medicaid-reimbursed care in an Intermediate Care Facility for the Mentally Retarded:

1. Medical Necessity of Care: Care must be expected to enhance the individual's functional ability or to prevent or delay the deterioration or loss of functional ability. Care in an Intermediate Care Facility for the Mentally Retarded must be ordered and supervised by a physician.

2. Diagnosis of Mental Retardation or Related Conditions.

3. Need for Specialized Services for Mental Retardation or Related Conditions: The individual must require a program of specialized services for mental retardation or related conditions provided under the supervision of a qualified mental retardation professional (QMRP). The individual must also have a significant deficit or impairment in adaptive functioning in one of the following areas: communication, comprehension, behavior, or activities of daily living (e.g., toileting, bathing, eating, dressing/grooming, transfer, mobility).

(c) Individuals with mental retardation or related conditions who were in an Intermediate Care Facility for the Mentally Retarded or who were in community residential placements funded by the Division of Intellectual Disabilities on or prior to the effective date of this rule may be deemed by the Bureau of TennCare to meet the requirements of (4)(b)2. and (4)(b)3.

(d) For continued Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded, an individual must continue to meet the criteria specified in (4)(a) and (4)(b), unless otherwise exempted by (4)(c).

(5) Grievance process

(a) A Medicaid Eligible or the legal representative of the Medicaid Eligible has the right to appeal the denial of an ICF/MR PreAdmission Evaluation and to request a Commissioner's Administrative Hearing by submitting a written letter of appeal to the Bureau of TennCare within thirty (30) calendar days of receipt of the notice of denial.

(b) If the Bureau of TennCare denies an ICF/MR PreAdmission Evaluation, the individual will be notified in the following manner:

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

2. If an ICF/MR PreAdmission Evaluation is resubmitted with additional information for review and if the Bureau of TennCare continues to deny the ICF/MR PreAdmission Evaluation, another written notice of denial shall be sent as described in (5)(b)1.

(Rule 1200-13-01-.15, continued)

(c) The individual has the right to be represented at the hearing by anyone of their 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 with disabilities who require assistance with appeals.

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

Authority: *T.C.A. §§ 4-5-202, 4-5-203, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 11.* ***Administrative History:*** *Original rule filed June 22, 2000; effective September 5, 2000. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.*

1200-13-01-.16 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed September 11, 1987; effective October 31, 1987. Amendment filed March 6, 1991; effective April 20, 1991. Amendment filed September 9, 1991; effective October 24, 1991. Amendment filed November 27, 1991; effective January 11, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 26, 2007; effective date April 11, 2007. Emergency rule filed March 1, 2010; effective through August 28, 2010.*

1200-13-01-.17 REPEALED.

Authority: *T.C.A. §§ 4-5-202 and 71-5-105.* ***Administrative History:*** *Original rule filed February 12, 1986; effective March 14, 1986. Amendment filed March 1, 1988; effective April 15, 1988. Amendment filed July 28, 2004; effective October 11, 2004. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Repeal filed February 1, 2013; effective July 29, 2013.*

1200-13-01-.18 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, Executive Order No. 23, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed May 1985; effective June 23, 1985. Amendment filed November 5, 1990; effective December 20, 1990. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed September 18, 2007; effective December 2, 2007.*

1200-13-01-.19 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed September 10, 1985; effective October 10, 1985. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 26, 2007; effective April 11, 2007.*

1200-13-01-.20 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1994.* ***Administrative History:*** *Original rule filed June 2, 1988; effective July 17, 1988. Amendment filed April 19, 1990; effective June 3, 1990. Amendment filed April 30, 1992; effective June 14, 1992. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 26, 2007; effective April 11, 2007.*

1200-13-01-.21 REPEALED.

Authority: *T.C.A. §§ 4-5-202 and 71-5-105.* ***Administrative History:*** *Original rule filed January 29, 1990; effective March 15, 1990. Amendment filed October 24, 1991; effective December 8, 1991. Amendment filed November 27, 1991; effective January 11, 1992. Amendment filed March 10, 1992; effective April 24, 1992. Amendment filed August 4, 1992; effective September 18, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed March 18, 1994; effective June 1, 1994. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Repeal filed February 1, 2013; effective July 29, 2013.*

1200-13-01-.22 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, Executive Order No. 23, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed December 1, 1988; effective January 15, 1989. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed September 18, 2007; effective December 2, 2007.*

1200-13-01-.23 NURSING HOME PREADMISSION SCREENINGS FOR MENTAL ILLNESS AND MENTAL RETARDATION.

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

(2) Medicaid-certified nursing facilities may not admit individuals applying for admission unless these persons are screened to determine if they have mental illness or mental retardation regardless of method of payment or "known diagnosis." A Medicaid-certified nursing facility is prohibited from admitting any new resident who has mental illness or mental retardation (or a related condition), unless that individual has been determined by the Tennessee Department of Mental Health and Developmental Disabilities and/or the Division of Intellectual Disabilities Services, as applicable, not to be in need of specialized services and appropriate for placement in a nursing facility. (The individual must also meet the Bureau of TennCare's preadmission criteria for nursing facility services). The criteria to be used in making determinations will be categorized into two levels: 1) identification screens (Level I) and 2) preadmission screening/resident reviews evaluations (Level II).

(a) Criteria for Identification Screen (Level I)

1. Prior to admission of any person to a nursing facility, it must be determined if:

(i) For Mental Illness:

(I) The individual has a diagnosis of MI. (See definition of MI in Rule 1200-13-01-.02.)

(II) The person has any recent (within the last two years) history of mental illness, or has been prescribed a major tranquilizer on a regular basis in the absence of justifiable neurological disorder.

(III) There is any presenting evidence of mental illness (except primary diagnosis of Alzheimer's disease or dementia) including possible disturbances in orientation or mood.

(ii) For Mental Retardation or Persons with Related Conditions:

(I) The individual has a diagnosis of MR. (See definition of MR in Rule 1200-13-01-.02.)

(Rule 1200-13-01-.23, continued)

(II) There is any history of mental retardation or developmental disability in the identified individual's past.

(III) There is any presenting evidence (cognitive or behavior functions) that may indicate the person has mental retardation or developmental disability.

(IV) The person is referred by an agency that serves persons with mental retardation (or other developmental disabilities), and the person has been deemed to be eligible for that agency's services.

(V) The preceding criteria must also be applied to residents of a nursing facility who have not received an identification screen.

(VI) There must be a record of the identification screen results and interpretation in the nursing home resident's record.

(VII) Results of the identification screen must be used (unless there is other indisputable evidence that the individual is not mentally ill or mentally retarded) in determining whether an individual has (or is suspected to have) mental illness or mental retardation and therefore must be subjected to the PASRR process. Findings from the evaluation should be used in making determinations about whether an individual has mental illness or mental retardation.

(b) Any individual for whom there is a negative response for all of the identification evaluative criteria for mental retardation or mental illness and for whom there is no other evidence of a condition of mental illness or mental retardation may be admitted to or continue to reside in a Medicaid-certified nursing facility without being determined appropriate for nursing facility placement through the PASRR evaluation process (Level II).

(c) Any individual for whom there is a positive response for any of the identification evaluative criteria for mental retardation or mental illness may not be admitted to or continue to reside in a Medicaid-certified nursing facility without being determined appropriate for nursing facility placement through the PASRR evaluation process (Level II).

(d) Exemptions from Level II Review

An individual who has a diagnosis of mental illness or mental retardation will be exempt from the PASRR process if they meet any of the following criteria:

1. Dementia - This must be a primary diagnosis based on criteria in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition; or it may be the secondary diagnosis (including Alzheimer's disease and related disorders) as long as the primary diagnosis is not a major mental illness. The primary or secondary diagnosis of dementia (including Alzheimer's disease and related disorders) must be based on a neurological examination. Dementia is not allowed as an exemption if the individual has, or is suspected of having, a diagnosis of mental retardation.

2. Convalescent Care - Any person with MI or MR as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified NF after release from an acute care hospital for a period of recovery without being subjected to the PASRR process for evaluation of MI or MR.

(Rule 1200-13-01-.23, continued)

3. Terminal Illness - Under 42 U.S.C.A. § 1395x(dd)(3)(A), a Medicare beneficiary is considered to be terminally ill if he has a medical prognosis that his life expectancy is six (6) months or less. This same standard is to be applied to Medicaid recipients with MI, MR, or related conditions who are found to be suffering from a terminal illness. An individual with MI or MR, as long as that person is not a danger to self and/or others, may be admitted to or reside in a Medicaid-certified NF without being subjected to the PASRR/MI or PASRR/MR evaluative process if he is certified by a physician to be "terminally ill," as that term is defined in 42 U.S.C.A. § 1395x(dd)(3)(A), and requires continuous nursing care and/or medical supervision and treatment due to his physical condition.

4. Severity of Illness - Any person with mental illness or mental retardation who is comatose, ventilator dependent, functions at the brain stem level, or has a diagnosis of: Severe Parkinson's Disease, Huntingdon's Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure, or Chronic Obstructive Pulmonary Disease, and any other diagnosis so determined by the Centers for Medicare and Medicaid Services.

(e) Processes upon expiration of exemption

1. If an individual is admitted to a nursing facility as a Medicare patient, with a "30-day hospital discharge exemption" on the PASRR screen form, and it is determined that the individual will need to extend the stay beyond 30 days, it is the responsibility of the nursing facility to notify TennCare and to ensure that a PASRR evaluation is completed no more than 40 days from the original date of admission (i.e., within 10 days of expiration of the 30-day exemption). If Medicaid reimbursement will be sought, this includes submission and disposition of the PAE which will be required in order to timely complete the PASRR evaluation.

2. If an individual enters the facility with an exemption of "120-day short term stay" on the PASRR screen form and it is determined that the individual will need to extend the stay beyond 120 days, it is the responsibility of the nursing facility to notify TennCare at least seven (7) working days prior to expiration of the 120 days in order to ensure that a PASRR evaluation is completed timely before the 120-day exemption expires. If Medicaid reimbursement will be sought, the PAE must also be submitted to TennCare with sufficient time for review and approval. In such case, it is the responsibility of the nursing facility to notify TennCare and to submit a completed PAE at least ten (10) working days prior to expiration of the 120 days in order to ensure that a PASRR evaluation is completed timely before the 120-day exemption expires.

(3) Right to Appeal - Each patient has the right to appeal any decision made. The appeal process will be handled in accordance with T.C.A. §71-5-113.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed June 29, 1989; effective; August 14, 1989. Amendment filed March 30, 1995; effective June 15, 1995. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.*

1200-13-01-.24 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed October 21, 1991; effective December 5, 1991. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-01-.25 TENNESSEE'S HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED UNDER SECTION 1915 (c) OF THE SOCIAL SECURITY ACT (STATEWIDE MR WAIVER).

(1) Definitions: The following definitions shall apply for interpretation of this rule:

(a) Adult Dental Services - accepted dental procedures which are provided to adult Enrollees (i.e., age 21 years or older) as specified in the Plan of Care. Adult Dental Services may include fillings, root canals, extractions, the provision of dentures and other dental treatments to relieve pain and infection. Preventive dental care is not covered under Adult Dental Services.

(b) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.

(c) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.

(d) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.

(e) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a Pre-Admission Evaluation signifying that the named individual requires services provided through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.

(f) Covered Services or Covered Waiver Services – The services which are available through Tennessee's Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled when medically necessary and when provided in accordance with the Waiver as approved by the Centers for Medicare and Medicaid Services.

(g) Day Services - individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities.

(h) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.

(Rule 1200-13-01-.25, continued)

(i) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(j) Enrollee - a Medicaid Eligible who is enrolled in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(k) Environmental Accessibility Modifications – only those interior or exterior physical modifications to the Enrollee's place of residence which are required to ensure the health, welfare and safety of the Enrollee or which are necessary to enable the Enrollee to function with greater independence.

(l) Family Model Residential Support – a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(m) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities and Homes for the Aged.

(n) Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled or "Waiver" - the Home and Community Based Services waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who have mental retardation and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.

(o) ICF/MR Pre-Admission Evaluation (ICF/MR PAE) – the assessment form used by the State Medicaid Agency to document the current medical and habilitative needs of an individual with mental retardation and to document that the individual meets the Medicaid level of care eligibility criteria for care in an ICF/MR.

(p) Individual Support Plan – the individualized written Plan of Care.

(q) Individual Transportation Services –non-emergency transport of an Enrollee to and from approved activities specified in the Plan of Care.

(r) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for an ICF/MR.

(s) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have the State Medicaid Agency make reimbursement for covered services.

(t) Medicaid State Plan – the plan approved by the Center for Medicare and Medicaid Services which specifies the covered benefits for the Medicaid program in Tennessee.

(Rule 1200-13-01-.25, continued)

(u) Medical Residential Services – a type of residential service provided in a residence where all residents require direct skilled nursing services and habilitative services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting. Medical Residential Services must be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services. The enrollee who receives Medical Residential Services shall require direct skilled nursing services on a daily basis and at a level which cannot for practical purposes be provided through two or fewer daily skilled nursing visits. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(v) Nursing Services –skilled nursing services that fall within the scope of Tennessee's Nurse Practice Act and that are directly provided to the Enrollee in accordance with a plan of care. Nursing Services shall be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services.

(w) Nutrition Services - assessment of nutritional needs, nutritional counseling, and education of the Enrollee and of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat. Nutrition Services are intended to promote healthy eating practices and to enable the Enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.

(x) Occupational Therapy Services – diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(y) Operational Administrative Agency - the approved agency with which the State Medicaid Agency contracts for the administration of the day-to-day operations of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(z) Orientation and Mobility Training – assessment of the ability of an Enrollee who is legally blind to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the Enrollee and of caregivers responsible for assisting in the mobility of the Enrollee.

(aa) Personal Assistance – the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(bb) Personal Emergency Response System - a stationary or portable electronic device used in the Enrollee's place of residence which enables the Enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device.

(Rule 1200-13-01-.25, continued)

(cc) Physical Therapy Services - diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(dd) Plan of Care – an individualized written Plan of Care which describes the medical and other services (regardless of funding source) to be furnished to the Enrollee, the Waiver Service frequency, and the type of provider who will furnish each Waiver Service and which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees.

(ee) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.

(ff) Re-evaluation - the annual process approved by the State Medicaid Agency by which a licensed physician or registered nurse or a Qualified Mental Retardation Professional assesses the Enrollee's need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.

(gg) Residential Habilitation - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee’s Nurse Practice Act.

(hh) Respite - services provided to an Enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness or injury, or when unpaid caregivers need relief from routine caregiving responsibilities.

(ii) Safety Plan - an individualized plan by which the Operational Administrative Agency ensures the health, safety and welfare of Enrollees who do not have 24-hour direct care services.

(jj) Specialized Medical Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls or appliances which enable an Enrollee to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment, and supplies for the proper functioning of such items. Specialized Medical Equipment, Supplies, and Assistive Technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician or nurse practitioner) based on an assessment of the Enrollee’s needs and capabilities and shall be furnished as specified in the Plan of Care. Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that Specialized Medical Equipment and Assistive Technology which requires custom fitting meets the needs of the Enrollee and may include training of the Enrollee by a physical therapist, occupational therapist or speech therapist to effectively utilize such customized equipment.

(kk) Speech, Language and Hearing Services – diagnostic, therapeutic and corrective services which are within the scope of state licensure which enable an Enrollee to

(Rule 1200-13-01-.25, continued)

improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function.

(ll) State Medicaid Agency – the bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program in Tennessee.

(mm) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Operational Administrative Agency to provide Waiver Services to an Enrollee.

(nn) Support Coordination - case management services that assist the Enrollee in identifying, selecting, obtaining, coordinating and using both paid services and natural supports to enhance the Enrollee's independence, integration in the community and productivity as specified in the Enrollee's Plan of Care. Support Coordination shall be person-centered and shall include, but is not limited to, ongoing assessment of the Enrollee's strengths and needs; development, evaluation and revision of the Plan of Care; assistance with the selection of service providers; provision of general education about the Waiver program, including Enrollee rights and responsibilities; and monitoring implementation of the plan of care and initiating individualized corrective actions as necessary (e.g., reporting, referring, or appealing to appropriate entities).

(oo) Support Coordinator - the person who is responsible for developing the Individual Support Plan and participating in the development of, monitoring and assuring the implementation of the Plan of Care; who provides Support Coordination services to an Enrollee; and who meets the qualifications for a Support Coordinator as specified in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(pp) Supported Living - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain or improve skills necessary to reside in a home that is under the control and responsibility of the Enrollee. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(qq) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Intellectual Disabilities Services (DIDS). DIDS shall submit a Transfer Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.

(rr) Vehicle Accessibility Modifications - interior or exterior physical modifications to a vehicle owned by the Enrollee or to a vehicle which is owned by the guardian or conservator of the Enrollee and which is routinely available for transport of the Enrollee. Such modifications must be intended to ensure the transport of the Enrollee in a safe manner.

(2) Covered Services and Limitations.

(Rule 1200-13-01-.25, continued)

(a) Adult Dental Services.

1. Adult Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting.

2. Adult Dental Services shall exclude orthodontic services.

3. Adult Dental Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the waiver.

(b) Behavioral Respite Services.

1. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider.

2. Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence.

3. Behavioral Respite Services shall be limited to a maximum of sixty (60) days per Enrollee per year.

4. Enrollees who receive Behavioral Respite Services shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Behavioral Respite Services is being provided.

(c) Behavior Services.

1. Behavior Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Behavior Services shall be provided face to face with the Enrollee except for Enrollee-specific training of staff; behavior assessment and plan development; and presentation of Enrollee behavior information at human rights committee meetings, behavior support committee meetings, and Enrollee planning meetings.

3. Reimbursement for presentation of Enrollee behavior information at meetings shall be limited to a maximum of five (5) hours per Enrollee per year per provider. Reimbursement for behavior assessments shall be limited to a maximum of eight (8) hours per assessment with a maximum of two (2) assessments per year. Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first thirty (30) days following its approval for use shall be limited to a maximum of six (6) hours.

(d) Day Services.

1. Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the Enrollee's place of residence if there

(Rule 1200-13-01-.25, continued)

is a health, behavioral, or other medical reason or if the Enrollee has chosen retirement. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

2. With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day (i.e., between the hours of 7:30 a.m. and 6:00 p.m.), as specified in the Plan of Care.

3. Day Services shall be limited to a maximum of six (6) hours per day and five (5) days per week up to a maximum of 243 days per Enrollee per year.

4. Transportation to and from the Enrollee's place of residence to Day Services and transportation that is needed during the time that the Enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day Services reimbursement rate (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service; or

   (ii) Transportation necessary for Orientation and Mobility Training.

5. Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

6. For an Enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies or unrelated vocational training expenses such as the following:

   (i) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

   (ii) Payments that are passed through to users of supported employment programs; or

   (iii) Payments for vocational training that is not directly related to an Enrollee's supported employment program.

(e) Environmental Accessibility Modifications.

1. Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning, construction of an additional room) are excluded from coverage.

2. Any modification which is not of direct medical or remedial benefit to the Enrollee is excluded from coverage.

3. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an Enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.

4. Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per Enrollee per two (2) year period.

(Rule 1200-13-01-.25, continued)

(f) Family Model Residential Support.

1. With the exception of homes that were already providing services to three (3) residents prior to January 1, 2004, a Family Model Residential Support home shall have no more than two (2) residents who receive services and supports.

2. The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

3. Transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

(ii) Transportation necessary for Behavioral Respite Services; or

(iii) Transportation necessary for Orientation and Mobility Training.

4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

5. Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to the Enrollee's parent, step-parent, spouse, child, or sibling or to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(g) Individual Transportation Services.

Individual Transportation Services shall not be used for:

1. Transportation to and from Day Services;

2. Transportation to and from supported or competitive employment;

3. Transportation of school aged children to and from school;

4. Transportation to and from medical services covered by the Medicaid State Plan; or

5. Transportation of an Enrollee receiving a residential service, except as described herein for Orientation and Mobility Training or Behavioral Respite Services.

(h) Medical Residential Services.

1. The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day when the Enrollee is not at school and shall be responsible for the cost of Day Services needed by the Enrollee.

(Rule 1200-13-01-.25, continued)

2. Transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

   (ii) Transportation necessary for Behavioral Respite Services; or

   (iii) Transportation necessary for Orientation and Mobility Training.

3. Reimbursement for Medical Residential Services shall not include the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator. Reimbursement shall not be made for room and board if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the Enrollee, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's place of residence. If an Enrollee owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

5. Medical Residential Services providers must be licensed by the Department of Mental Health and Developmental Disabilities as a Mental Retardation Residential Habilitation Facility provider or a Supported Living Service provider and ensure that employed nurses are licensed to practice in the state of Tennessee.

(i) Nursing Services.

1. Nursing Services shall be provided face to face with the Enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.

2. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.

3. This service shall be provided in home and community settings, as specified in the Plan of Care, excluding inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. An Enrollee who is receiving Medical Residential Services shall not be eligible to receive Nursing Services during the hours Medical Residential Services are being provided.

5. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

(Rule 1200-13-01-.25, continued)

6. Nursing Services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

(j) Nutrition Services.

1. Nutrition Services must be provided face to face with the Enrollee except for Enrollee-specific training of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat and except for that portion of the assessment involving development of the POC.

2. Nutrition Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Speech, Language and Hearing Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

3. Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one (1) assessment visit per month with a maximum of three (3) assessment visits per year per Enrollee per provider Nutrition Services other than such assessments (e.g., Enrollee-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one (1) visit per day. Nutrition Services assessments shall not be billed on the same day with other Nutrition Services.

(k) Occupational Therapy Services.

1. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.

2. Occupational Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).

4. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.

5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a

(Rule 1200-13-01-.25, continued)

maximum of three (3) assessments per year per Enrollee per provider. Occupational Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(l) Orientation and Mobility Training.

1. Orientation and Mobility Training shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Behavior Services; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Orientation and Mobility Training shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

3. Reimbursement for an Orientation and Mobility Training assessment with development of the Orientation and Mobility Training plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Orientation and Mobility Training assessments shall not be billed on the same day with other Orientation and Mobility Training services. Orientation and Mobility Training services other than such assessments (e.g., Enrollee training; Enrollee-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of fifty-two (52) hours of services per Enrollee per year.

4. Enrollees receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training.

(m) Personal Assistance.

1. Personal Assistance may be provided in the home or community; however, it shall not be provided in school settings and shall not be provided to replace personal assistance services required to be covered by schools or services available through the Medicaid State Plan.

2. An Enrollee who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance. Personal Assistance shall not be provided during the same time period when the Enrollee is receiving Day Services.

3. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the Enrollee. The Personal Assistance provider shall not be the spouse and shall not be the Enrollee's parent if the Enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(Rule 1200-13-01-.25, continued)

(n) Personal Emergency Response System. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

(o) Physical Therapy Services.

1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

2. Physical Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).

4. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.

5. Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Physical Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Physical Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(p) Residential Habilitation.

1. A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.

2. The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

3. Transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

(Rule 1200-13-01-.25, continued)

(ii) Transportation necessary for Behavioral Respite Services; or

(iii) Transportation necessary for Orientation and Mobility Training.

4. Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator.

5. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

(q) Respite.

1. Respite may be provided in the Enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider.

2. An Enrollee receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Respite as a service.

3. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence.

4. Respite shall be limited to a maximum of thirty (30) days per Enrollee per year.

5. Enrollees who receive Respite shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite is being provided.

(r) Specialized Medical Equipment and Supplies and Assistive Technology.

1. Face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that specialized medical equipment and assistive technology which requires custom fitting meets the needs of the Enrollee and training of the Enrollee by a physical therapist, occupational therapist, or speech therapist to effectively utilize such customized equipment shall be limited to a maximum of three (3) hours per Enrollee per day.

2. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.

3. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.

4. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.

(Rule 1200-13-01-.25, continued)

5. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per Enrollee per two (2) year period.

(s) Speech, Language and Hearing Services.

1. Services must be provided by a licensed speech language pathologist or by a licensed audiologist.

2. Speech, Language and Hearing Services must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Speech, Language and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language and Hearing assessments (i.e., assess and treat orders are not accepted).

4. Speech, Language and Hearing Services assessments shall not be billed on the same day with other Speech, Language and Hearing Services

5. Speech, Language and Hearing Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Speech, Language, and Hearing Services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(t) Support Coordination. There must be at least one face-to-face contact with the Enrollee per calendar month. If the Enrollee receives a residential service, the Support Coordinator shall have at least one face-to-face contact with the Enrollee in the Enrollee's place of residence each quarter.

(u) Supported Living.

1. The Supported Living provider shall not own the Enrollee's place of residence or be a co-signer of a lease on the Enrollee's place of residence unless the Supported Living provider signs a written agreement with the Enrollee that states that the Enrollee will not be required to move if the primary reason is because the Enrollee desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to an Enrollee if such entity requires, as a condition of renting or leasing, the Enrollee to move if the Supported Living provider changes.

2. The Supported Living home shall have no more than three (3) residents including the Enrollee.

(Rule 1200-13-01-.25, continued)

3. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must have an operable smoke detector and a second means of egress.

4. The Supported Living provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

5. Transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

   (ii) Transportation necessary for Behavioral Respite Services; or

   (iii) Transportation necessary for Orientation and Mobility Training.

6. Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's home. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

7. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

8. The Enrollee or the Enrollee's guardian or conservator shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.

9. The Enrollee shall have the right to manage personal funds as specified in the Individual Support Plan.

(v) Vehicle Accessibility Modifications.

1. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.

2. Vehicle Accessibility Modifications shall be limited to a maximum of $20,000 per Enrollee per five (5) year period.

(w) Out-of-State Services. A provider of Personal Assistance, Residential Habilitation, Supported Living, Medical Residential Services, and Family Model Residential Services may provide such Covered Service outside the State of Tennessee and be reimbursed only when provided in accordance with the following:

1. Covered Services provided out of state shall be for the purpose of visiting relatives or for vacations and shall be included in the Enrollee's Plan of Care. Trips to casinos or other gambling establishments shall be excluded from coverage.

(Rule 1200-13-01-.25, continued)

2. Covered Services provided out of state shall be limited to a maximum of fourteen (14) days per Enrollee per year.

3. The waiver service provider agency must be able to assure the health and safety of the Enrollee during the period when Covered Services will be provided out of state and must be willing to assume the additional risk and liability of provision of Covered Services out of state.

4. During the period when Covered Services are being provided out of state, the waiver service provider agency shall maintain an adequate amount of staffing to meet the needs of the Enrollee and must ensure that staff meet the applicable provider qualifications.

5. The provider agency which provides Covered Services out of state shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the Waiver. The costs of travel, lodging, food, and other expenses incurred by the Enrollee while receiving out-of-state services shall be the responsibility of the Enrollee and shall not be reimbursed through the waiver.

(x) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(3) Eligibility.

(a) To be eligible for enrollment in the Waiver, an individual must meet all of the following criteria:

1. The individual must be a resident of the State of Tennessee.

2. The individual must, but for the provision of Waiver Services, require the LOC provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in TennCare Rule 1200-13-01-.15, except that requirements pertaining to a psychological evaluation shall be in accordance with Rule 1200-13-01-.25(3)(a)5.

3. The individual's habilitative, medical, and specialized services needs must be such that they can be effectively and safely met through the Waiver, as determined by the Operational Administrative Agency based on a pre-enrollment assessment.

4. The individual must have an unexpired ICF/MR Pre-Admission Evaluation which has been approved by the State Medicaid Agency or by its designee and which lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

5. The individual must have a psychological evaluation included as part of the approved Pre-Admission Evaluation which meets the following:

(i) The psychological evaluation shall document that the individual:

(I) Has mental retardation manifested before eighteen (18) years of age and has an IQ test score of seventy (70) or below; or

(Rule 1200-13-01-.25, continued)

(II) Is a child five (5) years of age or younger who has a developmental disability with a high probability of resulting in mental retardation (i.e., a condition of substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in mental retardation); and

(ii) There is no time limit for when the psychological evaluation is conducted as long as it is completed prior to the submission of the PAE, and as long as the evaluation meets the requirements specified in 1200-13-01-.25(3)(a)5.(i) above, and the person's current medical, social, developmental and psycho-social history continues to support the evaluation.

(iii) A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver shall be required if the person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.

6. The individual shall have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual.

(i) An individual who does not have 24-hour-per-day direct care services shall:

(I) Have an individualized Safety Plan that:

I. Is based on a written assessment of the individual's functional capabilities and habilitative, medical, and specialized services needs by the Independent Support Coordinator in consultation with individuals who are knowledgeable of the individual's capability of functioning without direct care services twenty-four (24) hours per day;

II. Addresses the individual's capability of functioning when direct care staff are not present;

III. Addresses the ability of the individual to self-administer medications when direct care staff are not present;

IV. Specifies whether a Personal Emergency Response System will be used by the individual to secure help in an emergency;

V. Is updated as needed, but no less frequently than annually, by the Operational Administrative Agency to ensure the health and safety of the individual; and

VI. Is an attachment to the ICF/MR PAE or, if applicable, to the Transfer Form.

(II) Have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual as needed but no less frequently than one day each week.

(Rule 1200-13-01-.25, continued)

7. An individual must have a place of residence with an environment that is adequate to reasonably ensure health, safety and welfare. Any licensed facility in which the individual resides must meet all applicable fire and safety codes.

(b) A Transfer Form approved by the State Medicaid Agency:

1. May be used to transfer an Enrollee having an approved unexpired ICF/MR PAE from the Waiver to an ICF/MR;

2. May be used to transfer an individual having an approved unexpired ICF/MR PAE from an ICF/MR to the Waiver;

3. May be used to transfer an individual from one MR Waiver to a different Home and Community Based Services MR Waiver Program as specified in 1200-13-01-.25(1)(qq) above; and

4. Shall include an initial plan of care that lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

(4) Intake and Enrollment.

(a) When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Operational Administrative Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver and shall offer the choice of available institutional services or Waiver program services. Notice to the individual shall contain:

1. A simple explanation of the Waiver and Covered Services;

2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and

3. A statement that participation in the Waiver is voluntary.

(b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.

(c) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in an ICF/MR.

(d) Upon implementation of the ECF CHOICES program, all new enrollment into the Statewide Waiver shall be closed; provided, however, that a child age 18-21 who has an Intellectual Disability and is aging out of State custody or is determined by TennCare to no longer be able to safely continue living with their family may be enrolled into the Statewide Waiver subject to (b) above if all eligibility and enrollment criteria are met, only until such time that the State has authority under the terms and conditions of the 1115 Waiver to provide for enrollment of such child into ECF CHOICES, when appropriate..

(5) Certification and Re-evaluation.

(a) The ICF/MR Pre-Admission Evaluation shall include a signed and dated certification by the individual's physician that the individual requires Waiver Services.

(b) The Operational Administrative Agency shall perform a re-evaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least every twelve (12) months thereafter. The re-evaluation shall be documented in a format approved by the State Medicaid Agency and shall be performed by a licensed physician or registered nurse or a Qualified Mental Retardation Professional.

(c) The Operational Administrative Agency shall maintain in its files for a minimum period of three (3) years a copy of the re-evaluations of need for continued stay.

(6) Disenrollment.

(a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's guardian or conservator to the Operational Administrative Agency. Prior to disenrollment the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(b) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:

1. The Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled is terminated.

2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.

3. An Enrollee moves out of the State of Tennessee; provided however, that when the Enrollee is the dependent of a military service member who is a legal resident of the state, but has left the state temporarily due to the military service member’s military assignment out of state, such dependent may re-enroll in the Waiver upon return to the State, so long as all conditions of eligibility are met.

4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.

5. The Enrollee’s medical or behavioral needs become such that the health, safety, and welfare of the Enrollee cannot be assured through the provision of Waiver Services.

6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.

7. The Enrollee or the Enrollee's guardian or conservator refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability of the Operational Administrative Agency to ensure quality care or the health and safety of the Enrollee.

8. The health, safety, and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan.

9. The Enrollee was transferred to a hospital, NF, ICF/MR, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period

(Rule 1200-13-01-.25, continued)

exceeding one hundred twenty (120) days, if such period began prior to March 1, 2010, or a period exceeding ninety (90) days if such period begins on or after March 1, 2010.

(c) The Operational Administrative Agency shall notify the State Medicaid Agency in writing prior to involuntary disenrollment of an Enrollee and shall give advance notice to the Enrollee of the intended involuntary disenrollment and of the Enrollee's right to appeal and have a fair hearing.

(d) If an Enrollee has been involuntarily disenrolled from the Waiver, the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(7) Plan of Care.

(a) All Waiver Services for the Enrollee shall be provided in accordance with an approved Plan of Care.

1. Prior to the development of the initial Individual Support Plan, Covered Services shall be provided in accordance with the physician's initial plan of care included in the approved ICF/MR Pre-Admission Evaluation.

2. Each Enrollee shall have a comprehensive individualized written Plan of Care (the Individual Support Plan) that shall be developed for the Enrollee within sixty (60) calendar days of admission into the Waiver.

3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.

(b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:

1. The Support Coordinator shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.

2. A team consisting of the Support Coordinator and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but no less frequently than every twelve (12) calendar months, and shall document such review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.

(8) Physician Services.

(a) The Operational Administrative Agency shall ensure that each Enrollee receives physician services as needed and that each Enrollee has a medical examination, documented in the Enrollee's record, in accordance with the following schedule:

Age	Minimum frequency of medical examinations
Up to age 21	In accordance with Medicaid EPSDT periodicity standards

(Rule 1200-13-01-.25, continued)

21-64	Every one (1) to three (3) years, as determined by the Enrollee's physician
Over age 65	Annually

(b) All Covered Services to be provided prior to the development of the initial Individual Support Plan shall be physician ordered and shall be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(c) When required by state law, Covered Services shall be ordered or reordered, by a licensed physician, licensed nurse practitioner, physician assistant, a licensed dentist, or other appropriate health care provider.

(9) Waiver Administration. The Operational Administrative Agency shall be responsible for the administration of the day-to-day operations of the Waiver under the oversight of the State Medicaid Agency and shall ensure that Covered Services are provided in accordance with state and federal laws, rules, regulations and policies established by the State Medicaid Agency. The Operational Administrative Agency shall be responsible for the following activities, whether provided directly or through subcontract:

(a) Marketing of the Waiver to potential Enrollees;

(b) Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;

(c) Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;

(d) Enrollment of eligible individuals into the Waiver;

(e) Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;

(f) Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;

(g) Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;

(h) Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;

(i) Ensuring that Waiver providers maintain comprehensive Enrollee records and documentation of services provided to Enrollees in accordance with state and federal laws, rules, regulations and State Medicaid Agency policies;

(j) Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;

(k) Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;

(l) Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;

(m) Assurance of a statewide provider network adequate to meet the needs of Enrollees;

(Rule 1200-13-01-.25, continued)

(n) Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;

(o) Ensuring that Waiver Services providers have a signed provider agreement which includes a requirement for compliance with the Division of Mental Retardation Services Provider Manual in the delivery of waiver services;

(p) Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;

(q) Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;

(r) Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;

(s) Compliance with the appeals process specified in TennCare rule 1200-13-13-.11 to ensure that Enrollees are afforded advance notice and the right to appeal an adverse decision and have a fair hearing;

(t) Ensuring that providers and subcontractors comply with the quality monitoring guidelines and requirements established by the State Medicaid Agency, by the Operational Administrative Agency, and by the Centers for Medicare and Medicaid Services, and with other state and federal laws, rules, and regulations affecting the provision of Waiver Services;

(u) Collection of applicable patient liability from Enrollees;

(v) Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;

(w) Recoupment of payments made to Waiver providers when there is lack of documentation to support that services were provided or there is a lack of medical necessity of services, or when inappropriate payments have been made due to erroneous or fraudulent billing; and

(x) Expenditure and revenue reporting in accordance with state and federal requirements.

(10) Reimbursement.

(a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care had been provided in an ICF/MR. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in an ICF/MR.

(b) The Operational Administrative Agency shall be reimbursed for Waiver Services at the rate per unit of service actually paid by the Operational Administrative Agency to the Waiver service provider or at the maximum rate per unit of service established by the State Medicaid Agency, whichever is less.

(c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational Administrative Agency or its designee shall complete appropriate forms

(Rule 1200-13-01-.25, continued)

showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency's fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.

(d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency's fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.

(e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.

(f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.

(g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.

(h) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.

(i) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Operational Administrative Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.

(11) Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13-13-.11.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed July 6, 2001; effective September 19, 2001. Amendment filed June 20, 2007; effective September 3, 2007. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendments filed June 26, 2015; effective September 24, 2015. Amendments filed September 30, 2016; effective December 29, 2016.*

1200-13-01-.26 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed July 28, 2004; effective October 11, 2004. Public necessity rule filed August 30, 2007; effective through February 11, 2008. Amendment filed November 30, 2007; effective February 13, 2008.*

1200-13-01-.27 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed July 28, 2004; effective October 11, 2004. Public necessity rule filed December 28, 2007; effective through June 10, 2008. Repeal of rule filed March 27, 2008; effective June 10, 2008.*

1200-13-01-.28 HOME AND COMMUNITY BASED SERVICES WAIVER FOR PERSONS WITH MENTAL RETARDATION UNDER SECTION 1915(c) OF THE SOCIAL SECURITY ACT (ARLINGTON MR WAIVER).

(1) Definitions: The following definitions shall apply for interpretation of this rule:

(a) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.

(b) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.

(c) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.

(d) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a Pre-Admission Evaluation signifying that the named individual requires services provided through the Home and Community Based Services Waiver for Persons with Mental Retardation as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.

(e) Covered Services or Covered Waiver Services – The services which are available through Tennessee's Home and Community Based Services Waiver for Persons with Mental Retardation when medically necessary and when provided in accordance with the Waiver as approved by the Centers for Medicare and Medicaid Services.

(f) Day Services - individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities.

(g) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.

(h) Dental Services - accepted dental procedures which are provided to Enrollees age twenty-one (21) years or older, as specified in the Plan of Care. Dental Services may include preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments to relieve pain and infection.

(Rule 1200-13-01-.28, continued)

(i) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Home and Community Based Services Waiver for Persons with Mental Retardation.

(j) Enrollee - a Medicaid Eligible who is enrolled in the Home and Community Based Services Waiver for Persons with Mental Retardation.

(k) Environmental Accessibility Modifications – only those interior or exterior physical modifications to the Enrollee's place of residence which are required to ensure the health, welfare and safety of the Enrollee or which are necessary to enable the Enrollee to function with greater independence.

(l) Family Model Residential Support – a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(m) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities and Homes for the Aged.

(n) Home and Community Based Services Waiver for Persons with Mental Retardation or "Waiver" - the Home and Community Based Services waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who have mental retardation and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.

(o) ICF/MR Pre-Admission Evaluation (ICF/MR PAE) – the assessment form used by the State Medicaid Agency to document the current medical and habilitative needs of an individual with mental retardation and to document that the individual meets the Medicaid level of care eligibility criteria for care in an ICF/MR.

(p) Individual Support Plan – the individualized written Plan of Care.

(q) Individual Transportation Services –non-emergency transport of an Enrollee to and from approved activities specified in the Plan of Care.

(r) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for an ICF/MR.

(s) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have the State Medicaid Agency make reimbursement for covered services.

(t) Medicaid State Plan – the plan approved by the Centers for Medicare and Medicaid Services which specifies the covered benefits for the Medicaid program in Tennessee.

(Rule 1200-13-01-.28, continued)

(u) Medical Residential Services – a type of residential service provided in a residence where all residents require direct skilled nursing services and habilitative services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting. Medical Residential Services must be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services. The enrollee who receives Medical Residential Services shall require direct skilled nursing services on a daily basis and at a level which cannot for practical purposes be provided through two or fewer daily skilled nursing visits. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(v) Nursing Services –skilled nursing services that fall within the scope of Tennessee's Nurse Practice Act and that are directly provided to the Enrollee in accordance with a plan of care. Nursing Services shall be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services.

(w) Nutrition Services - assessment of nutritional needs, nutritional counseling, and education of the Enrollee and of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat. Nutrition Services are intended to promote healthy eating practices and to enable the Enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.

(x) Occupational Therapy Services – diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(y) Operational Administrative Agency - the approved agency with which the State Medicaid Agency contracts for the administration of the day-to-day operations of the Home and Community Based Services Waiver for Persons with Mental Retardation.

(z) Orientation and Mobility Training – assessment of the ability of an Enrollee who is legally blind to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the Enrollee and of caregivers responsible for assisting in the mobility of the Enrollee.

(aa) Personal Assistance – the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(bb) Personal Emergency Response System - a stationary or portable electronic device used in the Enrollee's place of residence which enables the Enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device.

(Rule 1200-13-01-.28, continued)

(cc) Physical Therapy Services - diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(dd) Plan of Care – an individualized written Plan of Care which describes the medical and other services (regardless of funding source) to be furnished to the Enrollee, the Waiver Service frequency, and the type of provider who will furnish each Waiver Service and which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees.

(ee) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.

(ff) Re-evaluation - the annual process approved by the State Medicaid Agency by which a licensed physician or registered nurse or a Qualified Mental Retardation Professional assesses the Enrollee's need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.

(gg) Residential Habilitation - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee’s Nurse Practice Act.

(hh) Respite - services provided to an Enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness or injury, or when unpaid caregivers need relief from routine caregiving responsibilities.

(ii) Safety Plan - an individualized plan by which the Operational Administrative Agency ensures the health, safety and welfare of Enrollees who do not have 24-hour direct care services.

(jj) Specialized Medical Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls or appliances which enable an Enrollee to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment, and supplies for the proper functioning of such items. Specialized Medical Equipment, Supplies and Assistive Technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician or nurse practitioner) based on an assessment of the Enrollee’s needs and capabilities and shall be furnished as specified in the Plan of Care. Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist or speech therapist to assure that Specialized Medical Equipment and Assistive Technology which requires custom fitting meets the needs of the Enrollee and may include training of the Enrollee by a physical therapist, occupational therapist or speech therapist to effectively utilize such customized equipment.

(kk) Speech, Language and Hearing Services – diagnostic, therapeutic and corrective services which are within the scope of state licensure which enable an Enrollee to

(Rule 1200-13-01-.28, continued)

improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function.

(ll) State Medicaid Agency – the bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program in Tennessee.

(mm) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Operational Administrative Agency to provide Waiver Services to an Enrollee.

(nn) Support Coordination - case management services that assist the Enrollee in identifying, selecting, obtaining, coordinating and using both paid services and natural supports to enhance the Enrollee's independence, integration in the community and productivity as specified in the Enrollee's Plan of Care. Support Coordination shall be person-centered and shall include, but is not limited to, ongoing assessment of the Enrollee's strengths and needs; development, evaluation and revision of the Plan of Care; assistance with the selection of service providers; provision of general education about the Waiver program, including Enrollee rights and responsibilities; and monitoring implementation of the plan of care and initiating individualized corrective actions as necessary (e.g., reporting, referring, or appealing to appropriate entities).

(oo) Support Coordinator - the person who is responsible for developing the Individual Support Plan and participating in the development of, monitoring and assuring the implementation of the Plan of Care; who provides Support Coordination services to an Enrollee; and who meets the qualifications for a Support Coordinator as specified in the Home and Community Based Services Waiver for Persons with Mental Retardation.

(pp) Supported Living - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain or improve skills necessary to reside in a home that is under the control and responsibility of the Enrollee. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(qq) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Intellectual Disabilities Services (DIDS). DIDS shall submit a Transfer Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.

(rr) Vehicle Accessibility Modifications - interior or exterior physical modifications to a vehicle owned by the Enrollee or to a vehicle which is owned by the guardian or conservator of the Enrollee and which is routinely available for transport of the Enrollee. Such modifications must be intended to ensure the transport of the Enrollee in a safe manner.

(Rule 1200-13-01-.28, continued)

(ss) Vision Services - routine eye examinations and refraction; standard or special frames for eyeglasses; standard, bifocal, multifocal or special lenses for eyeglasses; contact lenses; and dispensing fees for ophthalmologists, optometrists, and opticians.

(2) Covered Services and Limitations.

(a) Behavioral Respite Services.

1. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider.

2. Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence.

3. Behavioral Respite Services shall be limited to a maximum of sixty (60) days per Enrollee per year.

4. Enrollees who receive Behavioral Respite Services shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Behavioral Respite Services is being provided.

(b) Behavior Services.

1. Behavior Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Behavior Services shall be provided face to face with the Enrollee except for Enrollee-specific training of staff; behavior assessment and plan development; and presentation of Enrollee behavior information at human rights committee meetings, behavior support committee meetings, and Enrollee planning meetings.

3. Reimbursement for presentation of Enrollee behavior information at meetings shall be limited to a maximum of five (5) hours per Enrollee per year per provider. Reimbursement for behavior assessments shall be limited to a maximum of eight (8) hours per assessment with a maximum of two (2) assessments per year. Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first thirty (30) days following its approval for use shall be limited to a maximum of six (6) hours.

(c) Day Services.

1. Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the Enrollee's place of residence if there is a health, behavioral, or other medical reason or if the Enrollee has chosen retirement. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

(Rule 1200-13-01-.28, continued)

2. With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day (i.e., between the hours of 7:30 a.m. and 6:00 p.m.), as specified in the Plan of Care.

3. Day Services shall be limited to a maximum of six (6) hours per day and five (5) days per week up to a maximum of 243 days per Enrollee per year.

4. Transportation to and from the Enrollee's place of residence to Day Services and transportation that is needed during the time that the Enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day Services reimbursement rate (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service; or

   (ii) Transportation necessary for Orientation and Mobility Training.

5. Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

6. For an Enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies or unrelated vocational training expenses such as the following:

   (i) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

   (ii) Payments that are passed through to users of supported employment programs; or

   (iii) Payments for vocational training that is not directly related to an Enrollee's supported employment program.

(d) Dental Services.

1. Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting.

2. Dental Services shall exclude orthodontic services.

3. Dental Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the Waiver.

(e) Environmental Accessibility Modifications.

1. Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning, construction of an additional room) are excluded from coverage.

2. Any modification which is not of direct medical or remedial benefit to the Enrollee is excluded from coverage.

3. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the

(Rule 1200-13-01-.28, continued)

accessibility of an Enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.

4. Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per Enrollee per two (2) year period.

(f) Family Model Residential Support.

1. With the exception of homes that were already providing services to three (3) residents prior to January 1, 2004, a Family Model Residential Support home shall have no more than two (2) residents who receive services and supports.

2. The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

3. Transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

(ii) Transportation necessary for Behavioral Respite Services; or

(iii) Transportation necessary for Orientation and Mobility Training.

4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

5. Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to the Enrollee's parent, step-parent, spouse, child, or sibling or to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(g) Individual Transportation Services.

Individual Transportation Services shall not be used for:

1. Transportation to and from Day Services;

2. Transportation to and from supported or competitive employment;

3. Transportation of school aged children to and from school;

4. Transportation to and from medical services covered by the Medicaid State Plan; or

5. Transportation of an Enrollee receiving a residential service, except as described herein for Orientation and Mobility Training or Behavioral Respite Services.

(h) Medical Residential Services.

(Rule 1200-13-01-.28, continued)

1. The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day when the Enrollee is not at school and shall be responsible for the cost of Day Services needed by the Enrollee.

2. Transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

   (ii) Transportation necessary for Behavioral Respite Services; or

   (iii) Transportation necessary for Orientation and Mobility Training.

3. Reimbursement for Medical Residential Services shall not include the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator. Reimbursement shall not be made for room and board if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the Enrollee, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's place of residence. If an Enrollee owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

5. Medical Residential Services providers must be licensed by the Department of Mental Health and Developmental Disabilities as a Mental Retardation Residential Habilitation Facility provider or a Supported Living Service provider and ensure that employed nurses are licensed to practice in the state of Tennessee.

(i) Nursing Services.

1. Nursing Services shall be provided face to face with the Enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.

2. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.

3. This service shall be provided in home and community settings, as specified in the Plan of Care, excluding inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. An Enrollee who is receiving Medical Residential Services shall not be eligible to receive Nursing Services during the hours Medical Residential Services are being provided.

(Rule 1200-13-01-.28, continued)

5. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

6. Nursing Services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

(j) Nutrition Services.

1. Nutrition Services must be provided face to face with the Enrollee except for Enrollee-specific training of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat and except for that portion of the assessment involving development of the POC.

2. Nutrition Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Speech, Language and Hearing Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

3. Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one (1) assessment visit per month with a maximum of three (3) assessment visits per year per Enrollee per provider Nutrition Services other than such assessments (e.g., Enrollee-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one (1) visit per day. Nutrition Services assessments shall not be billed on the same day with other Nutrition Services.

(k) Occupational Therapy Services.

1. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.

2. Occupational Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).

4. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.

5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (30 assessments per year per Enrollee per provider. Occupational Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(l) Orientation and Mobility Training.

1. Orientation and Mobility Training shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Behavior Services; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Orientation and Mobility Training shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

3. Reimbursement for an Orientation and Mobility Training assessment with development of the Orientation and Mobility Training plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Orientation and Mobility Training assessments shall not be billed on the same day with other Orientation and Mobility Training services. Orientation and Mobility Training services other than such assessments (e.g., Enrollee training; Enrollee-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of fifty-two (52) hours of services per Enrollee per year.

4. Enrollees receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training.

(m) Personal Assistance.

1. Personal Assistance may be provided in the home or community; however, it shall not be provided in school settings and shall not be provided to replace personal assistance services required to be covered by schools or services available through the Medicaid State Plan.

2. An Enrollee who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance. Personal Assistance shall not be provided during the same time period when the Enrollee is receiving Day Services.

3. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the Enrollee. The Personal Assistance provider shall not be the spouse and shall not be the Enrollee's

(Rule 1200-13-01-.28, continued)

parent if the Enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(n) Personal Emergency Response System. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

(o) Physical Therapy Services.

1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

2. Physical Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).

4. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.

5. Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Physical Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Physical Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(p) Residential Habilitation.

1. A Residential Habilitation home shall have no more than four (4) residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.

2. The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

3. Transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

(ii) Transportation necessary for Behavioral Respite Services; or

(iii) Transportation necessary for Orientation and Mobility Training.

4. Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator.

5. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

(q) Respite.

1. Respite may be provided in the Enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider.

2. An Enrollee receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Respite as a service.

3. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence.

4. Respite shall be limited to a maximum of thirty (30) days per Enrollee per year.

5. Enrollees who receive Respite shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite is being provided.

(r) Specialized Medical Equipment and Supplies and Assistive Technology.

1. Face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that specialized medical equipment and assistive technology which requires custom fitting meets the needs of the Enrollee and training of the Enrollee by a physical therapist, occupational therapist, or speech therapist to effectively utilize such customized equipment shall be limited to a maximum of three (3) hours per Enrollee per day.

2. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.

3. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.

(Rule 1200-13-01-.28, continued)

4. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.

5. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per Enrollee per two (2) year period.

(s) Speech, Language and Hearing Services.

1. Services must be provided by a licensed speech language pathologist or by a licensed audiologist.

2. Speech, Language and Hearing Services must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Speech, Language and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language and Hearing assessments (i.e., assess and treat orders are not accepted).

4. Speech, Language and Hearing Services assessments shall not be billed on the same day with other Speech, Language and Hearing Services.

5. Speech, Language and Hearing Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Speech, Language, and Hearing Services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(t) Support Coordination. There must be at least one face-to-face contact with the Enrollee per calendar month. If the Enrollee receives a residential service, the Support Coordinator shall have at least one face-to-face contact with the Enrollee in the Enrollee's place of residence each quarter.

(u) Supported Living.

1. The Supported Living provider shall not own the Enrollee's place of residence or be a co-signer of a lease on the Enrollee's place of residence unless the Supported Living provider signs a written agreement with the Enrollee that states that the Enrollee will not be required to move if the primary reason is because the Enrollee desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to an Enrollee if such entity requires, as a condition of renting or leasing, the Enrollee to move if the Supported Living provider changes.

2. The Supported Living home shall have no more than three (3) residents including the Enrollee.

3. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must have an operable smoke detector and a second means of egress.

4. The Supported Living provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

5. Transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

   (ii) Transportation necessary for Behavioral Respite Services; or

   (iii) Transportation necessary for Orientation and Mobility Training.

6. Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's home. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

7. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

8. The Enrollee or the Enrollee's guardian or conservator shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.

9. The Enrollee shall have the right to manage personal funds as specified in the Individual Support Plan.

(v) Vehicle Accessibility Modifications.

1. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.

2. Vehicle Accessibility Modifications shall be limited to a maximum of $20,000 per Enrollee per five (5) year period.

(w) Vision Services. Vision Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the Waiver.

(x) Out-of-State Services. A provider of Personal Assistance, Residential Habilitation, Supported Living, Medical Residential Services, and Family Model Residential Services may provide such Covered Service outside the State of Tennessee and be reimbursed only when provided in accordance with the following:

(Rule 1200-13-01-.28, continued)

1. Covered Services provided out of state shall be for the purpose of visiting relatives or for vacations and shall be included in the Enrollee's Plan of Care. Trips to casinos or other gambling establishments shall be excluded from coverage.

2. Covered Services provided out of state shall be limited to a maximum of fourteen (14) days per Enrollee per year.

3. The waiver service provider agency must be able to assure the health and safety of the Enrollee during the period when Covered Services will be provided out of state and must be willing to assume the additional risk and liability of provision of Covered Services out of state.

4. During the period when Covered Services are being provided out of state, the waiver service provider agency shall maintain an adequate amount of staffing to meet the needs of the Enrollee and must ensure that staff meet the applicable provider qualifications.

5. The provider agency which provides Covered Services out of state shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the Waiver. The costs of travel, lodging, food, and other expenses incurred by the Enrollee while receiving out-of-state services shall be the responsibility of the Enrollee and shall not be reimbursed through the waiver.

(y) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(3) Eligibility.

(a) To be eligible for enrollment in the Waiver, an individual must meet all of the following criteria:

1. The individual must be a resident of the State of Tennessee.

2. The individual must be a class member certified in United States vs. State of Tennessee, et. al. (Arlington Developmental Center).

3. The individual must, but for the provision of Waiver Services, require the level of care provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in Rule 1200-13-01-.15, except that requirements pertaining to a psychological evaluation shall be in accordance with Rule 1200-13-01-.28(3)(a)6.

4. The individual's habilitative, medical, and specialized services needs must be such that they can be effectively and safely met through the Waiver, as determined by the Operational Administrative Agency based on a pre-enrollment assessment.

5. The individual must have an unexpired ICF/MR Pre-Admission Evaluation which has been approved by the State Medicaid Agency or by its designee and which lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

(Rule 1200-13-01-.28, continued)

6. The individual must have a psychological evaluation included as part of the approved Pre-Admission Evaluation which meets the following:

   (i) The psychological evaluation shall document that the individual has mental retardation manifested before eighteen (18) years of age and has an IQ test score of seventy (70) or below; and

   (ii) There is no time limit for when the psychological evaluation is conducted as long as it is completed prior to the submission of the PAE, and as long as the evaluation meets the requirements specified in 1200-13-01-.28(3)(a)6.(i) above, and the person's current medical, social, developmental and psycho-social history continues to support the evaluation.

   (iii) A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver shall be required if the person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.

7. The individual shall have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual.

   (i) An individual who does not have 24-hour-per-day direct care services shall:

      (I) Have an individualized Safety Plan that:

         I. Is based on a written assessment of the individual's functional capabilities and habilitative, medical, and specialized services needs by the Independent Support Coordinator in consultation with individuals who are knowledgeable of the individual's capability of functioning without direct care services twenty-four (24) hours per day;

         II. Addresses the individual's capability of functioning when direct care staff are not present;

         III. Addresses the ability of the individual to self-administer medications when direct care staff are not present;

         IV. Specifies whether a Personal Emergency Response System will be used by the individual to secure help in an emergency;

         V. Is updated as needed, but no less frequently than annually, by the Operational Administrative Agency to ensure the health and safety of the individual; and

         VI. Is an attachment to the ICF/MR PAE or, if applicable, to the Transfer Form.

      (II) Have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual as needed but no less frequently than one day each week.

8. An individual must have a place of residence with an environment that is adequate to reasonably ensure health, safety and welfare. Any licensed facility in which the individual resides must meet all applicable fire and safety codes.

(b) A Transfer Form approved by the State Medicaid Agency:

1. May be used to transfer an Enrollee having an approved unexpired ICF/MR PAE from the Waiver to an ICF/MR;

2. May be used to transfer an individual having an approved unexpired ICF/MR PAE from an ICF/MR to the Waiver;

3. May be used to transfer an individual from one MR Waiver to a different Home and Community Based Services MR Waiver Program as specified in 1200-13-01-.28(1)(qq) above; and

4. Shall include an initial plan of care that lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

(4) Intake and Enrollment.

(a) When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Operational Administrative Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver and shall offer the choice of available institutional services or Waiver program services. Notice to the individual shall contain:

1. A simple explanation of the Waiver and Covered Services;

2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and

3. A statement that participation in the Waiver is voluntary.

(b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.

(c) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in an ICF/MR.

(d) Upon implementation of the ECF CHOICES program, all new enrollment into the Arlington Waiver (effective upon its renewal on January 1, 2015, the Comprehensive Aggregate Cap Waiver) shall be limited to individuals who have been identified by the state as a former member of the certified class in the United States vs. State of Tennessee, et al. (Arlington Developmental Center), a current or former member of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), or a person discharged from a State Developmental Center (Clover Bottom or Greene Valley) or the Harold Jordan Center following a stay of at least 90 days.

(5) Certification and Re-evaluation.

(Rule 1200-13-01-.28, continued)

(a) The ICF/MR Pre-Admission Evaluation shall include a signed and dated certification by the individual's physician that the individual requires Waiver Services.

(b) The Operational Administrative Agency shall perform a re-evaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least every twelve (12) months thereafter. The re-evaluation shall be documented in a format approved by the State Medicaid Agency and shall be performed by a licensed physician or registered nurse or a Qualified Mental Retardation Professional.

(c) The Operational Administrative Agency shall maintain in its files for a minimum period of three (3) years a copy of the re-evaluations of need for continued stay.

(6) Disenrollment.

(a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's guardian or conservator to the Operational Administrative Agency. Prior to disenrollment the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(b) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:

1. The Home and Community Based Services Waiver for Persons with Mental Retardation is terminated.

2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.

3. An Enrollee moves out of the State of Tennessee; provided however, that when the Enrollee is the dependent of a military service member who is a legal resident of the state, but has left the state temporarily due to the military service member’s military assignment out of state, such dependent may re-enroll in the Waiver upon return to the State, so long as all conditions of eligibility are met.

4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.

5. The Enrollee’s medical or behavioral needs become such that the health, safety, and welfare of the Enrollee cannot be assured through the provision of Waiver Services.

6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.

7. The Enrollee or the Enrollee's guardian or conservator refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability of the Operational Administrative Agency to ensure quality care or the health and safety of the Enrollee.

8. The health, safety and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan.

(Rule 1200-13-01-.28, continued)

9. The Enrollee was transferred to a hospital, NF, ICF/MR, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding one hundred twenty (120) days, if such period began prior to March 1, 2010, or a period exceeding ninety (90) days if such period begins on or after March 1, 2010.

(c) The Operational Administrative Agency shall notify the State Medicaid Agency in writing prior to involuntary disenrollment of an Enrollee and shall give advance notice to the Enrollee of the intended involuntary disenrollment and of the Enrollee's right to appeal and have a fair hearing.

(d) If an Enrollee has been involuntarily disenrolled from the Waiver, the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(7) Plan of Care.

(a) All Waiver Services for the Enrollee shall be provided in accordance with an approved Plan of Care.

1. Prior to the development of the initial Individual Support Plan, Covered Services shall be provided in accordance with the physician's initial plan of care included in the approved ICF/MR Pre-Admission Evaluation.

2. Each Enrollee shall have a comprehensive individualized written Plan of Care (the Individual Support Plan) that shall be developed for an Enrollee within sixty (60) calendar days of admission into the Waiver.

3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.

(b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:

1. The Support Coordinator shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.

2. A team consisting of the Support Coordinator and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but no less frequently than every twelve (12) calendar months, and shall document such review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.

(8) Physician Services.

(a) The Operational Administrative Agency shall ensure that each Enrollee receives physician services as needed and that each Enrollee has a medical examination, documented in the Enrollee's record, in accordance with the following schedule:

Age Minimum frequency of medical examinations

(Rule 1200-13-01-.28, continued)

Up to age 21	In accordance with Medicaid EPSDT periodicity standards
21-64	Every one (1) to three (3) years, as determined by the Enrollee's physician
Over age 65	Annually

(b) All Covered Services to be provided prior to the development of the initial Individual Support Plan shall be physician ordered and shall be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(c) When required by state law, Covered Services shall be ordered or reordered, by a licensed physician, licensed nurse practitioner, physician assistant, a licensed dentist, or other appropriate health care provider.

(9) Waiver Administration. The Operational Administrative Agency shall be responsible for the administration of the day-to-day operations of the Waiver under the oversight of the State Medicaid Agency and shall ensure that Covered Services are provided in accordance with state and federal laws, rules, regulations and policies established by the State Medicaid Agency. The Operational Administrative Agency shall be responsible for the following activities, whether provided directly or through subcontract:

(a) Marketing of the Waiver to potential Enrollees;

(b) Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;

(c) Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;

(d) Enrollment of eligible individuals into the Waiver;

(e) Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;

(f) Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;

(g) Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;

(h) Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;

(i) Ensuring that Waiver providers maintain comprehensive Enrollee records and documentation of services provided to Enrollees in accordance with state and federal laws, rules, regulations and State Medicaid Agency policies;

(j) Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;

(k) Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;

(l) Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;

(Rule 1200-13-01-.28, continued)

(m) Assurance of a statewide provider network adequate to meet the needs of Enrollees;

(n) Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;

(o) Ensuring that Waiver Services providers have a signed provider agreement which includes a requirement for compliance with the Division of Mental Retardation Services Provider Manual in the delivery of waiver services;

(p) Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;

(q) Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;

(r) Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;

(s) Compliance with the appeals process specified in TennCare rule 1200-13-13-.11 to ensure that Enrollees are afforded advance notice and the right to appeal an adverse decision and have a fair hearing;

(t) Ensuring that providers and subcontractors comply with the quality monitoring guidelines and requirements established by the State Medicaid Agency, by the Operational Administrative Agency, and by the Centers for Medicare and Medicaid Services, and with other state and federal laws, rules, and regulations affecting the provision of Waiver Services;

(u) Collection of applicable patient liability from Enrollees;

(v) Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;

(w) Recoupment of payments made to Waiver providers when there is lack of documentation to support that services were provided or there is a lack of medical necessity of services, or when inappropriate payments have been made due to erroneous or fraudulent billing; and

(x) Expenditure and revenue reporting in accordance with state and federal requirements.

(10) Reimbursement.

(a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care had been provided in an ICF/MR. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in an ICF/MR.

(b) The Operational Administrative Agency shall be reimbursed for Waiver Services at the rate per unit of service actually paid by the Operational Administrative Agency to the Waiver service provider or at the maximum rate per unit of service established by the State Medicaid Agency, whichever is less.

(Rule 1200-13-01-.28, continued)

(c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational Administrative Agency or its designee shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency's fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.

(d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency's fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.

(e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.

(f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.

(g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.

(h) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.

(i) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Operational Administrative Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.

(11) Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13-13-.11.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed June 20, 2007; effective September 3, 2007. Public necessity rules filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendments filed June 26, 2015; effective September 24, 2015. Amendments filed September 30, 2016; effective December 29, 2016.*

1200-13-01-.29 TENNESSEE'S SELF-DETERMINATION WAIVER UNDER SECTION 1915(c) OF THE SOCIAL SECURITY ACT (SELF-DETERMINATION MR WAIVER PROGRAM).

(1) Definitions: The following definitions shall apply for interpretation of this rule:

(Rule 1200-13-01-.29, continued)

(a) Adult Dental Services - accepted dental procedures which are provided to adult Enrollees (i.e., age 21 years or older) as specified in the Plan of Care. Adult Dental Services may include fillings, root canals, extractions, the provision of dentures and other dental treatments to relieve pain and infection. Preventive dental care is not covered under Adult Dental Services.

(b) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.

(c) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.

(d) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.

(e) Case Manager – an individual who assists the Enrollee or potential Enrollee in gaining access to needed Waiver and other Medicaid State Plan services as well as other needed services regardless of the funding source; develops the initial interim Plan of Care and facilitates the development of the Enrollee's Plan of Care; monitors the Enrollee's needs and the provision of services included in the Plan of Care; monitors the Enrollee's budget, and authorizes alternative emergency back-up services for the Enrollee if necessary.

(f) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a Pre-Admission Evaluation signifying that the named individual requires services provided through the Tennessee Self-Determination Waiver Program as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.

(g) Covered Services or Covered Waiver Services – The services which are available through the Tennessee Self-Determination Waiver Program when medically necessary and when provided in accordance with the Waiver as approved by the Centers for Medicare and Medicaid Services.

(h) Day Services - individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities.

(i) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.

(j) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Tennessee Self-Determination Waiver Program.

(k) Emergency Assistance – a supplementary increase in the amount of approved Covered Waiver Services for the purpose of preventing the permanent out of home placement of the Enrollee which is provided in one of the following emergency situations:

(Rule 1200-13-01-.29, continued)

1. Permanent or temporary involuntary loss of the Enrollee's present residence;

2. Loss of the Enrollee's present caregiver for any reason, including death of a caregiver or changes in the caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the Enrollee; or

3. Significant changes in the behavioral, medical or physical condition of the Enrollee that necessitate substantially expanded services.

(l) Enrollee - a Medicaid Eligible who is enrolled in the Tennessee Self-Determination Waiver Program.

(m) Environmental Accessibility Modifications – only those interior or exterior physical modifications to the Enrollee's place of residence which are required to ensure the health, welfare and safety of the Enrollee or which are necessary to enable the Enrollee to function with greater independence.

(n) Financial Administration Entity – an entity which meets the State Medicaid Agency requirements to provide Financial Administration services and which has been approved by the OAA to provide Financial Administration services.

(o) Financial Administration – a service which facilitates the employment of Waiver Service providers by the Enrollee and the management of the Enrollee's self-directed budget and is provided to assure that Enrollee-managed funds specified in the Plan of Care are managed and distributed as intended. Financial Administration includes filing claims for Enrollee-managed services and reimbursing individual Covered Waiver Service providers; deducting all required federal, state and local taxes, including unemployment fees, prior to issuing reimbursement or paychecks; making Workers Compensation premium payments for Waiver Service providers employed by the Enrollee; verifying that goods and services for which reimbursement is requested have been authorized in the Plan of Care; ensuring that requests for payment are properly documented and have been approved by the Enrollee or the Enrollee's guardian or conservator; and assisting the Enrollee in meeting applicable employer-of-record requirements. It also includes maintaining a separate account for each Enrollee's self-determination budget; preparation of required monthly reports detailing disbursements of self-determination budget funds, the status of the expenditure of self-determination budget funds in comparison to the budget, and expenditures for standard method services made by the state on the Enrollee's behalf; and notification of the Operational Administrative Agency when expenditure patterns potentially will result in the premature exhaustion of the Enrollee's self-determination budget. It includes, in addition, verification that self-managed Waiver Service providers meet the State Medicaid Agency provider qualification requirements.

(p) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities and Homes for the Aged

(q) ICF/MR Pre-Admission Evaluation (ICF/MR PAE) – the assessment form used by the State Medicaid Agency to document the current medical and habilitative needs of an individual with mental retardation and to document that the individual meets the Medicaid level of care eligibility criteria for care in an ICF/MR.

(r) Individual Support Plan – the individualized written Plan of Care.

(Rule 1200-13-01-.29, continued)

(s) Individual Transportation Services –non-emergency transport of an Enrollee to and from approved activities specified in the Pan of Care.

(t) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for an ICF/MR.

(u) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have the State Medicaid Agency make reimbursement for covered services.

(v) Medicaid State Plan - the plan approved by the Centers for Medicare and Medicaid Services which specifies the covered benefits for the Medicaid program in Tennessee.

(w) Nursing Services –skilled nursing services that fall within the scope of Tennessee's Nurse Practice Act and that are directly provided to the Enrollee in accordance with a plan of care. Nursing Services shall be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services.

(x) Nutrition Services - assessment of nutritional needs, nutritional counseling, and education of the Enrollee and of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat. Nutrition Services are intended to promote healthy eating practices and to enable the Enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.

(y) Occupational Therapy Services – diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(z) Operational Administrative Agency - the approved agency with which the State Medicaid Agency contracts for the administration of the day-to-day operations of the Tennessee Self-Determination Waiver Program.

(aa) Orientation and Mobility Services for Impaired Vision assessment of the ability of an Enrollee who is legally blind to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the Enrollee and of caregivers responsible for assisting in the mobility of the Enrollee.

(bb) Personal Assistance – the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(cc) Personal Emergency Response System - a stationary or portable electronic device used in the Enrollee's place of residence which enables the Enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device.

(Rule 1200-13-01-.29, continued)

(dd) Physical Therapy Services - diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(ee) Plan of Care – an individualized written Plan of Care which describes the medical and other services (regardless of funding source) to be furnished to the Enrollee, the Waiver Service frequency, and the type of provider who will furnish each Waiver Service and which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees.

(ff) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.

(gg) Re-evaluation - the annual process approved by the State Medicaid Agency by which a licensed physician or registered nurse or a Qualified Mental Retardation Professional assesses the Enrollee's need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.

(hh) Respite - services provided to an Enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness or injury, or when unpaid caregivers need relief from routine caregiving responsibilities.

(ii) Safety Plan - an individualized plan by which the Operational Administrative Agency ensures the health, safety and welfare of Enrollees who do not have 24-hour direct care services.

(jj) Self-Directed or Self-Determined or Self-Managed – the direct management of one or more Covered Services specified in subparagraph (2)(b) with the assistance of a Financial Administration Entity which pays the Enrollee’s service providers, handles taxes and other payroll or benefits related to the employment of the service providers, and provides other financial administration services as specified in subparagraph (1)(o).

(kk) Self-Direction or Self-Determination or Self-Management – the process whereby an Enrollee or the Enrollee’s guardian or conservator directly manages one or more Covered Services specified in subparagraph (2)(b) with the assistance of a Financial Administration Entity which pays the Enrollee’s service providers, handles taxes and other payroll or benefits related to the employment of the service providers, and provides other financial administration services as specified in subparagraph (1)(o).

(ll) Specialized Medical Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls or appliances which enable an Enrollee to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment, and supplies for the proper functioning of such items. Specialized Medical Equipment, Supplies and Assistive Technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician or nurse practitioner) based on an assessment of the Enrollee’s needs and capabilities and shall be furnished as specified in the Plan of Care. Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist or speech therapist to assure that Specialized Medical Equipment and Assistive Technology which requires custom fitting meets the needs of the Enrollee and may include training of the Enrollee by a physical therapist,

(Rule 1200-13-01-.29, continued)

occupational therapist or speech therapist to effectively utilize such customized equipment.

(mm) Speech, Language and Hearing Services – diagnostic, therapeutic and corrective services which are within the scope of state licensure which enable an Enrollee to improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function.

(nn) State Medicaid Agency – the Bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program in Tennessee.

(oo) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Operational Administrative Agency to provide Waiver Services to an Enrollee.

(pp) Supports Broker – the person or entity that provides Supports Brokerage services to an Enrollee.

(qq) Supports Brokerage – an activity designed to enable an Enrollee to manage self-directed services and provide assistance to the Enrollee to locate, access and coordinate needed services. It includes provision of training to the Enrollee in Enrollee-managed services; assistance in the recruitment of individual providers of Enrollee-managed services and negotiation of payment rates; assistance in the scheduling, training and supervision of individual providers; assistance in managing and monitoring the Enrollee's budget; and assistance in monitoring and evaluating the performance of individual providers. It may also include assistance in locating and securing services and supports and other community resources that promote community integration, community membership and independence.

(rr) Tennessee Self-Determination Waiver Program or "Waiver" - the Home and Community Based Services waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals on the Waiting List who have mental retardation and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.

(ss) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Intellectual Disabilities Services (DIDS). DIDS shall submit a Transfer Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.

(tt) Vehicle Accessibility Modifications - interior or exterior physical modifications to a vehicle owned by the Enrollee or to a vehicle which is owned by the guardian or conservator of the Enrollee and which is routinely available for transport of the Enrollee. Such modifications must be intended to ensure the transport of the Enrollee in a safe manner.

(Rule 1200-13-01-.29, continued)

(uu) Waiting List – A document prepared and updated by the Operational Administrative Agency which lists persons who are seeking home and community-based mental retardation services in Tennessee.

(2) Self-Direction of Covered Services.

(a) Self-Directed Services.

1. The Covered Services specified in subparagraph (2)(b) may be Self-Directed or Self-Managed by the Enrollee or the Enrollee's guardian or conservator in accordance with State Medicaid Agency guidelines.

2. The Enrollee or the Enrollee's guardian or conservator shall have the right to decide whether to Self-Direct the Covered Services specified in subparagraph (2)(b) or to receive them through the provider-directed service delivery method. When the Enrollee or the Enrollee's guardian or conservator does not choose to Self-Direct a Covered Service, such service shall be furnished through the provider-directed service delivery method.

3. When the Enrollee or the Enrollee's guardian or conservator elects to Self-Direct one or more of the Covered Services specified in Subparagraph (2)(b), a Financial Administration Entity must provide Financial Administration services.

(b) The following Covered Services may be Self-Directed:

1. Day Services which are not facility-based.

2. Individual Transportation Services.

3. Personal Assistance.

4. Respite Services when provided by an approved respite provider who serves only one (1) Enrollee.

(c) The following Covered Services shall not be Self-Directed:

1. Adult Dental Services.

2. Behavioral Respite Services.

3. Behavior Services.

4. Day Services which are facility-based.

5. Emergency Assistance.

6. Nursing Services.

7. Nutrition Services.

8. Occupational Therapy Services.

9. Orientation and Mobility Training.

10. Personal Emergency Response Systems.

(Rule 1200-13-01-.29, continued)

11. Physical Therapy Services.

12. Respite Services when provided by an approved respite provider who serves more than one (1) Enrollee.

13. Specialized Medical Equipment and Supplies and Assistive Technology.

14. Speech, Language and Hearing Services.

(d) Termination of Self-Direction of Covered Services.

1. Self-Direction of Covered Services by the Enrollee may be voluntarily terminated by the Enrollee or the Enrollee's guardian or conservator at any time.

2. Self-Direction of Covered Services by the Enrollee may be involuntarily terminated for any of the following reasons:

(i) The Enrollee or the Enrollee's guardian or conservator does not carry out the responsibilities required for the Self-Direction of Covered Services; or

(ii) Continued use of Self-Direction as the method of service management would result in the inability of the Operational Administrative Agency to ensure the health and safety of the Enrollee.

3. Termination of Self-Direction of Covered Services shall not affect the Enrollee's receipt of Covered Services. Covered Services shall continue to be provided through the provider-directed method of service delivery.

(e) Changing the Amount of Self-Directed Services by the Enrollee.

1. The Enrollee shall have the flexibility to change the amount of those Self-Directed Covered Services specified in subparagraph (2)(b) that have been approved in the Individual Support Plan if:

(i) The change is consistent with the needs, goals, and objectives identified in the Individual Support Plan;

(ii) The change does not affect the total amount of the Enrollee's self-determination budget; and

(iii) The Enrollee notifies the Financial Administration Entity, the Supports Broker (if applicable) and the Case Manager.

2. The Case Manager and the Financial Administration Entity shall maintain documentation of such changes by the Enrollee in the amount of the Self-Directed Covered Services for audit purposes.

(3) Covered Services and Limitations.

(a) Adult Dental Services.

1. Adult Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting.

2. Adult Dental Services shall exclude orthodontic services.

(Rule 1200-13-01-.29, continued)

3. Adult Dental Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the waiver.

(b) Behavioral Respite Services.

1. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider.

2. Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence.

3. Enrollees who receive Behavioral Respite Services shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Behavioral Respite Services is being provided.

(c) Behavior Services.

1. Behavior Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Behavior Services shall be provided face to face with the Enrollee except Enrollee-specific training of staff; behavior assessment and plan development; and presentation of Enrollee behavior information at human rights committee meetings, behavior support committee meetings, and Enrollee planning meetings.

3. Reimbursement for presentation of Enrollee behavior information at meetings shall be limited to a maximum of five (5) hours per Enrollee per year per provider. Reimbursement for behavior assessments shall be limited to a maximum of eight (8) hours per assessment with a maximum of two (2) assessments per year. Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first thirty (30) days following its approval for use shall be limited to a maximum of six (6) hours.

(d) Day Services.

1. Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the Enrollee's place of residence if there is a health, behavioral, or other medical reason or if the Enrollee has chosen retirement. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

2. Day Services provided in a provider's day habilitation facility shall be provided during the provider agency's normal business hours.

3. Transportation to and from the Enrollee's place of residence to Day Services and transportation that is needed during the time that the Enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day

(Rule 1200-13-01-.29, continued)

Services reimbursement rate (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service; or

(ii) Transportation necessary for Orientation and Mobility Training.

4. Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

5. For an Enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies or unrelated vocational training expenses such as the following:

(i) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(ii) Payments that are passed through to users of supported employment programs; or

(iii) Payments for vocational training that is not directly related to an Enrollee's supported employment program.

(e) Environmental Accessibility Modifications.

1. Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning, construction of an additional room) are excluded from coverage.

2. Any modification which is not of direct medical or remedial benefit to the Enrollee is excluded from coverage.

3. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an Enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.

(f) Individual Transportation Services.

Individual Transportation Services shall not be used for:

1. Transportation to and from Day Services;

2. Transportation to and from supported or competitive employment;

3. Transportation of school aged children to and from school; or

4. Transportation to and from medical services covered by the Medicaid State Plan.

(g) Reserved

(h) Nursing Services.

(Rule 1200-13-01-.29, continued)

1. Nursing Services shall be provided face to face with the Enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.

2. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.

3. This service shall be provided in home and community settings, as specified in the Plan of Care, excluding inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

5. Nursing Services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

(i) Nutrition Services.

1. Nutrition Services must be provided face to face with the Enrollee except for Enrollee-specific training of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat and except for that portion of the assessment involving development of the POC.

2. Nutrition Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Speech, Language and Hearing Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

3. Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one (1) assessment visit per month with a maximum of three (3) assessment visits per year per Enrollee per provider Nutrition Services other than such assessments (e.g., Enrollee-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one (1) visit per day. Nutrition Services assessments shall not be billed on the same day with other Nutrition Services.

(j) Occupational Therapy Services.

1. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.

2. Occupational Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).

4. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.

5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Occupational Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(k) Orientation and Mobility Services for Impaired Vision.

1. Orientation and Mobility Services for Impaired Vision shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Behavior Services; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two (2) services to be provided concurrently.

2. Orientation and Mobility Services for Impaired Vision shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

3. Reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with development of the Orientation and Mobility Services for Impaired Vision plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Orientation and Mobility Services for Impaired Vision assessments shall not be billed on the same day with other Orientation and Mobility services. Orientation and Mobility Services for Impaired Vision other than such assessments (e.g., Enrollee training; Enrollee-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of fifty-two (52) hours of services per Enrollee per year.

(l) Personal Assistance.

1. Personal Assistance may be provided in the home or community; however, it shall not be provided in school settings and shall not be provided to replace personal assistance services required to be covered by schools or services available through the Medicaid State Plan.

2. Personal Assistance shall not be provided during the same time period when the Enrollee is receiving Day Services.

(Rule 1200-13-01-.29, continued)

3. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the Enrollee. The Personal Assistance provider shall not be the spouse and shall not be the Enrollee's parent if the Enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(m) Personal Emergency Response System. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

(n) Physical Therapy Services.

1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

2. Physical Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).

4. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.

5. Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Physical Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Physical Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(o) Respite.

1. Respite may be provided in the Enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider.

(Rule 1200-13-01-.29, continued)

2. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence.

3. Enrollees who receive Respite shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite is being provided.

(p) Specialized Medical Equipment and Supplies and Assistive Technology.

1. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.

2. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.

3. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.

(q) Speech, Language and Hearing Services.

1. Services must be provided by a licensed speech language pathologist or by a licensed audiologist.

2. Speech, Language and Hearing Services must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Speech, Language and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language and Hearing assessments (i.e., assess and treat orders are not accepted).

4. Speech, Language and Hearing Services assessments shall not be billed on the same day with other Speech, Language and Hearing Services.

5. Speech, Language and Hearing Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Speech, Language, and Hearing Services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(Rule 1200-13-01-.29, continued)

(r) Vehicle Accessibility Modifications. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.

(s) Out-of-State Services. A provider of Personal Assistance may provide Personal Assistance outside the State of Tennessee and be reimbursed only when provided in accordance with the following:

1. Personal Assistance provided out of state shall be for the purpose of visiting relatives or for vacations and shall be included in the Enrollee's Plan of Care. Trips to casinos or other gambling establishments shall be excluded from coverage.

2. Personal Assistance provided out of state shall be limited to a maximum of fourteen (14) days per Enrollee per year.

3. The Personal Assistance provider must be able to assure the health and safety of the Enrollee during the period when Personal Assistance will be provided out of state and must be willing to assume the additional risk and liability of provision of Personal Assistance out of state.

4. During the period when Personal Assistance is being provided out of state, staffing by qualified Personal Assistance staff shall be maintained in accordance with the Individual Support Plan to meet the needs of the Enrollee.

5. The Personal Assistance provider or provider agency which provides Personal Assistance out of state shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by Personal Assistance staff during the provision of out-of-state Personal Assistance shall not be reimbursed through the Waiver. The costs of travel, lodging, food, and other expenses incurred by the Enrollee while receiving out-of-state Personal Assistance shall be the responsibility of the Enrollee and shall not be reimbursed through the waiver.

(t) Emergency Assistance.

1. Emergency Assistance shall be provided only in one of the following emergency situations:

(i) Permanent or temporary involuntary loss of the Enrollee's present residence;

(ii) Loss of the Enrollee's present caregiver for any reason, including death of a caregiver or changes in the caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the Enrollee; or

(iii) Significant changes in the behavioral, medical or physical condition of the Enrollee that necessitate substantially expanded services.

2. Emergency Assistance shall be available only to Enrollees whose needs cannot be accommodated within the $30,000 budget limitation on Covered Waiver Services.

(Rule 1200-13-01-.29, continued)

3. The amount of Emergency Assistance shall be limited to $6,000 per Enrollee per year. Prior authorization by the Enrollee's Case Manager shall be required and shall be renewed every thirty (30) calendar days.

4. Emergency Assistance shall only be used to provide a supplementary increase in the amount of other Covered Waiver Services.

(u) The cost of all Covered Services, including any Emergency Assistance, shall not exceed $36,000 per year per Enrollee.

(v) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(4) Eligibility.

(a) To be eligible for enrollment in the Waiver, an individual must meet all of the following criteria:

1. The individual must be a resident of the State of Tennessee.

2. The individual shall have an established non-institutional place of residence and shall not require staff-supported residential services provided through a Home and Community Based Services Waiver (e.g., Residential Habilitation and Supported Living as defined in TennCare rule 1200-13-01-.25).

3. The individual must, but for the provision of Waiver Services, require the level of care provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in TennCare Rule 1200-13-01-.15, except that requirements pertaining to a psychological evaluation shall be in accordance with Rule 1200-13-01-.29(4)(a)6.

4. The individual's habilitative, medical, and specialized services needs must be such that they can be effectively and safely met through the Waiver, as determined by the Operational Administrative Agency based on a pre-enrollment assessment.

5. The individual must have an unexpired ICF/MR Pre-Admission Evaluation which has been approved by the State Medicaid Agency or by its designee and which lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

6. The individual must have a psychological evaluation included as part of the approved Pre-Admission Evaluation which meets the following:

(i) The psychological evaluation shall document that the individual:

(I) Has mental retardation manifested before eighteen (18) years of age and has an IQ test score of seventy (70) or below; or

(II) Is a child five (5) years of age or younger who has a developmental disability with a high probability of resulting in mental retardation (i.e., a condition of substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in mental retardation); and

(Rule 1200-13-01-.29, continued)

(ii) There is no time limit for when the psychological evaluation is conducted as long as it is completed prior to the submission of the PAE, and as long as the evaluation meets the requirements specified in 1200-13-01-.29(4)(a)6.(i) above, and the person's current medical, social, developmental and psycho-social history continues to support the evaluation.

(iii) A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver shall be required if the person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.

7. The individual shall have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual.

(i) An individual who does not have 24-hour-per-day direct care services shall:

(I) Have an individualized Safety Plan that:

I. Is based on a written assessment of the individual's functional capabilities and habilitative, medical, and specialized services needs by the Case Manager in consultation with individuals who are knowledgeable of the individual's capability of functioning without direct care services twenty-four (24) hours per day;

II. Addresses the individual's capability of functioning when direct care staff are not present;

III. Addresses the ability of the individual to self-administer medications when direct care staff are not present;

IV. Specifies whether a Personal Emergency Response System will be used by the individual to secure help in an emergency;

V. Is updated as needed, but no less frequently than annually, by the Operational Administrative Agency to ensure the health and safety of the individual; and

VI. Is an attachment to the ICF/MR PAE or, if applicable, to the Transfer Form.

(II) Have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual as needed but no less frequently than one day each week.

8. The individual shall have a place of residence with an environment that is adequate to reasonably ensure health, safety and welfare.

(b) A Transfer Form approved by the State Medicaid Agency:

(Rule 1200-13-01-.29, continued)

1. May be used to transfer an Enrollee having an approved unexpired ICF/MR PAE from the Waiver to an ICF/MR;

2. May be used to transfer an individual having an approved unexpired ICF/MR PAE from an ICF/MR to the Waiver;

3. May be used to transfer an individual from one MR Waiver to a different Home and Community Based Services MR Waiver Program as specified in 1200-13-01-.29(1)(ss) above; and

4. Shall include an initial plan of care that lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

(5) Intake and Enrollment.

(a) When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Operational Administrative Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver and shall offer the choice of available institutional services or Waiver program services. Notice to the individual shall contain:

1. A simple explanation of the Waiver and Covered Services;

2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and

3. A statement that participation in the Waiver is voluntary.

(b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.

(c) Upon implementation of the ECF CHOICES program, all new enrollment into the Self-Determination Waiver shall be closed; provided, however, that a child age 18-21 who has an Intellectual Disability and is aging out of State custody or is determined by TennCare to no longer be able to safely continue living with their family may be enrolled into the Self-Determination Waiver subject to (b) above if all eligibility and enrollment criteria are met, only until such time that the State has authority under the terms and conditions of the 1115 Waiver to provide for enrollment of such child into ECF CHOICES, when appropriate.

(6) Certification and Re-evaluation.

(a) The ICF/MR Pre-Admission Evaluation shall include a signed and dated certification by the individual's physician that the individual requires Waiver Services.

(b) The Operational Administrative Agency shall perform a re-evaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least every twelve (12) months thereafter. The re-evaluation shall be documented in a format approved by the State Medicaid Agency and shall be performed by a licensed physician or registered nurse or a Qualified Mental Retardation Professional.

(c) The Operational Administrative Agency shall maintain in its files for a minimum period of three (3) years a copy of the re-evaluations of need for continued stay.

(Rule 1200-13-01-.29, continued)

(7) Disenrollment.

(a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's guardian or conservator to the Operational Administrative Agency. Prior to disenrollment the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(b) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:

1. The Tennessee Self-Determination Waiver Program is terminated.

2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.

3. An Enrollee moves out of the State of Tennessee; provided however, that when the Enrollee is the dependent of a military service member who is a legal resident of the state, but has left the state temporarily due to the military service member’s military assignment out of state, such dependent may re-enroll in the Waiver upon return to the State, so long as all conditions of eligibility are met.

4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.

5. The Enrollee’s medical or behavioral needs become such that the health, safety and welfare of the Enrollee cannot be assured through the provision of Waiver Services.

6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.

7. The Enrollee or the Enrollee's guardian or conservator refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability of the Operational Administrative Agency to ensure quality care or the health and safety of the Enrollee.

8. The health, safety and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan.

9. The Enrollee was transferred to a hospital, NF, ICF/MR, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding one hundred twenty (120) days, if such period began prior to March 1, 2010, or a period exceeding ninety (90) days if such period begins on or after March 1, 2010.

10. The cost for all Covered Waiver services, including Emergency Assistance services, has reached the Waiver limit of $36,000 per year per Enrollee and the State cannot assure the health and safety of the Enrollee.

(c) The Operational Administrative Agency shall notify the State Medicaid Agency in writing prior to involuntary disenrollment of an Enrollee and shall give advance notice to the Enrollee of the intended involuntary disenrollment and of the Enrollee’s right to appeal and have a fair hearing.

(Rule 1200-13-01-.29, continued)

(d) If an Enrollee has been involuntarily disenrolled from the Waiver, the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(8) Plan of Care.

(a) All Waiver Services for the Enrollee shall be provided in accordance with an approved Plan of Care.

1. Prior to the development of the initial Individual Support Plan, Covered Services shall be provided in accordance with the physician's initial plan of care included in the approved ICF/MR Pre-Admission Evaluation.

2. Each Enrollee shall have an individualized written Plan of Care (the Individual Support Plan) that shall be developed for an Enrollee within sixty (60) calendar days of admission into the Waiver.

3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.

(b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:

1. The Case Manager shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.

2. A team consisting of the Case Manager and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but no less frequently than every twelve (12) calendar months, and shall document such review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.

(9) Physician Services.

(a) The Operational Administrative Agency shall ensure that each Enrollee receives physician services as needed and that each Enrollee has a medical examination, documented in the Enrollee's record, in accordance with the following schedule:

Age	Minimum frequency of medical examinations
Up to age 21	In accordance with Medicaid EPSDT periodicity standards
21-64	Every one (1) to three (3) years, as determined by the Enrollee's physician
Over age 65	Annually

(b) All Covered Services to be provided prior to the development of the initial Individual Support Plan shall be physician ordered and shall be included in the physician’s plan of care section of the Pre-Admission Evaluation application.

(Rule 1200-13-01-.29, continued)

(c) When required by state law, Covered Services shall be ordered or reordered, by a licensed physician, licensed nurse practitioner, physician assistant, a licensed dentist, or other appropriate health care provider.

(10) Waiver Administration. The Operational Administrative Agency shall be responsible for the administration of the day-to-day operations of the Waiver under the oversight of the State Medicaid Agency and shall ensure that Covered Services are provided in accordance with state and federal laws, rules, regulations and policies established by the State Medicaid Agency. The Operational Administrative Agency shall be responsible for the following activities, whether provided directly or through subcontract:

(a) Marketing of the Waiver to potential Enrollees;

(b) Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;

(c) Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;

(d) Enrollment of eligible individuals into the Waiver;

(e) Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;

(f) Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;

(g) Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;

(h) Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;

(i) Ensuring that Waiver providers maintain comprehensive Enrollee records and documentation of services provided to Enrollees in accordance with state and federal laws, rules, regulations and State Medicaid Agency policies;

(j) Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;

(k) Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;

(l) Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;

(m) Assurance of a statewide provider network adequate to meet the needs of Enrollees;

(n) Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;

(o) Ensuring that Waiver Services providers have a signed provider agreement which includes a requirement for compliance with the Division of Mental Retardation Services Provider Manual in the delivery of waiver services;

(Rule 1200-13-01-.29, continued)

(p) Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;

(q) Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;

(r) Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;

(s) Compliance with the appeals process specified in TennCare rule 1200-13-13-.11 to ensure that Enrollees are afforded advance notice and the right to appeal an adverse decision and have a fair hearing;

(t) Ensuring that providers and subcontractors comply with the quality monitoring guidelines and requirements established by the State Medicaid Agency, by the Operational Administrative Agency, and by the Centers for Medicare and Medicaid Services, and with other state and federal laws, rules, and regulations affecting the provision of Waiver Services;

(u) Oversight and monitoring of the Financial Administration entity;

(v) Collection of applicable patient liability from Enrollees;

(w) Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;

(x) Recoupment of payments made to Waiver providers when there is lack of documentation to support that services were provided or there is a lack of medical necessity of services, or when inappropriate payments have been made due to erroneous or fraudulent billing; and

(y) Expenditure and revenue reporting in accordance with state and federal requirements.

(11) Reimbursement.

(a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care had been provided in an ICF/MR. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in an ICF/MR. Reimbursement for the cost of all Covered Services, including any Emergency Assistance, shall not exceed $36,000 per year per Enrollee.

(b) The Operational Administrative Agency shall be reimbursed for Waiver Services at the rate per unit of service actually paid by the Operational Administrative Agency to the Waiver service provider or at the maximum rate per unit of service established by the State Medicaid Agency, whichever is less.

(c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational Administrative Agency or its designee shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency’s fiscal agent that processes and pays vendor

(Rule 1200-13-01-.29, continued)

claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.

(d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency's fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.

(e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.

(f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.

(g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.

(h) The Operational Administrative Agency shall be responsible for ensuring that the Financial Administration entity fulfills its financial, ministerial, and clerical responsibilities associated with the provision of Financial Administration services to an Enrollee who Self-Directs one or more Covered Services. Examples of such responsibilities include the hiring and employment of service providers by the Enrollee or the Enrollee's guardian or conservator; management of Enrollee accounts; disbursement of funds to Waiver service providers while withholding appropriate deductions; reviewing documentation of Covered Services to assure Enrollee approval prior to payment; ensuring that Waiver service providers possess the necessary qualifications established by the State Medicaid Agency.

(i) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.

(j) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Operational Administrative Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.

(12) Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13-13-.11.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed June 20, 2007; effective September 3, 2007. Public necessity rules filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendments filed June 26, 2015; effective September 24, 2015. Amendments filed September 30, 2016; effective December 29, 2016.*

1200-13-01-.30 TENNCARE ICF/MR SERVICES.

(Rule 1200-13-01-.30, continued)

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

(2) Eligibility for Medicaid-reimbursed care in an ICF/MR.

(a) The individual must be determined by DHS to be financially and categorically eligible for Medicaid-reimbursed LTC services.

(b) The individual must have a valid, unexpired ICF/MR PAE that has been approved by the Bureau in accordance with Rule 1200-13-01-.15.

(3) Conditions of participation for ICFs/MR.

(a) The ICF/MR must enter into a provider agreement with the Bureau.

(b) The ICF/MR must be certified by the State, showing it has met the standards set out in 42 C.F.R., Part 442, Subpart C and 42 C.F.R., Part 483.

(c) ICFs/MR participating in the State of Tennessee's TennCare Program shall be terminated as TennCare providers if certification or licensure is canceled by the State.

(d) If the resident has resources to apply toward payment, the payment made by the State will be his current maximum payment per day, charges or per diem cost (whichever is less), minus the available patient resources.

(e) Payments for residents requiring ICF/MR services will not exceed per diem costs or charges, whichever is less.

(f) If an ICF/MR (upon submission of a cost report and audit of its cost), has collected on a per diem basis during the period covered by the cost report and audit, more than cost reimbursement allowed for the ICF/MR patient, the facility shall be required to reimburse the State (through the Bureau and/or the ICF/MR's Third Party), for that portion of the reimbursement collected in excess of the cost reimbursement allowed.

(g) Regardless of the reimbursement rate established for an ICF/MR, no ICF/MR may charge TennCare Enrollees an amount greater than the amount per day charge to private paying patients for equivalent accommodations and services.

(h) Personal laundry services in an ICF/MR shall be considered a covered service and included in the per diem rate. TennCare Enrollees may not be charged for personal laundry services.

(4) Conditions that ICFs/MR must meet to receive Medicaid reimbursement.

(a) An ICF/MR that has entered into a provider agreement with the Bureau of TennCare is entitled to receive Medicaid reimbursement for covered services provided to an ICF/MR Eligible if

1. The Bureau has received an approvable ICF/MR PAE for the individual within ten (10) calendar days of the ICF/MR 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.

2. For the transfer to an ICF/MR of an individual having an approved unexpired ICF/MR PAE, the Bureau has received an approvable Transfer Form within ten

(Rule 1200-13-01-.30, continued)

(10) calendar days after the date of the transfer. For transfer from ICF/MR services to an HCBS MR Waiver program, the transfer form must be submitted and approved prior to enrollment in the HCBS MR Waiver Program.

3. 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 ICF/MR PAE within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change. The effective date of payment for ICF/MR services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE which has been updated.

(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 earlier than 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 ICF/MR services.

(c) An ICF/MR that admits a Medicaid Eligible without an approved ICF/MR PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement from the Bureau.

(5) Reimbursement methodology for ICFs/MR.

(a) Private for-profit and private not-for-profit ICFs/MR shall be reimbursed at the lower of Medicaid cost or charges. An annual inflation factor will be applied to operating costs. The trending factor shall be computed for facilities that have submitted cost reports covering at least six (6) months of program operations. For facilities that have submitted cost reports covering at least three (3) full years of program participation, the trending factor shall be the average cost increase over the three-year (3-year) period, limited to the seventy-fifth (75th) percentile trending factor of facilities participating for at least three (3) years. Negative averages shall be considered zero (0). For facilities that have not completed three (3) full years in the program, the one-year (1-year) trending factor shall be the fiftieth (50th) percentile trending factor of facilities participating in the program for at least three (3) years. For facilities that have failed to file timely cost reports, the trending factor shall be zero (0). Capital-related costs are not subject to indexing. Capital-related costs are property, depreciation, and amortization expenses included in Section F.18 and F.19 of the Nursing Facility Cost Report Form. All other costs, including home office costs and management fees, are operating costs. Once a per-diem rate is determined from a clean cost report, the rate will not be changed until the next rate determination except for audit adjustments, correction of errors, or termination of a budgeted rate. Reimbursement is not to exceed the amount budgeted by the State for private ICF/MR reimbursement. The Comptroller's Office shall be authorized to adjust per diem rates up or down as necessary during the year.

(Rule 1200-13-01-.30, continued)

(b) Public ICFs/MR that are owned by government shall be reimbursed at one hundred percent (100%) of allowable Medicaid costs with no cost-containment incentive. Reimbursement shall be based on Medicare principles of retrospective cost reimbursement with year-end cost report settlements. Interim per-diem rates for the fiscal year beginning July 1, 1995 and ending June 30, 1996 shall be established from budgeted cost and patient day information submitted by the government ICF/MR facilities. Thereafter, interim rates shall be based on the providers' cost reports. There will be a tentative year-end cost settlement within thirty (30) days of submission of the cost reports and a final settlement within twelve (12) months of submission of the cost reports.

(c) Costs for supplies and other items, including any facility staff required to deliver the service, which are billed to Medicare Part B on behalf of all patients must be included as a reduction to reimbursable expenses in Section G of the NF cost report.

(6) Bed holds.

An ICF/MR will be reimbursed in accordance with this Paragraph for the recipient's bed in that facility during the recipient's temporary absence from that facility in accordance with the following:

(a) For days not to exceed fifteen (15) days per occasion while the recipient is hospitalized and the following conditions are met:

1. The resident intends to return to the ICF/MR.

2. The hospital provides a discharge plan for the resident.

3. At least eighty-five percent (85%) of all other beds in the ICF/MR certified at the recipient's designated level of care (i.e., intensive training, high personal care or medical), when computed separately, are occupied at the time of hospital admission. An occupied bed is one that is actually being used by a patient. Beds being held for other patients while they are hospitalized or otherwise absent from the facility are not considered to be occupied beds, for purposes of this calculation. Computations of occupancy percentages will be rounded to the nearest percentage point.

4. Each period of hospitalization must be physician ordered and so documented in the patient's medical record in the ICF/MR.

(b) For days not to exceed sixty (60) days per state fiscal year and limited to fourteen (14) days per occasion while the recipient, pursuant to a physician's order, is absent from the facility on a therapeutic home visit or other therapeutic absence.

(7) Other reimbursement issues.

(a) No change of ownership or controlling interest of an existing Medicaid provider, including ICFs/MR, can occur until monies as may be owed to the Bureau or its contractors are provided for. The purchaser shall notify the Bureau of the purchase at the time of ownership change and is financially liable for the outstanding liabilities to the Bureau or its contractors for one (1) year from the date of purchase or for one (1) year following the Bureau's receipt of the provider's Medicare final notice of program reimbursement, whichever is later. The purchaser shall be entitled to use any means available to it by law to secure and recoup these funds from the selling entity. In addition, purchasers of ICFs/MR are responsible for obtaining an accurate accounting

(Rule 1200-13-01-.30, continued)

and transfer of funds held in trust for Medicaid residents at the time of the change of ownership or controlling interest.

(b) If the Bureau or an MCO has not reimbursed a business for TennCare services provided under the TennCare Program at the time the business is sold, when such an amount is determined, the Bureau or the MCO shall be required to reimburse the person owning the business provided such sale included the sale of such assets.

(c) When a provider was originally paid within a retrospective payment system that is subject to regular adjustments and the provider disputes the proposed adjustment action, the provider must file with the State not later than thirty (30) days after receipt of the notice informing the provider of the proposed adjustment action, a request for hearing. The provider's right to a hearing shall be deemed waived if a hearing is not requested within thirty (30) days after receipt of the notice.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, and 71-5-109.* ***Administrative History:*** *Emergency rule filed March 1, 2010; effective through August 28, 2010. Original rule filed May 27, 2010; effective August 25, 2010. Emergency rule filed December 20, 2011; effective through June 17, 2012. Amendment filed March 14, 2012; effective June 12, 2012.*

1200-13-01-.31 TENNCARE EMPLOYMENT AND COMMUNITY FIRST CHOICES (ECF CHOICES) PROGRAM.

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

(2) Program components. The TennCare ECF CHOICES Program is a managed LTSS program that is administered by specified TennCare MCOs under contract with the Bureau. The specified MCOs are responsible for coordinating all covered physical, behavioral, and LTSS for their Members who qualify for and are enrolled in ECF CHOICES. The program consists of HCBS, as described in this Chapter.

(3) Eligibility for ECF CHOICES.

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

1. ECF CHOICES Group 4 (Essential Family Supports).

(i) Participation in ECF CHOICES Group 4 is limited to TennCare Members living at home with family who qualify for and are receiving TennCare-reimbursed ECF CHOICES HCBS. "Family" shall mean individual(s) to whom the child or adult with I/DD is legally related, whether the relationship is by blood, by marriage, or by adoption. "Family" shall not include a foster care or paid living arrangement. To be eligible for ECF CHOICES Group 4, Applicants must meet the following criteria:

(I) Be in one of the defined target populations;

(II) Qualify in the specified eligibility categories;

(III) Meet NF LOC or be "At Risk for Institutionalization," as defined in Rule 1200-13-01-.02;

(IV) Need and upon enrollment in ECF CHOICES Group 4, receive on an ongoing basis ECF CHOICES HCBS;

(Rule 1200-13-01-.31, continued)

(V) Have needs that can be safely and appropriately met in the community and at a cost that does not exceed the Expenditure Cap, as described in Section 1200-13-01-.31(4)(d); and

(VI) Qualify in one of the priority categories for which enrollment into ECF CHOICES is currently open and for which a slot is available, or for an available reserve capacity slot.

(ii) Target Populations for ECF CHOICES Group 4. Only persons in one of the target populations below may qualify to enroll in ECF CHOICES Group 4:

(I) Persons who have an intellectual disability as defined in Rule 1200-13-01-.02.

(II) Persons who have a developmental disability as defined in Rule 1200-13-01-.02.

(iii) Eligibility Categories Served in ECF CHOICES Group 4. Participation in ECF CHOICES Group 4 is limited to TennCare Members who are in the ECF CHOICES Group 4 target population(s) and qualify in one of the following eligibility categories:

(I) SSI eligible, who are determined eligible for SSI by the Social Security Administration. SSI eligibles are enrolled in TennCare Medicaid.

(II) ECF CHOICES 217-Like Group as defined in Rule 1200-13-01-.02. Persons who qualify in the ECF CHOICES 217-Like Group are enrolled in TennCare Standard.

(III) Interim ECF CHOICES At-Risk Group as defined in Rule 1200-13-01-.02. Persons who qualify in the Interim ECF CHOICES At-Risk Group are enrolled in TennCare Standard.

2. ECF CHOICES Group 5 (Essential Supports for Employment and Independent Living).

(i) Participation in ECF CHOICES Group 5 is limited to TennCare Members who qualify for and are receiving TennCare-reimbursed ECF CHOICES HCBS. To be eligible for ECF CHOICES Group 5, Applicants must meet the following criteria:

(I) Be in one of the defined target populations;

(II) Qualify in the specified eligibility categories;

(III) Do not meet NF LOC but are At Risk for Institutionalization, as defined in Rule 1200-13-01-.02, provided however, that an adult age 21 and older who meets NF LOC may choose to enroll in ECF CHOICES Group 5, subject to (V) below when the enrollment target for ECF CHOICES Group 6 has been reached;

(IV) Need and upon enrollment in ECF CHOICES Group 5, receive on an ongoing basis ECF CHOICES HCBS;

(Rule 1200-13-01-.31, continued)

(V) Have needs that can be safely and appropriately met in the community and at a cost that does not exceed the Expenditure Cap, as described in Section 1200-13-01-.31(4)(d); and

(VI) Qualify in one of the priority categories for which enrollment into ECF CHOICES is currently open and for which a slot is available, or for an available reserve capacity slot.

(ii) Target Populations for ECF CHOICES Group 5. Only persons in one of the target populations below may qualify to enroll in ECF CHOICES Group 5:

(I) Adults age 21 or older who have an intellectual disability, as defined in Rule 1200-13-01-.02.

(II) Adults age 21 or older who have a developmental disability, as defined in Rule 1200-13-01-.02.

(iii) Eligibility Categories Served in ECF CHOICES Group 5. Participation in ECF CHOICES Group 5 is limited to TennCare Members who are in the ECF CHOICES Group 5 target population(s) and qualify in one of the following eligibility categories:

(I) SSI eligible, who are determined eligible for SSI by the Social Security Administration. SSI eligibles are enrolled in TennCare Medicaid.

(II) ECF CHOICES 217-Like Group as defined in Rule 1200-13-01-.02. Persons who qualify in the ECF CHOICES 217-Like Group are enrolled in TennCare Standard.

(III) Interim ECF CHOICES At-Risk Group as defined in Rule 1200-13-01-.02. Persons who qualify in the Interim ECF CHOICES At-Risk Group are enrolled in TennCare Standard.

3. ECF CHOICES Group 6 (Comprehensive Supports for Employment and Community Living).

(i) Participation in ECF CHOICES Group 6 is limited to TennCare Members who qualify for and are receiving TennCare-reimbursed ECF CHOICES HCBS. To be eligible for ECF CHOICES Group 6, Applicants must meet the following criteria:

(I) Be in one of the defined target populations;

(II) Qualify in the specified eligibility categories:

(III) Meet NF LOC, provided however, that the State may grant an exception to individuals transitioning from the Statewide or Comprehensive Aggregate Cap Waivers who are At Risk for Institutionalization and meet the ICF/IID level of care but not the NF level of care;

(IV) Need and upon enrollment in ECF CHOICES Group 6, receive on an ongoing basis ECF CHOICES HCBS;

(Rule 1200-13-01-.31, continued)

(V) Have needs that can be safely and appropriately met in the community and at a cost that does not exceed the Expenditure Cap, as described in Section 1200-13-01-.31(4)(d); and

(VI) Qualify in one of the priority categories for which enrollment into ECF CHOICES is currently open and for which a slot is available, or for an available reserve capacity slot.

(ii) Target Populations for ECF CHOICES Group 6. Only persons in one of the target populations below may qualify to enroll in ECF CHOICES Group 6:

(I) Adults age 21 or older who have an intellectual disability, as defined in Rule 1200-13-01-.02.

(II) Adults age 21 or older who have a developmental disability, as defined in Rule 1200-13-01-.02.

(iii) Eligibility Categories Served in ECF CHOICES Group 6. Participation in ECF CHOICES Group 6 is limited to TennCare Members who are in the ECF CHOICES Group 6 target population(s), meet NF LOC (except as provided in (i)(III) above, and qualify in one of the following eligibility categories:

(I) SSI eligible, who are determined eligible for SSI by the Social Security Administration. SSI eligibles are enrolled in TennCare Medicaid.

(II) ECF CHOICES 217-Like Group as defined in Rule 1200-13-01-.02. Persons who qualify in the ECF CHOICES 217-Like Group are enrolled in TennCare Standard.

(b) Level of Care (LOC). All Enrollees in TennCare ECF 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 not be required for enrollment in ECF CHOICES.

1. Applicants shall meet NF LOC criteria or be At Risk for Institutionalization, as defined in Rule 1200-13-01-.02 in order to enroll in ECF CHOICES Group 4 (Essential Family Supports).

2. Applicants shall not be required to meet NF LOC, but shall be At Risk for Institutionalization as defined in Rule 1200-13-01-.02 in order to enroll in ECF CHOICES Group 5 (Essential Supports for Employment and Community Living), provided however, that an adult age 21 and older who meets NF LOC may choose to enroll in ECF CHOICES Group 5, subject to requirements specified in 1200-13-01-.31(3)(a)(2)(i)(V) when the enrollment target for ECF CHOICES Group 6 has been reached;

3. Applicants shall meet NF LOC in order to enroll in ECF CHOICES Group 6 (Comprehensive Supports for Community Living). For enrollment in ECF CHOICES Group 6, the State may grant an exception to individuals transitioning from the Statewide or Comprehensive Aggregate Cap Waivers who are At Risk for Institutionalization and meet the ICF/IID level of care but not the NF level of care.

(Rule 1200-13-01-.31, continued)

(c) With respect to the PASRR process described in Rule 1200-13-01-.23, members in ECF CHOICES 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 Rule 1200-13-01-.05 and defined in Rule 1200-13-01-.02.

(d) All Members in TennCare ECF CHOICES 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 the ECF CHOICES Group in which the Member is or will be enrolled, including ECF CHOICES HCBS up to the applicable Expenditure Caps for each benefit group, as described in Rule 1200-13-01-.31(4)(d), non-ECF 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 who are willing and able to provide such care.

(4) Enrollment in TennCare ECF CHOICES. Enrollment into ECF CHOICES shall be processed by the Bureau as follows:

(a) There shall be separate Enrollment Targets for ECF CHOICES Groups 4, 5, and 6. The Enrollment Target for each ECF CHOICES Group functions as a cap on the total number of persons who can be enrolled into that ECF CHOICES Group at any given time.

1. Effective July 1, 2016, the Enrollment Target for ECF CHOICES shall be five hundred (500) for Group 4, one thousand (1,000) for Group 5, and two hundred (200) for Group 6.

2. Once the Enrollment Target (including Reserve Capacity as defined in Rule 1200-13-01-.02 and as described in Rule 1200-13-01-.31(4)(b) is reached for a particular ECF CHOICES Group, qualified Applicants shall not be enrolled into that ECF CHOICES Group or qualify in the ECF CHOICES 217-Like Group or the Interim ECF CHOICES At-Risk Group 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 or receiving services in an ICF/IID who meets requirements to enroll in ECF CHOICES Group 4, 5, or 6 can enroll in ECF CHOICES even though the Enrollment Target has been met. This Member will be served in ECF CHOICES outside the Enrollment Target but shall be moved within the ECF CHOICES Enrollment Target at such time that a slot becomes available. A request to transition a Member from CHOICES Group 1 or an ICF/IID to ECF CHOICES in excess of the ECF CHOICES Enrollment Targets must specify the name of the facility 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 ECF CHOICES Group 4, 5, or 6, but who cannot enroll in ECF CHOICES 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 ECF CHOICES Group 4, 5, or 6, as applicable, based on all applicable eligibility and enrollment criteria, regardless of the Enrollment Targets. The person will be served in ECF CHOICES Group 4, 5 or 6 outside the Enrollment Target, but shall be moved within the ECF CHOICES Group 4, 5, or 6

(Rule 1200-13-01-.31, continued)

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 PCSP which the MCO has confirmed are willing and able to initiate HCBS as required by TennCare upon the Member's enrollment into ECF CHOICES Group 4, 5, or 6.

(iii) If a Potential Applicant is not permitted to proceed with application for enrollment into ECF CHOICES because the Enrollment Target has been reached, the Potential Applicant shall remain on the Referral List for ECF CHOICES.

(iv) Once the ECF CHOICES Enrollment Target for an ECF CHOICES Group is reached, any persons enrolled in that Group in excess of the Enrollment Target in accordance with this Rule must receive the first available slots in that Group. Only after all persons enrolled in excess of the Enrollment Target have been moved under the Enrollment Target can additional persons be enrolled into the ECF CHOICES Group.

(b) Reserve Capacity.

1. The Bureau shall reserve 250 slots within the ECF CHOICES Groups 4, 5, 6 Enrollment Target. These slots are available only to the following:

(i) Applicants being discharged from a NF or ICF/IID;

(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;

(iii) Applicants with ID who have an Aging Caregiver as defined in these rules;

(iv) Applicants determined by an Interagency Review Committee to meet one or more Emergent Circumstances criteria as defined in these rules; and

(v) Applicants determined by an Interagency Review Committee to meet Multiple Complex Health Conditions criteria as defined in these rules.

2. Only Applicants who meet specified reserve capacity criteria (including new Applicants seeking to establish eligibility in the ECF CHOICES 217-Like Group or the Interim ECF CHOICES At-Risk Group as well as current SSI-eligible individuals seeking enrollment into ECF CHOICES) may be enrolled into reserve capacity 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. TennCare may also require confirmation that an Applicant meets other applicable reserve capacity criteria, i.e., Aging Caregiver, Emergent Circumstances, or Multiple Complex Health Conditions.

3. Once all reserve capacity slots set aside for a particular purpose have been filled, persons who meet such criteria shall not proceed with the enrollment process, but shall remain on the Referral List for ECF CHOICES.

(Rule 1200-13-01-.31, continued)

4. If a Potential Applicant does not meet criteria for a Reserve Capacity slot, the Potential Applicant shall not proceed with the enrollment process, but shall remain on the Referral List for ECF CHOICES.

(c) Enrollment into ECF CHOICES.

1. To qualify for enrollment into ECF CHOICES Group 4:

(i) An Applicant must be in one of the target populations: an individual with an intellectual or developmental disability;

(ii) An Applicant must have an approved unexpired PAE for NF LOC or be determined to be At Risk for Institutionalization as defined in Rule 1200-13-01-.02;

(iii) An Applicant must be approved by TennCare for TennCare reimbursement of LTSS as an SSI recipient, or in the ECF CHOICES 217-Like Group or the Interim ECF CHOICES At-Risk Group defined in Rule 1200-13-01-.02;

(iv) 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 Expenditure Cap, as described in this Rule, except in instances where the Applicant is not eligible for TennCare at the time of ECF CHOICES application, in which case, such determination shall be made by the MCO upon enrollment into ECF CHOICES Group 4; and

(v) 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.

2. To qualify for enrollment into ECF CHOICES Group 5:

(i) An Applicant must be in one of the target populations: an individual with an intellectual or developmental disability who is over twenty-one (21) years old;

(ii) An Applicant must have an approved unexpired PAE for NF LOC or be determined to be At Risk for Institutionalization as defined in Rule 1200-13-01-.02;

(iii) An Applicant must be approved by TennCare for TennCare reimbursement of LTSS as an SSI recipient, or in the ECF CHOICES 217-Like Group or the Interim ECF CHOICES At-Risk Group defined in Rule 1200-13-01-.02;

(iv) 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 Expenditure Cap, as described in this Rule, except in instances where the Applicant is not eligible for TennCare at the time of ECF CHOICES application, in which case, such determination shall be made by the MCO upon enrollment into ECF CHOICES Group 5; and

(Rule 1200-13-01-.31, continued)

(v) 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.

3. To qualify for enrollment into ECF CHOICES Group 6:

(i) An Applicant must be in one of the target populations: an individual with an intellectual or developmental disability who is over twenty-one (21) years old;

(ii) An Applicant must have an approved unexpired PAE for NF LOC and require specialized services/supports for their I/DD;

(iii) An Applicant must be approved by TennCare for TennCare reimbursement of LTSS as an SSI recipient or in the ECF CHOICES 217-Like Group as defined in Rule 1200-13-01-.02;

(iv) 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 Expenditure Cap, as described in this Rule, except in instances where the Applicant is not eligible for TennCare at the time of ECF CHOICES application, in which case, such determination shall be made by the MCO upon enrollment into ECF CHOICES Group 6; and

(v) 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.

(d) Expenditure Caps for ECF CHOICES.

1. Each Member enrolling or enrolled in ECF CHOICES shall be subject to an Expenditure Cap on the benefit package assigned to that member, depending on the member's need. Each benefit package has a distinct Expenditure Cap, outlined below:

(i) For Members enrolled in Group 4, the expenditure cap shall be fifteen thousand dollars ($15,000) per person per calendar year. The Expenditure Cap shall apply to Group 4 ECF CHOICES HCBS only (not other Medicaid services). For Members enrolled in Group 4, the cost of minor home modifications shall not count against the expenditure cap. There shall be no exceptions to the Expenditure Cap for a Member enrolled in Group 4.

(ii) For Members enrolled in Group 5, the Expenditure Cap shall be thirty thousand dollars ($30,000) per person per calendar year. The Expenditure Cap shall apply to Group 5 ECF CHOICES HCBS only (not other Medicaid services). All ECF CHOICES HCBS shall be counted against a CHOICES Group 5 Member's Expenditure Cap, including the cost of minor home modifications.

(I) TennCare may grant an exception for emergency needs up to six thousand dollars ($6,000) per calendar year. Any exception that may

(Rule 1200-13-01-.31, continued)

be granted shall apply only for the calendar year in which the exception is approved.

(II) Expenditures for ECF CHOICES HCBS for a Member enrolled in CHOICES Group 5 shall not exceed $36,000 per calendar year.

(iii) The Expenditure Cap for a member enrolled in ECF CHOICES Group 6 shall depend on the Member's assessed level of need as defined in Rule 1200-13-01-.02.

(I) An ECF CHOICES Group 6 member assessed to have a low or moderate level of need shall have an Expenditure Cap of $45,000 per calendar year.

(II) An ECF CHOICES Group 6 member assessed to have a high level of need shall have an Expenditure Cap of $60,000 per calendar year.

(III) TennCare may grant an exception only for an ECF CHOICES Group 6 Member assessed to have exceptional medical or behavioral needs pursuant to the Level of Need process described in Rule 1200-13-01-.02. If an exception is granted, the Member's Expenditure Cap shall be based on the average annualized cost of the comparable level of care in an institution as follows:

I. For an ECF CHOICES Group 6 member who has an intellectual disability and is assessed pursuant to the Level of Need process described in Rule 1200-13-01-.02 to have exceptional medical or behavioral needs, the Member's Expenditure Cap shall be based on the average annualized cost of services in a private ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities).

II. For an ECF CHOICES Group 6 member who has a developmental disability and is assessed pursuant to the Level of Need process described in Rule 1200-13-01-.02 to have exceptional medical or behavioral needs, the Member's Expenditure Cap shall be based on the average annualized cost of nursing facility services plus the average annualized cost of specialized services that a person with a developmental disability would be expected to need in a nursing facility. On a case-by-case basis and applicable only to an ECF CHOICES Group 6 member who has a developmental disability and is assessed pursuant to the Level of Need process described in Rule 1200-13-01-.02 to have exceptional medical or behavioral needs, and is receiving Community Living Supports (not Family Model) at the CLS-4 level of reimbursement, this Expenditure Cap may be exceeded when necessary to permit access to Supported Employment Individual Employment Support.

III. The average annualized cost of the comparable level of care in an institution (private ICF/IID or NF) shall be adjusted by TennCare each calendar year.

(Rule 1200-13-01-.31, continued)

IV. The average annualized cost of specialized services that a person with a developmental disability would be expected to need in a nursing facility may also be adjusted each calendar year.

V. When an ECF CHOICES Group 6 member has exceptional medical or behavioral needs and has an Expenditure Cap based on the average annualized cost of care in a private ICF/IID or NF plus specialized services in the NF, the cost of any home health or private duty nursing reimbursed by TennCare shall be counted against the Member's Expenditure Cap.

2. The Expenditure Cap shall be used to determine:

(i) Whether or not an Applicant qualifies to enroll in an ECF CHOICES benefit group (4, 5, or 6);

(ii) Whether or not a Member qualifies to remain enrolled in an ECF CHOICES benefit group (4, 5, or 6);

(iii) The total cost of ECF CHOICES HCBS a Member can receive while enrolled in an ECF CHOICES Benefit Group, excluding only for Members in Group 4 the cost of Minor Home Modifications. The Expenditure Cap functions as a limit on the total cost of ECF CHOICES HCBS, excluding only for Members in Group 4 the cost of Minor Home Modifications, that can be provided by the MCO to the Member in the home or community setting. ECF CHOICES HCBS in excess of a Member's Expenditure Cap are non-covered benefits.

3. A Member shall not be 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 Support Coordinator.

4. Application of the Expenditure Cap.

(i) When a Member is enrolled in any ECF CHOICES Group (including transition from another CHOICES or ECF CHOICES Group), the Member's Expenditure Cap shall be pro-rated for the remainder of that calendar year (i.e., the portion of the calendar year that the Member will actually be enrolled in the ECF CHOICES Group).

(ii) When an ECF CHOICES Group 6 member has exceptional medical or behavioral needs and has an Expenditure Cap based on the average annualized cost of care in a private ICF/IID or NF (plus specialized services in the NF), the cost of any home health or private duty nursing reimbursed by TennCare shall be counted against the Member's Expenditure Cap.

(Rule 1200-13-01-.31, continued)

(iii) Except as specified in Rule 1200-13-01-.31(4)(d)1.(iii)(III)V., TennCare services other than ECF CHOICES HCBS shall not be counted against a Member's Expenditure Cap.

(iv) The annual Expenditure Cap shall be applied on a calendar year basis. The Bureau and the MCOs will track utilization of ECF CHOICES HCBS excluding only for Members in Group 4 the cost of Minor Home Modifications, across each calendar year.

(v) A Member's Expenditure Cap must also be applied prospectively on a twelve (12) month basis. This is to ensure that a Member's PCSP does not establish a threshold level of supports that cannot be sustained over the course of time. This means that, for purposes of person-centered planning, the MCO will always project the total cost of ECF CHOICES HCBS (excluding only for Members in Group 4 the cost of 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 PCSP 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 ECF CHOICES HCBS for a full twelve (12) month period following the date of service delivery.

(vi) If it can be reasonably anticipated, based on the ECF 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 ECF CHOICES.

5. As the setting of an individual's Expenditure 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 Expenditure Cap calculation.

(i) A Member has a right to due process regarding his Expenditure Cap when services are denied or reduced, when a determination is made that an Applicant cannot be enrolled into ECF CHOICES, or a currently enrolled ECF CHOICES Member can no longer remain enrolled in ECF 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 Expenditure 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 Expenditure Cap was calculated appropriately, and to present all relevant and material evidence pertaining to such action.

(iii) Denial of or reductions in ECF CHOICES HCBS based on a Member's Expenditure Cap shall constitute an adverse action, as defined in Rules 1200-13-13-.01 and 1200-13-14-.01, and shall give rise to 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.

(Rule 1200-13-01-.31, continued)

(iv) Denial of enrollment and/or involuntary disenrollment because a person's Expenditure 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.

(5) Disenrollment from ECF CHOICES. A Member may be disenrolled from ECF CHOICES voluntarily or involuntarily.

(a) Voluntary disenrollment from ECF 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 ECF 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. Election by the Member to receive institutional services (e.g., NF or ICF/IID services), including hospice services in a NF, which is not a LTSS, provided however, that a Member shall not be disenrolled from ECF CHOICES in order to receive Short-Term NF care as defined in 1200-13-01-.02;

2. Election by the Member to enroll in an MCO that does not administer the ECF CHOICES program (i.e., United Healthcare Community Plan until such time as specified by TennCare or TennCare Select, including Select Community); 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 ECF 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 representative/conservator or caregiver refuses to abide by the PCSP.

(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'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 Expenditure Cap 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 or her Patient Liability. The MCO and/or its participating providers are unwilling to serve the Member in ECF CHOICES because he has not paid his or her Patient Liability, and/or no other MCO is willing to serve the Member in ECF CHOICES.

(6) Transitioning To and From ECF CHOICES.

(a) Transition from CHOICES Group 1 to ECF CHOICES.

1. A member may request to transition from CHOICES Group 1 to ECF CHOICES at any time. The member's MCO is responsible for assessing the member's services and supports needs in the community, developing and implementing a transition plan, as appropriate, and submitting the transition request to TennCare. Only an MCO may submit to TennCare a request to transition a Member from CHOICES Group 1 to ECF CHOICES. An MCO may request to transition a Member from CHOICES Group 1 to ECF CHOICES only when the Member chooses to transition from the NF to an HCBS setting and meets eligibility criteria to enroll in that group, as specified in Rule 1200-13-01-.31(3). Members shall not be required to transition from CHOICES Group 1 to ECF CHOICES.

2. A Member that has already been discharged from the NF shall not be transitioned to ECF CHOICES. Once a Member has discharged from the NF, the Member has voluntarily disenrolled from CHOICES Group 1 and must be newly enrolled into ECF CHOICES, in accordance with these rules. A new PAE shall be required for enrollment into ECF CHOICES.

3. When Members move from CHOICES Group 1 to ECF CHOICES, TennCare must recalculate the Member's Patient Liability based on the Community PNA.

(b) Transition from ECF CHOICES to CHOICES Group 1.

1. An MCO may request to transition a Member from ECF CHOICES to CHOICES Group 1 only under the following circumstances:

(i) The MCO provides advance notification to TennCare, which shall include documentation of thoroughly exploring and exhausting all attempts to provide services in a more integrated community setting.

(ii) The member must meet the nursing facility level of care in place at the time of admission and make an informed choice to transition to a nursing facility and enroll in CHOICES Group 1. Informed choice requires thorough exploration and exhaustion of all integrated community setting options.

(iii) A PASRR shall be completed prior to admission, the member must be determined appropriate for placement in a nursing facility, and all identified specialized services must be coordinated by the MCO immediately upon admission.

2. When Members transition from ECF CHOICES to CHOICES Group 1, TennCare must recalculate the Member's Patient Liability based on the Institutional PNA.

3. At such time as a transition between ECF CHOICES and CHOICES Group 1 is made, the MCO shall issue notice of transition to the Member. Because the Member has elected the transition, such transition shall not constitute an adverse

(Rule 1200-13-01-.31, continued)

action. Thus, the notice will not include the right to appeal or request a fair hearing regarding the Member's decision.

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

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

(7) Benefits in the TennCare ECF CHOICES Program.

(a) Members of ECF CHOICES receive HCBS as specified in an approved Initial Support Plan or PCSP, as applicable, in addition to medically necessary covered benefits available for TennCare Medicaid and TennCare Standard recipients, as specified in Rules 1200-13-13-.04 and 1200-13-14-.04. While receiving ECF CHOICES HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.

(b) Members are not eligible to receive any other HCBS during the time that Short-Term NF services are provided. ECF CHOICES HCBS such as Minor Home Modifications 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.

(c) All ECF CHOICES HCBS must be authorized by the MCO in order for MCO payment to be made for the services. ECF CHOICES HCBS must be specified in an approved Initial Support Plan or PCSP, as applicable, and authorized by the MCO prior to delivery of the service in order for MCO payment to be made for the service.

(d) ECF CHOICES HCBS covered under the ECF CHOICES Program 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 (c) above.

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(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
1. Adult Dental Services	Covered for adults age 21 and older in accordance with limitations specified in Rule 1200-13-01-.02. Orthodontic services are excluded from coverage. Limited to a maximum of five thousand dollars ($5,000) per person per calendar year, and a maximum of seven thousand five hundred dollars ($7,500) per person across three (3) consecutive calendar years.	No
2. Assistive Technology, Adaptive Equipment and Supplies	Covered with a limit of five thousand dollars ($5,000) per person per calendar year. Not covered under ECF CHOICES if available under Section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. §§ 1401 et seq.).	No

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
3. Community Integration Support Services	Covered in accordance with limitations specified in Rule 1200-13-01-.02. Not covered as a separate service for persons receiving CLS or CLS-FM. For members not working in the community (excludes a facility-based setting) and not receiving any employment services: Up to 20 hours per week of Community Integration Support Services and Independent Living Skills Training combined after completing an Employment Informed Choice process. For members working in the community or receiving at least one employment service: Up to 30 hours per week of Community Integration Support Services, Independent Living Skills Training, and Individual or Small Group Employment Supports combined. For members working in individualized integrated employment or self-employment: Up to 40 hours per week of Community Integration Support Services, Independent Living Skills Training, Job Coaching, Co-Worker Supports and the hours worked without paid supports combined. For members working in individualized integrated employment or self-employment at least 30 hours a week: Up to 50 hours per week of Community Integration Support Services, Independent Living Skills Training, Job Coaching, Co-Worker Supports and the hours worked without paid supports combined. Payment for attendance and materials and supplies at classes and conferences and club/association dues can be covered, but cannot exceed five hundred dollars ($500) per year for children under age twenty (21) or one thousand dollars ($1,000) for adults age twenty-one (21) or older.	No

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
4. Community Living Supports (CLS) and Community Living Supports—Family Model (CLS-FM)	Covered only for adults age 21 and older enrolled in ECF CHOICES Group 5 or 6.	No
5. Community Support Development, Organization and Navigation	Covered only for Members enrolled in ECF CHOICES Group 4.	No
6. Community Transportation	Covered for transportation to employment and to support participation in community activities when public or other community-based transportation services are not available or when assistance is needed in order to access such benefits. Shall not supplant NEMT available for medical appointments. Limited to $225 per month for Members electing to receive this benefit through Consumer Direction.	Yes
7. Conservatorship Counseling and Assistance	Covered. Limited to five hundred dollars ($500) in one-time assistance per member. Legal or court fees may be reimbursed only upon completion of counseling services to protect and preserve individual rights and freedoms.	No
8. Family Caregiver Education and Training	Covered only for Members enrolled in ECF CHOICES Group 4 when approved in advance by the Member's MCO. Limited to five hundred dollars ($500) per calendar year.	No

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
9. Family Caregiver Stipend in lieu of SHC	Covered only for Members enrolled in ECF CHOICES Group 4 and only when supports for employment and community integration are provided. For a child under age eighteen (18), the Family Caregiver Stipend shall be limited to five hundred dollars ($500) per month. For an adult age eighteen (18) or older, the Family Caregiver Stipend shall be no more than one thousand dollars ($1,000) per month.	No
10. Family-to-Family Support	Covered only for Members enrolled in ECF CHOICES Group 4.	No
11. Health Insurance Counseling/Forms Assistance	Covered only for Members enrolled in ECF CHOICES Group 4. Limited to fifteen (15) hours per person per calendar year.	No

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
12. Independent Living Skills Training	Covered in accordance with limitations specified in Rule 1200-13-01-.02. Not covered as a separate service for persons receiving CLS or CLS-FM. For members not working in the community (excludes a facility-based setting) and not receiving any employment services: Up to 20 hours per week of Independent Living Skills Training and Community Integration Support Services combined after completing an Employment Informed Choice process. For members working in the community or receiving at least one employment service: Up to 30 hours per week of Independent Living Skills Training, Community Integration Support Services, and Individual or Small Group Employment Supports combined. For members working in individualized integrated employment or self-employment: Up to 40 hours per week of Independent Living Skills Training, Community Integration Support Services, Job Coaching, Co-Worker Supports and the hours worked without paid supports combined. For members working in individualized integrated employment or self-employment at least 30 hours a week: Up to 50 hours per week of Independent Living Skills Training, Community Integration Support Services, Job Coaching, Co-Worker Supports and the hours worked without paid supports combined.	No
13. Individual Education and Training Services	Covered only for Members enrolled in ECF CHOICES Group 5 or 6 when approved in advance by the Member's MCO. Limited to five hundred dollars ($500) per Member per calendar year.	No

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
14. Integrated Employment Path Services (time limited prevocational training)	Covered for persons age 16 or older in accordance with limitations specified in Rule 1200-13-01-.02. Limited to no more than twelve (12) months. One extension of up to twelve (12) months can be allowed only if the individual is actively pursuing individualized employment in an integrated setting and has documentation that a service(s) (e.g. Job Development or Self-Employment Start-Up funded by Tennessee Rehabilitation Services, this Waiver or another similar source) is concurrently authorized for this purpose. Limited to 30 hours per week of Integrated Employment Path Services, other Individual or Small Group Employment Supports, Independent Living Skills Training, and Community Integration Support Services combined.	No
15. Minor Home Modifications	Covered in accordance with limitations specified in Rule 1200-13-01-.02 and with a limit of $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime.	No
16. Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living	Covered only for Members enrolled in ECF CHOICES Group 5 or 6. Limited to one thousand five hundred dollars ($1,500) per person per lifetime.	No
17. Personal Assistance	Covered only for ECF CHOICES Members enrolled in Group 5 or 6. In ECF CHOICES Group 6 (Comprehensive Supports for Employment and Community Living) benefit group, Personal Assistance is limited to two hundred fifteen (215) hours per month.	Yes

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
18. Respite	Covered with limitations as follows: Up to thirty (30) days of service per person per calendar year or up to two hundred sixteen (216) hours per person per calendar year, depending on the needs and preferences of the individual as reflected in the PCSP. The two (2) limits cannot be combined in a calendar year.	Yes for hourly Respite only; daily Respite shall not be available through Consumer Direction
19. Specialized Consultation and Training	Covered only for adults age 21 or older enrolled in ECF CHOICES Group 5 or 6. Limited to five thousand dollars ($5,000) per person per calendar year, except for adults in the Comprehensive Supports for Employment and Community Living benefit group determined to have exceptional medical and/or behavioral support needs pursuant to the Level of Need process described in Rule 1200-13-01-.02. For adults age 21 and older in ECF CHOICES Group 6 (Comprehensive Supports for Employment and Community Living) determined by TennCare to have exceptional medical and/or behavioral support needs, Specialized Consultation and Training shall be limited to ten thousand dollars ($10,000) per person per calendar year.	No
20. Supportive Home Care (SHC)	Covered only for Members enrolled in ECF CHOICES Group 4.	Yes
21. Supported Employment Individual Employment Support	Covered for persons age 16 or older (or age 14 or older, as specified) in accordance with limitations specified in Rule 1200-13-01-.02, and with the following components:	No

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
	Exploration – Covered for persons age 14 or older in accordance with limitations specified in Rule 1200-13-01-.02. Limited to once per year (with a minimum 365-day interval between services) and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment.	No

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
	Benefits Counseling – Covered for persons age 16 or older in accordance with limitations specified in Rule 1200-13-01-.02. Limited to people receiving individual employment supports. Persons receiving small group employment supports are not eligible for this benefit. Initial Benefits Counseling for someone actively considering or seeking individualized integrated employment or self-employment, or career advancement in these types of employment: up to twenty (20) hours. This service may be authorized no more than once every two (2) years (with a minimum of two 365-day intervals between services). Supplementary Benefits Counseling for someone evaluating an individualized integrated job offer/promotion or self-employment opportunity: up to an additional six (6) hours. This service may be authorized up to three (3) times per year if needed. PRN problem-solving services for someone to maintain individualized integrated employment or self-employment: up to eight (8) hours per situation requiring PRN assistance. This service may be authorized up to four (4) times per year if necessary for the individual to maintain individualized integrated employment or self-employment. Service must not be available under Section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. §§ 1401, et seq.). ECF may not fund this service if CWIC Benefits Counseling services funded through the Federal Work Incentives Planning and Assistance (WIPA) program are available.	No

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
	Discovery - Covered for persons age 14 or older in accordance with limitations specified in Rule 1200-13-01-.02. Limited to no more than ninety (90) calendar days from the date of service initiation.	No
	Situational Observation and Assessment – Covered for persons age 14 or older in accordance with limitations specified in Rule 1200-13-01-.02. Limited to once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within twelve (12) months.	No
	Job Development Plan or Self-Employment Plan – Covered for persons age 16 or older in accordance with limitations specified in Rule 1200-13-01-.02. Limited to once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within twelve (12) months. Medicaid funds may not be used to defray the capital expenses associated with starting a business.	No

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
	Job Development Plan or Self-Employment Start Up – Covered for persons age 16 or older in accordance with limitations specified in Rule 1200-13-01-.02. Limited to once per year (with a minimum 365-day interval between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within nine (9) months.	No
	Job Coaching – Covered for persons age 16 or older in accordance with limitations specified in Rule 1200-13-01-.02. Covered only for members working in individualized integrated employment or self-employment. Limited to 40 hours per week of Job Coaching, Co-Worker Supports, the hours worked without paid supports, Independent Living Skills Training, and Community Integration Support Services combined. For members working in individualized integrated employment or self-employment at least 30 hours a week: Limited to 50 hours per week of Job Coaching, Co-Worker Supports, the hours worked without paid supports, Independent Living Skills Training, and Community Integration Support Services combined.	No

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
	Co-Worker Supports – Covered for persons age 16 or older in accordance with limitations specified in Rule 1200-13-01-.02. Covered only for members working in individualized integrated employment or self-employment. Limited to 40 hours per week of Co-Worker Supports, Job Coaching, the hours worked without paid supports, Independent Living Skills Training, and Community Integration Support Services combined. For members working in individualized integrated employment or self-employment at least 30 hours a week. Limited to 50 hours per week of Co-Worker Supports, Job Coaching, the hours worked without paid supports, Independent Living Skills Training, and Community Integration Support Services combined.	No
	Career Advancement – Covered for persons age 16 or older in accordance with limitations specified in Rule 1200-13-01-.02. This service shall not be authorized retroactive to a promotion or second job being made available to a person. Supports for Career Advancement may be authorized and paid once every three (3) years (with a minimum of three 365-day intervals between services), if evidence exists that the individual is eligible for promotion or able to present as a strong candidate for employment in a second job (e.g. has strong reference, performance reviews and attendance record from current employer).	No

(Rule 1200-13-01-.31, continued)

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction ("Eligible ECF CHOICES HCBS")
22. Supported Employment Small Group Supports	Covered for persons age 16 or older in accordance with limitations specified in Rule 1200-13-01-.02. Limited to 30 hours per week of Small Group or Individual Employment Supports, Integrated Employment Path Services, Independent Living Skills Training, and Community Integration Support Services combined.	No

(8) Consumer Direction (CD).

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

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

1. CD shall be limited to the following HCBS:

(i) Personal Assistance.

(ii) Supportive Home Care.

(iii) Hourly Respite. (Daily Respite shall not be available through CD.)

(iv) Community Transportation.

2. ECF CHOICES Members determined to need Eligible ECF CHOICES HCBS may elect to receive one or more of the Eligible ECF CHOICES HCBS through a Contract Provider, or they may participate in CD.

3. ECF CHOICES Members who do not need Eligible ECF CHOICES HCBS shall not be offered the opportunity to enroll in CD.

4. The model of CD that will be implemented in ECF CHOICES is a modified budget authority model.

5. Each Eligible ECF CHOICES HCBS identified in the Member's PCSP that the Member elects to receive through CD shall have an individual monthly or annual budget, as specified below.

6. The amount of the budget authorized for each Eligible ECF CHOICES HCBS the Member elects to receive through CD shall be based on a comprehensive needs assessment performed by a Support Coordinator that identifies the Member's

(Rule 1200-13-01-.31, continued)

needs, the availability of family and other unpaid caregivers to meet those needs, and the gaps in care for which paid ECF CHOICES may be authorized.

(i) Each Eligible ECF CHOICES HCBS received through CD shall have a separate budget.

(ii) The budget for each Eligible ECF CHOICES HCBS received through CD shall be based on the number of units of that service the member is assessed to need, subject to applicable benefit limits and the Member's Expenditure Cap.

(iii) Once the budget for each Eligible ECF CHOICES HCBS is determined and authorized, the Member shall have flexibility to determine the rate of reimbursement for that service (subject to any limitations established by TennCare), and to purchase additional units of the service so long as the budget for that service is not exceeded.

(iv) The budget for each Eligible ECF CHOICES HCBS shall be separately maintained. A Member shall not direct money from the budget for one Eligible ECF CHOICES HCBS to purchase a different Eligible ECF CHOICES HCBS, provided however, that a Member's PCSP (and consequently, the budget for any affected Eligible ECF CHOICES HCBS) may be amended based on the Member's needs, as appropriate.

(v) Any money remaining in a Member's monthly budget for Personal Assistance, Supportive Home Care or Community Transportation at the end of a month shall not be carried over to the next month, and cannot be used to purchase units of service in any other month.

(vi) Any money remaining in a Member's annual budget for hourly Respite at the end of the calendar year shall not be carried over to the next year, and cannot be used to purchase additional units of service in a subsequent calendar year.

7. The amount of the budget for each Eligible ECF CHOICES HCBS shall be authorized as follows:

(i) Personal Assistance for Members enrolled in ECF CHOICES Group 5 or Group 6 and Supportive Home Care for Members enrolled in ECF CHOICES Group 4 shall have a monthly budget if provided through Consumer Direction.

(I) A Member shall only direct CD Workers to provide Personal Assistance or Supportive Home Care, as applicable, up to the amount of the authorized monthly budget for that service.

(II) A Member shall not ask or allow a CD Worker to provide services in excess of the authorized monthly budget for that service.

(III) If a Member exhausts the authorized monthly budget for a service before the month has ended, additional services shall not be authorized for the remainder of the month.

(IV) If a Member (or his Representative for CD) is not able to manage services within the approved budget for the service, the Member may not be able to remain in CD.

(ii) Community Transportation for Members enrolled in ECF CHOICES shall have a monthly budget if provided through CD.

(I) The monthly budget shall be based on the number of days in the month that the Member is expected to need Community Transportation services.

(II) The Member may receive the first month's budget allotment in advance. The advance monthly budget allotment shall be used to purchase only Community Transportation services as defined in these rules.

(III) A Member may purchase Community Transportation services in the most cost-efficient manner possible, including public transportation (e.g., bus passes), paying a co-worker to share gas expenditures, etc.

(IV) A Member shall not reimburse any person who resides with the Member for Community Transportation.

(V) The Member is obligated to maintain a Community Transportation log and receipts for Community Transportation expenditures as required by TennCare and to submit such information on a monthly basis to his MCO.

(VI) A Member shall only purchase Community Transportation up to the amount of the authorized monthly budget for that service.

(VII) The Member's monthly Community Transportation budget shall be reimbursed only for documented purchases of Community Transportation services submitted to the MCO.

(VIII) A Member shall not be reimbursed for Community Transportation services in excess of the authorized monthly budget for that service.

(IX) If a Member exhausts the authorized monthly budget for Community Transportation services before the month has ended, additional services shall not be authorized for the remainder of the month.

(X) If a Member (or his Representative for CD) is not able to manage services within the approved budget for the service, the Member may not be able to remain in CD.

(iii) Respite services for Members enrolled in ECF CHOICES shall have an annual budget if provided through Consumer Direction.

(I) The annual budget shall operate on a calendar year (January 1 through December 31).

(II) A Member who elects to receive Respite through CD shall receive up to 216 hours per year of Respite services. (Daily Respite shall not be available through CD.)

(Rule 1200-13-01-.31, continued)

(III) A Member shall only direct CD Workers to provide Respite services, as applicable, up to the amount of the authorized annual budget for that service.

(IV) A Member shall not ask or allow a CD Worker to provide services in excess of the authorized annual budget for that service.

(V) If a Member exhausts the authorized annual budget for Respite services before the calendar year has ended, additional services shall not be authorized for the remainder of the year.

(VI) If a Member (or his Representative for CD) is not able to manage services within the approved budget for the service, the Member may not be able to remain in CD.

8. HH Services, PDN Services, and ECF CHOICES HCBS other than those specified above shall not be available through CD.

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

1. Be a Member of ECF CHOICES.

2. Be determined by a Support Coordinator, based on a comprehensive needs assessment, to need one or more Eligible ECF 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 the PCSP, 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. An ECF CHOICES Member assessed to need one or more Eligible ECF 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.

(Rule 1200-13-01-.31, continued)

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 for CD 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 Support 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 Support 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 paid 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 Support 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 Support Coordinator and his Supports Broker that he intends to change Representative. The Support 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

(Rule 1200-13-01-.31, continued)

of a Support 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) Finding, interviewing, hiring and firing Workers;

(ii) Determining Workers' duties and developing job descriptions;

(iii) Training Workers to provide personalized support based on the Member's needs and preferences;

(iv) Scheduling Workers;

(v) Ensuring there are enough workers hired to provide all of the support needed by the Member (including when the worker scheduled is unable to report to work);

(vi) Ensuring the worker(s) keep correct time sheets for the services and supports provided;

(vii) Reviewing and approving hours reported by Consumer-Directed Workers;

(viii) Ensuring Workers provide only as much support as assigned to provide and as needed by the Member;

(ix) Ensuring that no Worker provides more than 40 hours of support each week unless the Member or Representative for CD has decided to pay overtime out of the Member's approved budget;

(x) Managing the services the Member needs within the Member's approved budget for each service;

(xi) Supervising Workers;

(xii) Evaluating Worker performance and addressing any identified deficiencies or concerns;

(xiii) Setting wages from a range of reimbursement levels established by the Bureau;

(xiv) Reviewing and ensuring proper documentation for services provided; and

(xv) 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:

(Rule 1200-13-01-.31, continued)

(i) The person is not enrolled in TennCare or in ECF CHOICES.

(ii) The Member does not need one or more of the HCBS eligible for CD, as specified in the PCSP.

(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, with the assistance of his Support Coordinator, to identify and address 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 the completion of CD enrollment paperwork and assistance with employer functions as requested.

2. The FEA shall:

(i) Assign a Supports Broker to each ECF CHOICES Member electing to participate in CD of Eligible ECF CHOICES 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, requesting from TennCare the

assignment of Medicaid provider ID numbers, and holding TennCare provider agreements.

(iv) Provide initial and ongoing training to workers on CD and other relevant issues such as the use of the FEA time keeping system.

(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 PCSP.

6. The Support 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 ECF 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 support.

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 Expenditure Cap as described in Rule 1200-13-01-.31(4)(d). If the higher cost of services delivered by a Contract Provider would

(Rule 1200-13-01-.31, continued)

result in a Member's Expenditure 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 Assistance, Supportive Home Care or hourly Respite services. A Member shall not reimburse any person who resides with the Member for Community Transportation.

(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) Complete 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) Verification that the person has not been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 128B(f) of the Social Security Act);

(vi) Complete all required training;

(vii) Complete all required applications to become a TennCare provider;

(viii) Sign an abbreviated Medicaid agreement;

(ix) Be assigned a Medicaid provider ID number;

(x) Sign a Service Agreement; and

(Rule 1200-13-01-.31, continued)

(xi) 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 the completion of a background check for a potential Worker. A background check may reveal a potential Worker's past criminal conduct that may pose an unacceptable risk to the Member. Any of the following findings may place the Member at risk and may 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; and/or

(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.

4. Individualized Assessment of a Consumer-Directed Worker with a Criminal Background.

(i) If a potential Worker's background check includes past criminal conduct, the Member (or Representative for CD) must review the past criminal conduct with the help of the FEA. The Member (or Representative for CD), with the assistance of the FEA, will consider the following factors:

(I) Whether or not the evidence gathered during the potential Worker's individualized assessment shows the criminal conduct is related to the job in such a way that could place the Member at risk;

(II) The nature and gravity of the offense or conduct, such as whether the offense is related to physical or sexual or emotional abuse of another person, if the offense involves violence against another person, or the manufacture, sale, or distribution of drugs; and

(III) The time that has passed since the offense or conduct and/or completion of the sentence.

(ii) After considering the above factors and any other evidence submitted by the potential Worker, the Member (or Representative for CD) must decide whether to hire the potential Worker.

(iii) If a Member (or Representative for CD) decides to hire the Worker, the FEA shall assist the Member (or Representative for CD) in notifying the Member's MCO of this decision and shall collaborate with the Member's MCO to amend the Member's PCSP to reflect the Member's (or CD Representative's) decision to voluntarily assume the risk associated with hiring an individual with a criminal history and that the Member (or Representative for CD) is solely responsible for any negative consequences stemming from that decision. The FEA shall also collaborate with the Member's MCO on a risk mitigation strategy.

5. Service Agreement.

(Rule 1200-13-01-.31, continued)

(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 typical 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.

6. Payments to Consumer-Directed Workers.

(i) Rates. Members participating in CD have the flexibility to set wages for their Workers from a range of reimbursement levels established by TennCare.

(ii) Payments to Consumer-Directed Workers. In order to receive payment for services rendered, all Workers must:

(I) Deliver services in accordance with the services specified in the Member's PCSP, the monthly or annual budget as approved in the MCO's service authorization, and in accordance with the schedule set by the Member or the Member's Representative for CD and Worker assignments determined by the Member or his Representative.

(II) Use the FEA time keeping system to record in and out times for 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 directed by the Employer of Record who by such direction, agrees to pay the worker over-time pay out of the Member's budget in accordance with the Fair Labor Standards Act. This shall reduce the amount of services that may be purchased for the Member during that month.

(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

(Rule 1200-13-01-.31, continued)

Member and/or Representative does not want to terminate the Worker.

(j) 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 ECF CHOICES HCBS shall not affect a Member's eligibility for LTSS or enrollment in ECF CHOICES, provided the Member continues to meet all requirements for enrollment in ECF CHOICES as defined in this Chapter.

(iii) If a Member voluntarily withdraws or is involuntarily withdrawn from CD, any Eligible ECF CHOICES HCBS he receives shall be provided through Contract Providers, subject to the requirements in this Chapter.

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 ECF CHOICES.

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

(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 work with the Support Coordinator to identify and address 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 ECF 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 Support Coordinator or FEA has identified health, safety and/or welfare issues.

(XIII) A Support 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 eligible 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 ECF CHOICES, his participation in CD shall be terminated

(9) HCBS Providers in ECF CHOICES.

(a) HCBS providers delivering services under ECF CHOICES must meet specified license, training and background check requirements and shall meet conditions for reimbursement outlined in their provider agreements with the TennCare MCOs.

(b) MCOs may contract with non-participating HCBS providers as needed through a single case agreement and will reimburse the provider at no less than eighty percent (80%) of the lowest rate paid to any contracted HCBS provider in the state for that service.

(10) Appeals.

(a) Appeals related to determinations of eligibility for TennCare Medicaid or TennCare Standard are processed by TennCare, in accordance with Chapters 1200-13-13 and 1200-13-14.

(Rule 1200-13-01-.31, continued)

(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, provided however that notice and continuation of benefits shall not be provided for ECF CHOICES HCBS identified in the Initial SP that are needed by the ECF CHOICES member immediately upon enrollment in ECF CHOICES while the Support Coordinator develops the comprehensive PCSP. A member may request a fair hearing regarding any covered benefit not approved in the PCSP that he believes is needed.

(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 ECF 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 ECF 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 ECF 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 ECF CHOICES, involuntary disenrollment from ECF 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 ECF CHOICES only, if the appeal is received prior to the date of action, continuation of ECF 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 PCSP shall be made available through Contract Providers pending resolution of the appeal.

(e) A member may present all relevant and material evidence pertaining to the adverse action.

(11) Management of the Referral List for ECF CHOICES.

(a) A new referral list shall be established for ECF CHOICES.

(Rule 1200-13-01-.31, continued)

(b) The referral list shall be managed by TennCare on a statewide basis.

1. The ECF CHOICES referral list management process generally includes three (3) steps: screening, intake and enrollment. The referral management process shall be used to help manage Potential Applicants and Applicants for ECF CHOICES in accordance with established prioritization and enrollment criteria.

2. Intake and enrollment into ECF CHOICES from the referral list shall proceed in accordance with these Rules and with TennCare policies and protocols.

3. Potential Applicants for ECF CHOICES shall be categorized on the ECF CHOICES referral list as follows:

(i) Category 1 - Any age or level of disability, employed and in need of supports to maintain employment that are not otherwise available as vocational rehabilitation services funded under Section 110 of the Rehabilitation Act of 1973, 29 U.S.C. § 730, or as special education or related services as those terms are defined in Section 602 of the Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. § 1401.

(I) Includes youth age 18-22 transitioning from school and young adults completing post-secondary education or training who are employed and in need of supports to maintain employment.

(II) If employment is lost after enrollment into ECF CHOICES occurs, the person shall not be disenrolled if other ECF CHOICES HCBS are needed on an ongoing basis, which may include supports to obtain and maintain new employment.

(ii) Category 2 - 18-22 years old, regardless of the level of disability, transitioning from school and young adults completing post-secondary education or training who are employed or who have the commitment of employment from an employer and are in need of employment supports that are not otherwise available as vocational rehabilitation services funded under Section 110 of the Rehabilitation Act of 1973, 29 U.S.C. § 730.

Includes individuals age 18-22 and young adults completing post-secondary education or training who are participating in paid or unpaid internships with the commitment of employment and individuals with more significant needs who may require employment customization.

(iii) Category 3 - Any age or level of disability, recently unemployed and in need of supports to obtain and/or maintain new employment that are not otherwise available as vocational rehabilitation services funded under Section 110 of the Rehabilitation Act of 1973, 29 U.S.C. § 730

(iv) Category 4 - 18-22 years old, regardless of the level of disability, transitioning from school with expressed desire for employment.

(v) Category 5 - Unemployed, regardless of the level of disability, with desire and commitment to work.

(vi) Category 6 - Youth of transition age, regardless of the level of disability, living at home with family caregivers, who are actively planning for employment as part of the transition process and in need of supports

(Rule 1200-13-01-.31, continued)

provided in ECF CHOICES, including for individuals with more significant needs, employment customization, in order to achieve and maintain employment that are not otherwise available as vocational rehabilitation services funded under Section 110 of the Rehabilitation Act of 1973, 29 U.S.C. § 730, or as special education or related services as those terms are defined in Section 602 of the Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. § 1401.

Category 6 shall be applicable only to enrollment into ECF CHOICES Group 4 (Essential Family Supports).

4. ECF CHOICES referral list categories are listed in the order of prioritization. These categories shall be applicable for all non-reserve capacity slots for Potential Applicants of all ages and levels of disability, and for all ECF CHOICES benefit groups.

5. Potential Applicants on the ECF CHOICES referral list shall have the opportunity to apply for enrollment into ECF CHOICES when the category in which they are placed on the ECF CHOICES referral list is open for enrollment, and when there is an available slot in which the Potential Applicant can be enrolled, if all applicable eligibility and enrollment criteria are met.

6. ECF CHOICES referral list categories shall apply only to prioritization for enrollment into ECF CHOICES.

7. Employment shall not be a condition or requirement for enrollment in ECF CHOICES.

   (i) Potential Applicants who are not employed and not interested in employment may be enrolled in ECF CHOICES in accordance with these rules and with TennCare policies and protocols for management of the statewide ECF CHOICES referral list, including prioritization criteria.

   (ii) Criteria applicable to ECF CHOICES referral list categories shall apply only to prioritization for enrollment into ECF CHOICES.

   (iii) Persons prioritized for enrollment in ECF CHOICES on the basis of employment who are enrolled in ECF CHOICES and subsequently lose their job shall not be disenrolled from ECF CHOICES because they are no longer employed, so long as other ECF CHOICES HCBS are needed on an ongoing basis, which may include supports to obtain and maintain new employment.

8. A person who does not meet the conditions for any of the Categories specified above shall be placed on the ECF CHOICES referral list in an “Other Active” category if ECF CHOICES HCBS are requested at time of referral or in a “Deferred” category if ECF CHOICES HCBS are not requested at time of referral.

9. Reserve Capacity Slots.

   In addition to the categories identified above, a specified number of slots shall be held in reserve capacity for individuals who meet one or more of the following criteria:

   (i) One or more emergent circumstances as follows:

(Rule 1200-13-01-.31, continued)

(I) The person's primary caregiver is recently deceased and there is no other caregiver available to provide needed long-term supports.

(II) The person's primary caregiver is permanently incapacitated and there is no other caregiver available to provide needed long-term supports.

(III) There is clear evidence of serious abuse, neglect, or exploitation in the current living arrangement. The person must move from the living arrangement to prevent further abuse, neglect or exploitation, and there is no alternative living arrangement available.

(IV) Enrollment into ECF CHOICES is necessary in order to facilitate transition out of a long-term care institution, i.e., a NF or a private or public ICF/IID into a more integrated community-based setting.

(V) The person is an adult age 21 or older enrolled in ECF CHOICES Group 4 (Essential Family Supports) or ECF CHOICES Group 5 (Essential Support for Employment and Independent Living) and has recently experienced a significant change in needs or circumstances. TennCare has determined via a Safety Determination that the person can no longer be safely served within the array of benefits available in ECF CHOICES Group 4 (Essential Family Supports) or 5 (Essential Supports for Employment and Independent Living), as applicable, the person meets NF level of care, and must be transitioned to ECF CHOICES Group 6 in order to sustain community living in the most integrated setting.

(VI) The health, safety or welfare of the person or others is in immediate and ongoing risk of serious harm or danger. Other interventions including Behavioral Health Crisis Prevention, Intervention and Stabilization services, where applicable, have been tried but were not successful in minimizing the risk of serious harm to the person or others without additional services available in ECF CHOICES, and the situation cannot be resolved absent the provision of such services available in ECF CHOICES.

(ii) The Potential Applicant has multiple complex chronic or acquired health conditions that prevent the person from being able to work, and the Potential Applicant is in urgent need of supports in order to maintain the current living arrangement and delay or prevent the need for more expensive services (applicable only to individuals of working age).

(iii) A Potential Applicant may apply for enrollment into a reserve capacity slot for persons in emergent circumstances or who have multiple complex health conditions only if determined through an Interagency Committee review process, including both TennCare and DIDD, that enrollment into ECF CHOICES is the most appropriate way to provide needed supports. Such review shall include consideration of other options, including the relative costs of such options.

(iv) Discharge from another service system (DCS, DMHSAS, etc.) shall not be deemed an emergent situation unless specified emergent criteria are met and unless diligent and timely efforts to plan and prepare for discharge and to facilitate transition to community living without long-term services and supports available in ECF CHOICES have been made, and it is determined

(Rule 1200-13-01-.31, continued)

through the Interagency Committee review process that enrollment in ECF CHOICES is the most appropriate way to provide needed supports.

10. The waiting list maintained by DIDD for the 1915(c) HCBS Waivers shall be one source of referrals for ECF CHOICES. Persons on the DIDD waiting list for the 1915(c) HCBS Waivers as of June 30, 2016:

    (i) Shall be automatically referred for the ECF CHOICES program and placed on the ECF CHOICES referral list.

    (ii) May submit documentation regarding employment that shall be reviewed in determining their category on the ECF CHOICES referral list, or if they may meet criteria for a reserve capacity slot based on emergent circumstances or multiple complex health conditions.

    (iii) Who do not submit information regarding employment or indicating that they may meet criteria for enrollment in a reserve capacity slot based on emergent circumstances or multiple complex health conditions shall be placed on the ECF CHOICES referral list in the "Other Active" category, unless they are currently on the HCBS Waiver waiting list in a "Deferred" category, in which case they shall be automatically placed on the ECF CHOICES referral list in the "Deferred" category.

11. A Potential Applicant may request an administrative review of his or her category on the ECF CHOICES referral list at any time. This request should be submitted to TennCare in writing.

12. A Potential Applicant may submit additional information at any time that may affect his or her category on the ECF CHOICES referral list. The additional information should be submitted to the Potential Applicant's MCO (if the Potential Applicant is assigned to an MCO participating in ECF CHOICES), or to DIDD (if the Potential Applicant is assigned to an MCO not participating in ECF CHOICES or is not currently enrolled in TennCare).

13. A Potential Applicant shall not be granted a fair hearing regarding the category in which he has been placed on the ECF CHOICES referral list.

14. A Potential Applicant shall be entitled to a determination regarding his or her eligibility to enroll in the ECF CHOICES program and, if the application is denied, to due process, including notice and the right to request a fair hearing only when the Potential Applicant is determined to meet criteria for an available reserve capacity slot or meets prioritization criteria for an available program slot for which enrollment is currently open and will be enrolled into the program if all applicable eligibility and enrollment criteria are met.

(12) Safety Determination Requests. (See Rule 1200-13-01-.05(6)).

Authority: *T.C.A. §§ 4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.*

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CHAPTER 1200-13-02
REPEALED

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1200-13-02-.01 Repealed
1200-13-02-.02 Repealed
1200-13-02-.03 Repealed
1200-13-02-.04 Repealed
1200-13-02-.05 Repealed
1200-13-02-.06 Repealed
1200-13-02-.07 Repealed
1200-13-02-.08 Repealed

1200-13-02-.01 REPEALED.

Authority*: T.C.A. §§14-23-105, 14-23-109, 71-5-105, 71-5-109 and 4-5-202.* ***Administrative History****: Original rule filed January 18, 1979, effective March 5, 1979. Amendment filed March 8, 1983; effective April 7, 1983. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed March 8, 1984; effective June 12, 1984. Amendment filed June 2, 1988, effective July 17, 1988. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-02-.02 REPEALED.

Authority*. T. C.A. §14-1905, 4-5-202, 71-5-105, and 71-5-109.* ***Administrative History****: Original rule filed January18, 1979; effective March 5,1979. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-02-.03 REPEALED.

Authority*: T. C.A. §§14-23-105, 14-23-109, 4-5-202, 71-5-105, and 71-5-109.* ***Administrative History****: Original rule filed January 18, 1979; effective March 5, 1979. Amendment filed March 8, 1983; effective April 7, 1983. Amendment filed June 23, 1983; effective July 25, 1983. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-02-.04 REPEALED.

Authority*: T.C.A. §§14-1905, 14-23-105, 14-23-109, 71-5-105, 71-5-109 and 4-5-202.* ***Administrative History****: Original rule filed January 18, 1979, effective March 5, 1979. Amendment filed March 8, 1983; effective April 7, 1983. Amendment filed March 8, 1984, effective June 12, 1984. Amendment filed June 2, 1988, effective July 17, 1988. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-02-.05 REPEALED.

Authority: *T.C.A. §§71-5-105, 71-5-109 and 4-5-202.* ***Administrative History****: Original rule filed January 18, 1979. Rule renumbered as 1200-13-02-.06. New rule filed June 2, 1988; effective July 17, 1988. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-02-.06 REPEALED.

Authority*: T. C.A. §§14-1905, 71-5-105, 71-5-109 and 4-5-202.* ***Administrative History****: (Formerly numbered as 1200-13-02-.05.) Original rule filed January 18, 1979. Amendment filed June 2, 1988; effective July 17, 1988. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-02-.07 REPEALED.

Authority: *T.C.A. 14-23-105, 14-23-109, 14-23-130, 14-23-201, 71-5-105, 71-5-109 and 4-5-202.* ***Administrative History:*** *(Formerly numbered as 1200-13-02-.06). Original rule filed June 25, 1985; effective July 25, 1985. Amendment filed June 2, 1988, effective July 17, 1988. Amendment filed January 30, 1989; effective March 16, 1989. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-02-.08 REPEALED.

Authority*. T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Public Chapter 358 of the Acts of 1993.* ***Administrative History****: Original rule filed June 2, 1988; effective July 17, 1988. Repeal filed June 22, 1989; effective August 4, 1989. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed May 5, 2009; effective July 19, 2009.*

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1200-13-3-.01 Repealed
1200-13-3-.02 Repealed
1200-13-3-.03 Repealed

1200-13-3-.01 REPEALED.

Authority: *T.C.A. 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original Rule filed August 15, 1979; effective September 29, 1979. Repealed and New Rule filed December 17, 1980; effective February 2, 1981. Repeal filed February 8, 2008; effective April 23, 2008.*

1200-13-3-.02 REPEALED.

Authority: *T.C.A. 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original Rule filed September 29, 1979. Repealed and New Rule filed December 17, 1980: effective February 2, 1981. Repeal filed February 8, 2008; effective April 23, 2008.*

1200-13-3-.03 REPEALED.

Authority: *T.C.A. 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original Rule filed August 15, 1979; effective September 29, 1979. Repealed and New Rule filed December 17, 1980; effective February 2, 1981. Repeal filed February 8, 2008; effective April 23, 2008.*

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1200-13-04-.01 Repealed
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1200-13-04-.08 Repealed
1200-13-04-.09 Repealed
1200-13-04-.10 Repealed
1200-13-04-.11 Repealed
1200-13-04-.12 Repealed
1200-13-04-.13 Repealed
1200-13-04-.14 Repealed

1200-13-04-.01 REPEALED.

Authority. *T.C.A. §14-1905, 4-5-202, 7-5-105, and 7-5-109.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24, 1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04- .02 REPEALED.

Authority: *T.C.A. §14-1905, 4-5-202, 7-5-105, and 7-5-109*. ***Administrative History:*** Original rule filed December 10, 1979; *effective January 24, 1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04-.03 REPEALED.

Authority: *T.C.A. §14-1905, 4-5-202, 7-5-105, and 7-5-109.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24, 1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04- .04 REPEALED.

Authority: *T.C.A. §14-1905, 4-5-202, 7-5-105, and 7-5-109.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24, 1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04-.05 REPEALED.

Authority: *T.C.A. §14-1905*, *4-5-202, 7-5-105, and 7-5-109*. ***Administrative History:*** Original rule filed December 10, 1979; *effective January 24, 1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04-.06 REPEALED.

Authority*: T.C.A. §14-1905, 4-5-202, 7-5-105, and 7-5-109.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24,1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04-.07 REPEALED.

Authority: *T.C.A. §14-1905, 4-5-202, 7-5-105, and 7-5-109.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24,1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04-.08 REPEALED.

Authority: *T.C.A. §14-1905, 4-5-202, 7-5-105, and 7-5-109.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24, 1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04-.09 REPEALED.

Authority: *T.C.A. §14-1905, 4-5-202, 7-5-105, and 7-5-109.* ***Administrative History****: Original rule filed December 10, 1979, effective January 24, 1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04-.10 REPEALED.

Authority: *T.C.4. §14-1905, 4-5-202, 7-5-105, and 7-5-109.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24. 1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04-.11 REPEALED.

Authority: *T.C.A. §14-1905, 4-5-202, 7-5-105, and 7-5-109.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24, 1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04-.12 REPEALED.

Authority: *T.C.A. §14-1905, 4-5-202, 7-5-105, and 7-5-109.* ***Administrative History****: Original rule filed December 10, 1979; effective January 24, 1980. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04-.13 REPEALED.

Authority: *T.C.A. §§71-5-105, 71-5-109 and 4-5-202.* ***Administrative History****: Original rule filed February 21,1991; effective April 7, 1991. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-04-.14 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Public Chapter 358 Acts of 1993.* ***Administrative History****: Original rule filed March 18, 1994; effective June 1, 1994. Repeal filed May 5, 2009; effective July 19, 2009.*

RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-05
HOSPITAL RATE VARIATION CORRIDORS

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1200-13-05-.01 DEFINITIONS.

(1) Bureau of TennCare (Bureau). The administrative unit of TennCare which is responsible for the administration of TennCare as defined elsewhere in these rules.

(2) Existing Contracts. The contracts that were in place between a Tennessee hospital and a TennCare MCO as of July 1, 2013.

(3) Hospital. A general or specialty acute care facility licensed as a hospital by the Tennessee Department of Health pursuant to T.C.A. § 68-11-206, excluding hospitals that are categorized as Rehabilitation, Research, Long Term Acute or Psychiatric on the 2013 Joint Annual Report of Hospitals.

(4) Inpatient Services. Routine, nonspecialized services that are provided at many or most hospitals in the state to patients admitted to the hospital as inpatients.

(5) MCO (Managed Care Organization). An appropriately licensed Health Maintenance Organization (HMO) contracted with the Bureau of TennCare to manage the delivery, provide for access, contain the cost, and ensure the quality of specified covered medical and behavioral benefits to TennCare enrollee-members through a network of qualified providers.

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(6) Medicare. A hospital's fee-for-service reimbursement under Title XVIII including that hospital's adjustment for DSH, wage index, etc., and excluding only Indirect Medical Education (IME), pass through payments, and any Medicare payment adjustments for Sequestration, Value Based Purchasing, Readmissions and Hospital Acquired Conditions.

(7) Medicare Severity Diagnosis Related Groups (MS-DRG). The Medicare statistical system of classifying any inpatient stay into groups for the purpose of payment.

(8) New Contract. Any initial contract between an MCO and a hospital that did not exist on July 1, 2013. Contracts in place on July 1, 2013, that have been materially altered since July 1, 2013, are not new contracts.

(9) Outpatient Services. Services that are provided by a hospital to patients in the outpatient department of the hospital and patients receiving outpatient observation services.

(Rule 1200-13-05-.01, continued)

(10) Rate Corridors. Upper and lower limits established by the state's actuary and approved by the Bureau, in consultation with the Tennessee Hospital Association (THA), for payments by MCOs to hospitals for services provided to TennCare enrollees. The Rate Corridors are based on a hospital's Medicare reimbursement that existed in FFY 2011 and used to determine the parameters of TennCare rates for contracts between Tennessee hospitals and TennCare MCOs after July 1, 2013. The determination of whether a hospital's TennCare rates are within the prescribed Rate Corridors shall be made on the basis of reimbursement from all TennCare MCOs with which the hospital has a contract. The Rate Corridors, which were calculated by the State's actuary as the budget neutral corridors, are as follows:

(a) For inpatient services, the minimum level is 53.8% and the maximum level is 80% of the hospital's Medicare for 2011.

(b) For outpatient services, the minimum level is 93.2% and the maximum level is 104% of the hospital's Medicare for 2011.

(c) For cardiac surgery, the minimum level is 32% and the maximum level is 83% of the hospital's Medicare for 2011.

(d) For specialized neonatal services the minimum level is 4% and the maximum level is 174% of the hospital's Medicare for 2011.

(e) For other specialized services the minimum level is 49% and the maximum level is 164% of the hospital's Medicare for 2011.

(11) Specialized Services. Services that are typically provided in a small subset of hospitals, such as transplants, neonatal intensive care and level 1 trauma.

(12) TennCare. The TennCare waiver demonstration program(s) and/or Tennessee's traditional Medicaid program.

(13) TennCare Actuary. The actuarial firm selected by the Bureau to assist the Bureau in establishing the capitation rates for TennCare MCOs each year.

(14) Total TennCare Rates. Payment rates for each hospital in the aggregate from all MCOs with which the hospital has network contracts.

(15) Year 1 Corridors. The initial upper and lower limits established by the Bureau in consultation with THA based on a hospital's Medicare reimbursement that existed in FFY 2011 and that were used to implement rate variation limitations in contracts between Tennessee hospitals and TennCare MCOs from July 1, 2012 until July 1, 2013. The Year 1 Corridors are as follows:

(a) For inpatient services, the minimum level was 40% and the maximum level was 90% of the hospital's Medicare for 2011.

(b) For outpatient services, the minimum level was 90% and the maximum level was 125% of the hospital's Medicare for 2011.

(c) For cardiac surgery, the minimum level was 30% and the maximum level was 80% of the hospital's Medicare for 2011.

(d) For specialized neonatal services the minimum level was 4% and the maximum level was 180% of the hospital's Medicare for 2011.

(e) For other specialized services the minimum level was 30% and the maximum level was 160% of the hospital's Medicare for 2011.

(Rule 1200-13-05-.01, continued)

Authority: *T.C.A. §§ 4-5-208, 12-4-301, 71-5-105, 71-5-109, and 71-5-2801.* ***Administrative History:*** *Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed January 13, 1987; effective February 27, 1987. Amendment filed September 25, 1992; effective November 9, 1992. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.02 IMPLEMENTATION OF CONTRACT AMENDMENTS FOR EXISTING CONTRACTS BETWEEN HOSPITALS AND MCOS.

These contracts set rates for a period of two years effective July 1, 2013, and provided for rate amendments to be negotiated and implemented on July 1, 2015.

(1) For hospitals that had existing contracts with MCOs in place on July 1, 2013, and the MCO and hospital had negotiated contract amendments to bring rates for total TennCare into the Rate Corridors and the rates in the contracts have not been adjusted since July 1, 2013, the MCOs will reissue those amendments with a new effective date of July 1, 2015.

(2) In the case of a hospital that had contracts with MCOs in place on July 1, 2013, which contracts included amendments implementing rates within the Rate Corridors, and where the rates in the contracts have been adjusted since July 1, 2013, the Bureau shall evaluate the rates in the current contracts to determine if the total TennCare rates for the hospital are within the Rate Corridors. If the rate adjustments cause the total TennCare reimbursement for the hospital to be outside of the Rate Corridors, the affected MCOs shall implement contract amendments approved by the Bureau in consultation with the TennCare Actuary to bring the hospital rates into the Rate Corridors effective July 1, 2015.

(3) In the case of a hospital with contracts in existence on July 1, 2013, which contracts include rates outside of the Rate Corridors, the affected MCOs shall implement contract amendments to bring total TennCare rates into the Rate Corridors with an effective date of July 1, 2015. The Bureau shall verify that the new contract rates in conjunction with contracts between the hospital and all other MCOs bring the hospital's total TennCare rates within the Rate Corridors.

Authority: *T.C.A. §§ 4-5-208, 71-5-105, 71-5-109, and 71-5-2801.* ***Administrative History****: Original rule filed June 26, 1985; effective July 26, 1985. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.03 IMPLEMENTATION OF NEW CONTRACTS BETWEEN HOSPITALS AND MCOS ENTERED INTO AFTER JULY 1, 2013.

These contracts have not yet been in effect for a period of time sufficient to negotiate rate amendments for a July 1, 2015, implementation date. In the case of a hospital that entered into a contract with an MCO after July 1, 2013, including a hospital that entered into a contract with an MCO with rates within Year 1 Corridors effective January 1, 2015, the affected MCOs shall implement contract amendments that bring the hospital rates within the Rate Corridors no later than September 30, 2015.

Authority*: T.C.A. §§ 4-5-208, 71-5-105, 71-5-109, and 71-5-2801.* ***Administrative History****: Original rule filed June 26, 1985; effective July 26, 1985. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.04 EXCLUSION OF ANY HOSPITAL FROM TENNCARE NETWORKS.

A hospital that does not accept a contract amendment required by this Rule shall be excluded effective October 1, 2015, from participation in the TennCare MCO network to which the contract amendment applies.

Authority*: T.C.A. §§ 4-5-208, 71-5-105, 71-5-109, and 71-5-2801.* ***Administrative History****: Original rule*

(Rule 1200-13-05-.04, continued)
filed June 26, 1985; effective July 26, 1985. Amendment filed January 30, 1989; effective March 16, 1989. Amendment filed April 14, 1989; effective May 8, 1989. Amendment filed October 14, 1998; effective December 28, 1998. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.

1200-13-05-.05 OUT-OF-NETWORK REIMBURSEMENT.

Out-of-Network payments to all hospitals shall be governed by TennCare Medicaid Rule 1200-13-13-.08(2)(a)-(c) and TennCare Standard Rule 1200-13-14-.08(2)(a)-(c).

Authority: *T.C.A. §§ 4-5-208, 71-5-105, 71-5-109, and 71-5-2801* ***Administrative History****: Original rule filed June 26, 1985; effective July 26, 1985. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.06 AGREEMENTS BETWEEN HOSPITALS AND MCOS FOR LIMITED SERVICES.

Rates for a single case agreement negotiated between the MCOs and hospitals that are not in network with the MCOs to ensure access to services for TennCare enrollees may not exceed the ceiling or be below the floor of the Rate Corridors appropriate for those services.

Authority*: T.C.A. §§ 4-5-208, 71-5-105, 71-5-109, and 71-5-2801.* ***Administrative History****: Original rule filed June 26, 1985; effective July 26, 1985. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05.-07 CHANGES TO HOSPITAL RATES NEGOTIATED BETWEEN MCOS AND HOSPITALS AFTER SEPTEMBER 30, 2015.

To ensure that each hospital's total TennCare reimbursement remains within the Rate Corridors, proposed rate changes after September 30, 2015, shall be evaluated by the Bureau to determine if the proposed rate change will move the hospital's total TennCare rates outside of the Rate Corridors. If the evaluation indicates the change will put the hospital outside of the Rate Corridors, the Bureau shall provide the adjustments necessary to ensure that the contract is compliant with the limits of the Rate Corridors. TennCare rates between a hospital and an MCO may not be modified after September 30, 2015, without approval from the Bureau.

Authority: *T.C.A. §§ 4-5-208, 71-5-105, 71-5-109, 71-5-2801.* ***Administrative History:*** *Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed November 10, 1988; effective December 25, 1988. Amendment filed May 8, 1991; effective June 22, 1991. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.08 CATEGORIZATION OF NEW SERVICES ADDED AFTER JULY 1, 2015.

MS-DRG classifications serve as the basis for identifying services as inpatient or specialized. MS-DRG classifications may change and new MS-DRG classifications may be added from time to time. New or modified MS-DRG classifications shall be evaluated for assignment to appropriate inpatient or specialized categories by the Bureau in consultation with THA and the TennCare Actuary.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-109, 71-5-2801, and 71-5-2803; Public Chapter 913 of the Acts of 1992.* ***Administrative History.*** *Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed February 21, 1986; effective March 23, 1986. Amendment filed September 12, 1986, effective October 27, 1986. Amendment filed May 29, 1987, effective July 13, 1987. Amendment filed June 2, 1988, effective July 17, 1988. Amendment filed August 8, 1990, effective September 22, 1990. Amendment filed October 21, 1991; effective December 5,, 1991. Amendment filed September 25, 1992; effective November 9, 1992. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.09 REPEALED.

***Authority**: T.C.A. §§ 4-5-208, 71-5-105, 71-5-109 and 71-5-2801. **Administrative History**: Original rule filed June 26, 1985; effective July 26,1 985. Amendment filed August 8, 1990; effective September 22, 1990. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.10 REPEALED.

***Authority**. T.C.A. §§ 4-5-208, 71-5-105, 71-5-109 and 71-5-2801.**Administrative History**. Original rule filed June 26, 1985, effective July 26, 1985. Amendment filed April 29, 1986; effective May 29, 1986. Amendment filed December 30, 1986, effective February 13, 1987. Amendment filed December 8,1989; effective January 22, 1990. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.11 REPEALED.

***Authority:** T.C.A. §§ 4-5-208, 71-5-105, 71-5-109 and 71-5-2801. **Administrative History:** Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed December 31, 1986; effective February 14, 1987. Amendment filed October 30, 1990; effective December 14, 1990. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed September 18, 1991; effective November 2, 1991. Amendment filed January 20, 1993; effective March 6, 1993. Amendment filed October 22, 1993; effective January 5, 1994. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.12 REPEALED.

***Authority:** T.C.A. §§ 4-5-208, 71-5-105, 71-5-109 and 71-5-2801. **Administrative History**: Original rule filed June 26, 1985; effective July 26, 1985. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.13 REPEALED.

***Authority:** T.C.A. §§ 4-5-208, 71-5-105, 71-5-109 and 71-5-2801.. **Administrative History**. Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed April 30, 1987, effective June 14, 1987. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.14 REPEALED.

***Authority:** T.C.A. §§ 4-5-208, 71-5-105, 71-5-109 and 71-5-2801. **Administrative History:** Original rule filed June 26, 1985; effective July 26, 1985. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.15 REPEALED.

***Authority**: T.C.A. §§14-23-105, 14-23-109, 4-5-208, 71-5-105, 71-5-109, 71-1-2801, and 4-5-202. **Administrative History**. Original rule filed June 26, 1995, effective July 26, 1985. Amendment filed March 25, 1987, effective May 9, 1987. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.16 REPEALED.

***Authority**: T.C.A. §§ 4-5-208, 71-5-105, 71-5-109 and 71-5-2801.**. Administrative History**: Original rule filed June 26, 1985; effective July 26, 1985. Amendment filed May 8, 1991; effective June 22, 1991. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.17 REPEALED.

Authority: *T.C.A. §§ 4-5-208, 71-5-105, 71-5-109 and 71-5-2801..* ***Administrative History****: Original rule filed June 26, 1985; effective July 26,1985. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

1200-13-05-.18 REPEALED.

Authority: *T.C.A. §§ 4-5-208, 71-5-105, 71-5-109 and 71-5-2801..* ***Administrative History****: Original rule filed March 18, 1994; effective June 1, 1994. Emergency rule filed July 1, 2015; effective through December 28, 2015. Amendment filed September 21, 2015; effective December 20, 2015.*

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF TENNCARE

CHAPTER 1200-13-6
NURSING FACILITY LEVEL I PROGRAM

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1200-13-6-.01 DETERMINATION OF REIMBURSABLE COSTS ON LEVEL I NURSING FACILITY CARE PROVIDED BY THE BUREAU OF TENNCARE. The Department, in consultation with the Comptroller of the Treasury and the Tennessee Health Care Association, shall establish the rules and regulations for the determination of the reimbursable per diem cost for services provided to Medicaid recipients as part of the nursing facility Level I program. The method of cost determination shall include depreciation on buildings, equipment, and fixtures, and interest expense as allowable items of cost. The reimbursable per diem cost may take into consideration the kinds, levels, and quantities of services provided to the recipients by the institution, the cost of providing such services, and the levels and types of patient care required for recipients.

Authority: *T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.*

1200-13-6-.02 APPROVAL OF THE DEPARTMENT REQUIRED FOR PARTICIPATION. Only those institutions designated by and contracting with the Department as rendering Level I nursing facility services may participate and be reimbursed as a provider under these provisions. The Department shall notify the Comptroller of the Treasury when a provider enters the program and when its participation terminates.

Authority: *T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.*

1200-13-6-.03 EXTENT OF REIMBURSEMENT TO BE DETERMINED BY THE DEPARTMENT. The reimbursable costs of institutions rendering Level I nursing facility services shall be reimbursable by each recipient and the State to the extent determined by the Department with the remainder not allowable as outside support from any other source available to the provider. The provider shall be limited to reimbursable per diem rate as determined by the Comptroller as the maximum it may collect from both sources for program services.

Authority: *T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.*

1200-13-6-.04 BILLING PROCEDURE TO BE DETERMINED BY THE DEPARTMENT. Institutions providing Level I nursing facility services for Medicaid recipients shall bill the Department on the forms and in the manner designated by the Department.

Authority: *T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.*

1200-13-6-.05 CHARGES TO NURSING FACILITY LEVEL I RECIPIENTS. The charge schedule of a provider must be applied uniformly to each recipient as services are furnished to the recipient. Appropriate write-offs or adjustments shall be made to each account to reduce the gross charges to the contractual or legal collection limits of the various medical programs. The Comptroller of the Treasury must be notified of any changes in the schedule of charges.

Authority: *T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.*

1200-13-6-.06 COVERED SERVICES. The specific items and services covered under the Level I nursing facility program shall be those defined and approved by the Department. Other non-covered services may be charged directly to the recipient (refer to the applicable Provider Manual).

Authority: *T.C.A. §§12-4-301, 71-5-105, 71-5-109, and 4-5-202.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed June 2, 1988; effective July 17, 1988. Amendment filed August 17, 1995; effective October 31, 1995.*

1200-13-6-.07 SUBMISSION OF COST REPORTS BY PROVIDERS. Medicaid program providers of Level I nursing facility services will be required to submit to the Comptroller of the Treasury a pro-forma (budgeted) cost report upon beginning participation as a new provider. New providers shall file a first actual cost report within six (6) or nine (9) months of commencing operations, depending on proximity of starting date to fiscal year end. Leases and changes of ownership are not considered new providers for this purpose and thus no budgeted cost reports are filed for leases or changes in ownership. Thereafter, cost reports shall be filed at their fiscal year end and submitted on forms described in rule 1200-13-6-.08. The report shall be due within three (3) months after the end of the designated fiscal period. An extension may be requested for due cause. Such cost reports must be completed in accordance with Medicare reimbursement principles except where these rules may specify otherwise. In the event that the provider does not file the required cost report by the due date, the provider shall be subject to a penalty of ten dollars ($10.00) per day in accordance with state law. In the event that a provider discovers a significant omission of costs, it may file an amended cost report at any time prior to the due date of its next annual cost report. After that time, the cost report cannot be amended for cost omissions. Amended cost reports shall be subject to the same requirements as other cost reports, and will be the only accepted means to claim omitted costs. Rate increases resulting from submission of omitted costs will not be retroactive.

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed December 1, 1988; effective January 15, 1989. Amendment filed July 5, 1990; effective August 19, 1990. Amendment filed August 17, 1995; effective October 31, 1995. Amendment filed July 25, 2002; effective October 8, 2002.*

1200-13-6-.08 COST REPORT FOR THE NURSING FACILITY LEVEL I PROGRAM

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT
SUITE 1500 JAMES K. POLK STATE OFFICE BUILDING
NASHVILLE, TENNESSEE 37243-0264

IMPORTANT: Read Footnotes and Instructions and Accounting Principles before completing this form. Any form not properly completed may be rejected. DO NOT CHANGE THE EXISTING NOMENCLATURE. If the provider has accounts or descriptions that do not fit the existing categories, report the amounts in "Other" and attach a schedule with the desired nomenclature. This will keep information comparable among cost reports.

Provider Numbers:[1] Level I _____Date Submitted _____, 19_____
Level II _____

Name of Facility [2]
_____

Mailing Address _____
Street, P.O. Box, RFD City State Zip Code

Physical Address _____
Street, P.O. Box, RFD City State Zip Code

Name of Present Administrator _____( )_____
Telephone Number

Name of Home Office/Management
Company_____

Mailing Address_____
Street, P.O. Box, RFD City State Zip Code

Contact Person _____( )_____
Telephone Number

Accounting Period Covered by this Report: From _____, 19____ thru _____, 19_____

Fiscal Year End _____

ACCRUAL ACCOUNTING MUST BE USED FOR THIS REPORT [3,4]
ENTER ALL AMOUNTS IN WHOLE DOLLARS

_____

A. Type of Facility (Check only one)

1.	For Profit:	_____	Sole Proprietor	_____	Partnership	_____	Corporation
2.	Nonprofit:	_____	Church	_____	Corporation	_____	Other
3.	Government:	_____	State	_____	County	_____	Other

_____

(Rule 1200-13-6-.08, continued)

B. Statistical and Other Data [5]	(a)	(b)	(c)	(d)	(e)
Skilled	Certified Beds	(a + b) Other NF Beds	TOTAL NF BEDS	(c + d) Non-NF Beds	TOTAL BEDS
1. Licensed beds - beginning of the accounting period	_____	_____	_____	_____	_____
a. Bed change - date_____	_____	_____	_____	_____	_____
b. Bed change - date_____	_____	_____	_____	_____	_____
2. Licensed beds - end of the accounting period	_____	_____	_____	_____	_____
3. Possible bed days for the period [6]	_____	_____	_____	_____	_____

4. Inpatient days for the period [7]

a. Medicare - Skilled	_____	g. Private ICF/MR	_____
b. Medicaid - NF2	_____	h. Other NF1	_____
c. Medicaid - NF1	_____	i. Other NF2	_____
d. Private - NF1	_____	j. TOTAL NURSING FACILITY DAYS	
e. Private - NF2	_____	(Add items a - i)	_____
f. Medicaid ICF/MR	_____	k. Non-nursing facility days	_____
		l. TOTAL DAYS - Add items j and k	_____

5. Percent Occupancy (4.j. divided by 3.c.)

6. Meals served during the period [8]

a. Patients		_____
b. Employees		_____
(1) Considered part of compensation (Provided free of charge)	_____	
(2) Paid for by employees	_____	
c. Guests		_____
(1) Provided free of charge	_____	
(2) Paid for by guests	_____	
d. Owners		_____
(1) Provided free of charge	_____	
(2) Paid for by owners	_____	
e. Total Meals		_____

B. *Statistical and Other Data (continued)*

7. List names of all persons living in the home that are not patients and their position or relationship to the home, such as owners, employees, etc. (If none, so state).

(Rule 1200-13-6-.08, continued)

Name	Title, Position, or Relationship	Amount of Salary	Where in Section F is salary shown?
_____	_____	_____	_____
_____	_____	_____	_____

8. List changes in ownership during this reporting period and those changes anticipated during the next reporting period.

From	Type of Control	To	Type of Control	Date of Change
_____		_____		_____
_____		_____		_____
_____		_____		_____

C. Balance Sheet (Date _____, 19___)

1. Assets

a. Current Assets:

(1) Cash on hand and in bank		$_____
(2) Accounts receivable	$_____	
Less allowance	_____	_____
(3) Other accounts receivable	_____	
Less allowance	_____	_____
(4) Notes receivable		_____
(5) Due from officers/owners		_____
(6) Inventory of supplies on hand		_____
(7) Prepaid expenses		_____
(8) Investments		_____
(9) Intercompany receivables		_____
(10) Other current assets (Specify)		
_____		_____
_____		_____

C. *Balance Sheet (continued)*

(11) Total Current Asset - Add items (1) through (10) $_____

b. Fixed Assets:

	Cost	Accumulated Depreciation	Book Value
(1) Land	$_____	_____	$_____

(Rule 1200-13-6-.08, continued)

(2) Land Improvements	$_____	_____	$_____
(3) Buildings	_____	_____	_____
(4) Leasehold or building improvements	_____	_____	_____
(5) Fixed Equipment	_____	_____	_____
(6) Movable Equipment	_____	_____	_____
(7) Motor vehicles	_____	_____	_____
(8) Construction in progress	_____	_____	_____
(9) Other depreciable assets (Specify)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
(10) Total Fixed Assets Add items (1) through (9)	$_____	$_____	$_____

c. Other Assets (if any):

(1) Deposits on loan	$_____
(2) Long term investments	_____
(3) Special funds	_____
(4) Patient trust funds	_____
(5) Unamortized pre-opening expenses	_____
(6) Unamortized organization expenses	_____
(7) Other (Specify)	
_____	_____
_____	_____
_____	_____

C. *Balance Sheet (continued)*

(8) Total Other Assets - Add items (1) through (7)	$_____
d. Total Assets - Add items a(11), b(9), and c(8)	$_____

2. Liabilities

a. Current Liabilities:

(1) Accounts payable	$_____

(Rule 1200-13-6-.08, continued)

(2) Mortgages payable within one year _____

(3) Notes and loans payable within one year _____

(4) Salaries and wages payable _____

(5) Payroll taxes payable _____

(6) Accrued taxes _____

(7) Deferred income _____

(8) Patient trust funds due to patients _____

(9) Intercompany payables _____

(10) Other current liabilities (specify)

_____ _____

_____ _____

_____ _____

(11) Total Current Liabilities - Add items (1) through (10) $_____

b. Long Term Liabilities

(1) Mortgages payable beyond one year $_____

(2) Notes payable beyond one year _____

(3) Unsecured loans _____

(4) Loans from owners _____

(5) Other long term liabilities (Specify)

_____ _____

_____ _____

C. *Balance Sheet (continued)*

(6) Total Long Term Liabilities Add items (1) through (5) $_____

c. Total Liabilities - Add items a(11) and b(6) $_____

3. Capital (Owner's Equity or Fund Balance)

a. Net Worth:

(1) Individual $_____

(2) Partnership _____

(Rule 1200-13-6-.08, continued)

(3) Corporation

(a) Capital stock (at par or stated value) _____

(b) Paid in capital _____

(c) Treasury stock _____

(d) Retained earnings _____

(4) Fund Balance (Nonprofit) _____

b. Total Capital - Add items a(1) through a(4) $_____

4. Total Liabilities and Capital (Section C, item 2c plus item 3b) $_____

D. *Summary Statement of Income, Expense, and Retained Earnings*

1. Income [28]

a. Gross Routine Service Charges

	(1) Room & Board	(2) Other Covered Services	(3) (1) + (2) Total
(1) Medicare Skilled	$_____	$_____	$_____
(2) Medicaid - NF2	$_____	_____	_____
(3) Medicaid - NF1	$_____	_____	_____
(4) Private - NF1	$_____	_____	_____
(5) Private - NF2	$_____	_____	_____
(6) Medicaid - ICF/MR	$_____	_____	_____
(7) Private - ICF/MR	$_____	_____	_____

D. *Summary Statement of Income, Expense, and Retained Earnings (continued)*

(8) Other NF1	_____	_____	_____
(9) Other NF2	_____	_____	_____
(10) TOTAL ROUTINE NF CHARGES Add items (1) through (9)	$_____	$_____	$_____
(11) Non-NF routine charges			$_____

(Rule 1200-13-6-.08, continued)

(12) TOTAL ROUTINE CHARGES - Add items (10) and (11) $_____

b. Other Income

(1) Pharmacy $_____

(2) Laboratory _____

(3) X-ray _____

(4) All therapies _____

(5) Other ancillaries (Specify)

_____ _____

_____ _____

(6) Cable TV income _____

(7) Rental income from non-routine nursing home operations _____

(8) Rental income from non-nursing home facilities _____

(9) Non-routine barber/beauty shop income _____

(10) Employee, owner, and guest meals _____

(11) Vending machine income _____

(12) Non-routine laundry income _____

(13) Interest and investment income on other than funded depreciation accounts (Attach Itemized Schedule) _____

(14) Interest on funded depreciation deposits _____

(15) Contributions, donations, and grants _____

D. *Summary Statement of Income, Expense, and Retained Earnings (continued)*

(16) Miscellaneous income Attach Itemized Schedule) _____

(17) Total Other Income Add items (1) through (16) $_____

c. Total Income Add items a(12) and b(17) $_____

2. Deductions from Revenue:

a. Bad Debt Expenses

(Rule 1200-13-6-.08, continued)

(1) Applicable to Medicaid NF1 patients $_____

(2) Applicable to other patients _____

(3) Other bad debts (Specify)
_____ _____

b. Contractual Allowance and Other Adjustments

(1) Applicable to Medicaid NF1 patients $_____

(2) Applicable to other patients _____

(3) Other (Specify) _____ _____

c. Deductions from Revenue Add items 2a through 2b _____

3. Net Revenue Item 1c minus 2c _____

4. Operating Expense (Item F.21.) _____

5. Profit or (Loss) Item 3 minus 4 $_____

6. Additions and Deductions:

a. Additions other than revenue (Specify)

(1) _____ $_____

(2) _____ _____

(3) Total Additions $_____

b. Deductions

(1) Dividends _____

(2) Withdrawal of earnings _____

(3) Other (Specify) _____ _____

(4) Total Deductions _____

D. *Summary Statement of Income, Expense, and Retained Earnings (continued)*

c. Net Additions Over Deductions Item a(3) minus b(4) $_____

7. Increase or (Decrease) in Balance of Retained Earnings for the Period - Add items 5 and 6c $_____

8. Beginning Balance (If different from prior year ending balance, explain) $_____

(Rule 1200-13-6-.08, continued)

9. Retained Earnings (or Fund Balance) at the end of the reporting period - Add items 7 and 8 $_____

E. *Information concerning Ownership of the Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, including Home Office Costs; Charge Rates; and Patient Transportation.*[9,10,11]

1. Statement of Compensation to Owners [13]

	Name (1)	Title (2)	Proprietors & Partners Percent Share of Operating Profit or (Loss) (3)	Corporate Shareholders Percent of Providers Stock Owned (4)
a.				
b.				
c.				
d.				

Lines a through d continued below.

	Percentage of Customary Work Week Devoted to this Facility (5)	Inclusive Dates of Employment at this Facility (6)	Amount of Compensation Included in Operating Costs for the Period (7)	Where in Section F is the Compensation included? (8)
a.				
b.				
c.				
d.				

*Attach a statement describing actual duties performed by each individual listed.

E. *Information concerning Ownership of the Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, including Home Office Costs; Charge Rates; and Patient Transportation.* [9,10,11] *(continued)*

2. Statement of Compensation Paid to Administrators (Other than Owners) and Relatives of Owners and Administrators [13,14]

	Name (1)	Title (2)	Relationship to Owners, Administrators, or Assistant Administrators (3)	Percentage of Customary Work Week Devoted to this Facility (4)
a.				
b.				

(Rule 1200-13-6-.08, continued)

c.			
d.			

Lines a through d continued below.

	Inclusive Dates of Employment at this Facility (5)	Amount of Compensation Included in Operating Costs for the Period (6)	Where in Section F is the Compensation included? (7)
a.			
b.			
c.			
d.			

*Attach a statement describing actual duties performed by each individual listed.

3. Intercompany Transfers and Transactions with Related Organizations, Including Home Office and Parent Companies [15,16,17]

   Note: A Home Office cost report and attached apportionment schedules must be filed before these costs can be considered allowable.

E. *Information concerning Ownership of the Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, including Home Office Costs; Charge Rates; and Patient Transportation.* [9,10,11] *(continued)*

   a. List all expenses included in Section F which were paid or accrued to a Related Organization:

Name of Organization	Amount	Department or Account in Section F

   b. Attach a schedule listing

      (1) All intercompany transfers and transactions between the facility and any Related Organization.

      (2) The names of all business entities

         (a) that are related organizations, and

(Rule 1200-13-6-.08, continued)

(b) with whom the provider, during the reporting period, had more than $25,000 in business transactions or transacted 5 percent or more of the total operating expenses of the provider, whichever is less. (See footnote 12)

(3) Names, titles, positions, duties, and total compensation received by all members of Boards of Directors, Corporation Officers, Administrators, Owners, and any other key employees and their relatives, who constructively own 5 percent or more, of any of the organizations in (2) above, and the percentage of constructive ownership by each person listed. If none, so indicate.

4. List the name(s) and address(es) of the owner(s) of the land and buildings. [9,10,11]

_____

_____

5. If the land and buildings are rented, state the relationships (family and business) of the operator(s) of the nursing home to the owner(s) of the land and building, if any. If not related, so state. [9,10,11]

_____ _____

_____ _____

E. *Information concerning Ownership of the Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, including Home Office Costs; Charge Rates; and Patient Transportation.* [9,10,11] *(continued)*

6. Daily Room & Board Charge Rates

	NF1	NF2	ICF/MR
Private Room Rate:			
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
Semi-Private Room Rate:			
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
Other Room Rates (Specify):			
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
_____			
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____
effective date _____	_____	_____	_____

(Rule 1200-13-6-.08, continued)

Note: Any rate or charge change made during the year should be listed. Please do not include a charge range.

If charges have changed since the close of the accounting period, explain: _____

_____

_____

7. Patient NonEmergency Transportation

a. Does your facility provide or arrange to provide for non-emergency patient transportation?

_____

_____

E. *Information concerning Ownership of the Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, including Home Office Costs; Charge Rates; and Patient Transportation.* [9,10,11] *(continued)*

b. If you arrange for the transportation, provide the name of the organization and the amount of expense included in Section F that was paid for the service.

_____

_____

c. If your facility provides the transportation, do you bill Medicaid separately for the service?

_____

If yes, what is the amount of income and where is it included in Section D?

_____

_____

F. *Operating Expenses*: (Expenses per General Ledger) [4,18,19]
*Enter all amounts in whole dollars.

Department or Account _____(1)_____	Amount of Expense ___(2)____	Totals __(3)___	FTEs [18] __(4)__
1. Administration and General			
a. Salary of administrator	$_____		_____
b. Other compensation to administrator	_____		
c. Other administrative salaries	_____		_____
d. Office supplies and printing	_____		

(Rule 1200-13-6-.08, continued)

e. Communications _____

f. Travel (Motor Vehicle) _____

g. Travel (Other) _____

h. Advertising [18] _____

i. Licenses, dues, and subscriptions _____

j. Professional training and education _____

F. *Operating Expenses*: (Expenses per General Ledger) [4,18,19] (continued)
*Enter all amounts in whole dollars.

Department or Account _____(1)_____	Amount of Expense ___(2)____	Totals __(3)___	FTEs [18] __(4)__
k. Conference registration and fees	_____		
l. Accounting and auditing	_____		
m. Legal services	_____		
n. Pharmacy consultant services	_____		
o. Other professional services	_____		
p. Management fees	_____		
q. Franchise tax and filing fees	_____		
r. Public relations [18]	_____		
s. Excise taxes	_____		
t. Insurance (excluding amounts properly included in item 18d)	_____		
u. Utilization review fees	_____		
v. Other [18] _____	_____		
w. Total Add items a through v		$_____	

2. Employee Benefits

a. Social Security and Unemployment Insurance _____

b. Other employee benefits (Attach Itemized Schedule) _____

(Rule 1200-13-6-.08, continued)

c. Total - Add items a and b _____

3. Dietary

a. Dietary salaries _____ _____

b. Raw food _____

F. *Operating Expenses*: (Expenses per General Ledger) [4,18,19] (continued)
*Enter all amounts in whole dollars.

Department or Account _____(1)_____	Amount of Expense ___(2)____	Totals __(3)___	FTEs [18] __(4)__
c. Supplies	_____		
d. Purchased services (Attach Itemized Schedule)	_____		
e. Other [18] _____	_____		
f. Total Add items a through e		_____	
4. Housekeeping			
a. Housekeeping salaries	$_____		_____
b. Supplies	_____		
c. Purchased services (Attach Itemized Schedule)	_____		
d. Other [18] _____	_____		
e. Total - Add items a through d		_____	
5. Laundry and Linen			
a. Laundry and linen salaries	_____		_____
b. Linen and bedding	_____		
c. Supplies	_____		
d. Purchased services (Attach Itemized Schedule)	_____		
e. Other [18] _____	_____		
f. Total - Add items a through e		_____	
6. Plant Operation and Maintenance			
a. Operation and maintenance salaries	_____		_____
b. Fuel (Heating)	_____		

(Rule 1200-13-6-.08, continued)

F. *Operating Expenses*: (Expenses per General Ledger) [4,18,19] (continued)
*Enter all amounts in whole dollars.

Department or Account _____(1)_____	Amount of Expense ___(2)____	Totals __(3)___	FTEs [18] __(4)__
c. Gas	_____		
d. Electricity	_____		
e. Water and sewage	_____		
f. Supplies	_____		
g. Purchased services (Attach Itemized Schedule)	_____		
h. Repairs	_____		
i. Other [18] _____	_____		
j. Total Add items a through i		_____	
7. Medical and Nursing			
a. Salaries Medical Director	_____		_____
b. Salaries Registered Professional Nurses (RNs) _____			_____
c. Salaries Licensed Practical Nurses (LPNs)	_____		_____
d. Salaries Attendants, orderlies, and aides	_____		_____
e. Salaries Other nursing personnel	_____		_____
f. Supplies	_____		
g. Purchased services (Attach Itemized Schedule)	_____		
h. Routine medical supplies [20]	_____		
i. Other [18] _____	_____		
j. Total Add items a through i		_____	
8. Physicians Care (Excluding Medical Director)			
a. Physicians salaries or fees	$_____		_____

F. *Operating Expenses*: (Expenses per General Ledger) [4,18,19] (continued)
*Enter all amounts in whole dollars.

(Rule 1200-13-6-.08, continued)

Department or Account _____(1)_____	Amount of Expense ___(2)____	Totals __(3)___	FTEs [18] __(4)__
b. Other salaries or fees	_____		_____
c. Other [18] _____	_____		
d. Total Add items a through c		$_____	
9. Pharmacy (Excluding consultant fees)			
a. Pharmacy salaries or fees	_____		_____
b. Drugs and pharmaceuticals	_____		
c. Supplies	_____		
d. Purchased services (Attach Itemized Schedule)	_____		
e. Other [18] _____	_____		
f. Total Add items a through e		_____	
10. Laboratory			
a. Laboratory salaries or fees	_____		_____
b. Supplies	_____		
c. Purchased services (Attach Itemized Schedule)	_____		
d. Other [18] _____	_____		
e. Total Add items a through d		_____	
11. X-ray			
a. X-ray salaries or fees	_____		_____
b. Supplies	_____		
c. Purchased services (Attach Itemized Schedule)	_____		

F. *Operating Expenses*: (Expenses per General Ledger) [4,18,19] (continued)
*Enter all amounts in whole dollars.

(Rule 1200-13-6-.08, continued)

Department or Account _____(1)_____	Amount of Expense ___(2)____	Totals __(3)___	FTEs [18] __(4)__
d. Other [18] _____	_____		
e. Total Add items a through d		_____	
12. Recreational Activities			
a. Recreational salaries	_____		_____
b. Supplies	_____		
c. Purchased services (Attach Itemized Schedule)	_____		
d. Other [18] _____	_____		
e. Total Add items a through d		_____	
13. Social Service			
a. Social service salaries	_____		_____
b. Other [18] _____	_____		
c. Total Add items a and b		_____	
14. Physical Therapy			
a. Salaries	$_____		_____
b. Supplies	_____		
c. Purchased services (Attach Itemized Schedule)	_____		
d. Other [18] _____	_____		
e. Total Add items a through d		$_____	
15. Psychiatric Services [21]			
a. Salaries	_____		_____
b. Purchased services (Attach Itemized Schedule)	_____		

F. *Operating Expenses*: (Expenses per General Ledger) [4,18,19] (continued)
*Enter all amounts in whole dollars.

(Rule 1200-13-6-.08, continued)

Department or Account (1)	Amount of Expense (2)	Totals (3)	FTEs [18] (4)
c. Other [18] _____	_____		
d. Total Add items a through c		_____	
16. Psychological Services [21]			
a. Salaries	_____		_____
b. Purchased services (Attach Itemized Schedule)	_____		
c. Other [18] _____	_____		
d. Total Add items a through c		_____	
17. Medical Records			
a. Salaries	_____		_____
b. Supplies	_____		
c. Other [18] _____	_____		
d. Total Add items a through c		_____	
18. Property Expense			
a. Real estate taxes on property used only for nursing home purposes	_____		
b. Rent or lease fee on buildings or equipment used only for nursing home purposes	_____		
c. Interest expense on buildings or equipment used only for nursing home purposes	_____		
d. Insurance on property used only for nursing home purposes	_____		
e. Total Add items a through d		_____	

F. *Operating Expenses*: (Expenses per General Ledger) [4,18,19] (continued)
*Enter all amounts in whole dollars.

(Rule 1200-13-6-.08, continued)

Department or Account _____(1)_____	Amount of Expense ___(2)____	Totals __(3)___	FTEs [18] __(4)__
19. Depreciation and Amortization [30] (Complete Schedule L)			
a. Land improvements	_____		
b. Buildings	_____		
c. Leasehold/building improvements	_____		
d. Fixed equipment	_____		
e. Movable equipment	_____		
f. Automotive equipment	$_____		
g. Other depreciation (Specify on Schedule L)	_____		
h. Amortization of pre-opening costs	_____		
i. Amortization of organization cost	_____		
j. Other Amortization (Specify on Schedule L)	_____		
k. Total Add items a through j		$_____	
20. Other Expenses (Specify) (Attach schedule if additional space is needed)			
a. Salaries _____	_____		_____
b. Vending machines	_____		
c. Purchased barber and beauty services	_____		
d. Cable TV (not beneficial to all patients)	_____		
e. Other interest not included on line 18 (Include on Schedule M)	_____		
f. Annual nursing home privilege tax	_____		
g. Other [18] _____	_____		

F. *Operating Expenses*: (Expenses per General Ledger) [4,18,19] (continued)
*Enter all amounts in whole dollars.

(Rule 1200-13-6-.08, continued)

Department or Account	Amount of Expense	Totals	FTEs [18]
(1)	(2)	(3)	(4)
h. Total Add items a through g			

21. Total Operating Expense Add totals in column 3, items 1 through 20 $_____ _____

G. Adjustments for Calculating Allowable Routine Operating Expense [22]

1. Total Amount of Expenses Per Books (Total should equal amount under Section F, Item 21) $_____

2. Adjustments to be made (Deduct only items included in item 1 above)

	Description of Expense or Income	Base [23]	Amount
a.	Research and medical education	_____	$_____
b.	Vending machines, concessions, etc.	_____	_____
c.	Non-routine barber and beauty shop income	_____	_____
d.	Non-routine medical and surgical supply income	_____	_____
e.	Non-routine laundry income	_____	_____
f.	Applicable miscellaneous income	_____	_____
g.	Interest and investment income (limited to interest expense)	_____	_____
h.	Telephone charges paid for by patients, guests, employees, and others	_____	_____
i.	Guest, owner, and employee meals not considered as a part of compensation; and the cost of free meals to guests	_____	_____
j.	Drugs, supplies, or other services purchased by non-patients	_____	$_____
k.	Income from rental of facility furniture and equipment to patients and non-patients	_____	_____

G. *Adjustments for Calculating Allowable Routine Operating Expense* [22] (continued)

(Rule 1200-13-6-.08, continued)

	Description of Expense or Income	Base [23]	Amount
l.	Rental, maintenance, insurance, depreciation, taxes, and other expenses of non-nursing home facilities (attach supporting schedules)	_____	_____
m.	Bad debts or provisions therefor, charity and courtesy allowances included in operating expenses	_____	_____
n.	Expenses applicable to outpatients	_____	_____
o.	Amounts collected for and paid to pharmacists, physicians, and other professional individuals	_____	_____
p.	Non-allowable purchased services	_____	_____
q.	Salaries or fees paid to physicians for treatment of individual patients and related expenses	_____	_____
r.	Pharmacy (Amount shown in Section F, Item 9f as well as any other applicable amount)	_____	_____
s.	Laboratory (Amount shown in Section F, Item 10e)	_____	_____
t.	X-ray (Amount shown in Section F, Item 11e as well as any other applicable amount)	_____	_____
u.	Cable TV (Other than those in lounge or lobby for general benefit of all patients). (Amount shown in Section F, Item 20d as well as any other applicable amount)	_____	_____
v.	Facilities or accommodations furnished owners, administrators, and other non-patients not considered compensation. [24] (Attach computation sheets)	_____	_____
w.	Indirect expenses apportioned to Ancillary Departments (Amount in Section H, Item 20)	_____	_____

G. *Adjustments for Calculating Allowable Routine Operating Expense* [22] (continued)

x.	Related organization:			
	(1) Expense paid to a related organization		$_____	
	(2) Cost of services by the related organization		$_____	_____
	(Difference between (1) and (2) is the amount to be adjusted) (Attach supporting cost data and schedules)			

(Rule 1200-13-6-.08, continued)

	Description of Expense or Income	Base [23]	Amount
y.	Excess owner's compensation	_____	_____
z.	Excise taxes (Amount shown in Section F, Item 1s)	_____	_____
aa.	Cost of items billed and collected from Medicare Part B on behalf of Medicaid NF1 recipients	_____	_____
bb.	All other items or services which are not covered by NF1 Medicaid services [25]	_____	_____
cc.	Other adjustments (Specify on an attached itemized schedule)	_____	_____
dd.	Total Add items a through cc		$_____

3. Total Allowable Routine Operating Costs Item G1 minus G2dd $_____

H. Allocation of Cost to Routine, Ancillary, and Extra Charge Areas [26,27]

Cost Item	Total (1)	Routine (2)	Pharmacy (3)	Laboratory (4)	Radiology (5)	Other Ancillary (6)
1. Administration & General (F1) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
2. Employee Benefits (F2) Allocation Statistics Cost	_____ $_____	_____ $_____	_____ $_____	_____ $_____	_____ $_____	_____ $_____

H. *Allocation of Cost to Routine, Ancillary, and Extra Charge Areas* [26,27]

Cost Item	Total (1)	Routine (2)	Pharmacy (3)	Laboratory (4)	Radiology (5)	Other Ancillary (6)
3. Dietary (F3) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
4. Housekeeping (F4) Allocation						

(Rule 1200-13-6-.08, continued)

Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
5. Laundry and Linen (F5) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
6. Plant Operation and Maintenance (F6) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
7. Medical and Nursing (F7) Allocation Statistics Cost	_____	_____	_____	_____	_____	_____
	$_____	$_____	$_____	$_____	$_____	$_____
8. Recreational Activities (F12) Allocation Statistics Cost	_____	_____	_____	_____	_____	_____
	$_____	$_____	$_____	$_____	$_____	$_____
9. Social Services (F13) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
10. Physical Therapy (F14) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
11. Psychiatric Services (F15) Allocation Statistics	_____	_____	_____	_____	_____	_____
	$_____	$_____	$_____	$_____	$_____	$_____
12. Psychological Services (F16) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
13. Medical Records (F17) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
14. Property Expense (F18) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
15. Building Depreciation (F19a-c) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____

(Rule 1200-13-6-.08, continued)

Cost Item	Total (1)	Routine (2)	Pharmacy (3)	Laboratory (4)	Radiology (5)	Ancillary (6)
16. Equipment and Other Depreciation (F19d-g) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
17. Amortization (F19h-j) Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
18. Any Other Shared Cost Allocation Statistics	_____	_____	_____	_____	_____	_____
Cost	$_____	$_____	$_____	$_____	$_____	$_____
19. Totals	$_____	$_____	$_____	$_____	$_____	$_____

20. Allocated Ancillary Costs (Columns 3, 4, 5, and 6) $_____

I. *Total Ancillary and Extra Charge Area Costs* [26]

	Pharmacy	Laboratory	Radiology	Other Ancillary
1. Direct Costs (F8, F9, F10, etc.)	$_____	$_____	$_____	$_____
2. Indirect Costs (H19)	_____	_____	_____	_____
3. Total	$_____	$_____	$_____	$_____

J. Summary of Ancillary Charges [28]

	(a) Medicare Skilled	(b) Medicaid NF2	(c) Private	(d) Total
1. Pharmacy	$_____	$_____	$_____	$_____
2. Laboratory	_____	_____	_____	_____
3. X-ray	_____	_____	_____	_____
4. All therapies	_____	_____	_____	_____
5. Other ancillaries (Specify)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(Rule 1200-13-6-.08, continued)

6. Totals - Add items 1 through 5

$_____ $_____ $_____ $_____

K. Calculation of Expenses Applicable to NF1 Program (Reimbursable Cost) [29]

a. Facilities rendering one level of care (NF1 only)

(1) Total Nursing Facility Days (B.4.j.)	(2) Medicaid NF1 Inpatient Days (B.4.c.)	(3) % Medicaid NF1 Days to Total Days (Col. 2 / Col. 1)	(4) Total Allowable Routine Operating Costs (G.3.)	(5) Expenses Applicable to NF1 Program (Col. 3 x Col. 4)

b. Facilities rendering more than one level of care.

(1) Total Routine NF Charges (D.1.a.10.)	(2) Routine Charges to Medicaid NF1 Patients (D.1.a.3.)	(3) % Medicaid NF1 Charges to Total Charges (Col. 2 / Col. 1)	(4) Total Allowable Routine Operating Costs (G.3.)	(5) Expenses Applicable to NF1 Program (Col. 3 x Col. 4)
		%	$_____	$_____

L. Depreciation and Amortization Schedule [30]

Asset	Cost	Date Acquired	Estimated Useful Life	Salvage Value	Method	Current Period Depreciation
Land Improvements	$_____			$_____	S/L	$_____
Building					S/L	
Leasehold/Building Improvements					S/L	
Movable Equipment					S/L	
Other Depreciable Assets					S/L	
					S/L	
					S/L	
					S/L	
Totals	$_____					$_____

(Rule 1200-13-6-.08, continued)

Amortization	Original Amount	Starting Date	Amortization Period	Method of Amortization	Current Period Amortization
Pre-opening Cost	$_____	_____	5 years	S/L	$_____
Organization Cost	$_____	_____	5 years	S/L	$_____
Other (Specify)	$_____	_____	_____	S/L	$_____
_____	$_____	_____	_____	S/L	$_____
Totals	$_____				_____

M. *Loans, Mortgages, and Notes* [15]

1. List individually all loans, mortgages, and notes made in the name of the facility, operators, and/or owners of the facility, for which the related interest expense has been included as an allowable cost. If the amount of previously outstanding loans, mortgages, or notes was increased during the period, list amount and date of increase. State the name of the lender (optional, if not identified by name, enter some code which will be traceable to the provider's records), date of loan, amount of principal, and the amount of interest for the accounting period. List new obligations incurred during this period in item 2. below.

Name of Lender	Date of Loan	Beginning Balance	Ending Balance	Current Period Interest Expense
_____	_____	$_____	$_____	$_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Total Interest Expense for Item 1				_____

2. For each new obligation incurred during this reporting period state the name of lender (optional, if not identified by name, enter some code which will be traceable to the provider's records), amount of the new obligation, interest expense included in Section F, the disposition of the proceeds of the loan, and the date the obligation was incurred. Do not duplicate items in 1 above.

(Rule 1200-13-6-.08, continued)

Name of Lender	Purpose for Loan	Date of Loan	Original Amount	Ending Amount	Current Period Interest Expense
_____	_____	_____	$_____	$_____	$_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Total Interest Expense for Item 2 $_____

Total Interest Expense - Add items in 1 and 2 $_____

N. *Statement of Equity Capital* [31]

	Date	Amount
1. Change in Equity Capital (Dates are required for c, d, and e)		
a. Equity Capital Beginning of Period		$_____
b. Net Income (Loss) for the Period (Item D.5.)		_____
c. Capital Investments (Withdrawals) during the period (Attach schedule if more than one entry)		
_____	_____	_____
d. Gain (Loss) on Fixed Assets (Attach schedule if more than one entry)		
_____	_____	_____
e. Other Increases (Decreases) (Specify Attach schedule if more than one entry)		
_____	_____	_____
f. Equity Capital - End of Period		$_____
2. Reconciliation of Equity Capital with Total Capital		
a. Total Capital (Item C.3.b.)		$_____
b. Additions (Deductions) (Identify each entry)		
_____	$_____	
_____	_____	

(Rule 1200-13-6-.08, continued)

_____ _____

_____ _____ _____

c. Equity Capital - End of Period $_____

O. *Certification by Owner, Officer, or Administrator of Facility*

I, _____, _____ of the
(Name) (Title)

_____, _____, _____
(Name of Facility) (City) (State)

do certify that I have examined the attached report for the fiscal period beginning _____, 19_____, and ending _____, 19_____, the accompanying *Footnotes and Instructions and Accounting Principles*, and that to the best of my knowledge and belief, this report is a true and correct statement of the information required, and that charges and expenses for services provided to Medicaid Program recipients were in accordance with applicable state and federal regulations. I understand that any false claims, statements, or documents, or the concealment of a material fact may lead to prosecution under applicable Federal or State Laws.

Date _____, 19_____
Signature of Authorized Representative of Facility

_____
Typed Name of Authorized Representative

_____
Title

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original chapter filed January 12, 1988; effective February 26, 1988. Amendment filed December 1, 1988; effective January 15, 1989. Amendment filed August 17, 1995; effective October 30, 1995. Amendment filed January 21, 2000; effective April 5, 2000.*

1200-13-6-.09 FOOTNOTES AND INSTRUCTIONS FOR THE NURSING FACILITY LEVEL I COST REPORT.

(1) General

1. Enter the NF-1 Provider number as issued by the Tennessee Department of Health and the NF-2 Provider number as issued by Medicare. Providers with numbers other than NF-1 and NF-2 may include them on the Level II line.

2. Enter name of facility exactly as shown on the license (permit) to operate issued by the Tennessee Department of Health.

3. Cash basis accounting is not acceptable for purposes of this report. All amounts must be reported in whole dollars.

(Rule 1200-13-6-.09, continued)

4. Adequate financial records, statistical data, and source documents must be maintained for proper determination of costs under the program.

B. Statistical Data

5. All statistics to be reported in this section will be for the same period as the accounting period covered by this report.

6. Possible bed days should be the sum of the count of the number of licensed beds for each day of the accounting period.

7. An inpatient day is that period of service rendered a patient between the census taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day. All days charged for must be included in the patient day statistics including leave days, reserved bed days, etc. A census will be recorded each day during the accounting period. All such records must be available for verification by the Comptroller's Office. All inpatient days must be identified by the categories indicated.

8. Report all meals provided to patients, employees, guests, and owners. The cost of meals provided to owners must be included in compensation stated in Section E. Adequate meal records must be maintained.

E. Ownership of Facility; Compensation of Owners, Administrators, and Relatives of Owners and Administrators; Related Party Transactions, Including Home Office Costs; Charge Rates; and Patient Transportation

9. Controlling interest is defined as a person or entity that:

(a) has an ownership interest totaling five percent (5%) or more in a disclosing entity,

(b) has an indirect ownership interest equal to five percent (5%) or more in a disclosing entity,

(c) has a combination of direct and indirect ownership interest obligation secured by the disclosing entity if that interest equals at least five percent (5%) of the value of the property or assets of the disclosing entity,

(d) is an officer or director of a disclosing entity that is organized as a corporation, or

(e) is a partner in a disclosing entity that is organized as a partnership.

Indirect ownership interest is defined as any ownership interest in an entity that has an ownership interest in the disclosing entity. This includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. EXAMPLE: A owns ten percent (10%) of the stock of Corporation B which owns eighty percent (80%) of the stock of the disclosing entity. A's interest is an eight percent (8%) indirect ownership interest in the disclosing entity and must be disclosed.

The amount of ownership, mortgage, deed of trust, note, or other obligation is determined by multiplying the percentage owned in the obligation by the percentage of the disclosing entity's assets used to secure the obligation. EXAMPLE: A owns ten percent (10%) of a note secured

by sixty percent (60%) of the provider's assets. A's interest in the provider's assets is six percent (6%) and must be disclosed.

10. Disclosing entities are defined as hospitals, skilled nursing facilities, clinical laboratories, renal disease facilities, health maintenance organizations, and rural health clinics (as established by P. L. 95210) under Title XVIII (Medicare), entities (other than practitioners or groups of practitioners) that furnish or arrange for the furnishing of services under the Title XIX or Title V (Children's Special Service) programs; fiscal intermediaries, fiscal agents, and carriers participating in Medicare or Medicaid; and providers of health related services under the Title XX program.

11. Information relating to ownership shall be maintained at the facility and available for audit and upon request at any time.

12. The amounts of business transacted with entities that are not related entities need not be disclosed in the cost report. However, in the event of a request, the disclosure of the amounts and the ownership of the business entity with whom the provider transacted business of more than $25,000 or five percent or more of the total operating expenses of the provider, whichever is less, may be required within 30 days of the request.

13. For reimbursement purposes, a reasonable allowance or compensation for services of an owner or persons related to an owner is an allowable cost, provided the services are performed in a necessary function. The requirement that the function be necessary means that had the owner not rendered the services, the institution would have had to employ another person to perform them. The services must be related to patient care and pertinent to the operation and sound management of the institution.

    Total compensation to such persons must be listed in Section E, Items 1 and 2. Where such amounts include items other than salaries, a schedule must be attached that identifies the amounts and the method of assigning values to these benefits. All such costs included in Section F must be reported in Section E.

    The Comptroller's Office will review these amounts and compare them with allowable compensation ranges and make necessary adjustments. The Comptroller will consider the duties, responsibilities, and managerial authority of the person as well as the services performed for other institutions and his engagements in other occupations. Only one fulltime position, or its equivalent will be allowed for each person. The duties performed, time spent, and compensation received by such a person must be substantiated by appropriate records. Allowable ranges can be found in Chapter 1200-13-6-.11.

14. Complete Section E, Item 2 only for individuals who are not owners of the facility. If the individual is related to any owner by blood or marriage, this relationship must be indicated in Column 3. See PRM, Part 1, Section 902.5.

15. All loan transactions with related parties as defined in footnotes 9 and 10 shall be fully disclosed in Section E and the corresponding interest expense shall be disallowed in Section G.

16. The hospital parent or a hospital-based nursing home shall not be considered as a home office if the hospital is a regular provider in the Medicaid hospital program and files the appropriate Medicare-Medicaid hospital cost report in a timely manner. Costs allocated to the nursing home on the hospital's Medicare-Medicaid cost report are includable in Section F of this cost report. These amounts do not have to be audited by the Certified Public Accountant or licensed Public Accountant if significant portions of the corresponding expenses before allocation are apportioned to the hospital and prior approval is received from the Comptroller's Office. The

report by the Certified Public Accountant must disclose the amounts allocated to the hospital and nursing facility, the bases used, and the corresponding figures which were not included in the audit.

17. Home Office costs directly related to those services performed for individual providers which relate to patient care, plus an appropriate share of indirect costs (overhead, rent, administrative salaries, etc.) may be allowable to the extent they are reasonable. Home Office costs or related organization costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable costs when allocated to providers. Nursing facility cost reports will not be processed until the home office costs are submitted.

F. Operating Expenses

18. Itemized schedules must be attached to support advertising, public relations, "other," and "purchased services" accounts. Amounts not supported will be disallowed.

Enter in the appropriate classification the number of personnel employed full-time as of the end of the fiscal period covered by this statement. Report the fulltime equivalent (FTE) of all personnel working in the particular classification. For example, if five people are employed full-time as LPNs, one person is employed as an LPN one day per week (eight hours per day), and another person works as an LPN two days per week (eight hours per day), the total LPNs to be reported should be 5.6 full-time equivalent employees. The number of personnel in each particular classification under Section F, Column (4), "FTEs", must coincide with the salaries reported in each particular classification of Section F, Column (2), "Amount of Expense". Payroll records are to be available for verification by the Comptroller's Office.

19. All facilities should properly identify and include in Section F. "Operating Expense," the cost of providing to all patients the medical supplies, equipment, and services specified by the Department of Health as covered services. These are items and services (per the Department of Health contract with all facilities) for which the facility may not receive extra payments from Medicaid patients, their relatives or others.

20. Include the cost of covered supplies only. Do not include drugs or pharmacy items that are not covered by the NF-1 program. Drugs and pharmacy should be included in item F.9.

21. Psychiatric and Psychological Services can be provided only to ICF/MR patients in an ICF/MR licensed facility.

22. The purpose of Section G, "Adjustments for Calculating Allowable Routine Operating Expense" is to determine the cost of room and board, nursing care, medical and nursing supplies, and other services as specified and defined by the Department of Health as NF-1 covered services. Consequently, the cost of any items or services not a part of the cost of providing NF-1 covered services included in Section F, "Operating Expense" are to be deducted from operating expenses in Section G. Accounting and other records of participating facilities are subject to audit and verification by the Comptroller's Office for proper determination of cost of covered services. In addition to the items specifically identified in Section G, the following are also expenses not considered a part of the cost of providing routine service, and should be deducted. This list is not to be considered all inclusive. Generally, where an item is not specifically addressed, Medicare reimbursement principles apply.

a. Interest paid:

(1) On borrowed funds used for a non-allowable expenditure.

(Rule 1200-13-6-.09, continued)

(2) On borrowed funds which create excess working capital.

(3) On borrowed funds used for investing in other than provider's health care operations.

(4) To partners (owners), stockholders, or related organizations or relatives.

(5) On borrowed funds used to fund depreciation.

b. Any imputed value of produce, supplies or space donated to the provider.

c. Purchase discounts, cash discounts, trade discounts, quantity discounts or allowances.

d. Purchase refunds or rebates.

e. Costs which are not necessary or related to patient care.

f. Costs of non-competing covenant agreements.

g. Insurance premiums paid on the lives of owners, officers, and key personnel, if the provider is the direct or indirect beneficiary. If another party is beneficiary, the premiums are to be considered as compensation to the respective owner, officer, or key employee and should be disclosed separately.

h. Cost of personal comfort items and other non-covered items, as may be specified and defined by the Department of Health.

i. Cost of luxury items such as TV, telephone, and radio in patient rooms. (This does not include those items placed in lounges or recreation rooms to be used by all patients).

j. Any fines, penalties, or interest paid on any tax payments or interest charges on overdue payables.

k. Federal, State, or local income taxes, or excess profit taxes.

l. Any taxes for which exemptions are available but not taken.

m. Sales taxes collected by the provider and remitted to the state.

n. Real estate taxes and other expenses on property purchased and held for investment or expansion, and not used in rendering patient service.

o. Self employment taxes applicable to owners, partners, members of joint ventures, etc.

p. Casualty and other losses such as liability, theft, larceny, embezzlement, that are insurable but uninsured. (When insured, the insurance premiums and cost of deductibles for these losses are allowable). Medicare principles must apply.

q. Advertising costs incurred:

(1) To raise funds for the provider.

(2) Which are designed to encourage physicians to utilize the provider's facilities in their capacity as an independent practitioner.

(3) In connection with the issuance of the provider's own stock or sale of stock held by the provider in another corporation.

(4) Which seek to increase patient population or utilization of the provider's facilities by the general public.

r. Membership dues, initiation fees, subscription costs or special assessments paid to Social, Fraternal, or other organizations whose activities are unrelated to the profession or business of their members.

s. Cost of private duty nurses and attendants.

t. Travel expenses which are personal in nature, not proper or related to patient care, and auto expenses applicable to non-business uses of the vehicles. Detailed justification for out of state travel must be retained for audit verification.

u. Any other costs which are identified and specified as non-allowable by the Medicaid Program manuals, or federal or state rules or regulations.

23. The cost of excludable expenses should be deducted. In the relatively few instances where such costs cannot be adequately determined, deduct the revenue received therefrom. If the amount shown is revenue enter "R" as the base.

24. Cost of facilities furnished to owners, administrators, and other non-patients must be determined on a reasonable basis. Where the nursing home has no plan for determining reasonable charges for these facilities, the patient charge schedule may be used by the Comptroller of the Treasury in arriving at the amount of exclusion.

25. In Section G. Item 2bb any costs or expenses included in Section F, "Operating Expense," for the items or services for which Medicaid NF-1 patients may be charged extra by the facility in addition to the established reimbursable cost rate of the facility are to be deducted from operating expense.

26. Facilities with no ancillary or extra charge areas should omit Sections H and I.

H. Allocation of Cost to Routine, Ancillary and Extra Charge Areas

(Facilities with no ancillary or extra charge areas can omit this section).

27. The statistical bases below shall be used to apportion indirect costs to ancillary and extra charge areas unless prior approval is obtained in writing from the Comptroller of the Treasury.

	Cost Item	Basis
1.	Administration and General	Direct Costs (Section F)
2.	Employee Benefits	Salaries
3.	Dietary	Meals Served
4.	Housekeeping	Square Feet or Actual Time Spent
5.	Laundry	Pounds
6.	Plant Operation and Maintenance	Square Feet
7.	Medical and Nursing	Actual Cost
8.	Recreational Activities	Time Spent
9.	Social Services	Time Spent

(Rule 1200-13-6-.09, continued)

10.	Property Expenses	Square Feet
11.	Building Depreciation	Square Feet
12.	Equipment and Other Depreciation	Dollar Value
13.	Any other cost which should be allocated to Ancillary or Extra-Charge areas	Any reasonable basis approved by the State Comptroller's Office

The first line under each cost item to be allocated should show the allocation statistics used to apportion the total cost. The second line should show the costs after allocation. The allocation formula is:

$$\frac{\text{Area Statistic}}{\text{Total Statistic}} \times \text{Total Cost} = \text{Area Cost}$$

J. Patient Log Summary of Charges

28. Routine charges must be based on the facility's established daily charge rate before contractual allowances. Ancillary charges (Section J) do not apply to Medicaid NF1 recipients.

29. If a facility is rendering only one level of care, the percentages of costs of the NF-1 program will be determined as a percentage of Medicaid NF-1 patient days to total patient days (Section K, Item a). If a facility is rendering more than one level of care, the percentage of costs to the NF-1 program will be determined as a percentage of Medicaid NF-1 covered charges to total covered charges (Section K, Item b).

L. Depreciation and Amortization Schedule

30. The Depreciation and Amortization Schedule (Section L) must be completed. Fixed Asset cost must agree with the Fixed Asset cost by classification shown in Section C. Do not include land, as land is not considered a depreciable asset. The sum of the current period total amortization expense reported in Section L and the current year unamortized expense reported in Section C.1.c. (Items (5) and (6)) should equal the unamortized expense reported in Section C.1.c. (Items (5) and (6)) of the prior period cost report.

N. Statement of Equity Capital

31. Equity Capital means the net worth of a provider, excluding those assets not related to patient care. Specifically, Equity Capital, includes:

(a) a provider's investment in plant, property, and equipment (net of depreciation and associated long-term debt) related to patient care plus funds deposited by a provider who leases plant, property, and equipment related to patient care and is required by terms of the lease to deposit such funds (net of noncurrent debt related to such investment or deposited funds) and

(b) net working capital maintained for necessary and proper operation of patient care activities.

Providers of chain organizations may assign an appropriate share of the equity capital of the home office to each facility. This assignment must be shown in the home office cost report. Debt representing loans from partners, stockholders, or related organizations and for which the interest is not an allowable cost shall be considered as equity capital and shall not be subtracted in the determination of (a) or (b) above.

(Rule 1200-13-6-.09, continued)

Investments, excess fixed assets, excess inventory, goodwill, loans to officers, owners, related organizations, or employees, uncollectible accounts and notes receivable, cash in excess of reasonable needs, and other assets, current or noncurrent, that are not reasonably related to patient care must be excluded from equity capital. Further, any capital expenditure that has not been approved by the Tennessee Health Facilities Commission or its successor agency in accordance with state law must be excluded from equity capital.

If the current year's beginning equity capital does not agree with the prior year's ending equity capital shown on the prior year's cost report, Section N, Statement of Equity Capital, a reconciliation must be attached.

All entries on line 1c, 1d, or 1e must be dated. Any changes in equity capital reported on lines 1c, 1d, and 1e must be supported by a schedule showing the date and amount of each change that has occurred during the period. EXAMPLE - If the beginning balance of a loan to an owner is $10,000 and the ending balance is $12,000 and the net change of $2,000 occurred at different dates in different amounts (e.g., on February 15, the owner repaid $1,000; on April 20, the owner repaid $1,000; on June 10, the owner borrowed $3,000; on September 5, the owner repaid $2,000; and on October 20, the owner borrowed $3,000) each increase and/or decrease during the period must be dated with the appropriate amounts reported separately. A return on equity amount cannot be calculated unless the changes are dated and the amounts are reported accurately.

32. Reserved

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed January 12, 1987; effective February 26, 1988. Amendment filed December 1, 1988; effective January 15, 1989. Amendment filed September 14, 1992; effective October 29, 1992. Amendment filed August 17, 1995; effective October 31, 1995. Amendment filed January 21, 2000; effective April 5, 2000.*

1200-13-6-.10 MEDICAID NURSING FACILITY LEVEL I ACCOUNTING PRINCIPLES.

(1) Reimbursable Cost

This cost report must be completed in accordance with Medicare laws and principles of cost reimbursement as updated, except as specified in the cost report, the Footnotes and Instructions, and below:

(a) Only the straight line method of computing depreciation is permitted.

(b) Expenses related to disallowed capital expenditures such as depreciation, interest on borrowed funds, the return on equity capital in the case of proprietary providers, and repairs, are not allowable costs. Disallowed capital expenditures are those that have not been approved by the Tennessee Health Facilities Commissioner or its successor agency in accordance with state law.

(c) Bad debt is not an allowable expense.

(d) Costs may be included only for covered services as defined by the Department of Health.

(e) The reimbursement of excessive capitol costs arising from low occupancy is not permitted by the Medicaid NF-1 Program. Accordingly, Medicaid capital-related costs before application of any ceilings shall be recalculated according to the following scale:

(Rule 1200-13-6-.10, continued)

Facility % Occupancy	Percent of Actual Allowable Costs
80% and above	100%
75% to 79.999%	95%
70% to 74.999%	90%
65% to 69.999%	85%
60% to 64.999%	80%
55% to 59.999%	75%
50% to 54.999%	70%
Below 50%	60%

In addition, no incentive provisions will apply to providers with occupancies below 80%.

(f) Assets not relating to patient care, uncollectible accounts and notes receivable, and advances or loans to owners are to be excluded from equity capital.

(g) On a new lease effective after June 30, 1976, and renewal of such lease between either related or unrelated persons or entities, the lesser of rent on real property or equipment or the amount of the lessor's depreciation, interest, other allowable costs, and return on equity capital, in accordance with principle 2 of this section, will be considered on an item by item basis. Renewal of a lease negotiated before July 1, 1976, at the same rental amount or at an amount fixed or determinable according to conditions provided for in the original lease will not be considered a new lease according to this provision. This provision does not apply to the rental of equipment for periods of less than one year.

In cases where a provider leases a facility from a municipality or other governmental unit or agency at a nominal rental fee (e.g., $1.00 per year) and the lease meets the Medicare criteria for the allowance of depreciation in lieu of rent, other costs to the governmental agency, which are otherwise allowable, may also be included in the reimbursable cost to the provider. When depreciation and other costs to the governmental agency are included by the provider, these costs must be specified as such and supporting documents must be available for audit in the same manner as the provider's own records.

(h) In regard to the revaluation of assets, recovery of depreciation, and limitation of capital related costs on assets sold or transferred at a gain, the Tennessee Medicaid Program will allow the lesser of

1. the asset's purchase price at the time of sale,

2. the fair market value at the time of sale, or

3. for bona fide arms length sales on and after July 1, 1988, the seller's allowable historical basis trended forward by the asset revaluation multipliers. These multipliers are computed by the Comptroller's Office based on the lesser of 50% of the Consumer Price Index or 50% of the Dodge Construction Index (measured from the seller's date of acquisition) and then reduced by the seller's accumulated deprecation to the time of sale.

Furthermore, for sales on and after July 1, 1988, the new provider's combination of down payment and loan principal cannot exceed the revalued basis. The down payment is applied to the revalued basis first, and the remaining amount is the allowable debt basis.

(Rule 1200-13-6-.10, continued)

The new provider's allowable useful lives on assets purchased cannot be less than the seller's remaining useful lives at the time of purchase. The provider of record (buyer) is responsible for providing the necessary initial information to the Comptroller's Office in order to make the necessary revaluation. In subsequent years' cost reports, the provider is responsible for maintaining records on assets subject to the revaluation limitation and must enter in Section G.2.cc. the excess of book depreciation and interest over the Medicaid allowable amount. Assets and debt acquired subsequent to and not related to the change of ownership are not subject to revaluation limitations. In no case can interest expense on assets subject to revaluation limits exceed actual interest incurred by the new owner.

ILLUSTRATIVE EXAMPLE

Seller's original building cost was $1,250,000 on July 1, 1980, with a useful life of 40 years. On July 1, 1992, the facility is purchased by Buyer for $3,500,000 who decides to invest some of his own money in the purchase and finance the remainder at 9%. Accumulated depreciation for the building as of July 1, 1992 is $375,000, and the net book value is therefore $875,000. The portion of the selling price allocated to the building is $1,531,250. Buyer's remaining useful life for the building is 28 years. Buyer reported depreciation for the building for FYE 6/30/93 of $54,688. The building revaluation and depreciation limit is computed below. The index for assets acquired in 1980 and sold in 1992 is 1.17.

Seller's original building cost in 1980	$1,250,000
Cost multiplier	1.17
Revalued original cost	$1,462,500
Accumulated depreciation	($375,000)
Allowable basis to buyer	$1,087,500
Allowable depreciation ($1,087,500/28)	$38,839
Reported depreciation	$54,688
Non-allowable depreciation	$15,849

Assuming the provider's allowable basis for all assets (including the building and equipment) is $2,292,322, allowable return on equity and interest would be computed as follows:

(i) If the buyer, (a for-profit entity), pays $1,000,000 down and finances the remaining $2,500,000 of the purchase, then he is allowed return on equity on $1,000,000 and interest expense of $1,292,322 at 9% for the loan term. Allowable interest expense decreases each year as principal is repaid.

(ii) If the buyer (a for-profit entity) pays $2,500,000 down and finances the remaining $1,000,000 of the purchase, then he is allowed return on equity of $2,292,322 and NO interest expense.

(iii) If the buyer (a not-for-profit entity) pays $1,000,000 down and finances the remaining $2,500,000 of the purchase, then he is allowed NO return on equity, and is allowed interest expense of $1,292,322 at 9% for the loan term. Allowable interest expense decreases each year as principal is repaid.

(i) A return on equity of no more than the amount allowed under Medicare principles in effect for services prior to October 1, 1993, shall be included as an allowable cost for proprietary providers, limited to $1.50 per patient day, and by the maximum payment rate.

(j) The effect of minimum wage and other direct pass-through cost items will be eliminated in the application of the inflation allowance.

(Rule 1200-13-6-.10, continued)

(k) An incentive payment will be included in the reimbursable rate for providers who sufficiently contain costs as provided herein and maintain an average occupancy rate of 80% or greater. Certain expenses are fixed and not controllable on a day today basis. These expenses include allowable rent, property taxes and insurance, depreciation, and interest. Total costs are determined for each provider and converted to a per patient day basis. Fixed costs are also determined for each provider and converted to a per patient day basis. Variable costs are determined by subtracting the fixed costs from the total costs. All intermediate care providers whose variable costs are less than the maximum reimbursement rate shall be eligible to receive a fifty percent (50%) cost containment incentive for every dollar they are below the maximum reimbursement rate, limited to three dollars ($3) per patient day and by the maximum reimbursement rate.

(l) No carryover of allowable costs shall be allowed.

(m) Providers of ICF/MR Services

1. For providers of ICF/MR services, the total of management fees charged by a non-related management company plus the total of home office costs claimed by a related parent company, is limited to the lesser of:

(i) Allowable costs of the non-related management company and the related parent company.

(ii) Charges, or

(iii) 45% of total allowable administrative costs of the provider.

(iv) In addition, management fees of a non-related management company is further limited by:

I. The amount specified in the management contract between the management company and the ICF/MR facility; and
II. The maximum component fees as defined in (h) below.

2. A non-related management company is an independent entity not related to the provider by ownership or control and which obtains its contract with the provider by means of an arms-length transaction. If a management company does not obtain its contract by means of an arms-length transaction, it will be deemed a related parent company. The management fees of a non-related management company are not allowable unless the company manages at least two ICF/MR facilities. A related parent company is one which owns, in part or in whole, its subsidiary ICF/MR facilities, or exercises significant control over its subsidiary ICF/MR facilities. A related parent company, as well as a non-related management company, maintains offices and administrative staff separate from and in addition to the individual facilities' administrative offices and administrative staff.

3. For purposes of this rule, the term ownership is as defined to rule 1200-13-6-.09E.9. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution. The term "control" includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise.

(Rule 1200-13-6-.10, continued)

4. The allowable costs of a non-related management company may include a profit factor equal to the return on equity percentage currently allowed under the program. Unless otherwise indicated by state rules, allowable costs are determined in accordance with Medicare principles of retrospective reimbursement. Interest paid on overdue management fees is considered part of the management fees in the year paid.

5. For purposes of this provision, charges is the amount claimed for reimbursement by a non-related management company or related parent company on provider cost reports submitted to the state.

6. For purposes of this rule, administrative and general costs of the provider include the following:

(i) Salary of administrator;
(ii) Other administrative salaries;
(iii) Office supplies and printing;
(iv) Communications (telephone, fax);
(v) Travel expenses;
(vi) Advertising and public relations;
(vii) Licenses, dues and subscriptions;
(vii) Professional training and education;
(ix) Conference registration and fees;
(x) Accounting, bookkeeping, and auditing expenses;
(xi) Legal services;
(xii) Pharmacy, nursing, dietary, and all other consulting services;
(xiii) Franchise and filing fees;
(xiv) Excise taxes;
(xv) Insurance (other than property insurance);
(xvi) Utilization review expenses;
(xvii) Management fees; and
(xviii) Home office costs.

7. The provider services tax is not included in administrative and general costs of the provider.

8. For purposes of this rule, maximum component fees are upper limits for services documented as provided by non-related management companies to client ICF/MR facilities. Component fees are allowable only if the service is not provided by the ICF/MR with its own staff or by independent contractors separate from the management company. Management companies and/or ICF/MR must maintain documentation that the service(s) are actually provided on-site at the ICF/MR facilities. Accounting and bookkeeping services do not necessarily have to be performed onsite at the provider. The annual maximum component limits are as follows for facilities greater than 50 beds:

Nurse Consultant Services	$10,500
Human Resource Services	$10,500
Crisis Intervention Services	$10,500
Pharmacy Consultant Services	$7,000
Dietary Consultant Services	$7,000
Social Service Consultant Services	$3,000
Activity Service Consulting	$1,500
Medical Records Consulting	$1,500
Accounting Services	$50,000
Bookkeeping Services	$20,000

(Rule 1200-13-6-.10, continued)

Staff Training Services	$10,000
Retainer for Legal Counsel	$3,000
General Oversight and Supervision	$50,000
Total	$184,500

9. The maximum annual allowable management fee for component services under this subsection, before consideration of allowances for management company profit and overhead, is $184,500. An additional 20% of the total allowed components will be added for overhead. In addition, a profit margin based on the total allowed components will be added. The profit percentage will be the current return on equity percentage used under the program. For facilities 50 beds or less, applicable amounts will be one-half the above amounts.

Illustrative Example

Assume the following: A non-related management company is limited to (a)4.(ii), maximum component fees. The management company manages five nursing facilities for the entire year. Four of the facilities have 100 beds and the fifth has 45 beds. Assume the applicable return on equity percentage is 7%. The management company documents that it has provided the following services to each of the five providers:

(i) Nurse Consulting
(ii) Human Resource Services
(ii) Crisis Intervention Services
(iv) Accounting
(v) Staff Training
(vi) General Oversight and Supervision

The maximum allowable management fee for each of the 100 bed facilities is $179,705 computed as follows:

Nurse Consulting	$10,500
Human Resource Services	$10,500
Crisis Intervention Services	$10,500
Accounting	$50,000
Staff Training	$10,000
General Oversight/Supervision	$50,000
Subtotal	$141,500
Add overhead (20%)	28,300
Add profit (7%)	9,905
Total Allowable	$179,705

The maximum allowable management fee for the 45 bed facility is $89,853.

10. It is the responsibility of ICF/MR providers to submit cost information of non-related management companies. Initially, the cost information is to be submitted on the effective date of this rule. Subsequently, the cost of non-related management companies shall include, but not be limited to, audited financial statements, a detailed trial balance, and allocation of costs to all managed facilities and owned facilities, if any, as well to other business activities of the management company. The cost information is subject to audit by the state Comptroller's Office. In the event that audited financial statements are

not available, unaudited statements shall be submitted. In the event that the fiscal year end of the management company differs from the fiscal year end of the ICF/MR provider(s), information from the most recently completed fiscal year shall be submitted. Cost reports submitted without the required management company cost information shall be considered incomplete and will not be processed. Providers will be subject to a penalty of $10 per day in accordance with state law until the required cost information is filed.

11. The provisions of this section do not apply to ICF/MR services covered under a capitated payment system nor to management contracts with annual fees less than $75,000.

(2) Workers Compensation Expenses

For Medicaid cost reporting purposes, when additional costs for workers compensation premiums are incurred from an insurance audit subsequent to a nursing facility's fiscal year end and the cost report has been filed with the Comptroller's Office without including the costs, the costs will be considered an expense in the year the amount becomes known. Should a workers compensation audit result in a premium credit, the credit will be applied to the next premium payment. In either case, amended cost reports cannot be filed.

(3) Disclosure of Information

The Tennessee Medical Assistance program will follow federal requirements pertaining to the disclosure of certain information about ownership interest, business transactions, convictions of program related criminal offenses, etc. as required by 42 CFR Chapter IV, Part 420, Subpart C, and Part 455, Subpart B, Principle C effective October 1, 1983.

(4) Patient Accounts and Patient Funds

Gross charges to the patients' accounts must match the charges to the patient log. Adjustments to the patients' accounts must then be made to bring the actual charges in line with the contractual and legal collection limits of the various medical programs. All charges in the patients' accounts must be supported by charge slips and the proper notes in the patients' files and must correspond to the charges reported on the Department billing forms. Personal funds held by the provider for Medicaid patients used in purchasing clothing and personal incidentals must be properly accounted for with detailed records of amounts received and disbursed and shall not be commingled with nursing facility funds. Patient funds in excess of $50 per patient must be kept in an insured interest bearing account. Interest earned must be credited to the patients.

(5) Patient Logs and Census

Each facility must maintain daily census records and an adequate patient log. The format of the log is to be determined by each individual provider and may be combined with the revenue journal or other records at the convenience of the provider. This log, however, must be sufficient to provide the following information on an individual basis and to accumulate monthly and yearly totals for Medicaid NF-1 patients and for all other patients.

(a) Days of service,

(b) Charges for items and services covered by the Medicaid NF-1 Program,

(c) Charges for items and services not covered by Medicaid NF-1 Program,

(Rule 1200-13-6-.10, continued)

(d) Patient income applicable to the cost of covered items and services received by Medicaid NF-1 patients,

(e) Amounts collected and receivable from the Medicaid NF-1 Program, and

(f) Amounts collected and receivable from all other sources.

(6) Patient Log Directions

(a) Suggested Patient Log

The headings below should be listed across the top of the page above the respective columns.

Column No.	Heading
1	Patient Name
2	Patient Days
3	Room and Board Charge
4	Total Other NF-1 Covered Charges
5	Total NF-1 Covered Charges (Col. 3 + Col. 4)
6	Total NF-1 Noncovered Charges
7	Total Actual Charges (Col. 5 + Col. 6)
8	Date Medicaid NF-1 Claim Paid
9	Amounts Collected and Receivable from NF-1 Program
10	Patient Income Applicable to NF-1 Covered Services
11	Amounts Collected and Receivable from Patients from NF-1 Noncovered Services
12	Amounts Collected and Receivable from Other Sources
13	Total Amounts Collected and Receivable
14	Comments

(b) Directions for Completion of the Sample Patient Log

The log should be maintained on a monthly basis with separate pages used for each month. Medicaid NF-1 patients should be listed in a separate section of the log so that Medicaid NF-1 program statistics can be generated. The columns should be completed and totaled as soon after the end of the month as the figures are available. Adjustments should be made to the monthly totals to reflect adjustments in the log due to changes in patient status, additional information, or other reasons. Complete explanations should accompany each adjustment. For non-program patients, columns 8 through 14 can be omitted or adapted for other uses.

Column 1. Patient Name--Enter the individual patient's name.

Column 2. Patient Days--Enter the patient days that the patient was charged for as this category of patient.

Column 3. Room and Board Charge--Enter the actual room and board charge, according to the facility's charge schedule, for the month.

Column 4. Total Other NF-1-Covered Charges--Enter the total of the charges other than room and board, according to the facility's charge schedule, for services covered by the NF-1 program.

Column 5. Total NF-1 Covered Charges--Enter the sum of column 3 and 4.

Column 6. Total NF-1Noncovered Charges--Enter the total of the charges, according to the facility's charge schedule, for services not covered by the NF-1 program.

Column 7. Total Actual Charges--Enter the sum of column 5 and column 6.

Column 8. Date Medicaid NF-1 Claim Paid--For each Medicaid NF-1 patient, enter the date that each claim was paid by the Department of Health. For other types of patients, leave blank or adapt for other use.

Column 9. Amounts Collected and Receivable From NF-1 Program--For each Medicaid NF-1 patient, enter the amount paid by and receivable from the Department of Health. For other types of patients, leave blank or adapt for other use.

Column 10. Patient Income Applicable to NF-1 Covered Services--For each Medicaid NF-1 patient, enter the amount of each patient's income applicable to NF-1 services. For other types of patients, leave blank, or adapt for other use.

Column 11. Amounts Collected and Receivable from Patients for NF-1 Noncovered Services--For each Medicaid NF-1 patient, enter the amounts collected and receivable for services not covered by the NF-1 program. For other types of patients, leave blank, or adapt for other use.

Column 12. Amounts Collected and Receivable from Other Sources For each Medicaid NF-1 patient, enter the amounts collected from other sources. State the source under Column 14. For other types of patients, leave blank, or adapt for other use.

Column 13. Total Amounts Collected and Due--For each Medicaid NF-1 patient, enter the sum of columns 9, 10, 11, and 12. For other types of patients, leave blank, or adapt for other use.

Column 14. Comments--This column is for special notes relating to the entries in the log.

(7) Sample Entries to Patient Accounts, NF1 Turnaround Document, and the Patient Log.

Basic Data

	Example	Example	Example
Month-September 30 days	30	30	30
Comptroller's Office Rate Per Day	66.09	66.09	66.09
Charge Schedule:			
Room and Board Rate Per Day	60.00	70.00	66.09
NF-1 Covered Items Per Month	45.00	-------	30.00
NF-1 Noncovered Items Per Month	20.00	40.00	10.00
Patient Income Per Month (Form 2362)	482.70	482.70	482.70
Allowance Per Month	30.00	30.00	30.00

Example 1 - Basic charge is for Room and Board only for private paying patients, all other supplies and services are charged as used.

(a) Patient Account Entries

(Rule 1200-13-6-.10, continued)

Date	Debit	Credit	Other Account	Nature of Charge or Credit
9/1	1,800.00		Revenue-Medicaid NF-1 Covered Services	Room & Board Charge ($60.00 x 30 days)
9/1		482.70	Cash	Collection of Patient Income Based on 2362 Information
9/30	45.00		Revenue-Medicaid NF-1 Covered Services	NF-1 Covered Items for September
9/30	20.00		Revenue-Medicaid NF-1 for September	NF-1 Noncovered Items
	Non-covered Services			
9/30		20.00	Cash	Collection for NF-1
	Non-covered Items from			Patient Personal Needs Funds
9/30		45.00	Contractual Adjustment	To adjust charge for covered services to contractual limits
10/31		1,500.00	Cash	Medicaid NF-1 Payment
	$1,865.00	$2,047.70		

*Patient account balance applicable to September is $182.70 overcollected

$66.09 x 30 = $1,982.70

(b) NF-1 TURNAROUND DOCUMENT

Number of Days of Service	30
Rate Assigned by the Comptroller of the Treasury	$66.09

$66.09 x 30 days = $1,982.70
Less 2362 Amount 482.70

$1,500.00

(c) Patient Log (See Example 1)

*An adjustment must be filed with the State of Tennessee.

Example 2 Basic charge is an all inclusive rate for all patients. No extra charges to any patients for routine covered service items are made. Non-covered services are charged to all patients.

(d) Patient Account Entries

(Rule 1200-13-6-.10, continued)

Date	Debit	Credit	Other Account	Nature of Charge or Credit
9/1	2,100.00		Revenue-Medicaid NF-1 Covered Services	Room & Board Charge (70.00 x 30 days)
9/1		482.70	Cash	Collection of Patient Income Based on 2362 Information
9/30	40.00		Revenue-Medicaid NF-1 Noncovered Services	NF-1 Non-Covered Items for September
9/30		30.00	Cash	Collection for NF-1 Noncovered Items from Patient Personal Needs Funds
9/30		117.30	Contractual Adjustment	To adjust charge for Covered Services to Contractual Limits
10/31		1,500.00	Cash	Medicaid NF-1 Payment
	$2,140.00	$2,130.00		

Patient account balance applicable to September is $10.00. This balance is solely due to charges for noncovered services. This amount can be collected from personal funds if such funds are or become available.

(e) NF-1 TURNAROUND DOCUMENT

Number of Days of Service 30

Rate Assigned by the Comptroller of the Treasury $66.09

$66.09 x 30 days = $1,982.70
Less 2362 Amount 482.70

$1,500.00

(f) Patient Log (See Example 2)

*An adjustment must be filed with the State of Tennessee.

Example 3 -Basic charge is for Room and Board only for private paying patients, all other supplies and services are charged as used.

(g) Patient Account Entries

(Rule 1200-13-6-.10, continued)

Date	Debit	Credit	Other Account	Nature of Charges or Credit
9/1	1,982.70		Revenue-Medicaid NF-1 Covered Services	Room & Board Charge (66.09 x 30 days)
9/1		482.70	Cash	Collection of Patient Income Based on 2362 Information
9/30	30.00		Revenue-Medicaid NF-1 Covered Services	NF-1 Covered Items for September
9/30	10.00		Revenue-Medicaid NF-1 Noncovered Services	NF-1 Noncovered Items for September
9/30		10.00	Cash	Collection for NF-1 Noncovered Items from Patient Personal Needs Funds
9/30		30.00	Contractual Adjustment	To Adjust Charge for Covered Services to Contractual Limits
10/31		1,500.00	Cash	Medicaid NF-1 Payment
	$2,022.70	$2,022.70		

Patient account balance applicable to September is zero.

(h) NF-1 TURNAROUND DOCUMENT

Number of Days of Service	30
Rate Assigned by the Comptroller of the Treasury	$66.09
$66.09 x 30 days =	$1,982.70
Less 2362 Amount	482.70
	$1,500.00

(i) Patient Log (See Example 3)

(Rule 1200-13-6-.10, continued)

PATIENT NAME (1)	PATIENT DAYS (2)	ROOM AND BOARD CHARGE (3)	TOTAL OTHER NF1 COVERED CHARGES (4)	TOTAL NF1 COVERED CHARGES (5)	TOTAL NF1 NONCOVERED CHARGES (6)	TOTAL ACTUAL CHARGE (7)	DATE MEDICAID NF1 CLAIM PAID (8)
EXAMPLE 1	30	$1,800.00	$45.00	$1,845.00	$20.00	$1,865.00	10/31
EXAMPLE 2	30	$2,100.00	$0.00	$2,100.00	$40.00	$2,140.00	10/31
EXAMPLE 3	30	$1,982.70	$30.00	$2,012.70	$10.00	$2,022.70	10/31

	AMOUNTS COLLECTED FROM NF1 PROGRAM (9)	PATIENT INCOME APPLICABLE TO NF1 COVERED SERVICES (10)	AMOUNTS COLLECTED FROM PATIENTS FOR NF1 NONCOVERED SERVICES (11)	AMOUNTS COLLECTED FROM OTHER SOURCES (12)	TOTAL AMOUNTS COLLECTED (13)	COMMENTS (14)
EXAMPLE 1 (continued)	$1,500.00	$482.70	$20.00	$0.00	$2,002.70	$182.70 OVERPAYMENT TO BE REFUNDED TO NF1 PROGRAM. $45.00 CONTRACTUAL ADJUSTMENT.
EXAMPLE 2 (continued)	$1,500.00	$482.70	$30.00	$0.00	$2,012.70	$117.30 CONTRACTUAL ADJUSTMENT.
EXAMPLE 3	$1,500.00	$482.70	$10.00	$0.00	$1,992.70	$30.00 CONTRACTUAL ADJUSTMENT.

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, 71-5-109, and Executive Order 23.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed June 15, 1989; effective July 30, 1989. Amendment filed August 17, 1990; effective October 1, 1990. Amendment filed September 14, 1992; effective October 29, 1992. Amendment filed August 17, 1995; effective October 31, 1995. Amendment filed July 15, 1996; effective September 28, 1996. Amendment filed May 18, 2000; effective August 2, 2000.*

1200-13-6-.11 NURSING FACILITY ALLOWABLE COMPENSATION RANGES.

(1) ALLOWABLE COMPENSATION RANGES FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED IN AN INDIVIDUAL NURSING FACILITY.

(a) Administrator:

Bed Size	Base Allowance	Amount Per Each Bed	In Excess of	To A Maximum of
25 or under	$20,230	$--		$10,230
26 - 50	20,621	390.34	26 beds	29,989
51 - 75	30,352	362.25	51 beds	39,046
76 - 100	39,213	169.75	76 beds	43,287
101 - 150	43,368	79.22	101 beds	47,250
151 & above	47,329	79.22	151 beds	59,274

(b) Other Positions:

	1-50 Beds	51-100 Beds	101-150 Beds	151 & Above Beds
Assistant or Co-Administrator	$--	$26,171	$27,020	$28,153
Bookkeeper1	7,401	20,230	22,351	24,474
Licensed Dietitian	23,767	24,616	25,323	26,738
Dietary Supervisor	15,702	17,684	19,522	21,502
Dietary Worker	14,429	14,429	14,429	14,429
Housekeeping Supervisor	14,855	16,552	17,964	19,664
Housekeeper	14,429	14,429	14,429	14,429
Laundry Supervisor	--	--	17,401	17,964
Laundry & Linen Worker	14,429	14,429	14,429	14,429
Maintenance Man	19,664	19,664	19,664	19,664
Medical Director	33,387	33,387	33,387	33,387
Director of Nursing	27,160	28,292	29,989	33,387
Registered Nurse	25,039	25,888	26,738	28,009
Licensed Practical Nurse	19,380	20,230	20,795	21,502
Speech, Occupational, Physical, Recreational Therapist	26,738	26,738	26,738	26,738
Attendants, Orderlies, Aides	15,702	15,702	15,702	15,702
Recreational Director Activity Coordinator Social Activities Director	15,702	15,702	15,702	15,702
	16,409	16,409	16,409	16,409
Medical Records Clerk	17,684	18,391	19,098	19,664
Secretary	20,514	20,514	20,514	20,514

(c) The above are maximum limits of allowable compensation to owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed on percentage of time spent. For purposes of this rule, a normal work week is defined as 40 hours.

(d) If the facility has under 51 beds, only (1) Administrator and/or Business Manager is allowed, and the rate is set according to bed size/Administrator table.

(e) Allowances for any position not specifically listed herein will be based on other comparable positions and other available information.

(Rule 1200-13-6-.11, continued)

(f) Allowances for any position shall not exceed the administrator's compensation.

(g) Other items of consideration to be used in adjustments to these maximum allowances are:

1. necessity of services provided and duties performed by the individual,

2. the time period during which these duties were performed,

3. accounting period bed changes based on dates of change,

4. other relevant circumstances and data verified by the Comptroller of the Treasury.

(h) Allowable compensation amounts shown above will be increased annually effective with cost reports ending June 30 and later based on the preliminary Skilled Nursing Facility Market Basket Index as computed by Health Care Financing Administration, Office of the Actuary, Division of National Cost Estimate, current as of June 30, but in no case will the annual compensation adjustment exceed 10%.

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, 71-5-109, Executive Order No. 1 of 1995, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed June 15, 1989; effective July 30, 1989. Amendment filed August 17, 1995; effective October 31, 1995. Amendment filed July 15, 1996; effective September 28, 1996.*

1200-13-6-.12 ALLOWABLE COMPENSATION RANGES FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED BY PARENT COMPANIES WHOSE SUBSIDIARY OR DIVISION PARTICIPATES IN THE BUREAU OF TENNCARE NURSING FACILITY LEVEL I PROGRAM.

(1) Chief Operating Executive:

Bed Size	Base Allowance	Amount Per Each Bed	In Excess of	To A Maximum of
200 and under	$27,729	$--	--	$27,729
201 - 500	27,746	19.81	201 beds	33,668
501 - 1,000	33,686	18.68	501 beds	43,005
1001 - 2,000	43,023	18.25	1,001 beds	61,254
2,001 and over	61,271	17.24	2,001 beds	160,421

(2) Other Positions:

	Allowance as % of Chief Operating Executive Compensation	Maximum
Medical Director (M.D.)	90%	N/A
Assistant Chief Operating Executive, Controller, Corporate Secretary, Treasurer, Attorney	75%	N/A
Accountant, Business Manager, Purchasing Agent, Regional Administrator, Regional VicePresident, Regional Executive Consultants, (Social Activities, Dietary, (R.D.), Physical Therapist (RPT), Medical Records (RRA),	70%	$36,356

(Rule 1200-13-6-.12, continued)

Nursing (B.S.R.N.))	65%	29,143
Secretaries/Clerks	25,514	
Bookkeepers		24,474

(3) The above are maximum limits of allowable cost for owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed according to time spent. For purposes of this rule, a normal work week is defined as 40 hours.

(4) No assistant operating executive will be authorized for a chain with 200 beds or less.

(5) If chief operating executive is a licensed administrator and is actually performing the duties of administrator in one of the facilities, those owner/administrator guidelines will apply.

(6) Other items of consideration to be used in adjustments to these maximum allowances:

(a) services provided to the facilities by home office,

(b) positions filled and duties performed by other personnel in the home office compared to related positions and duties performed by other personnel in the individual facilities,

(c) comparable salaries that would have to be paid to non-owners for the same services,

(d) accounting period bed changes based on dates of change, and

(e) other relevant circumstances and data verified by the Comptroller of the Treasury.

(7) Allowable compensation amounts will be increased annually using the same percentage that is developed under 1200-13-6-.11(8).

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed June 15, 1989; effective July 30, 1989.*

1200-13-6-.13 ESTABLISHMENT OF PER DIEM REIMBURSEMENT RATES.

(1) The Comptroller of the Treasury will establish per diem reimbursement rates for nursing facility Level I services provided to Tennessee Medicaid recipients.

(2) The Comptroller of the Treasury will use:

(a) the cost report required by rule 0380-1-10-.07,
(b) budgeted information supplied by the provider,
(c) the charge system of the provider, and
(d) any other data the Comptroller considers relevant in rate determination.

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.*

1200-13-6-.14 MAXIMUM AMOUNT OF REIMBURSABLE COST PAYABLE TO A PROVIDER.

(1) The maximum amount of reimbursable cost payable to a provider as provided for in these rules and regulations shall be the lesser of:

(a) The usual and customary charges for comparable services of a particular provider; or

(Rule 1200-13-6-.14, continued)

(b) A maximum program-wide rate for Nursing facility Level I services as may be established by the Department in consultation with the Department of Finance and Administration; or

(c) An allowable amount as determined by the Comptroller of the Treasury in accordance with the Department's rules. In the event that an item is not addressed in the Department's rules, Medicare principles of retrospective cost reimbursement shall apply.

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed august 17, 1995; effective October 31, 1995.*

1200-13-6-.15 AUDITING OF COST REPORTS. The cost reports filed in accordance with the rules above and all provider records pertaining thereto shall be subject to audit by the Comptroller of the Treasury or his agents. The cost reports filed in accordance with the rules above must provide adequate cost and statistical data. This data must be based on and traceable to the provider's financial and statistical records and must be adequate, accurate and in sufficient detail to support payment made for services rendered to beneficiaries. This data must also be available for and capable of verification by the Comptroller of the Treasury or his agents. The provider must permit the Comptroller or his agents to examine any records and documents necessary to ascertain information pertinent to the determination of the proper amount of program payments due. Data reflected on the cost report which cannot be substantiated may be disallowed with reimbursement being required of the provider.

Authority: *T.C.A. §§14-23-105, 14-23-109, 14-23-130, and 4-5-202.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988.*

1200-13-6-.16 RECORDS RETENTION. Each provider of Level I nursing facility services is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the cost report, and the provider is required to make such records available upon demand to representatives of the State Department of Health, the State Comptroller of the Treasury, or the United States Department of Health and Human Services.

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed January 12, 1988; effective February 26, 1988. Amendment filed August 17, 1995; effective October 31, 1995.*

RULES
OF
THE DEPARTMENT OF HEALTH AND ENVIRONMENT

CHAPTER 1200 - 13 - 7
RESERVED

RULES
OF
TENNESSEE DERPARTMENT OF HEALTH AND ENVIRONMENT
DIVISION OF MEDICAID

CHAPTER 1200-13-8
SKILLED NURSING HOME PROGRAM

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1200-13-8-.01 DETERMINATION OF REIMBURSABLE COST FOR SKILLED NURSING CARE. The Department, in consultation with the Comptroller of the Treasury and the Tennessee Health Care Association, shall establish the rules and regulations for the determination of the reimbursable per diem cost for those institutions or distinct parts thereof providing skilled nursing care. The Department may establish the maximum amount to be paid to such institutions.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.02 APPROVAL OF THE DEPARTMENT REQUIRED FOR PARTICIPATION. Only those institutions or distinct parts thereof designated and certified by, and contracting with, the Department as rendering skilled nursing care may participate and be reimbursed as a provider under these provisions. The Department shall notify the Comptroller of the Treasury when a provider enters the program and when its participation terminates.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.03 COVERED SERVICES. The specific items and services covered under skilled nursing care shall be those defined and approved by the Department. Noncovered services may be charged directly to the recipient.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.04 BILLING PROCEDURE. Institutions or distinct parts thereof rendering skilled nursing care shall bill the Department on the forms and in the manner designated by the Department.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.05 CHARGES TO SKILLED NURSING FACILITY RECIPIENTS. The charge schedule of a provider must be applied uniformly to all patients as services are furnished. Appropriate writeoffs or adjustments shall be made to each Medicaid recipient's account to reduce the gross charges to the contractual or legal collection limits of the Medicaid Program.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.06 EXTENT OF REIMBURSEMENT. The per diem reimbursable costs of institutions or distinct parts thereof rendering skilled nursing care shall be reimbursable by the State as provided in Rule 1200-13-8-.14 with the remainder not allowable as outside support from other sources. The provider shall be limited to reimbursable per diem as the maximum it may collect from all sources for program services.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.07 ESTABLISHMENT OF PROSPECTIVE PER DIEM COST RATES. The Comptroller of the Treasury will establish prospective per diem reimbursement rates for the institutions or distinct parts thereof rendering Level II nursing care (formerly referred to as skilled nursing care). The Comptroller of the Treasury shall consider the charge system of the provider, prior cost date, results of audits, budgeted information supplied by the provider in instances of new facilities, and any other relevant data submitted by the provider in establishing these rates.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989. Amendment filed July 15, 1996; effective September 28, 1996.*

1200-13-8-.08 SUBMISSION OF COST REPORTS BY PROVIDERS.

(1) In-state and out-of-state Providers of Medicaid Level II nursing care will be required to contract with the Department and submit to the Comptroller of the Treasury a pro-forma (budgeted) cost report upon beginning participation as a new provider. Leases and changes of ownership are not considered new providers for this purpose and thus no budgeted cost reports are filed for leases or changes in ownership. Thereafter, cost reports shall be filed at their fiscal year end on forms designated by the Department. The report shall be due within three (3) months after the end of the designated fiscal period or the alternative due date designated by Medicare if applicable. An extension may be requested for due cause. Such cost reports must be completed in accordance with Medicare reimbursement principles except where these rules may specify otherwise. All covered charges are to be in accordance with the Medicaid Program definition of covered services. Also, all charges to Medicaid recipients must be made consistently and in accordance with the providers schedule of charges in effect for the period covered for all patients. In the event that a provider does not file the required cost report by the due date, the provider shall be subject to a penalty of ten dollars ($10.00) per day in accordance with T.C.A. 12-4-304. In the event that a provider discovers a significant omission of costs, it may file an amended cost report at any time prior to the due date of its next annual cost report. After that time, the cost report cannot be amended for cost omissions. Amended cost reports shall be subject to the same requirements as other cost reports, and will be the only accepted means to claim omitted costs. Rate increases resulting from submission of omitted costs will not be retroactive.

(2) Providers of skilled nursing care that do not file cost reports required in this section or do not file the cost reports in a timely manner as provided in Medicare Principles of Reimbursement, in effect October 1, 1984, may be subject to sanctions as provided by the Medicare Principles of Reimbursement. Providers of skilled nursing care who fail to file cost reports for a specific period shall be subject to penalties in accordance with state law.

(3) After a period of five years following the implementation of Medicaid prospective payment for Level II nursing facility services on October 1, 1996, amended or corrected Level II nursing facility cost reports with claims for reimbursement for services prior to October 1, 1996 shall not be accepted.

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989. Amendment filed October 14, 1998; effective December 28, 1998. Amendment filed July 25, 2002; effective October 8, 2002.*

1200-13-8-.09 MAXIMUM COMPENSATION RANGES FOR OWNERS AND/OR THEIR RELATIVES. Effective for fiscal years ending June 30, 1984 and later, the following maximum compensation for owners and/or their relatives employed by an individual skilled care facility or by a parent company whose subsidiary or division participates in the Medicaid Skilled Care Program shall apply.

(1) MAXIMUM COMPENSATION FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED IN AN INDIVIDUAL SKILLED NURSING FACILITY.

(a) Administrator:

Bed Size	Base Allowance	Amount Per Each Bed	In Excess of	To A Maximum of
25 or under	$15,824	$--		$15,824
26 - 50	16,129	305.33	26 beds	23,457
51 - 75	23,741	283.29	51 beds	30,540
76 - 100	30,672	132.75	76 beds	33,858
101 - 150	33,922	61.96	101 beds	36,958
151 & above	37,019	61.96	151 beds	46,363

(b) Other Positions:

	1 - 50 Beds	51- 100 Beds	101- 150 Beds	151 & Above Beds
Assistant or Co-Administrator	$----	$20,471	$21,135	$22,020
Bookkeeper	13,611	15,824	17,483	19,143
Licensed Dietician	18,590	19,254	19,807	20,913
Dietary Supervisor	12,282	13,832	15,270	16,818
Dietary Worker	11,286	11,286	11,286	11,286
Housekeeping Supervisor	11,618	12,946	14,052	15,381
Housekeeper	11,286	11,286	11,286	11,286
Laundry Supervisor	---	---	13,611	14,052
Laundry & Linen Worker	11,286	11,286	11,286	11,286
Maintenance Man	15,381	15,381	15,381	15,381
Medical Director	26,114	26,114	26,114	26,114
Director of Nursing	21,244	22,130	23,457	26,114
Registered Nurse	19,585	20,249	20,913	21,909
Licensed Practical Nurse	15,159	15,824	16,265	16,818
Speech, Occupational, Physical, Recreational Therapist	20,913	20,913	20,913	20,913
Attendants, Orderlies, Aides	12,282	12,282	12,282	12,282
Recreational Director Activity Coordinator Social Activities Director	12,835	12,835	12,835	12,835
Medical Records Clerk	13,832	14,385	14,938	15,381
Secretary	16,045	16,045	16,045	16,045

(Rule 1200-13-8-.09, continued)

(c) The above are maximum limits of allowable compensation to owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed on percentage of time spent.

(d) If the facility has under 51 beds, only one (1) Administrator and/or Business Manager is allowed, and the rate is set according to bed size/Administrator table.

(e) Allowances for any position not specifically listed herein will be based on other comparable positions and other available information.

(f) Allowances for any position shall not exceed the administrator's compensation.

(g) Other items of consideration to be used in adjustments to these maximum allowances are:

1. necessity of services provided and duties performed by the individual,

2. the time period during which these duties were performed,

3. accounting period bed changes based on dates of change,

4. other relevant circumstances and data verified by the Comptroller of the Treasury.

(h) Allowable compensation amounts shown above will be adjusted annually effective with cost reports ending June 30 and later based on the preliminary Skilled Nursing Facility Market Basket Index as computed by Health Care Financing Administration, Office of the Actuary, Division of National Cost Estimate, current as of June 30, but in no case will the annual compensation adjustment exceed 10%.

(2) MAXIMUM COMPENSATION FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED BY PARENT COMPANIES WHOSE SUBSIDIARY OR DIVISION PARTICIPATES IN THE MEDICAID SKILLED NURSING PROGRAM

(a) Chief Operating Executive:

Bed Size	Base Allowance	Amount Per Each Bed	In Excess of	To A Maximum of
200 & Under	$21,688	$---	---	$21,688
201 500	21,703	15.49	201 beds	26,335
501 1,000	26,349	14.61	501 beds	33,638
1,001 2,000	33,652	14.27	1,001 beds	47,912
2,001 & over	47,925	13.49	2,001 beds	125,479

(b) Other Positions

	Allowance as % of Chief Operating Executive Compensation	Maximum
Medical Director (M.D.)	90%	
Assistant Chief Operating Executive, Controller, Corporate Secretary, Treasurer, Attorney	75%	

(Rule 1200-13-8-.09, continued)

	Allowance as % of Chief Operating Executive Compensation	Maximum
Accountant, Business Manager, Purchasing Agent, Regional Administrator, Regional ice President, Regional Executive	70%	$28,437
Consultants, (Social Activities, Dietary (R.D.), Physical Therapist (RPT), Medical Records (RRA), Nursing (B.S.R.N.)	65%	22,794
Secretaries/Clerks		16,045
Bookkeepers		19,143

The above are maximum limits of allowable cost for owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed according to time spent.

(c) No assistant operating executive will be authorized for a chain with 200 beds or less.

(d) If chief operating executive is a licensed administrator and is actually performing the duties of administrator in one of the facilities, those owner/administrator guidelines will apply.

(e) Other items of consideration to be used in adjustments to these maximum allowances:

1. services provided to the facilities by home office,

2. positions filled and duties performed by other personnel in the home office compared to related positions and duties performed by other personnel in the individual facilities,

3. comparable salaries that would have to be paid to nonowners for the same services,

4. accounting period bed changes based on dates of change, and

5. Other relevant circumstances and data verified by the Comptroller of the Treasury.

(f) Allowable compensation amounts will be adjusted annually using the same percentage that is developed under rule 1200-13-8-.09(1)(h).

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.10 EXPENSES RELATED TO DISALLOWED CAPITAL EXPENDITURES. Expenses related to disallowed capital expenditures, such as depreciation, interest on borrowed funds, the return on equity capital in the case of proprietary providers, and repairs are not allowable costs. Disallowed capital expenditures are those occurring on or after June 24, 1973, and on or before August 31, 1979, and that exceeds $100,000, or on or after September 1, 1979, and on or before July 17, 1984, that exceeds $150,000, and on or after July 18, 1984, and on or before April 17, 1985, that exceeds $500,000, and on or after April 18, 1985, and on or before June 30, 1987 that

(Rule 1200-13-8-.10, continued)

exceeds $1,000,000, and on or after July 1, 1987, that exceeds $1,500,000, or change the facility bed capacity, or substantially change the facility's services, and that have not been approved by the Tennessee Health Facilities Commission and or its successor agency.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.11 LEASE AND RENT EXPENSE. On a new lease negotiated after December 31, 1977, and renewal of such lease, the lesser of rent on real property or equipment or the amount of the lessor's depreciation, interest, other allowable costs, and return on equity capital, (for approved capital expenditures excluding expenses not considered allowable) in accordance with Rule 1200-138-.10, will be considered an allowable cost. Renewal of a lease negotiated before January 1, 1978, at the same rental amount or at an amount fixed or determinable according to conditions provided for in the original lease will not be considered a new lease according to this provision. This provision does not apply to the rental of equipment for periods of less than one year.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.12 CHANGE OF OWNERSHIP.

Additional capital costs due to revalued assets will be recognized only when an existing provider is purchased by another provider in a bona fide sale (arms length transaction). The new value for reimbursement purposes shall be the lesser of (1) the purchase price of the asset at the time of the sale, (2) the fair market value of the asset at the time of the sale (as determined by an MAI appraisal), (3) current reproduction cost of the asset depreciated on a straight line basis over its useful life to the time of the sale, or (4) for facilities under going a change of ownership on or after July 18, 1984, the acquisition cost to the first owner of record on or after July 18, 1984. The cost basis of depreciable assets in a sale not considered bona fide is additionally limited to (5) the seller's cost basis less accumulated depreciation. The purchaser has the burden of proving that the transaction is a bona fide sale should the issue arise. Gains realized from the disposal of depreciable assets while a provider is participating in the program are to be a deduction from allowable capital costs. All sales as of July 18, 1984, will be in compliance with the provisions of Section 2314 of DEFRA.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.13 RESERVED.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989. Repeal filed July 15, 1996; effective September 28, 1996.*

1200-13-8-.14 INCENTIVE PAYMENT. An incentive payment will be included in the reimbursable costs of Level II providers that sufficiently contain costs and maintain an average occupancy rate of 80% or greater. Skilled providers with operating costs less than the maximum reimbursable rate shall be eligible to receive a fifty percent (50%) cost-containment incentive for every dollar they are below the maximum reimbursement rate, limited to three dollars per patient day and by the maximum reimbursement rate. Operating costs are defined as total costs less capital-related costs.

Authority: *T.C.A. §§4-5-202, 12-4-301, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989. Amendment filed August 17, 1990; effective October 1, 1990. Amendment filed July 15, 1996; effective September 28, 1996.*

1200-13-8-.15 AUDITING OF COST REPORTS. The cost reports filed in accordance with the rules above and all provider records pertaining thereto shall be subject to audit by the Department, the Comptroller of the Treasury, or their agents. The cost reports filed in accordance with the rules above must provide adequate cost and statistical

(Rule 1200-13-8-.15, continued)

data. This data must be based on and traceable to the provider's financial and statistical records and must be adequate, accurate, and in sufficient detail, to support payment made for services rendered to beneficiaries. This data must also be available for and capable of verification by the Department, the Comptroller of the Treasury, or their agents. The provider must permit the Department, the Comptroller or their agents to examine any records and documents necessary to ascertain information pertinent to the determination of the proper amount of program payments due. Data as reflected on the cost report which cannot be substantiated shall be disallowed with reimbursement being required of the provider. The Department will provide for all costs of auditing performed under this provision. However, the costs of audits or other costs incurred in the preparation of cost reports are not covered by this provision.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

1200-13-8-.16 RECORDS RETENTION. Each provider of skilled nursing services is required to maintain adequate financial and statistical records which are accurate, and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the cost report, and the provider is required to immediately make such records available upon demand to representatives of the Department, the State Comptroller of the Treasury, or the United States Department of Health and Human Services, or their agents.

Authority: *T.C.A. §§4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 7, 1989; effective April 21, 1989.*

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH

DIVISION OF MEDICAID
CHAPTER 1200-13-9
PSYCHIATRIC HOSPITAL REIMBURSEMENT PROGRAM

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1200-13-9-.01 DEFINITIONS. The following definitions shall apply to Rules 1200-13-9-.02 through 1200-13-9-.14 inclusive, unless otherwise indicated.

(1) Capital Costs means those costs which are required or allowed by Title XVIII principles to be included in all depreciation columns on worksheet B of HCFA form 2552-85 (12/85). Capital costs shall not include costs associated with non-reimbursable cost centers.

(2) Direct Medical Education Costs means those costs associated with a nursing school or intern-resident services in an approved residency program which are required or allowed by Title XVIII principles to be included on worksheet B of HCFA form 2552-85 (12/85). Medical education costs shall not include costs associated with non-reimbursable cost centers, nor shall they include costs for routine, in-service training.

(3) Utilization Ratio means the ratio of Medicaid covered inpatient days attributable to patients determined eligible for Medicaid by the State of Tennessee to total inpatient days. Education costs are considered as a part of the operating component when educational services are an integral part of a recipient's acute inpatient psychiatric care involving active treatment pursuant to an individual plan of care developed by an interdisciplinary treatment team, and ordered by the recipient's attending physician.

(4) Medicaid Day means any part of a day, including the day of admission in which a person determined eligible for Medicaid by the State of Tennessee is admitted as an inpatient with the intention of remaining overnight. The day of discharge is not counted as a day. If admission and discharge occur on the same day, the day is considered one inpatient day.

(5) Operating Component means those costs, applicable to inpatient services only, which are required or allowed by Title XVIII principles to be included on worksheet E of HCFA form 2552-85 (12/85), including costs relating to hospital-based physicians if applicable, and COSTS for educational services when they are an integral part of a recipient's acute inpatient psychiatric care involving active treatment, pursuant to an individual plan of care developed by an interdisciplinary treatment team, and ordered by the recipient's attending physician, less the portion of capital-related and direct medical education costs attributable to patients determined eligible for Medicaid by the State of Tennessee.

(Rule 1200-13-9-.01, continued)

(6) Pass Through Component means the share which is attributable to patients determined eligible for Medicaid by the State of Tennessee of actual capital costs and actual direct medical education costs. Upon the effective date of these rules, the Services Tax will be an allowable cost included in the pass-through component.

(7) Title XVIII principles means, except where indicated otherwise, those Medicare principles which are applicable to hospitals, which were in effect on October 1, 1982, and which are described at 42 CFR Part 405.

(8) Base Year Cost Report for inpatient psychiatric services is the 12 month cost report (for each provider) ending in calendar year 1986. If a provider does not have a 12 month cost report ending within that time period, then the base year shall be the next preceding 12 month cost report. If there is no such cost report, then the base year shall be the most recently filed 12 month cost report. Inpatient psychiatric providers not meeting any of the above conditions shall be handled in accordance with Rule 1200-13-9-.11 NEW PROVIDERS.

(9) Hospital means both those health care facilities defined by *T.C.A. §68-11-201(10),* which are licensed by this Department and the Tennessee Board for Licensing Health Care Facilities pursuant to regulatory Chapter 1200-8-1, and those inpatient facilities licensed by the Tennessee Department of Mental Health and Mental Retardation, pursuant to *T.C.A. §33-2-501 et. seq.* as defined by regulatory chapter 0940-5-1-.06(l) and (3). "Hospital" also means the whole, or the distinct part, of a health care facility that has been certified by this Department and the Federal Health Care Financing Administration to participate as a provider of Medicaid inpatient hospital services (as defined by the October 1, 1986, edition of 42 CFR 440. 10 and 440.140) or inpatient psychiatric services for individuals under twenty-one (21) (as defined by the October 1, 1986, edition of 42 CFR 440.160).

Authority: *T.C.A. §§4-5-202,12-4-301, 71-5-105 and 71-5-109, Public Chapter 913 of the Acts of 1992.* ***Administrative History:*** *Original rule filed June 2, 1988; effective July 17, 1988. Amendment filed September 25, 1992; effective November 9, 1992.*

1200-13-9-.02 DETERMINATION OF REIMBURSABLE COST. The Comptroller of the Treasury in accordance with this chapter of the Department's rules and regulations shall make the determination of reimbursable per them cost for hospitals.

Authority: *T.C.A. §§71-5-105, 71-5-109 and 4-5-202.* ***Administrative History****. Original rule filed June 2, 1992; effective July 17, 1988.*

1200-13-9-.03 APPROVAL OF THE DEPARTMENT REQUIRED FOR PARTICIPATION. Only those in situations or distinct parts thereof accredited by the Joint Commission on Accreditation of Hospitals as psychiatric facilities and contracting with Medicaid may participate and be reimbursed as providers under these provisions. The Department shall notify the Comptroller of the Treasury when a provider enters the program and when its participation terminates.

Authority*. T. C.A. §§71-5-105, 71-5-109 and 4-5-202.* ***Administrative History****: Original rule filed June 2, 1992; effective July 17, 1988.*

1200-13-9-.04 COST REPORTS REQUIRED.

(1) In order to be eligible for payment by the Medicaid program for hospital services provided to Tennessee Medicaid beneficiaries, providers, including those paid by a prospective method, are required at each provider's fiscal year end, upon termination of provider status, change in ownership, or enrollment as a new provider, as per Rule 1200-13-9-.11, to submit to the

(Rule 1200-13-9-.04, continued)

Comptroller of the Treasury an annual cost report on forms designated by the Department. This report shall be submitted not later than three months from the end of each provider's fiscal year. Such cost reports must be completed in accordance with the Medicare principles of cost reimbursement set out in the Medicare Provider Reimbursement Manual, in effect on October 1, 1982, except where the Department may specify otherwise by these rules.

(2) Providers which fail to submit cost reports which comply with Title XVIII principles in effect on October 1, 1982 and described at 42 CFR Part 405 shall be subject to penalties imposed by such regulations. Except as stated in Rule 1200-13-9-.07(3), hospitals not filing cost reports for a specified period shall be required to refund all payments made under this program for that period.

(3) To be eligible to receive payment, contracting hospitals shall use uniform hospital statistics and classification of accounts as published by the American Hospital Association for all accounting records, or any other acceptable accounting methods approved by the Department of Health and Environment in consultation with the Comptroller and the Tennessee Hospital Association. However, accounts, statistics and records pertaining to "medical indigents", "bad debts" and "charity" shall be classified as defined by *T.C.A. §68-1-109*, as amended by Chapter 319 of the Public Acts of 1987.

(4) After a period of five years following the implementation of the TennCare Program on January 1, 1994, amended or corrected hospital cost reports with claims for reimbursement for services prior to January 1, 1994 shall not be accepted.

Authority: *T.C.A. §§71-5-105,71-5-109 and 4-5-202.* ***Administrative History****. Original rule filed June 2,1988; effective July 17, 1988. Amendment filed October 14, 1998; effective December 28, 1998.*

1200-13-9-.05 BILLING PROCEDURE. Institutions or distinct parts thereof rendering hospital care shall bill the Department or other agency or organization designated by the Department on the forms and in the manner designated. No provider shall charge for Medicaid patients more than is charged for private paying patients for equivalent accommodations and services.

Authority: *T.C.A. §§71-5-105, 71-5-109 and 4-5-202.* ***Administrative History****: Original rule filed June 2,1988, effective July 17, 1988.*

1200-13-9-.06 APPLICATION OF PROSPECTIVE PAYMENT METHOD. Except for those providers exempted by the provisions of Rule 1200-13-9-.07, all Medicaid providers of inpatient psychiatric services shall be paid by the prospective methods set forth in this chapter. For hospitals, or distinct parts thereof, certified to participate in Medicaid as providers of inpatient psychiatric services to persons under the age of twenty-one (21) these provisions apply to dates of service beginning on, or after, July 1, 1988. For institutions for mental diseases or distinct parts thereof, that are certified to participate in Medicaid as providers of inpatient hospital services for individuals age sixty-five (65) or older, these provisions apply to dates of service beginning on, or after, July 1, 1988. These effective dates apply without regard to the provider's fiscal year end.

Authority*: T.C.A. §§71-5-105,71-5-109 and 4-5-202.* ***Administrative History.*** *Original rule filed June 2,1988; effective July 17, 1988.*

1200-13-9-.07 PROVIDERS EXEMPTED FROM PROSPECTIVE PAYMENT SYSTEM. The prospective payment system shall not apply to the following hospitals and services:

(1) Any health care facility that is not a "hospital", as defined by Rule 1200-13-9-.01(9), skilled nursing facilities and intermediate care facilities located within hospitals when certified or licensed as "nursing" homes and swing beds, while being used to provide nursing services at less than the acute level of hospital care.

(Rule 1200-13-9-.07, continued)

(2) Inpatient services provided before July 1, 1988, by providers of either inpatient psychiatric services to persons under the age of twenty-one (21), or inpatient hospital services in institutions for mental disease to individuals age sixty-five (65) or older.

(3) Psychiatric hospitals which elect not to submit a cost report and which have less than $10,000 annually, based on the provider's fiscal year, in total charges to patients determined eligible for Medicaid by the State of Tennessee. Such providers shall be reimbursed an amount not to exceed 80% of reasonable charges for covered items billed by the provider. Reasonable charges are those which are charged by comparable providers for similar services. In the event that providers exceed $10,000 in total Tennessee Medicaid charges annually, they will be treated as new providers as specified in Rule 1200-13-9-.11.

(4) Outpatient hospital services, as defined by the October 1, 1986, edition of 42 CFR 440.20.

***Authority**: T.C.A. §§71-5-105, 71-.5-109 and 4-.5-202.* ***Administrative History**: Original rule filed June 2,1988; effective July 17, 1988.*

1200-13-9-.08 PROSPECTIVE PAYMENT METHODOLOGY.

(1) Except as provided by other provisions of this chapter, each hospital's reimbursable inpatient costs will be determined in accordance with Medicare Title XVIII principles from a base year cost reporting period, as defined by Rule 1200-13-9-.01(8). Costs will be separated into an operating component (defined by Rule 1200-13-9-.01(5)) and a pass-through component (defined by Rule 1200-13-9-.01(6). A trending factor (defined by Rule 1200-13-9-.08(3)) will be applied to the operating component only. The prospective rate will consist of the trended operating component. Tennessee Medicaid costs will be determined by a computed utilization ratio (defined by Rule 1200-13-9-.01(3)) from HCFA Form 2552 which must be submitted by the provider. The prospective payment (operating costs) will be made as a rate per inpatient day. On and after July 1, 1988, in psychiatric hospitals and institutions for mental disease, which dates apply without regard to the date upon which the provider's fiscal year may end, the pass-through component will not be a part of the per diem rate, but will, instead, be paid in lump sum amounts on a monthly basis.

(2) Pass Through Component

(a) For inpatient services in psychiatric facilities on or after July 1, 1988, irrespective of provider fiscal year end, the reimbursable per diem rate will consist of only the operating component. The remaining components: capital, direct medical education, and return on equity will be paid in a lump sum amount. Capital, direct medical education, and return on equity costs will be estimated from each provider's most recent cost report on file as of 4:30 p.m. C.D.T., Monday, June 30, 1988. The estimates will be used to compute a lump sum amount for capital, direct medical education, and return on equity. Payments will be made monthly starting July 1, 1988. Each provider's subsequent cost report will be used to adjust the capital, direct medical education, and return on equity for the subsequent fiscal year. This adjustment shall be effective on the first day of the next month, one month subsequent to the date of receipt of the provider's cost report. Capital, direct medical education, and return on equity costs will be subject to year end cost settlement for inpatient psychiatric services on and after July 1, 1988. Upon the effective date of these rules, the Services Tax will be an allowable cost included in the pass-through component.

(b) Additional costs due to revalued assets will be recognized only when an existing provider is purchased by another provider in a bona fide sale (arms length transaction). The new value for reimbursement purposes shall be the lesser of (1) the purchase price of the asset at the time of the sale, (2) the fair market value of the asset at the time of the sale (as determined by an MAI appraisal), (3) current reproduction cost of the asset depreciated on a straight line basis over its useful life to the time of the sale, or (4) for facilities undergoing a change of

(Rule 1200-13-9-.08, continued)

ownership on or after July 18, 1984, the acquisition cost to the first owner of record on or after July 18, 1984. The purchaser has the burden of proving that the transaction is a bona fide sale should the issue arise. Gains realized from the disposal of depreciable assets while a provider is participating in the program are to be a deduction from allowable capital costs.

(c) The payment of return on equity (for Proprietary providers only) will be determined by Medicare principles of cost reimbursement, 42 CFR Part 405, in effect on August 1, 1983 providing that, effective April 20, 1983, return on equity shall be adjusted to reflect 100% of the average rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

1. The return on equity for acute care and psychiatric proprietary provider will be reduced as follows: for cost reporting periods beginning after September 1986, payment will be 75% of the current amount; 50 % of the current amount for reporting periods beginning after September 1987; 25 % of the current amount for reporting periods beginning after September 1988; and zero thereafter.

(d) Beginning with fiscal years beginning July 1, 1987 and later, capital costs will be reduced by 3.5% for dates of service July 1, 1987 through September 30, 1987, by 7 % for dates of service October 1, 1987 through December 31, 1987, by 12% for dates of service January 1, 1988 through September 30, 1988 and by 15% for dates of service October 1, 1988 through September 30, 1989, by 0% for dates of service October 1, 1989 through December 31, 1989, and by 15 % for dates of service January 1, 1990 and later. Reduction will be figured into year end final settlements. Hospitals designated as Sole Community Hospitals are exempt from percentage reductions in capital costs. Upon the effective date of these rules, hospitals will be reimbursed 100% of their capital costs.

(3) Operating Component - Each facility's initial prospective rate shall also include an operating component which is computed from the base year cost report. In base years all providers including providers that are within the first three years of operation will be subject to the routine per diem cost limitations for prospective rate purposes. The routine per diem limitations for these purposes will be set in the same manner as those used for acute care hospitals. All new providers may have their prospective rate adjusted at the end of the first five year period. The operating component will be trended forward each year. The trending period shall be from the midpoint of each hospital's base year to the midpoint of the hospital's first cost reporting period subject to prospective payment. Trending to the new rebased year (1988 cost reports or if not available the prior cost report) will be computed by utilizing the indexing rate recommended by the Prospective Payment Assessment Commission, applied from the end of the hospital's fiscal year to October 1, 1989.

Thereafter, the treading index shall be that rate of increase on prospective payments as recommended by the Prospective Payment Assessment Commission and as published in the *Tennessee Administrative Register*. The trending indexes above shall be applied from October 1, 1989, to the midpoint of the state's fiscal year, no earlier than December 31, 1990, and shall be effective the first of the state's fiscal year, no earlier than July 1, 1990. When necessary, indexes will be prorated to correspond to the provider's year end. Each provider will be notified of their new operating rate due to indexing within 30 days of the beginning of the state’s fiscal year.

Medical malpractice insurance reimbursement will be limited to 7.5% of allowable malpractice insurance premiums for prospective rate purposes.

Education costs are considered as a part of the operating component, when educational services are an integral part of a recipients acute inpatient psychiatric care involving active treatment, pursuant to an individual plan of care developed by an inter-disciplinary treatment, and ordered by the recipient's attending physician.

(Rule 1200-13-9-.08, continued)

***Authority**: T.C.A. §§4-5-202, 12-4-301, 71-5-105 and 71-5-109; Public Chapter 913 of the Acts of 1992. **Administrative History**: Original rule filed June 2, 1988; effective July 17, 1988. Amendment filed August 8. 1990, effective September 22, 1990. Amendment filed September 25, 1992, effective November 9, 1992. Amendment filed November 17, 1983; effective January 31, 1994.*

1200-13-9-.09 MINIMUM OCCUPANCY ADJUSTMENT. Capital costs shall be adjusted each year, using the formula set out below, if a facility's occupancy rate, based on staffed beds during the year, is below a minimum level. If a hospital exceeds its minimum occupancy rate, the formula is not applied. The minimum level is as follows:

Hospitals over 100 beds - 70% Hospitals with 100 beds or fewer - 60%

The adjustment will be computed as follows and will be made at the same time as the pass through adjustment as set out in rule 1200-13-9-.08.

$$ACC = TCC \times \frac{T'BD}{ABD\ (Y)}$$

ACC = allowable capital costs
TCC = total capital costs
TBD = total beds used during the period
ABD = total bed days available during the period
Y = .6 for hospitals with 100 beds or fewer
= .7 for hospitals over 100 beds

All references to beds mean staffed beds. Staffed beds mean those beds which are equipped and available for patient use. Any beds or hospital wing which is unavailable for patient use, such as being closed for reasons including but not limited to, painting, maintenance, or insufficient nursing staff will not be considered staffed beds. It shall be the responsibility of the provider to determine, at least monthly, its number of staffed beds. A schedule showing the number of staffed and unstaffed beds, along with the reasons for being unstaffed, must be submitted with the cost report. This schedule is subject to audit in accordance with rule 1200-13-9-.14. If no schedule of staffed beds is received, staffed beds will be the number of beds at the end of the cost report period. For psychiatric providers, the minimum occupancy, adjustment will apply to services on and after July 1, 1988. The minimum occupancy adjustment will be applied before the adjustment specified in rule 1200-13-9.08(2)(d). Effective October 1, 1989, Tennessee Medicaid will not impose a minimum occupancy penalty.

***Authority**: T.C.A. §§4-5-202, 12-4-301, 71-5-105 and 71--5-109. **Administrative History**: Original rule filed June 2, 1988; effective July 17, 1988. Amendment filed August 8, 1990; effective September 22, 1990.*

1200-13-9-.10 MEDICAID DISPROPORTIONATE SHARE ADJUSTMENT (MDSA).

(1) Effective July 1, 1988, inpatient psychiatric hospitals having a utilization ratio at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments or a low income utilization rate exceeding 25 percent will receive a 1% adjustment to the prospective rate for each percentage above the 14% up to a cap of 3%; or a 2% adjustment to the prospective rate for each percentage above the 25% low income utilization rate up to a cap of 3%.

(a) Low income utilization rate will be calculated as follows and will use information obtained from the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of.

1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost

(Rule 1200-13-9-.10, continued)

reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost report period; and,

2. The total amount of the hospitals charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.

(b) No total payment of the disproportionate share adjustment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics.

(c) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.

(d) Beginning July 1, 1988, the disproportionate share adjustment will be paid on a monthly basis and established in June of each year. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July-June. This will be estimated based on projections from historical experience and the addition of any expected improvements.

(2) Effective July 1, 1989, psychiatric hospitals having over 3,000 patient days attributable to patients determined eligible for Medicaid by the state of Tennessee or a utilization ratio of 14% or one standard deviation above the mean utilization ratio for all hospitals, whichever is lower, will be provided a payment incentive. The MDSA shall not be subject to trending. The MDSA will be the higher of (a) or (b) but shall not exceed 34%.

(a) The prospective rate will be adjusted upward by 6% for each 1% increment in the utilization rate above 14% or one standard deviation above the mean, whichever is lower.

(b) The prospective rate will be adjusted upward by 6% for each increment of 1,000 reimbursed inpatient reported Medicaid days over 3,000 and the prospective rate will be increased upward by 3% if total days exceed 3,650 but are less than 4,000.

(c) No total payment of the disproportionate share adjustment will exceed 80% of inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics.

(d) Psychiatric hospitals that do not qualify under the criteria in (2) but have a low-income inpatient utilization rate exceeding 25% will receive the following payment incentive:

1. The prospective rate will be adjusted upward by 2% for each percentage above 25% up to a cap of 10%.

(Rule 1200-13-9-.10, continued)

2. No total payment of the disproportionate share adjustment will exceed 80% of inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics.

3. Low income utilization rate will be calculated as follows from information obtained from the latest Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:

(I) Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,

(ii) The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.

(e) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.

(f) The disproportionate share adjustment will be paid on a monthly basis and established in June of each year. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July - June. This will be estimated based on projections from historical experience and the addition of any expected improvements.

(3) Effective October 1, 1992, psychiatric hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or a 9.31 % Medicaid utilization ratio or having a low income utilization rate equal to or greater than 25 % will be provided a payment incentive (MDSA). The MDSA will be the higher of (a), (b), or (c) but cannot exceed 10% of inpatient and outpatient charity charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purposes of this rule, Medicaid days will not include days reimbursed by the Primary Care Network. For the purposes of this rule charity, unless otherwise specified, will be defined as inpatient and outpatient charity charges (including medically indigent, low income, and medically indigent other), bad debt, and Medicare and Medicaid contractual adjustments adjusted to cost. Charity will include charges for both in-state and out-of-state services.

(a) The prospective rate will be adjusted upward by a factor of 5.8 times the difference between the actual utilization rate and a 9.31% utilization rate.

(Rule 1200-13-9-.10, continued)

(b) The prospective rate will be adjusted upward by 5.8% times the number of days above 1,000 days divided by 1,000 days.

(c) The prospective rate will be adjusted upward by 2% times the difference between the low income utilization rate and a 25% low income utilization rate. This adjustment will be capped at 10%.

(d) Low-income utilization rate will be calculated as follows from information obtained from the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:

1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and

2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan) that is reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.

(e) Each year a predetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.

(f) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days. This will be estimated based on projections from historical experience and the addition of any expected improvements.

(g) The total amount of MDSA payments for both acute care and psychiatric hospitals will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments based on subparagraph (g) of paragraph (9) of the amendment to rule 1200-13-5-.11, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment.

(4) Effective July 1, 1993, psychiatric hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or a 10.45% Medicaid utilization ratio or having a low income utilization rate equal to or greater than 25% will be provided a payment incentive (MDSA). The MDSA will be the higher of (a), (b), or (c) but cannot exceed 10% of inpatient and outpatient "charity" charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purpose of this rule Medicaid days will not include days reimbursed by the Primary Care Network. For the purpose of this rule "charity", unless otherwise specified, will be defined as inpatient and outpatient "charity" charges (including medical), indigent, low income, and medically indigent other), bad debt, and Medicare and

(Rule 1200-13-9-.10, continued)

Medicaid contractual adjustments adjusted to cost. "Charity" will include charges for both instate and out-of-state services.

(a) The prospective rate will be adjusted upward by a factor of 5.8 times the difference between the actual utilization rate and a 10.45% utilization rate.

(b) The prospective rate will be adjusted upward by 5.8% times thc number of days above 1,000 days divided by 1,000 days.

(c) The prospective rate will be adjusted upwards by 2% times the difference between the low income utilization rate and a 25% low income utilization rate. This adjustment will be capped at 10%.

(d) Low-income utilization rate will be calculated as follows from information obtained from the 1991 Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:

1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from the state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and

2. The total amount of the hospital's charges for inpatient hospital services attributable to "charity care" (care provided to individuals who have no source of payment, thirty-party or personal resources(in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to "charity care" shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State Plan) that are reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.

(e) Each year a redetermination of the MDSA will be made at the same time the new pass-through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.

(f) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the number of Medicaid days reported on the 1992 cost report. In cases where the 1992 report is unavailable, the latest report on file will be used.

(g) The total amount of MDSA for both acute care and psychiatric hospitals will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments based on subparagraph (g) of paragraph (10) of the amendment to rule 1200-13-5-.11, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment.

***Authority**: T.C.A. §§12-4-301, 71-5-105, 71-5-109 and 4-5-202.* ***Administrative History:** Original rule filed August 2, 1989; effective September 16, 1989. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed January 20, 1993; effective March 6, 1993.*

1200-13-9-.11 RATE OR PAYMENT ADJUSTMENTS

(1) Prospective per diem rate or lump sum payment amounts are subject to adjustment in the event of a mistake.

(2) Operating per diem rates may be adjusted if there is a significant change in case mix resulting in a $25,000 effect on Tennessee Medicaid reimbursement. Case mix, for this purpose, is a diagnostic or therapeutic related factor requiring either an increase or decrease in the professional staff per patient ratio. Requests for adjustments must be accompanied by detailed supporting information. Such rate adjustments if approved become effective on the first day of the month following the approval.

(3) Providers may request an increase in monthly interim payments for return on equity, capital, and direct medical education if a provider's actual amounts are expected to exceed the estimated amount by at least 25%. Supporting financial data must be submitted with the request. No more than one request per year for an increase will be accepted per provider. The Commissioner reserves the right, after notifying the provider, to decrease estimated payments when information is made available indicating the estimated payments are materially higher than what is actually being incurred.

***Authority**: TC.A. §§71-5-105, 71-5-109 and 4--5-202. **Administrative History**: Original rule filed June 2, 1992; effective July 17,1988. Amendment renumbering 1200-13-.I0 through 1200-13-.14 to read 1200-13-.11 through 1200-13-.15 filed January 29, 1990; effective March 15, 1990.*

1200-13-9-.12 NEW PROVIDERS. New providers who have not submitted a cost report and who are entering the program for the first time will be required to submit a budgeted cost report from which an interim prospective operating rate will be set. Each new provider must submit, in accordance with rule 1200-13-9-.04 an actual cost report covering the first full year of actual operations, at which point a final prospective operating rate, with a retroactive adjustment, will be used. A change of ownership does not constitute a new provider. The budgeted cost report will also be used to estimate interim payments for capital, direct medical education, and return on equity.

***Authority**: T.C.A. §§71-5-105, 71-5-109 and 4-5-202. **Administrative History** :Original rule filed June 2,1988; effective July 17,1988. Amendment renumbering 1200-13-.10 through 1200-13-.14 to read 1200-13-.11 through 1200-13-.15 filed January 29, 1990; effective March 15, 1990.*

1200-13-9-.13 LOWER OF COST OR CHARGES LIMIT. In the base year, the lower of cost or charges limitation will be waived for prospective rate determination purposes only. The limitation will, however, be applied for settlement purposes for all periods prior to a facility's first Fiscal year under prospective payment. Carry forwards of unreimbursed costs will not be recognized once a provider's initial Fiscal year under the prospective payment method has begun.

***Authority:** T.C.A. §§ 71-5-105, 71-5-109 and 4-5-202. **Administrative History.** Original rule filed June 2, 1988; effective July 17, 1988. Amendment renumbering 1200-13-.10 through 1200-13-.14 to read 1200-13-.11 through 1200-13-.15 filed January 29, 1990; effective March 15, 1990.*

1200-13-9-.14 METHOD FOR PAYING PROVIDERS WHICH ARE EXEMPT FROM PROSPECTIVE SYSTEM.

(1) The Comptroller of the Treasury, will determine, in accordance with Medicare principles of cost reimbursement in effect on October 1, 1982, and described at 42 CFR Part 405, per diem reimbursable costs for those Medicaid providers of psychiatric hospital services exempted from the prospective system set out in Rules 1200-13-9-.06 through 1200-13-9-.12 inclusive, except

(Rule 1200-13-9-.14, continued)

those hospitals described in item (3) of Rule 1200-13-9-.07 which shall be reimbursable as described in that item. The maximum limit of such reimbursable costs shall be the lessor of: (a) the reasonable cost of covered services, or (b) the customary charges to the general public for such services. Provided, however, that such providers which are public hospitals rendering services free or at a nominal charge shall not be subject to the lower of cost or charges limitation but shall be paid fair compensation for services in accordance with provisions of 42 CFR Part 405 in effect on October 1, 1982. Covered services means covered services as defined by the Department. Each provider's per diem reimbursable cost will be based on the provider's cost report which is to be filled out and submitted in accordance with Rule 1200-13-9-.04.

(2) *Interim Rate.* The Comptroller of the Treasury will establish interim per diem reimbursable rates for providers "exempted from the prospective payment system. The interim rate remains in effect until the provider's actual reimbursable cost, based on the provider's cost report, is established. Interim rates shall be based on prior cost report data and shall be subject to revision upon further review, audit, and/or subsequent finding of the Comptroller of the Treasury. For new facilities, budgeted information supplied by the provider may be used to establish an interim rate.

(3) *Approval of Initial Settlement.*

When a provider's cost report is received, it is reviewed and compared with:

(a) The amount of charges for covered services provided to Medicaid beneficiaries by the provider during the provider's fiscal period.

(b) The amount of interim payments paid by the Department to the provider for the provider's fiscal period.

(c) The number of inpatient days approved for the provider by the Department during the provider's fiscal period.

On the basis of the comparison and review, the Comptroller of the Treasury will make an initial determination of the cost settlement due to the provider or the state for the designated period. Approval of the initial settlement will be subject to further review, audit, and/or subsequent finding of the comptroller of the Treasury. On the basis of the initial settlement, the Department or the fiscal agent will (as may be required) either make arrangements for an additional payment to the provider for services provided during the fiscal year or submit a claim to the provider requesting payment to the Department for the amount of overpayment to the provider during the fiscal year.

(4) *Approval of Final Cost Settlement.* After the necessary final review and/or auditing has been performed by the Comptroller of the Treasury, the Comptroller will advise the Department of the final cost settlement approved. On the basis of the approved final settlement, the Department or the fiscal agent will (as may be required) either make arrangements for an additional payment to the provider for services provided during the fiscal year or submit a claim to the provider requesting payment to the Department for the amount of overpayment made to the provider during the fiscal year.

(5) *Inpatient Routine Operating Per Diem Cost Limitation.* In the event that data is not available to compute the inpatient routine operating per diem cost limitation for all or any part of a provider's fiscal year, the Comptroller of the Treasury will use each provider's per diem cost limitation in effect prior to the provider's first fiscal year subject to prospective payment which will be appropriately trended, by that rate of increase on prospective payments allowed by Medicare as published annually in the *Federal Register* and in the *Tennessee Administrative Register*.

(Rule 1200-13-9-.14, continued)
***Authority**: T.C.A. §§71-5-105, 71-5-109 and 4-5-202. **Administrative History**: Original rule filed June 2, 1988; effective July 17, 1988. Amendment renumbering 1200-13-.10 through 1200-13-.14 to read 1200-13-.11 through 1200-13-.15 filed January 29, 1990; effective March 15, 1990.*

1200-13-9-.15 AUDIT

(1) All hospital cost reports are subject to audit at anytime by the Comptroller of the Treasury and the Department or their designated representative. Cost report data must be based on and traceable to the provider's financial statistical records and must be adequate, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. Retroactive adjustments to the prospective rate may be made for audit exceptions.

(2) Hospitals will be subject to medical audits at any time. Medical audits include, but are not limited to, "medical necessity" or "length of stay". Medical audit exceptions may result in a direct recoupment rather than a rate change.

(3) The Department will provide for all costs of auditing which may be required.

***Authority:** T.C.A. §§71-5-105, 71-5-109 and 4-5-202. **Administrative History**: Original rule filed June 2, 1988; effective July 17, 1988. Amendment renumbering 1200-13-.10 through 1200-13-.14 to read 1200-13-.11 through 1200-13-.15 filed January 29, 1990; effective March 15, 1990.*

1200-13-9-.16 TERMINATION OF MEDICAID PSYCHIATRIC HOSPITAL REIMBURSEMENT PROGRAM. For psychiatric hospital services provided prior to January 1, 1994, the rules as set out at rule chapter 1200-13-9 shall apply. Effective January 1, 1994, the rules of TennCare as set out at rule chapter 1200-13-12 shall apply except that Tennessee Medicaid will continue to pay Medicare premiums, deductibles and copayments in accordance with the Medicaid rules in effect prior to January 1, 1994, and as may be amended.

***Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993. **Administrative History**: Original rule filed March 18, 1994; effective June 1, 1994.*

RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION

CHAPTER 1200-13-10
BUREAU OF TENNCARE
REPEALED

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1200-13-10-.01	Repealed	1200-13-10-.04	Repealed
1200-13-10-.02	Repealed	1200-13-10-.05	Repealed
1200-13-10-.03	Repealed	1200-13-10-.06	Repealed

1200-13-10-.01 REPEALED.

***Authority**: T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Executive Order Number 23. **Administrative History**: Original rule filed June 12, 1991; effective July 27, 1991. Repeal filed November 30, 2007; effective February 13, 2008.*

1200-13-10-.02 REPEALED.

***Authority**: T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Executive Order Number 23. **Administrative History**: Original rule certified June 7, 1974; effective May 17, 1974. Amendment filed January 10, 1977, effective February 9, 1977. Amended filed March 13, 1978; effective April I2, 1978. Amendment filed May 7, 1979; effective June 21, 1979. Amendment filed October 28, 1981, effective December 14, 1981. Amendment filed June 12, 1991, effective July 27, 1991. Repeal filed November 30, 2007; effective February 13, 2008.*

1200-13-10-.03 REPEALED.

***Authority**: T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Executive Order Number 23. **Administrative History**: Original rule certified June 7, 1974; effective May 17, 1974. Repeal filed February 5, 1979; effective March 21, 1979. Amendment filed June 12, 1991, effective July 27, 1991. Repeal filed November 30, 2007; effective February 13, 2008.*

1200-13-10-.04 REPEAL.

***Authority:**. T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Executive Order Number 23. **Administrative History:** Original rule filed June 12, 1991; effective July 27, 1991. Repeal filed November 30, 2007; effective February 13, 2008.*

1200-13-10-.05 REPEALED.

***Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Executive Order Number 23. **Administrative History:** Original rule filed June 12, 1991; effective July 27, 1991. Repeal filed November 30, 2007; effective February 13, 2008.*

1200-13-10-.06 REPEALED.

***Authority:** T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order Number 23. **Administrative History**: Original rule filed March 18, 1994; effective June 1, 1994. Repeal filed November 30, 2007; effective February 13, 2008.*

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF MEDICAID

CHAPTER 1200-13-11
ADMINISTRATIVE FEES

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l200-13-11-.01 Fees

1200-13-11-.01 FEES.

(1) The Bureau of Medicaid hereby establishes fees for the reproduction of documents as follows:

	Service	Fee
(a)	Paper copy of records not requiring search (per page)	$ .75
(b)	Paper copy of records requiring search (per page)	$1.50
(c)	Microfiche copy of records, when available in microfiche (per microfiche page)	$ 3.04
(d)	Computer programming time, when necessary to produce records not currently available or in a different form/format than currently available, in addition to the copy costs describe, in (a) or (c) above (per one-half hour)	$18.00
(e)	The minimum total charge for computer programming time shall be	$108.00
(f)	Computer operational time for producing computer generated documents (per minute)	$ 1.75
(g)	Computer-generated output, paper, microfilm, microfiche, diskette, or tape (per 1,000 lines)	$ .60
(h)	The minimum total charge for reproduction of documents shall be	*$ 5.00*
(i)	In addition to the fees described above, a flat-rate charge for postage, shipping and handling will be assessed for documents which are mailed, faxed, shipped or otherwise transferred from the Bureau of Medicaid in any manner except hand-delivered at the Medicaid Administration building. This fee shall not be assessed for documents hand-delivered at the Medicaid Administration building.	$5.00

(2) The Bureau of Medicaid shall make records available for inspection during normal business hours upon request. When it is determined by the Bureau of Medicaid that considerable effort shall be required to locate or assemble records in a suitable work area, the request to inspect records shall be granted within a reasonable time. Such decision shall rest solely with the Bureau of Medicaid.

(3) The Bureau of Medicaid shall not permit records to be removed from the Bureau Administration building for purposes of inspection or reproduction except when directed to do so by court order.

(Rule 1200-13-11-01, continued)

(4) The Medicaid reproduction of documents fees and procedures for public inspections of records as set out in paragraph (1), (2), and (3) above will also be applicable to the Bureau of TennCare.

***Authority**: T.C.A. §§4-5-202. 71-5-105, 71-5-109 and Public Chapter 358 of the Acts of 1993.* ***Administrative History**: Original rule filed March 16, 1992; effective April 30, 1992. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed June 9, 1994; effective August 23, 1994.*

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1200-13-13-.01 DEFINITIONS.

(1) ABUSE shall mean enrollee practices, or enrollee involvement in practices, including overutilization, waste or fraudulent use/misuse of a TennCare Program that results in cost or utilization which is not medically necessary or medically justified. Abuse of a TennCare Pharmacy Program justifies placement on lock-in or prior approval status for all enrollees involved. Activities or practices which may evidence abuse of the TennCare Pharmacy Program include, but are not limited to, the following: forging or altering drug prescriptions, selling TennCare paid prescription drugs, failure to control pharmacy overutilization activity while on lock-in status and visiting multiple prescribers or pharmacies to obtain prescriptions that are not medically necessary.

(2) ACCESS TO HEALTH INSURANCE shall mean the opportunity an individual has to obtain group health insurance as defined elsewhere in these rules. If a person could have enrolled in work-related or other group health insurance during an employer's or group's open enrollment period and chose not to enroll (or had the choice made for him by a family member) that person shall not be considered to lack access to insurance upon closure of the open enrollment period. Neither the cost of an insurance policy or health plan nor the fact that an insurance policy is not as comprehensive as that of the TennCare Program shall be considered in determining eligibility to enroll in any TennCare category where being uninsured is an eligibility prerequisite.

(3) ADVERSE BENEFIT DETERMINATION shall mean, but is not limited to, a delay, denial, reduction, suspension or termination of TennCare benefits. See 42 C.F.R. § 438.400.

(4) APPLICATION PERIOD shall mean a specific time period determined by the Bureau of TennCare during which the Bureau will accept applications for the TennCare Standard Spend Down category as described in the Bureau's rules at 1200-13-14-.02.

(5) BENEFITS shall mean the health care package of services developed by the Bureau of TennCare and which define the covered services available to TennCare enrollees. Additional benefits are available through the TennCare CHOICES program, as described in Rule 1200-13-01-.05, and the ECF CHOICES program, as described in Rule 1200-13-01-.31. CHOICES benefits are available only to persons who qualify for and are enrolled in the CHOICES program. ECF CHOICES benefits are available only to persons who qualify for and are enrolled in the ECF CHOICES program.

(Rule 1200-13-13-.01, continued)

(6) BUREAU OF TENNCARE (BUREAU) shall mean the administrative unit of TennCare which is responsible for the administration of TennCare as defined elsewhere in these rules.

(7) CALL-IN LINE shall mean the toll-free telephone line used as the single point of entry during an open application period to accept new applications for the Standard Spend Down Program.

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

(9) CAPITATION RATE shall mean the amount established by the State for the purpose of providing payment to participating managed care contractors operating under a risk-based contract.

(10) CARETAKER RELATIVE shall mean that individual as defined at Tennessee Code Annotated § 71-3-153.

(11) CATEGORICALLY NEEDY shall mean that category of TennCare Medicaid-eligibles as defined at 1240-03-02-.02 of the rules of the Tennessee Department of Human Services - Division of Medical Services.

(12) CHOICES. See “TennCare CHOICES in Long-Term Care.”

(13) CHOICES 217-Like Group. See definition in Rule 1200-13-01-.02.

(14) CHOICES Group 1. See definition in Rule 1200-13-01-.02.

(15) CHOICES Group 2. See definition in Rule 1200-13-01-.02.

(16) CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) (formerly known as HCFA) shall mean the agency within the United States Department of Health and Human Services that is responsible for administering Title XVIII, Title XIX, and Title XXI of the Social Security Act.

(17) COBRA shall mean health insurance coverage provided pursuant to the Consolidated Omnibus Budget Reconciliation Act.

(18) CODE OF FEDERAL REGULATIONS (C.F.R.) shall mean Federal regulations promulgated to explain specific requirements of Federal law.

(19) COMMENCEMENT OF SERVICES shall mean the time at which the first covered service(s) is/are rendered to a TennCare member for each individual medical condition.

(20) COMMISSIONER shall mean the chief administrative officer of the Tennessee Department where the TennCare Bureau is administratively located, or the Commissioner’s designee.

(21) COMPLETED APPLICATION is an application where:

(a) All required fields have been completed;

(b) It is signed and dated by the applicant or the applicant’s parent or guardian;

(c) It includes all supporting documentation required by the TDHS or the Bureau to determine TennCare eligibility, technical and financial requirements as set out in these rules; and

(d) It includes all supporting documentation required to prove TennCare Standard medical eligibility as set out in these rules.

(22) CONTINUATION OR REINSTATEMENT OF BENEFITS (COB) shall mean the circumstances under which an enrollee may keep receiving, or, in the case of reinstatement, get back and keep receiving, the benefit under appeal until the appeal is resolved. See 42 C.F.R. §§ 431.230, 431.231 and 438.420.

(23) CONTINUOUS ENROLLMENT shall refer to the ability of certain individuals determined eligible for the TennCare Program to enroll at any time during the year. Continuous enrollment is limited to persons in the following two groups:

(a) TennCare Medicaid enrollees as defined in rule 1200-13-13-.02.

(b) Individuals who are losing their Medicaid, who are uninsured, who are under nineteen (19) years of age, and who meet the qualification for TennCare Standard as "Medicaid Rollovers," in accordance with the provisions of Rule 1200-13-14-.02.

(24) CONTRACT PROVIDER shall have the same meaning as Participating Provider.

(25) CONTRACTOR shall mean an organization approved by the Tennessee Department of Finance and Administration to provide TennCare-covered benefits to eligible enrollees in the TennCare Medicaid and TennCare Standard programs.

(26) CONTRACTOR RISK AGREEMENT (CRA) shall mean the document delineating the terms of the agreement entered into by the Bureau of TennCare and the Managed Care Contractors.

(27) CONTROLLED SUBSTANCE. A drug, substance, or immediate precursor identified by the U.S. Department of Justice, Drug Enforcement Administration or by the Tennessee Drug Control Act as having the potential for abuse and the likelihood of physical or psychological dependence if used incorrectly.

(28) CORE MEDICAID POPULATION shall mean individuals eligible under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq., with the exception of the following groups: individuals receiving SSI benefits as determined by the Social Security Administration; individuals eligible under a Refugee status; individuals eligible for emergency services as an illegal or undocumented alien; individuals receiving interim Medicaid benefits with a pending Medicaid disability determination; individuals with forty-five (45) days of presumptive or immediate eligibility; and children in DCS custody.

(29) COST-EFFECTIVE ALTERNATIVE SERVICE shall mean a service that is not a covered service but that is approved by TennCare and CMS and provided at an MCC's discretion. TennCare enrollees are not entitled to receive these services. Cost-effective alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in the MCC's judgment, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the MCC's judgment, would require more costly treatment in the future. Cost-effective alternative services need not be determined medically necessary except to the extent that they are provided as an alternative to covered Medicaid services. Even if medically necessary, cost effective alternative services are not covered services and are provided only at an MCC's discretion.

(30) COST SHARING shall mean the amounts that certain enrollees in TennCare are required to pay for their TennCare coverage and covered services. Cost sharing includes copayments.

(31) COVERED SERVICES shall mean the services and benefits that:

(a) TennCare contracted MCCs cover, as set out elsewhere in this Chapter and in Rule 1200-13-01-.05; or

(b) In the instance of enrollees who are eligible for and enrolled in federal Medicaid waivers under Section 1915(c) of the Social Security Act, the services and benefits that are covered under the terms and conditions of such waivers.

(32) CPT4 CODES are descriptive terms contained in the Physician's Current Procedural Terminology, used to identify medical services and procedures performed by physicians or other licensed health professionals.

(33) DBM (DENTAL BENEFITS MANAGER) shall mean a contractor approved by the Tennessee Department of Finance and Administration to provide dental benefits to enrollees in the TennCare Program to the extent such services are covered by TennCare.

(34) DELAY shall mean failure to provide timely receipt of TennCare services, and no specific waiting period may be required before the enrollee can appeal.

(35) DEMAND LETTER shall mean a letter sent by TennCare to a TennCare Standard enrollee with premium obligations notifying the enrollee that he is at least sixty (60) days delinquent in his premium payments.

(36) DISCONTINUED DEMONSTRATION GROUP shall mean the group of non-Medicaid eligible individuals who were enrolled in TennCare Standard on April 29, 2005, when the categories in which they were enrolled were terminated, and who have not yet been enrolled in TennCare Medicaid or disenrolled from the TennCare program.

(37) DISENROLLMENT shall mean the discontinuance of an individual's enrollment in TennCare.

(38) DURABLE MEDICAL EQUIPMENT (DME) shall mean equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, is suitable for use in any non-institutional setting in which everyday life activities take place, and is related to the patient's physical disorder. Orthotics and prosthetic devices, and artificial limbs and eyes are considered DME. Non-institutional settings do not include a hospital or nursing facility (NF). Routine DME items, including but not limited to wheelchairs (except as defined below), walkers, hospital beds, canes, commodes, traction equipment, suction machines, patient lifts, weight scales, and other items provided to a member receiving services in a NF that are within the scope of per diem reimbursement for NF services shall not be covered or reimbursable under the Medicaid program separate and apart from payment for the NF service. Customized orthotics, prosthetics, wheelchairs, wheelchair seating systems, and other items that are beyond the scope of Medicaid reimbursement for NF services shall be covered by the member's managed care organization, so long as such items:

(a) Are medically necessary for the continuous care of a member; and

(b) Must be custom-made or modified or may be commercially available, but must be individually measured and selected to address the member's unique and permanent medical need for positioning, support or mobility; and

(c) Are solely for the use of that member and not for other NF residents.

(39) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES, a covered benefit for TennCare Medicaid-enrolled children only, shall mean:

(Rule 1200-13-13-.01, continued)

(a) Screening in accordance with professional standards, and interperiodic, diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare Medicaid enrollees under age twenty-one (21); and

(b) Health care, treatment, and other measures, described in 42 U.S.C. § 1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.

(40) ELIGIBLE shall mean a person who has been determined to meet the eligibility criteria of TennCare Medicaid or TennCare Standard.

(41) Employment and Community First (ECF) CHOICES shall mean the program defined in Rule 1200-13-01-.02 and described in Rule 1200-13-01-.31.

(42) ENROLLEE shall mean an individual eligible for and enrolled in the TennCare program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the US Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act. As concerns MCC compliance with these rules, the term only applies to those individuals for whom the MCC has received at least one day's prior written or electronic notice from the TennCare Bureau of the individual's assignment to the MCC.

(43) ENROLLMENT shall mean the process by which a TennCare-eligible person becomes enrolled in TennCare.

(44) ESCORT shall mean an individual who accompanies an enrollee to receive a medically necessary service. For the purpose of determining whether an individual may qualify as an escort who may be transported without cost to the enrollee as a covered TennCare benefit, the following criteria apply:

(a) Any person over the age of twelve (12) selected by the enrollee;

(b) Any person under the age of twelve (12) is presumed to be too young to serve as an escort. At the time of request for transportation, this presumption can be overcome by specific facts provided by the enrollee, which would demonstrate to a reasonable person that the proposed escort could in fact be of assistance to the enrollee; and

(c) Any person under the age of six (6) is excluded in all cases from the role of escort.

(45) FAMILY shall mean that as defined in the rules of the Tennessee Department of Human Services found at 1240-01-03 and 1240-01-04, Family Assistance Division, and 1240-03-03, Division of Medical Services.

(46) FEDERAL FINANCIAL PARTICIPATION (FFP) shall mean the Federal Government's share of a state's expenditure under the Title XIX Medicaid Program.

(47) FINAL AGENCY ACTION shall mean the resolution of an appeal by the TennCare Bureau or an initial decision on the merits of an appeal by an administrative judge or hearing officer when such initial decision is not modified or overturned by the TennCare Bureau. Final agency action shall be treated as binding for purposes of these rules.

(48) FRAUD shall mean an intentional deception or misrepresentation made by a person who knows or should have known that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(Rule 1200-13-13-.01, continued)

(49) GRAND DIVISIONS shall mean the three (3) distinct geographic areas of the State of Tennessee, known as Eastern, Middle, and Western, as designated in Tennessee Code Annotated § 4-1-201.

(50) GROUP HEALTH INSURANCE shall mean an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly through insurance reimbursement mechanism. This definition includes those types of health insurance found in the Health Insurance Portability And Accountability Act of 1996, as amended, definition of creditable coverage (with the exception that the 50 or more participants criteria does not apply), which includes Medicare and TRICARE. Health insurance benefits obtained through COBRA are included in this definition. It also covers group health insurance available to an individual through membership in a professional organization or a school.

(51) HANDICAPPING MALOCCLUSION shall mean a malocclusion which causes one of the following medical conditions:

(a) A nutritional deficiency that has proven non-responsive to medical treatment without orthodontic treatment. The nutritional deficiency must have been diagnosed by a qualified treating physician and must have been documented in the qualified treating physician's progress notes. The progress notes that document the nutritional deficiency must predate the treating orthodontist's prior authorization request for orthodontics.

(b) A speech pathology that has proven non-responsive to speech therapy without orthodontic treatment. The speech pathology must have been diagnosed by a qualified speech therapist and must have been documented in the qualified speech therapist's progress notes. The progress notes that document the speech pathology must predate the treating orthodontist's prior authorization request for orthodontics.

(c) Laceration of soft tissue caused by a deep impinging overbite. Occasional cheek biting does not constitute laceration of soft tissue. Laceration of the soft tissue must be documented in the treating orthodontist's progress notes and must predate the treating orthodontist's prior authorization request for orthodontics.

Anecdotal information is insufficient to document the presence of a handicapping malocclusion. The presence of a handicapping malocclusion must be supported by the treating professional's progress notes and patient record.

(52) HEALTH INSURANCE, for the purposes of determining eligibility under these regulations:

(a) Shall mean:

1. Any hospital and medical expense-incurred policy;

2. Medicare;

3. TRICARE;

4. COBRA;

5. Medicaid;

6. State health risk pool;

7. Nonprofit health care service plan contract;

(Rule 1200-13-13-.01, continued)

8. Health maintenance organization subscriber contracts;

9. An employee welfare benefit plan to the extent that the plan provides medical care to an employee or his/her dependents (as defined under the terms of the plan) directly through insurance, any form of self insurance, or a reimbursement mechanism;

10. Coverage available to an individual through membership in a professional organization or a school;

11. Coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between the individual and the insurance company;

12. Any of the above types of policies where:

(i) The policy contains a type of benefit (such as mental health benefits) which has been completely exhausted;

(ii) The policy contains a type of benefit (such as pharmacy) for which an annual limitation has been reached;

(iii) The policy has a specific exclusion or rider of non-coverage based on a specific prior existing condition or an existing condition or treatment of such a condition; or

13. Any of the types of policies listed above will be considered health insurance even if one or more of the following circumstances exists:

(i) The policy contains fewer benefits than TennCare;

(ii) The policy costs more than TennCare; or

(iii) The policy is one the individual could have bought during a specified period of time (such as COBRA) but chose not to do so.

(b) Shall not mean:

1. Short-term coverage;

2. Accident coverage;

3. Fixed indemnity insurance;

4. Long-term care insurance;

5. Disability income contracts;

6. Limited benefits policies as defined elsewhere in these rules;

7. Credit insurance;

8. School-sponsored sports-related injury coverage;

9. Coverage issued as a supplemental to liability insurance;

(Rule 1200-13-13-.01, continued)

10. Automobile medical payment insurance;

11. Insurance under which benefits are payable with or without regard to fault and which are statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

12. A medical care program of the Indian Health Services (IHS) or a tribal organization;

13. Benefits received through the Veteran's Administration; or

14. Health care provided through a government clinic or program such as, but not limited to, vaccinations, flu shots, mammograms, and care or services received through a disease- or condition-specific program such as, but not limited to, the Ryan White Care Act.

(53) HEALTH MAINTENANCE ORGANIZATION (HMO) shall mean an entity licensed by the Tennessee Department of Commerce and Insurance under applicable provisions of Tennessee Code Annotated (T.C.A.) Title 56, Chapter 32 to provide health care services.

(54) HEALTH PLAN shall mean a Managed Care Organization authorized by the Tennessee Department of Finance and Administration to provide medical and behavioral services to enrollees in the TennCare Program.

(55) HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

(56) HOME HEALTH SERVICES shall mean:

(a) Any of the services identified in 42 C.F.R. § 440.70 and delivered in accordance with the provisions of 42 C.F.R. § 440.70. "Part-time or intermittent nursing services" and "home health aide services" are covered only as defined specifically in these rules.

1. Part-time or intermittent nursing services.

(i) To be considered "part-time or intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, and no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide services combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

(ii) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on a p.r.n. (as needed) basis. Nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period. If there is more than one person in a household who is determined to require TennCare-reimbursed home health nursing services, it is not necessary to have multiple nurses providing the services. A single nurse may provide services to multiple

enrollees in the same home and during the same hours, as long as he can provide these services safely and appropriately to each enrollee.

(iii) The above limits may be exceeded when medically necessary for children under the age of 21.

2. Home health aide services.

(i) Home health aide services must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. If there is more than one person in a household who is determined to require TennCare-reimbursed home health aide services, it is not necessary to have multiple home health aides providing the services. A single home health aide may provide services to multiple enrollees in the same home and during the same hours, as long as he can provide these services safely and appropriately to each enrollee.

(ii) The above limits may be exceeded when medically necessary for children under the age of 21.

(b) Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:

1. The child is non-ambulatory; and

2. The child has no or extremely limited ability to interact with caregivers; and

3. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g. the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and

4. No other children requiring adult care or supervision shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult, unless these children meet all the criteria stated above and are also receiving TennCare-reimbursed home health services.

(57) HEARING OFFICER shall mean an administrative judge or hearing officer who is not an employee, agent or representative of the MCC or who did not participate in, nor was consulted about, any TennCare Bureau review prior to the State Fair Hearing (SFH).

(58) INCOME shall mean that definition of income in rule 1240-01-04 of the Tennessee Department of Human Services - Family Assistance Division.

(Rule 1200-13-13-.01, continued)

(59) INDIVIDUAL HEALTH INSURANCE shall mean health insurance coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between that person and the insurance company.

(60) INITIATING PROVIDER shall mean the provider who renders the first covered service to a TennCare member whose current medical condition requires the services of more than one (1) provider.

(61) INMATE shall mean an individual confined in a local, state, or federal prison, jail, youth development center, or other penal or correctional facility, including a furlough from such facility.

(62) IN-NETWORK PROVIDER shall have the same meaning as Participating Provider.

(63) INPATIENT REHABILITATION FACILITIES shall mean rehabilitation hospitals and distinct parts of hospitals that are designated as 'IRFs' by Medicare.

(64) LICENSED MENTAL HEALTH PROFESSIONAL shall mean a Board eligible or a Board certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy with a current valid license by the Tennessee Licensing Board for the Healing Arts.

(65) LIMITED BENEFITS POLICY shall mean a policy of health coverage for a specific disease (e.g., cancer), or an accident occurring while engaged in a specified activity (e.g., school-based sports), or which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (e.g., hospital indemnity).

(66) LOCK-IN PROVIDER. A provider, pharmacy or physician, chosen by an enrollee on pharmacy lock-in status to whom the enrollee is assigned by TennCare for the purpose of receiving covered pharmacy services.

(67) LOCK-IN STATUS. The restriction of an enrollee to a specified physician, or to a specified pharmacy provider at a specified single location.

(68) LONG-TERM CARE shall mean programs and services described under Rule 1200-13-01-.01.

(69) MCC (MANAGED CARE CONTRACTOR) shall mean:

(a) A Managed Care Organization, Pharmacy Benefits Manager and/or a Dental Benefits Manager which has signed a TennCare Contractor Risk Agreement with the State and operates a provider network and provides covered health services to TennCare enrollees; or

(b) A Pharmacy Benefits Manager, Behavioral Health Organization or Dental Benefits Manager which subcontracts with a Managed Care Organization to provide services; or

(c) A State government agency that contracts with TennCare for the provision of services.

(70) MCO (Managed Care Organization) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical, behavioral, and long-term care services in the TennCare Program.

(71) MEDICAID shall mean the federal- and state-financed, state-run program of medical assistance pursuant to Title XIX of the Social Security Act. Medicaid eligibility in Tennessee is

(Rule 1200-13-13-.01, continued)

determined by the Tennessee Department of Human Services, under contract to the Tennessee Department of Finance and Administration. Tennessee residents determined eligible for SSI benefits by the Social Security Administration are also enrolled in Tennessee's TennCare Medicaid program.

(72) MEDICAID "ROLLOVER" ENROLLEE shall mean a TennCare Medicaid enrollee who no longer meets technical eligibility requirements for Medicaid and will be afforded an opportunity to enroll in TennCare Standard in accordance with the provisions of these rules.

(73) MEDICAL ASSISTANCE shall mean health care, services and supplies furnished to an enrollee and funded in whole or in part under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq. and Tennessee Code Annotated §§ 71-5-101, et seq. Medical assistance includes the payment of the cost of care, services, drugs and supplies. Such care, services, drugs, and supplies shall include services of qualified providers who have contracted with an MCC or are otherwise authorized to provide services to TennCare enrollees (i.e., emergency services provided out-of-network or medically necessary services obtained out-of-network because of an MCC's failure to provide adequate access to services in-network).

(74) MEDICAL RECORD shall mean all medical histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; x-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical documentation in written or electronic format; and analyses of such information.

(75) MEDICAL SUPPLIES shall mean covered medical supplies that are deemed medically necessary and appropriate and are prescribed for use in the diagnosis and treatment of medical conditions. Medically necessary medical supplies not included as part of institutional services shall be covered only when provided by or through a licensed home health agency, by or through a licensed medical vendor supplier or by or through a licensed pharmacist.

(76) MEDICALLY ELIGIBLE shall mean a person who has met the medical eligibility criteria for the TennCare Standard program through a mechanism permitted under the provisions of these rules.

(77) MEDICALLY NECESSARY is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in these rules, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in the Medical Necessity rule chapter at 1200-13-16.

(78) MEDICALLY NEEDY shall mean that category of TennCare Medicaid-eligibles as defined in rule 1240-03-02-.03 of the Tennessee Department of Human Services - Division of Medical Services.

(79) MEDICARE shall mean the program administered through the Social Security Administration pursuant to Title XVIII, available to most individuals upon attaining age sixty-five (65), to some disabled individuals under age sixty-five (65), and to individuals having End Stage Renal Disease (ESRD).

(80) MEMBER shall mean a TennCare Medicaid- or TennCare Standard-eligible individual who is enrolled in a managed care organization.

(81) NON-CONTRACT PROVIDER shall have the same meaning as Non-Participating Provider.

(Rule 1200-13-13-.01, continued)

(82) NON-PARTICIPATING PROVIDER shall mean a TennCare provider, as defined in this Rule, who is not contracted with a particular enrollee's MCO. This term may include TennCare providers who furnish services outside the managed care program on a fee-for-service basis, as well as TennCare providers who receive Medicare crossover payments from TennCare.

(83) NON-TENNCARE PROVIDER shall mean a provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.

(84) OPEN ENROLLMENT shall mean a designated period of time, determined by the Bureau of TennCare, during which persons who are not currently TennCare eligible may apply for the Standard Spend Down program.

(85) OPEN MEDICAID CATEGORIES shall mean those Medicaid eligibility categories for which enrollment has not been closed pursuant to authority granted by CMS as part of the TennCare demonstration project.

(86) OUT-OF-NETWORK PROVIDER shall have the same meaning as Non-Participating Provider.

(87) OUT-OF-STATE EMERGENCY PROVIDER shall mean a provider outside the State of Tennessee who does not participate in TennCare in any way except to bill for emergency services, as defined in this Chapter, provided out-of-state to a particular MCC's enrollee. An Out-of-State Emergency Provider is not required to enroll with TennCare, but for the episode for which he is recognized as an Out-of-State Emergency Provider, he must abide by all TennCare rules and regulations, including those concerning provider billing of enrollees as found in Rule 1200-13-13-.08. In order to receive payment from TennCare, Out-of-State Emergency Providers must be appropriately licensed in the state in which the emergency services were delivered, and they must not be excluded from participation in Medicare or Medicaid.

(88) OVERUTILIZATION shall mean any of the following:

(a) The enrollee initiated use of TennCare services or supplies at a frequency or amount that is not medically necessary or medically justified.

(b) Overutilization, or attempted overutilization, of the TennCare Pharmacy Program which justifies placement on lock-in status for all enrollees involved.

(c) Activities or practices which may evidence overutilization of the TennCare Pharmacy Program including, but not limited to, the following:

1. Treatment by several physicians for the same diagnosis;

2. Obtaining the same or similar controlled substances from several physicians;

3. Obtaining controlled substances in excess of the maximum recommended dose;

4. Receiving combinations of drugs which act synergistically or belong to the same class;

5. Frequent treatment for diagnoses which are highly susceptible to abuse;

6. Receiving services and/or drugs from numerous providers;

7. Obtaining the same or similar drugs on the same day or at frequent intervals; or

8. Frequent use of the emergency room in non-emergency situations in order to obtain prescription drugs.

(89) PARTICIPATING PROVIDER shall mean a TennCare provider, as defined in this Rule, who has entered into a contract with an enrollee's Managed Care Contractor.

(90) PBM (PHARMACY BENEFITS MANAGER) shall mean an organization approved by the Tennessee Department of Finance and Administration to administer pharmacy benefits to enrollees to the extent such services are covered by the TennCare Program. A PBM may have a signed TennCare Contractor Risk Agreement with the State, or may be a subcontractor to an MCO.

(91) PERSONAL CARE SERVICES shall refer to an optional Medicaid benefit defined at 42 C.F.R. § 440.167 that, per the Tennessee Medicaid State Plan, Tennessee has not elected to include in the TennCare benefit package. To the extent that such services are available to children under the age of 21 when medically necessary under the provisions of EPSDT, the Bureau of TennCare designates home health aides as the providers qualified to deliver such services. When medically necessary, personal care services may be authorized outside of the home setting when normal life activities temporarily take the recipient outside of that setting. Normal life activity for a child under the age of 21 means routine work (including work in supported or sheltered work settings); licensed child care; school and school-related activities; religious services and related activities; and outpatient health care services (including services delivered through a TennCare home and community based services waiver program). The home health aide providing personal care services may accompany the recipient but may not drive. Normal life activities do not include non-routine or extended home absences.

(92) PHYSICIAN shall mean a person licensed pursuant to chapter 6 or 9 of title 63 of the Tennessee Code Annotated.

(93) POVERTY LEVEL shall mean the poverty level established by the Federal Government.

(94) POWER SEATING ACCESSORIES. Accessories available to modify a power wheelchair base are covered by TennCare when all listed criteria are met as follows:

(a) Power Seat Elevation System.

1. It is ordered by the Enrollee's treating physician.

2. An assessment conducted by a licensed physical therapist or licensed occupational therapist establishes that:

(i) The Enrollee has the cognitive ability and enough upper extremity function to carry out mobility-related activities of daily living such as feeding, grooming, dressing, and transferring; and

(ii) The activities for which the accessory will be used are conducted primarily in the enrollee's home.

(b) Power Standing System.

1. It is ordered by the Enrollee's treating physician.

2. An assessment conducted by a licensed physical therapist or licensed occupational therapist establishes that the Enrollee:

(i) Has a chronic condition that causes him to have limited or no ability to stand; and

(ii) Has a physical condition that allows him to stand, when supported, for meaningful periods of time, i.e., he will not suffer loss of blood pressure or have problems with bowel or urine retention; and

(iii) Has the cognitive ability and enough upper extremity function to carry out mobility-related activities of daily living such as feeding, grooming, dressing, and transferring; and

(iv) Meets at least one other complex rehabilitation criterion for a power seat accessory such as a tilt seat and also qualifies for a Group 3 base Power Wheelchair.

(95) POWER WHEELCHAIR ACCESSORIES. All powered wheelchair accessories not defined in this rule as Power Seating Accessories are excluded from TennCare coverage but may be provided by an MCO as a cost effective alternative service as defined in this rule.

(96) PRESCRIBER. An individual authorized by law to prescribe drugs.

(97) PRIMARY CARE PHYSICIAN shall mean a physician responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

(98) PRIMARY CARE PROVIDER shall mean health care professional capable of providing a wide variety of basic health services. Primary care providers include practitioners of family, general, or internal medicine; pediatricians and obstetricians; nurse practitioners; midwives; and physician's assistant in general or family practice.

(99) PRIOR APPROVAL STATUS shall mean the restriction of an enrollee to a procedure wherein services, except in emergency situations, must be approved by the TennCare Bureau or the MCC prior to the delivery of services.

(100) PRIOR AUTHORIZATION shall mean the process under which services, except in emergency situations, must be approved by the TennCare Bureau or the MCC prior to the delivery in order for such services to be covered by the TennCare program.

(101) PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period.

(a) A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members. If there is more than one person in a household who is determined to require TennCare-reimbursed private duty nursing services, it is not necessary to have multiple nurses providing the services. A single nurse may provide services to multiple enrollees in the same home and during the same hours, as long as he can provide these services safely and appropriately to each enrollee.

(Rule 1200-13-13-.01, continued)

(b) If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home, that determines whether the nursing services are continuous or intermittent.

(c) Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:

1. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

2. Is ventilator dependent with a progressive neuromuscular disorder or spinal cord injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least 12 hours each day in order to avoid or delay tracheostomy (requires medical review); or

3. Has a functioning tracheostomy:

(i) Requiring suctioning; and

(ii) Oxygen supplementation; and

(iii) Receiving nebulizer treatments or requiring the use of Cough Assist/in-exsufflator devices; and

(iv) In addition, at least one subitem from each of the following items (I and II) must be met:

(I) Medication:

I. Receiving medication via a gastrostomy tube (G-tube); or

II. Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port; and

(II) Nutrition:

I. Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube); or

II. Receiving total parenteral nutrition.

(d) Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.

(e) A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period or an adult who needs nursing care but does not qualify for private duty

(Rule 1200-13-13-.01, continued)

nursing care per the requirements of these rules may receive medically necessary nursing care as an intermittent service under home health.

(f) General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have non-medical care needs which must be met, to the extent that private duty nursing services are provided to a person or persons under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

1. The child is non-ambulatory; and

2. The child has no or extremely limited ability to interact with caregivers; and

3. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse is present in the home without the presence of another responsible adult; and

4. No other children shall be present in the home during the time the private duty nurse is present in the home without the presence of another responsible adult, unless these children meet all of the criteria stated above and are also receiving TennCare-reimbursed private duty nursing services.

(102) PROVIDER shall mean an appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services. Providers are categorized as either TennCare Providers or Non-TennCare Providers. TennCare Providers may be further categorized as being one of the following:

(a) Participating Providers or In-Network Providers

(b) Non-Participating Providers or Out-of-Network Providers

(c) Out-of-State Emergency Providers

Definitions of each of these terms are contained in this Rule.

(103) PROVIDER-INITIATED REDUCTION, TERMINATION OR SUSPENSION OF SERVICES shall mean a decision to reduce, terminate, or suspend an enrollee's TennCare services which is initiated by the enrollee's provider, rather than by the MCC.

(104) PROVIDER WITH PRESCRIBING AUTHORITY shall mean, in the context of TennCare pharmacy services, a health care professional authorized by law or regulation to order prescription medications for his/her patients, and who:

(a) Participates in the provider network of the MCC in which the enrollee is enrolled; or

(b) Has received a referral of the enrollee, approved by the MCC, authorizing her to treat the enrollee; or

(c) In the case of a TennCare enrollee who is also enrolled in Medicare, is authorized to treat Medicare patients.

(Rule 1200-13-13-.01, continued)

(105) PRUDENT LAY PERSON shall mean a reasonable person who possesses an average knowledge of health and medicine.

(106) QUALIFIED LONG TERM CARE INSURANCE POLICY shall mean a long-term care insurance policy issued on or after October 1, 2008, that has been pre-certified by the Tennessee Department of Commerce and Insurance pursuant to Rule 0780-01-61 as:

(a) A policy that meets all applicable Tennessee Long Term Care Partnership requirements; or

(b) A policy that has been issued in another Partnership state and which is covered under a reciprocal agreement between such other state and the State of Tennessee.

(107) QUALIFYING MEDICAL CONDITION shall mean a medical condition which is included among a list of conditions established by the Bureau and which will render a qualified uninsured applicant medically eligible.

(108) QUALIFIED UNINSURED PERSON shall mean an uninsured person who meets the technical, financial, and insurance requirements for the TennCare Standard Program.

(109) READABLE shall mean easily understood language and format. See 42 C.F.R. § 438.10.

(110) REASSIGNMENT shall mean the process by which the Bureau of TennCare transfers an enrollee from one MCO to another as described in these rules.

(111) RECEIPT OF MAILED NOTICES shall mean that receipt of mailed notices is presumed to occur within five (5) days of mailing.

(112) RECERTIFICATION shall have the same meaning as Redetermination.

(113) RECONSIDERATION shall mean the mandatory process, triggered by an enrollee's request for a SFH, by which an MCC reviews and renders a decision affirming or reversing the MCC's adverse benefit determination. An MCC satisfies the plan-level requirements of 42 C.F.R. Part 438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a physician other than the original reviewing physician; and produces a timely written finding. See June 5, 2017, CMS letter from Jackie Glaze to Wendy Long, M.D., M.P.H.

(114) RESPONSIBLE PARTY(IES) shall mean the following individuals, who are representatives and/or relatives of recipients of medical assistance who are not financially eligible to receive benefits: parents, spouses, children, and guardians; as defined at Tennessee Code Annotated § 71-5-103(10).

(115) SSI (SUPPLEMENTAL SECURITY INCOME) BENEFITS shall mean the benefits provided through a program administered by the Social Security Administration for those meeting program eligibility requirements. Tennessee residents determined eligible for SSI benefits are automatically enrolled in TennCare Medicaid.

(116) STANDARD SPEND DOWN (SSD) shall mean the demonstration eligibility category composed of adults age twenty-one (21) and older who have been found to meet the criteria in rule 1200-13-14-.02.

(117) STATE FAIR HEARING (SFH) shall mean an evidentiary hearing requested by or on behalf of an enrollee to allow the enrollee to appeal an adverse benefit determination, which is conducted in accordance with 42 C.F.R. Part 431 Subpart E and the Tennessee Uniform Administrative Procedures Act, T.C.A. §§ 4-5-301, et seq. An initial order under T.C.A. § 4-5-

(Rule 1200-13-13-.01, continued)

314 shall be entered when an evidentiary hearing is held before a hearing officer. If any party appeals the initial order under T.C.A. § 4-5-315, the Commissioner may render a final order.

(118) TARGETED PHARMACY. A pharmacy meeting one of the following criteria:

(a) It is located outside the State of Tennessee.

(b) It has had previous controlled substance violations with the Tennessee State Board of Pharmacy.

(c) It appears to be an outlier to the norm in its dispensing of controlled substances.

(d) It has filled controlled substance prescriptions that are covered by TennCare for members locked in to a different pharmacy after being notified that the member was locked in to a different pharmacy.

(119) TARGETED PRESCRIBER. A prescriber with prescribing authority who is ranked as a top prescriber of controlled substances based on multiple factors which may include but are not limited to any of the following:

(a) The percentage of controlled substances prescribed.

(b) The percentage of Schedule II controlled substances prescribed.

(c) The percentage of Schedule III controlled substances prescribed.

(d) The percentage of short acting single ingredient opiates prescribed.

(e) The percentage of short acting combination product opiates prescribed.

(f) The percentage of long acting opiates prescribed.

(g) The average morphine equivalents per day prescribed.

(h) The percentage of rejected claims of controlled substances.

(120) TECHNICAL ELIGIBILITY REQUIREMENTS shall mean the eligibility requirements applicable to the appropriate category of medical assistance as discussed in Chapter 1240-03-03-.03 of the rules of the TDHS - Division of Medical Services, and the additional eligibility requirements set forth in these rules.

(121) TENNCARE shall mean 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.

(122) TENNCARE APPEAL FORM shall mean the TennCare form(s) which are completed by an enrollee or by a person authorized by the enrollee to do so, when an enrollee appeals an adverse benefit determination.

(123) TENNCARE CHOICES in Long-Term Care shall mean the program described in Rule 1200-13-01-.05.

(124) TENNCARE MEDICAID shall mean that part of the TennCare program, which covers persons eligible for Medicaid under Tennessee's Title XIX State Plan for Medical Assistance. The following persons are eligible for TennCare Medicaid:

(Rule 1200-13-13-.01, continued)

(a) Tennessee residents determined to be eligible for Medicaid in accordance with 1240-03-03 of the rules of the Tennessee Department of Human Services - Division of Medical Services.

(b) Individuals who qualify as dually eligible for Medicare and Medicaid are enrolled in TennCare Medicaid.

(c) A Tennessee resident who is an uninsured woman, under age sixty-five (65), a US citizen or qualified alien, is not eligible for any other category of Medicaid, has been diagnosed as the result of a screening at a Centers for Disease Control and Prevention (CDC) site with breast or cervical cancer, including pre-cancerous conditions.

(d) Tennessee residents determined eligible for SSI benefits by the Social Security Administration are automatically enrolled in TennCare Medicaid.

(125) TENNCARE MEDICAID ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to close enrollment into TennCare Medicaid for non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance and to disenroll non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance after completion of their twelve (12) months of eligibility.

(126) TENNCARE PHARMACY PROGRAMS shall mean any TennCare pharmacy carve-outs, including, but not limited to, enrollees with dual eligibility and all pharmacy services provided by the TennCare Managed Care Organizations (MCOs).

(127) TENNCARE PROVIDER shall mean a provider who accepts as payment in full for furnishing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with an MCC or TennCare. Such payment may include copayments from the enrollee or the enrollee's responsible party. Except in the case of Out-of-State Emergency Providers, as defined in this Rule, a TennCare provider must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including requirements regarding provider billing of patients as found in Rule 1200-13-13-.08. TennCare Providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in Medicare or Medicaid.

(128) TENNCARE SELECT shall mean a state self-insured HMO established by the Bureau of TennCare and administered by a contractor to provide medical services to certain eligible enrollees.

(129) TENNCARE SERVICES OR TENNCARE BENEFITS, for purposes of this rule, shall mean any medical assistance that is administered by the Bureau of TennCare or its contractors and which is funded wholly or in part with federal funds under the Medicaid Act or any waiver thereof, but excluding:

(a) Medical assistance that can be appealed through an appeal of a pre-admission evaluation (PAE) determination; and

(b) Medicare cost sharing services that do not involve utilization review by the Bureau of TennCare or its contractors.

(130) TENNCARE STANDARD shall mean that part of the TennCare Program which provides health coverage for Tennessee residents who are not eligible for Medicaid and who meet the eligibility criteria found in rule 1200-13-14-.02.

(Rule 1200-13-13-.01, continued)

(131) TENNCARE STANDARD ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to terminate coverage for adults aged nineteen (19) and older in TennCare Standard eligibility groups.

(132) TENNderCARE shall mean the name given to the preventive health care program for TennCare children.

(133) TERMINATION shall mean the discontinuance of an enrollee's coverage under the TennCare Medicaid or TennCare standard program.

(134) THIRD PARTY shall mean any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or a part of the costs of medical care of the enrollee.

(135) TRANSITION GROUP shall mean existing Medicaid Medically Needy adults age twenty-one (21) or older enrolled as of October 5, 2007, who have not yet been assessed for transition to the Standard Spend Down Demonstration population for non-pregnant adults age twenty-one (21) or older.

(136) TREATING PHYSICIAN (OR CLINICIAN) shall mean a health care provider who has provided diagnostic or treatment services for an enrollee (whether or not those services were covered by TennCare), for purposes of treating, or supporting the treatment of, a known or suspected medical condition. The term excludes providers who have evaluated an enrollee's medical condition primarily or exclusively for the purposes of supporting or participating in a decision regarding TennCare coverage.

(137) UNINSURED shall mean any person who does not have health insurance directly or indirectly through another family member, or who does not have access to group health insurance. For purposes of the Medicaid eligibility category of women under 65 requiring treatment for breast or cervical cancer, "Uninsured" shall mean any person who does not have health insurance or access to health insurance which covers treatment for breast or cervical cancer.

(138) VALID FACTUAL DISPUTE shall mean a dispute which, if resolved in favor of the enrollee, would result in the proposed action not being taken.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, 71-5-113, 71-5-146, 42 C.F.R. Part 431 Subpart E, 42 C.F.R. Part 438 Subpart F, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.01; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment filed April 9, 2003; effective June 23, 2003. Public necessity rule filed May 5, 2005; effective through October 17, 2005. Public necessity rule filed June 3, 2005; effective through November 15, 2005. Amendment filed July 14, 2005; effective September 27, 2005. Amendment filed July 20, 2005; effective October 3, 2005. Amendment filed July 28, 2005; effective October 11, 2005. Amendment filed September 1, 2005; effective November 15, 2005. Public necessity rule filed December 9, 2005; effective through May 23, 2006. Public necessity rule filed December 29, 2005; effective through June 12, 2006. Public necessity rules filed March 3, 2006; effective through August 15, 2006. Amendment filed March 3, 2006; effective May 17, 2006. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendments filed March 31, 2006; effective June 14, 2006. Amendment filed June 1, 2006; effective August 15, 2006. Public necessity rule filed December 1, 2006; expired May 5, 2007. Public necessity rule filed February 2, 2007; effective through July 16, 2007. Amendment filed January 26, 2007; effective April 11, 2007. Amendment filed May 2, 2007; effective July 16, 2007. Amendment filed June 11, 2007; effective August 25, 2007. Public necessity rule filed October 11, 2007; effective through March 24, 2008. Public necessity rule filed February 8, 2008; effective through July 22, 2008. Amendments filed May 7, 2008; effective July 21, 2008.*

(Rule 1200-13-13-.01, continued)

Public necessity rule filed September 8, 2008; effective through February 20, 2009. Amendment filed December 5, 2008; effective February 18, 2009. Amendment filed February 18, 2009; effective May 4, 2009. Amendments filed September 25, 2009; effective December 24, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendment filed July 1, 2013; effective September 29, 2013. Amendments filed October 3, 2013; effective January 1, 2014. Amendment filed December 23, 2014; effective March 23, 2015. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendment filed June 30, 2016; effective September 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016. Amendments filed July 3, 2017; effective October 1, 2017. Amendments filed September 25, 2017; effective, December 24, 2017.

1200-13-13-.02 ELIGIBILITY.

(1) Delineation of agency roles and responsibilities.

(a) The Tennessee Department of Finance and Administration (F&A) is the lead State agency for the TennCare Program.

(b) The Bureau of TennCare (Bureau) is the administrative unit within F&A with the responsibility for day-to-day operations of the TennCare Program. The Bureau is responsible for establishing policy and procedural requirements and criteria for TennCare.

1. With respect to the eligibility of children applying for TennCare as medically eligible persons, the Bureau is responsible for determining the presence of a qualifying medical condition under TennCare Standard.

2. With respect to the eligibility of individuals applying for the TennCare CHOICES program, the Bureau is responsible for determining that the individual meets level of care eligibility criteria for the long-term care services or reimbursement requested. For enrollment into CHOICES Group 2, the Bureau is also responsible for determining the state's ability to provide appropriate Home and Community Based Services (HCBS) as determined by the availability of slots under the established enrollment target in accordance with Rule 1200-13-01-.05 and for confirming a determination by an Area Agency on Aging and Disability or TennCare Managed Care Organization that:

(i) The individual is an adult aged sixty-five (65) or older, or an adult aged twenty-one (21) or older with physical disabilities; and

(ii) Such individual can be safely and appropriately served in the community and at a cost that does not exceed the individual's cost neutrality cap pursuant to Rule 1200-13-01-.05.

3. With respect to the eligibility of individuals applying for the ECF CHOICES program, the Bureau is responsible for determining that the individual meets all applicable eligibility and enrollment criteria, including target population, medical or level of care eligibility, categorical and financial eligibility, the state's ability to provide appropriate ECF HCBS (as defined in Rule 1200-13-01-.02) as determined by the availability of slots under the established enrollment target for each ECF CHOICES Group in accordance with Rule 1200-13-01-.31 and pursuant to intake and enrollment policies and processes described in 1200-13-01-.31 and in TennCare policies and protocols, and for confirming a determination by a TennCare Managed Care Organization that the individual can be safely and appropriately served in the community and at a cost that does not exceed the individual's expenditure cap pursuant to Rule 1200-13-01-.31.

(Rule 1200-13-13-.02, continued)

(c) The Tennessee Department of Human Services (DHS) is under contract with the Bureau to determine initial eligibility for TennCare Medicaid and TennCare Standard, as well as to redetermine, at regular intervals, whether eligibility should be continued. DHS is not responsible for making decisions about the presence of a qualifying medical condition for those applying as medically eligible persons under TennCare Standard.

(d) The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) Program. Tennessee residents determined eligible for SSI benefits are automatically eligible for and enrolled in TennCare Medicaid benefits.

(e) The Tennessee Department of Health (DOH) determines presumptive eligibility under TennCare Medicaid for pregnant women and for women diagnosed with breast or cervical cancer through administration of the Breast and Cervical Cancer Screening Program.

(2) Delineation of TennCare enrollee's responsibilities.

(a) It is the responsibility of each TennCare enrollee to report to the DHS any material change affecting any information given by the applicant/enrollee to DHS at the time of application or redetermination of his eligibility. This information includes, but is not limited to, changes in address, income, family size, employment, or access to insurance. The applicant/enrollee shall mail, or present in person, documentation of any such change to the DHS county office where the enrollee resides. This documentation must be presented within the time frame specified in Chapter 1240-01-16 of the rules of DHS.

(b) It is the responsibility of each TennCare enrollee to report to his provider that he is a TennCare enrollee.

(3) Technical and financial eligibility requirements for TennCare Medicaid. To be eligible for TennCare Medicaid, each individual must:

(a) Meet all technical requirements applicable to the appropriate category of medical assistance as described in the DHS - Division of Medical Services rule 1240-03-03-.02, and all financial eligibility requirements applicable to the appropriate category of medical assistance as described in the DHS - Division of Medical Services rule 1240-03-03-.03; or

(b) Meet the financial eligibility requirements of the SSI Program of the Social Security Administration and be approved for SSI benefits by the Social Security Administration; or

(c) Be a woman who:

1. Is under age sixty-five (65);

2. Is uninsured or has health insurance that does not provide coverage for treatment of breast or cervical cancer;

3. Is not eligible for Medicaid;

4. Is a U.S. citizen or qualified alien; and

5. Has been diagnosed with breast or cervical cancer, including a Precancerous condition, by a screening at a Centers for Disease Control and Prevention (CDC) site, and who needs treatment.

(Rule 1200-13-13-.02, continued)

(4) General application requirements.

(a) By applying for TennCare Medicaid, an applicant agrees to provide information to the Bureau, or its designee, about any third party coverage. MCCs shall release insurance information from their files to the Bureau of TennCare on a regular basis, as required by contract between the MCCs and the Department of Finance and Administration.

(b) By applying for TennCare Medicaid, an applicant grants permission and authorizes release of information to the Bureau, or its designee, to investigate any and all information provided, or any information not provided if it could affect eligibility, in order to determine TennCare eligibility; and, if approved, the amount of, if any, cost sharing which may be required of the applicant as found in these rules. Information may be verified through, but not limited to, the following sources:

1. The United States Internal Revenue Service (IRS);

2. State income tax records for Tennessee or any other state where income is earned;

3. The Tennessee Department of Labor and Workforce Development, and other employment security offices within any state where the applicant may have received wages or been employed;

4. Credit bureaus;

5. Insurance companies; or

6. Any other governmental agency or public or private source of information where such information may impact an applicant's eligibility or cost sharing requirements for the TennCare Program.

(c) By applying for TennCare, an applicant understands it is a felony offense, pursuant to *Tennessee Code Annotated* § 71-5-2601, to obtain TennCare coverage under false means or to help anyone get on TennCare under false means.

(5) Current eligibility groups under TennCare Medicaid.

(a) Eligibility for TennCare Medicaid is currently limited to individuals who are Tennessee residents as defined at 42 C.F.R. § 435.403, *Tennessee Code Annotated* § 71-5-120, and who are listed in DHS rule Chapter 1240-03-02, Coverage Groups under Medicaid.

1. Individuals enrolled as Categorically Needy, as defined at rule 1200-13-13-.01.

2. Individuals enrolled as Medically Needy, as defined at rule 1200-13-13-.01. Enrollment in this category is limited to pregnant women and children under the age of twenty-one (21). Eligibility for this category shall be for a period of one (1) year. At the end of that year, eligibility must be reestablished in order for these individuals to continue in the program. For non-pregnant individuals who are under age 21, eligibility in this category shall end when the individual reaches his twenty-first birthday or the individual reaches the end of his one (1) year eligibility, whichever comes first.

3. Individuals who are determined eligible for the SSI Program by the Social Security Administration.

(Rule 1200-13-13-.02, continued)

4. Women who have been enrolled as a result of needing treatment for breast or cervical cancer and who meet the technical requirements found at 1200-13-13-.02(3)(c).

(b) Effective date of eligibility.

1. For SSI eligibles, the date determined by the Social Security Administration in approving the individual for SSI coverage.

2. For all other Medicaid eligibles, the date of the application or the date of the qualifying event (such as the date that a spend-down obligation is met), whichever is later.

3. For persons applying for Medicaid eligibility during a period when the DHS offices are not open, the date the faxed application is received at DHS.

(6) Redetermination of TennCare Medicaid eligibility.

(a) Enrollees eligible for TennCare Medicaid as a result of being eligible for SSI benefits shall follow the Redetermination requirements of the Social Security Administration.

(b) An enrollee who qualifies for TennCare Medicaid through DHS shall have his TennCare Medicaid eligibility redetermined as required by the appropriate category of medical assistance as described in Chapter 1240-03-03 of the rules of DHS - Division of Medical Services. Prior to termination of Medicaid eligibility for enrollees of the Core Medicaid Population, eligibility will be reviewed in accordance with the following process:

1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all Core Medicaid enrollees. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories.

2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to DHS and to provide DHS with the necessary verifications to determine eligibility for open Medicaid categories.

3. Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.

4. If an enrollee provides some but not all of the necessary information to DHS to determine his eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, DHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request.

5. Enrollees who respond to the Request for Information within the thirty (30) day period shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while DHS reviews their eligibility for open Medicaid categories.

(Rule 1200-13-13-.02, continued)

6. Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices but before the date of termination shall retain their eligibility for TennCare Medicaid while DHS reviews their eligibility for open Medicaid categories. If DHS determines that the enrollee remains eligible for his current Medicaid category, the enrollee will remain enrolled in such Medicaid category. If DHS makes a determination that the enrollee is eligible for a different open Medicaid category, DHS will so notify the enrollee and the enrollee will be enrolled in the new appropriate TennCare Medicaid category. When the enrollee is enrolled in the appropriate TennCare Medicaid category, his eligibility in the previous category shall be terminated without additional notice. If a child is reviewed for Medicaid eligibility and is found not to be eligible for any open Medicaid category, the child will be reviewed for eligibility for TennCare Standard under rule 1200-13-14-.02. If DHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

7. Individuals may provide the information and verifications specified in the Request for Information after termination of eligibility. DHS shall review all such information pursuant to the rules, policies and procedures of DHS and the Bureau of TennCare applicable to new applicants for TennCare Medicaid coverage. The individual shall not be entitled to be reinstated into TennCare Medicaid pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of the application, or (b) the date spend down eligibility is met.

(c) A woman who has been determined eligible for TennCare Medicaid under 1200-13-13-.02(3)(c) of these rules shall annually recertify her eligibility in terms of continuation of active treatment, her address, and access to health insurance. If she is found to no longer be eligible through this review, the enrollee will be reviewed using the Redetermination process set forth in 1200-13-13-.02(6)(b) of these rules.

(7) Termination of eligibility.

(a) Eligibility for TennCare Medicaid shall cease when:

1. The individual no longer qualifies for TennCare Medicaid pursuant to Chapter 1240-03-03 of the rules of DHS; or

2. A woman determined eligible under 1200-13-13-.02(3)(c) of these rules:

(i) Reaches age sixty-five (65); or

(ii) Gains access to group health insurance that provides coverage for treatment of breast or cervical cancer as defined elsewhere in these rules; or

(iii) It has been determined that she no longer needs treatment for breast or cervical cancer, including pre-cancerous conditions.

(b) The TennCare Bureau will send Termination Notices to all Core Medicaid Population enrollees being terminated pursuant to state and federal law who are not determined to be eligible for open Medicaid categories pursuant to the Request for Information processes described herein.

(c) Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.

(d) Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal the termination and will inform enrollees how they may request a hearing. Appeals will be processed by DHS in accordance with rule 1200-13-13-.12.

(e) Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

(8) Disenrollment related to discontinued Medicaid categories.

Prior to the disenrollment of any enrollee in a discontinued Medicaid category based on coverage terminations resulting from TennCare Medicaid Eligibility Reforms, Medicaid eligibility shall be reviewed in accordance with the following:

(a) Ex Parte Review.

DHS will conduct an ex parte review for open Medicaid categories for all enrollees in eligibility groups due to be terminated as part of the TennCare Medicaid eligibility reforms. Such ex parte review shall be conducted in accordance with federal requirements as set forth by CMS in the Special Terms and Conditions of the TennCare demonstration project.

(b) Request for Information.

1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to enrollees in eligibility groups being terminated pursuant to TennCare Medicaid eligibility reforms. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories, as well as a list of the types of proof needed to verify certain information.

2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to DHS and to provide DHS with the necessary verifications to determine eligibility for open Medicaid categories.

3. Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request assistance in responding to this Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.

4. Enrollees will be given an opportunity until the date of termination to request one extension for good cause of the thirty (30) day time frame for responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or who, as a result of a health problem, mental health problem, learning problem, disability, or limited English proficiency, are unable to respond timely. The good cause exception does not confer an entitlement upon enrollees and the application of this exception will be within the discretion of DHS. Only one (1) thirty (30) day good cause extension can be granted to each enrollee. Good

(Rule 1200-13-13-.02, continued)

cause is determined by DHS eligibility staff. Good cause is not requested nor determined by filing an appeal. Requests for an extension of the thirty (30) day time frame to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. DHS will not accept a request for extension of the thirty (30) day time frame submitted by a family member, advocate, provider, or CMHC, acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his whereabouts are unknown. All requests for a good cause extension must be made prior to termination of Medicaid eligibility. A good cause extension will be granted if DHS determines that a health problem, mental health problem, learning problem, disability or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to DHS prior to termination of Medicaid eligibility and DHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion of DHS, and, if granted, shall provide the enrollee with an additional thirty (30) days inclusive of mail time from the date of DHS's decision to grant the good cause extension. DHS will send the enrollee a letter granting or denying the request for good cause extension. DHS's decisions with respect to good cause extensions shall not be appealable.

5. If an enrollee provides some but not all of the necessary information to DHS to determine his eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, DHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day time frame for responding to the Verification Request.

6. Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by DHS shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while DHS reviews their eligibility for open Medicaid categories.

7. DHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If DHS makes a determination that the enrollee is eligible for an open Medicaid category, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate Medicaid category. When the enrollee is enrolled in the appropriate TennCare Medicaid category, his eligibility in the discontinued Medicaid category shall be terminated without additional notice. If DHS makes a determination that the enrollee is not eligible for any open Medicaid categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period or any extension of such period granted by DHS, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

(Rule 1200-13-13-.02, continued)

8. Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices or after any extension of such time period granted by DHS but before the date of termination shall retain their eligibility for TennCare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while DHS reviews their eligibility for open Medicaid categories. If DHS makes a determination that the enrollee is eligible for an open Medicaid category, DHS will so notify the enrollee, and the enrollee will be enrolled in the appropriate TennCare Medicaid category, and his eligibility in the discontinued Medicaid category shall be terminated without additional notice. If DHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the TennCare Bureau will send the enrollee a twenty-(20) day advance Termination Notice.

9. Individuals may provide information and verifications specified in the Request for Information after termination of eligibility. DHS shall review all such information pursuant to the rules, policies and procedures of DHS and the Bureau of TennCare applicable to new applicants for TennCare coverage. The individual shall not be entitled to be reinstated into TennCare pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of application, or (b) the date spend down eligibility is met.

(c) Termination Notice.

1. The TennCare Bureau will send Termination Notices to all enrollees being terminated pursuant to TennCare Medicaid eligibility reforms who are not determined to be eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in this subparagraph.

2. Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.

3. Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and will inform enrollees how they may request a hearing.

4. Enrollees with a health problem, mental health problem, learning problem, or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

5. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day time frame in which to request a hearing.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.02; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment filed April 9, 2003; effective June 23, 2003. Public necessity rule filed April 29, 2005, effective through October 11, 2005. Public necessity rule filed June 3, 2005; effective through November 15, 2005. Amendment filed July 28, 2005; effective October 11, 2005. Amendments filed September 1, 2005; effective November 15, 2005. Public necessity rule filed December 9, 2005; effective through May 23, 2006. Public necessity rule filed March 3, 2006; effective through August 15, 2006.*

(Rule 1200-13-13-.02, continued)

Amendment filed March 3, 2006; effective May 17, 2006. Amendment filed June 1, 2006; effective August 15, 2006. Public necessity rule filed February 8, 2008; effective through July 22, 2008. Repeal and new rule filed May 7, 2008; effective July 21, 2008. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Amendment filed October 26, 2010; effective January 24, 2011. Amendment filed September 26, 2013; effective December 25, 2013. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.

1200-13-13-.03 ENROLLMENT, REASSIGNMENT, AND DISENROLLMENT WITH MANAGED CARE CONTRACTORS (MCCS).

(1) Enrollment.

There are three (3) different types of managed care entities that provide services to TennCare enrollees. Enrollment procedures differ according to the type of managed care entity, the geographic area, and the number of managed care entities operating in each geographic area. Enrollment procedures also differ for ECF CHOICES, as described in subparagraph (c) below.

(a) TennCare Managed Care Organizations (MCOs) other than TennCare Select.

1. Except as provided in subparagraph (c), individuals or families determined eligible for TennCare shall select a health plan (Managed Care Organization/MCO) at the time of application. The health plan must be available in the Grand Division of the State in which the enrollee lives. All family members living in the same household and enrolled in TennCare must be assigned to the same MCO except children determined by the Bureau to be eligible to enroll in TennCare Select. An enrollee is given his choice of MCOs when possible. If the requested MCO cannot accept new enrollees, the Bureau will assign each enrollee to an MCO that is accepting new enrollees. If no MCO is available to enroll new members in the enrollee's Grand Division, the enrollee will be assigned to TennCare Select until such time as another MCO becomes available. The Bureau may also assign TennCare children with special health care needs to TennCare Select.

Individuals enrolled as a result of being eligible for SSI benefits will be assigned to an MCO as they do not have the opportunity to select a health plan prior to the effective date of coverage, since they are enrolled through the Social Security Administration.

2. Except as provided in subparagraph (c), a TennCare enrollee may change MCOs one (1) time within the initial forty-five (45) calendar days (inclusive of mail time) from the date of the letter informing him of his MCO assignment, if there is another MCO in the enrollee's Grand Division that is currently permitted by the Bureau to accept new enrollees. No additional changes will be allowed except as otherwise specified in these rules. An enrollee shall remain a member of the designated plan until he is given an opportunity to change once each year during an annual change period. The annual change period will occur each year in March for enrollees in West Tennessee, in May for enrollees in Middle Tennessee, and in July for enrollees in East Tennessee. Thereafter, an MCO change is permitted only during an annual change period, unless the Bureau authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment as specified in paragraph (2)(b) below. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until he is enrolled in the requested MCO.

(Rule 1200-13-13-.03, continued)

3. Each MCO shall offer its enrollees, to the extent possible, freedom of choice among participating providers. If after notification of enrollment the enrollee has not chosen a primary care provider, one will be selected for him by the MCO. The period during which an enrollee may choose his primary care provider shall not be less than fifteen (15) calendar days.

4. In the event a pregnant woman entering an MCO's plan is receiving medically necessary prenatal care the day before enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the MCO's provider network until such time as the MCO can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health.

   In the event a pregnant woman entering the MCO's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period. Reimbursement to an out-of-network provider shall be as set out in rule 1200-13-13-.08.

(b) TennCare Select.

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

1. The TennCare populations included in the TennCare Select delivery system are as follows:

   (i) Children under the age of twenty-one (21) years who are eligible for Supplemental Security Income.

   (ii) Children in state custody and children leaving state custody for six (6) months post-custody as long as the child remains eligible.

   (iii) Children under the age of twenty-one (21) years in an institutional eligibility category who are receiving care in a Nursing Facility or an Intermediate Care Facility for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded) (ICF/MR), and children and adults in a Home and Community Based Services 1915(c) waiver for individuals with mental retardation.

   (iv) Enrollees living in areas where there is insufficient MCO capacity to serve them.

   After being assigned to TennCare Select, persons in categories (i) and (iii) above may choose to disenroll from TennCare Select and enroll in another MCO if one is available. Persons in categories (ii) and (iv) must remain in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

2. TennCare Select also provides the following functions:

(Rule 1200-13-13-.03, continued)

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

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

(iii) It is the only entity responsible for payment of the services described in 42 C.F.R. § 440.255, limited services for certain aliens.

(c) TennCare Managed Care Organizations (MCOs) for ECF CHOICES. Individuals enrolled in ECF CHOICES may select from only the MCOs participating in ECF CHOICES.

1. If an individual enrolled in an MCO other than an ECF CHOICES participating MCO wants to enroll in the ECF CHOICES program, the individual must choose to enroll in an ECF CHOICES participating MCO in order to enroll in ECF CHOICES.

2. If an individual enrolled in the ECF CHOICES program elects to transition to an MCO that is not participating in ECF CHOICES, the individual is choosing to voluntarily disenroll from ECF CHOICES. Because this is a voluntary decision, advance notice and the right to a fair hearing shall not be provided. However, the individual may elect to transition back to an ECF CHOICES participating MCO in order to resume enrollment in ECF CHOICES

(d) TennCare Dental Benefits Manager (DBM).

TennCare children shall be assigned to the Dental Benefits Manager (DBM) under contract with the Bureau to provide dental benefits through the TennCare Program. TennCare adults age 21 and older enrolled in ECF CHOICES shall be assigned to the DBM under contract with the Bureau to provide Adult Dental Services through the ECF CHOICES program as defined in 1200-13-01-.02.

(e) TennCare Pharmacy Benefits Manager (PBM).

TennCare enrollees who are eligible to receive pharmacy services shall be assigned to the Pharmacy Benefits Manager (PBM) under contract with the Bureau to provide pharmacy benefits for both medical and behavioral health services through the TennCare Program.

(2) Reassignment.

(a) Reassignment to an MCO other than the current MCO in which the TennCare enrollee is enrolled is subject to another MCO's capacity to accept new enrollees and must be approved by the Bureau of TennCare in accordance with one of the following:

1. During the initial forty-five (45) day period following notification of MCO assignment as described at rule 1200-13-13-.03, a TennCare enrollee may request a change of MCOs.

2. A TennCare enrollee must change MCOs if he moves outside the MCO's Grand Division, and that MCO is not authorized to operate in the enrollee's new place of

(Rule 1200-13-13-.03, continued)

residence. Until the TennCare enrollee selects or is assigned to a new MCO and his enrollment is deemed complete, his medical care will remain the responsibility of the original MCO.

3. If an enrollee's MCO withdraws from participation in the TennCare Program, TennCare will assign him to a MCO operating in his Grand Division, if one is available. The enrollee will be provided notice of the change and will have forty-five (45) days to select another MCO in his Grand Division. If no MCO is available to accept enrollees from an exiting plan, the enrollees will be assigned to TennCare Select until such time as another MCO becomes available.

4. An enrollee shall be given an opportunity to change MCOs once each year during an annual change period. Only one (1) MCO change is permitted every twelve (12) months, unless the Bureau authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until enrolled in the requested MCO. If an enrollee changes MCOs during an annual change period, all family members living in the same household and enrolled in TennCare shall also be changed except children enrolled in TennCare Select.

(b) A TennCare enrollee may change MCOs if the TennCare Bureau has granted a request for a change in MCOs or an appeal of a denial of a request for a change in MCOs has been resolved in his favor based on hardship criteria.

1. The following situations will not be determined to be "hardships":

(i) The enrollee is unhappy with the current MCO or primary care provider (PCP), but there is no hardship medical situation (as stated in Part 2 below);

(ii) The enrollee claims lack of access to services but the plan meets the state's access standard;

(iii) The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;

(iv) The enrollee is concerned that a current provider might drop out of the plan in the future;

(v) The enrollee is a Medicare beneficiary who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation; or

(vi) The enrollee's PCP is no longer in the MCO's network, the enrollee wants to continue to see the current PCP and has refused alternative PCP or provider choices offered by the MCO.

2. Requests for hardship MCO reassignments must meet all of the following six (6) hardship criteria for reassignment. Determinations will be made on an individual basis.

(i) A member has a medical condition that requires complex, extensive, and ongoing care; and

(Rule 1200-13-13-.03, continued)

(ii) The member's specialist has stopped participating in the member's current MCO network and has refused continuation of care to the member in his current MCO assignment; and

(iii) The ongoing medical condition of the member is such that another physician or provider with appropriate expertise would be unable to take over his care without significant and negative impact on his care; and

(iv) The current MCO has been unable to negotiate continued care for this member with the current specialist; and

(v) The current provider of services is in the network of one or more alternative MCOs; and

(vi) An alternative MCO is available to enrolled members (i.e., has not given notice of withdrawal from the TennCare Program, is not in receivership, and is not at member capacity for the member's region).

Requests to change MCOs submitted by TennCare enrollees shall be evaluated in accordance with the hardship criteria referenced above. If an enrollee's request to change MCOs is granted due to hardship, all family members living in the same household and enrolled in TennCare will be assigned to the new MCO except children determined by the Bureau to be eligible to enroll in TennCare Select. Upon denial of a request to change MCOs, enrollees shall be provided notice and appeal rights as described in applicable provisions of rule 1200-13-13-.11.

(c) Members receiving long-term services and supports.

1. In the event that a CHOICES member is determined, based on an assessment of needs, to require a long-term care service that is not currently available under the MCO in which he is currently enrolled, but that is available through another MCO, the Bureau shall work with the current MCO to arrange for provision of the required service, which may involve providing such service out-of-network. It shall be considered to be a hardship reason to change MCO assignment only if the current MCO, after working with the Bureau, is unable to provide the required service. In such cases, the MCO that is unable to provide the required service after working with the Bureau may be subject to sanctions.

2. A CHOICES or ECF CHOICES member may request and shall have cause to change MCO assignment if all of the following are met:

(i) The member receives institutional, residential, or employment support services in the MLTSS program in which he is enrolled;

(ii) The member's institutional, residential, or employment support services provider has stopped participating in the member's MCO network and has refused continuation of care to the member in his current MCO assignment;

(iii) The member's current MCO has been unable to negotiate continued services for the member with the current provider;

(iv) The member would have to change his residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO;

(Rule 1200-13-13-.03, continued)

(v) As a result, the member would experience a disruption in his residence or employment;

(vi) The current institutional, residential, or employment support services provider is in the network of one or more alternative MCOs; and

(vii) The alternative MCO the member has selected is available to enroll members (i.e., has not given notice of withdrawal from the TennCare Program, is not in receivership, and is not at member capacity for the member's region).

(d) Enrollees who are out-of-state on a temporary basis, but maintain their status as Tennessee residents under federal and state laws, shall be reassigned to TennCare Select for the period they are out-of-state.

(e) TennCare shall only accept a request to change MCO assignment from the affected enrollee, his parent, guardian, spouse, child over age eighteen (18), or responsible party as defined in Rule 1200-13-13-.01.

(3) Disenrollment.

(a) When it has been determined that an individual no longer meets the criteria for TennCare eligibility, that individual shall be disenrolled from the TennCare Program, including the CHOICES and ECF CHOICES program, as applicable. Services provided by the TennCare MCO in which the individual has been enrolled, as well as the PBM and DBM, if applicable, shall be terminated upon disenrollment. Such disenrollment action will be accompanied by appropriate due process procedures as described elsewhere in this Chapter. Disenrollment from the CHOICES program shall proceed as described in Rule 1200-13-01-.05. Disenrollment from the ECF CHOICES program shall proceed as described in Rule 1200-13-01-.31.

(b) Coverage shall cease at 12:00 midnight, local time, on the date that an individual is disenrolled from TennCare.

(c) TennCare may reassign individuals from a designated MCO and place them in another MCO as described elsewhere in these rules. A TennCare MCO may not reassign an enrollee without the permission of TennCare. A TennCare MCO shall not request the reassignment of a TennCare enrollee for any of the following reasons:

1. Adverse changes in the enrollee's health;

2. Pre-existing medical conditions; or

3. High cost medical bills.

Coverage by a particular MCO shall cease at 12:00 midnight local time on the date that an individual has been reassigned by TennCare from one MCO and placed in another plan. Coverage by the new MCO will begin when coverage by the old MCO ends.

Authority: *T.C.A. §§ 4-5-202, 4-5-203, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.03; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed April 29, 2005; effective through October 11, 2005. Amendments filed July 28, 2005; effective October 11, 2005. Public necessity rule filed December 29, 2005; expired*

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June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendment filed March 31, 2006; effective June 14, 2006. Amendment filed August 14, 2006; effective October 28, 2006. Public necessity rule filed February 8, 2008; effective through July 22, 2008. Repeal and new rule filed May 7, 2008; effective July 21, 2008. Amendments filed September 25, 2009; effective December 24, 2009. Amendment filed November 30, 2009; effective February 28, 2010. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendments filed October 26, 2010; effective January 24, 2011. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016. Amendments filed September 25, 2017; effective December 24, 2017.

1200-13-13-.04 COVERED SERVICES.

(1) Benefits covered under the managed care program

(a) TennCare MCCs shall cover the following services and benefits subject to any applicable limitations described in this Chapter. TennCare MCCs shall cover TennCare CHOICES services and benefits for individuals enrolled in the TennCare CHOICES program in accordance with Rule 1200-13-01-.05 and ECF CHOICES services and benefits for individuals enrolled in the ECF CHOICES program in accordance with Rule 1200-13-01-.31.

1. Any and all medically necessary services may require prior authorization or approval by the MCC, except where prohibited by law.

2. An MCC shall not refuse to pay for a service solely because of a lack of prior authorization as follows:

(i) EPSDT services. MCCs shall provide all medically necessary, covered services regardless of whether the need for such services was identified by a provider whose services had received prior authorization from the MCC or by an in-network provider.

(ii) Emergency services. MCCs shall not require prior authorization or approval for covered services rendered in the event of an emergency, as defined in these rules. Such emergency services may be reviewed on the basis of medical necessity or other MCC administrator requirements, but cannot be denied solely because the provider did not obtain prior authorization or approval from the enrollee's MCC.

3. MCCs shall not impose any service limitations that are more restrictive than those described herein; however, this shall not limit the MCC's ability to establish procedures for the determination of medical necessity.

4. Services for which there is no federal financial participation (FFP) are not covered.

5. Non-covered services are non-covered regardless of medical necessity.

(b) The following physical health and mental health benefits are covered under the TennCare managed care program. Benefits offered under the TennCare CHOICES program are also covered under the TennCare managed care program, as described in Rule 1200-13-01-.05. Benefits offered under the ECF CHOICES program are also covered under the TennCare managed care program, as described in Rule 1200-13-01-.31. There are some exclusions to the benefits listed below. The exclusions are listed in this rule and in Rule 1200-13-13-.10.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
1. Ambulance Services.	See "Emergency Air and Ground Transportation" and "Non-Emergency Ambulance Transportation."	See "Emergency Air and Ground Transportation" and "Non-Emergency Ambulance Transportation."
2. Bariatric Surgery, defined as surgery to induce weight loss.	Covered as medically necessary.	Covered as medically necessary.
3. Chiropractic Services [defined at 42 C.F.R. § 440.60(b)].	Covered as medically necessary.	Not covered.
4. Community Health Services, [defined at 42 C.F.R. § 440.20(b) and (c) and 42 C.F.R. § 440.90].	Covered as medically necessary.	Covered as medically necessary.
5. Dental Services [defined at 42 C.F.R. § 440.100].	Preventive, diagnostic, and treatment services covered as medically necessary. Dental services under EPSDT are provided in accordance with the state's periodicity schedule as determined after consultation with recognized dental organizations and at other intervals as medically necessary. Orthodontic services must be prior authorized by the Dental Benefits Manager (DBM). Orthodontic services are only covered for individuals under age 21. Effective October 1, 2013, TennCare reimbursement for orthodontic treatment approved and begun before age 21 will end on the individual's 21st birthday. For individuals receiving treatment prior to October 1, 2013, such treatment may continue until completion as long as the enrollee remains eligible for TennCare. Orthodontic treatment is not covered unless it is medically necessary to treat a handicapping malocclusion. Cleft palate, hemifacial microsomia, or mandibulofacial dysostosis shall be considered handicapping malocclusions. A TennCare-approved Malocclusion Severity	Not covered.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	Assessment (MSA) will be conducted to measure the severity of the malocclusion. An MSA score of 28 or higher, as determined by the DBM's dentist reviewer(s), will be used for making orthodontic treatment determinations of medical necessity. However, an MSA score alone cannot be used to deny orthodontic treatment. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for TennCare. The MCO is responsible for the provision of transportation to and from covered dental services, as well as the medical and anesthesia services related to the covered dental services.	
6. Durable Medical Equipment [defined at 42 C.F.R. § 440.70(b)(3) and 42 C.F.R. § 440.120(c)].	Covered as medically necessary.	Covered as medically necessary.
7. Emergency Air and Ground Transportation [defined at 42 C.F.R. § 440.170(a)(1) and (3)].	Covered as medically necessary.	Covered as medically necessary.
8. EPSDT Services, [defined at 42 C.F.R. § 441, Subpart B].	Screening and interperiodic screening covered in accordance with federal regulations. (Interperiodic screens are screens in between regular checkups which are covered if a parent or caregiver suspects there may be a problem.) Diagnostic and follow-up treatment services covered as medically necessary and in accordance with federal regulations. The periodicity schedule for child health screens is that set forth in the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care." All components of the screens	Not applicable. (EPSDT is for persons under age 21.)

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	must be consistent with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care."	
9. Home Health Care [defined at 42 C.F.R. § 440.70(a), (b), (c), and (e) and at Rule 1200-13-13-.01].	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (6) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 C.F.R. § 440.70.	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (6) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 C.F.R. § 440.70.
10. Hospice Care [defined at 42 C.F.R., Part 418].	Covered as medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.	Covered as medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
11. Inpatient and Outpatient Substance Abuse Benefits [defined as services for the treatment of substance abuse that are provided (a) in an inpatient hospital (as defined at 42 C.F.R. § 440.10) or (b) as outpatient hospital services (see 42 C.F.R. § 440.20(a)].	Covered as medically necessary.	Covered as medically necessary.
12. Inpatient Hospital Services [defined at 42 C.F.R. § 440.10].	Covered as medically necessary. Preadmission and concurrent reviews allowed.	Covered as medically necessary. Preadmission and concurrent reviews allowed.
13. Inpatient Rehabilitation Facility Services.	See "Inpatient Hospital Services."	Not Covered.
14. Lab and X-ray Services [defined at 42 C.F.R. § 440.30].	Covered as medically necessary.	Covered as medically necessary.
15. Medical Supplies [defined at 42 C.F.R. § 440.70(b)(3)].	Covered as medically necessary.	Covered as medically necessary.
16. Mental Health Case Management Services [defined as services rendered to support outpatient mental health clinical services].	Covered as medically necessary.	Covered as medically necessary.
17. Mental Health Crisis	Covered as medically necessary.	Covered as medically necessary.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
Services [defined as services rendered to alleviate a psychiatric emergency].		
18. Methadone Clinic Services [defined as services provided by a methadone clinic].	Covered as medically necessary.	Not covered.
19. Non-Emergency Ambulance Transportation, [defined at 42 C.F.R. § 440.170(a)(1) and (3)].	Covered as medically necessary.	Covered as medically necessary.
20. Non-Emergency Transportation [defined at 42 C.F.R. § 440.170(a)(1) and (3)].	Covered as necessary for enrollees lacking accessible transportation for covered services. Emphasis shall be placed on the utilization of fixed route and/or public transportation where appropriate and available. The travel to access primary care and dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCC is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether the enrollee has access to transportation. If the enrollee is a minor child, transportation must be provided for the child and an accompanying adult. However, transportation for a minor child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. Any decision to deny transportation of a minor child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in	Covered as necessary for enrollees lacking accessible transportation for covered services. Emphasis shall be placed on the utilization of fixed route and/or public transportation where appropriate and available. The travel to access primary care and dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCC is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether the enrollee has access to transportation. For persons dually eligible for Medicare and Medicaid, non-emergency transportation to access medical services covered by Medicare is provided, as long as these services would be covered by TennCare for the enrollee if he did not have Medicare. The Medicare provider of the medical service does not have to participate in TennCare. Transportation to these medical services is covered within the same access standards as those applicable for TennCare enrollees who are not also Medicare beneficiaries. One escort is allowed per enrollee if the enrollee requires assistance. Assistance is defined for purposes of this rule as help provided to the enrollee that enables the enrollee to receive a medically necessary service. Examples of assistance are: physical assistance such as holding doors

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	accordance with the appeals process. Tennessee recognizes the "mature minor exception" to permission for medical treatment. The provision of transportation to and from covered dental services is the responsibility of the MCO. For persons dually eligible for Medicare and Medicaid, non-emergency transportation to access medical services covered by Medicare is provided, as long as these services would be covered by TennCare for the enrollee if he did not have Medicare. The Medicare provider of the medical services does not have to participate in TennCare. Transportation to these medical services is covered within the same access standards as those applicable for TennCare enrollees who are not also Medicare beneficiaries. One escort is allowed per enrollee if the enrollee requires assistance. Assistance is defined for purposes of this rule as help provided to the enrollee that enables the enrollee to receive a medically necessary service. Examples of assistance are: physical assistance such as holding doors or pushing wheelchairs; language assistance such as interpreter services or reading for someone who is illiterate; or decision making assistance. See rule 1200-13-13-.01 for a definition of who may be an escort.	or pushing wheelchairs; language assistance such as interpreter services or reading for someone who is illiterate; or decision making assistance. See rule 1200-13-13-.01 for a definition of who may be an escort.
21. Occupational Therapy [defined at 42 C.F.R. § 440.110(b)].	Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, stabilize or ameliorate impaired functions.	Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.
22. Organ and Tissue Transplant Services and Donor Organ/Tissue	Covered as medically necessary. Experimental or investigational	Covered as medically necessary when coverable by Medicare. Experimental or investigational transplants

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
Procurement Services [defined as the transfer of an organ or tissue from individual to a TennCare enrollee.	transplants are not covered.	are not covered.
23. Outpatient Hospital Services [defined at 42 C.F.R. § 440.20(a)].	Covered as medically necessary.	Covered as medically necessary.
24. Outpatient Mental Health Services (including Physician Services), [defined at 42 C.F.R. § 440.20(a), 42 C.F.R. § 440.50, and 42 C.F.R. § 440.90].	Covered as medically necessary.	Covered as medically necessary.
25. Pharmacy Services [defined at 42 C.F.R. § 440.120(a) and obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy, or those administered to a long-term care facility (nursing facility) resident].	Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Persons dually eligible for Medicaid and Medicare will receive their pharmacy services through Medicare Part D. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO if not covered by Medicare.	(A) Covered as medically necessary, subject to the limitations set out below. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Persons dually eligible for Medicaid and Medicare will receive their pharmacy services through Medicare Part D. (B) Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are not covered by TennCare. (C) Pharmacy services with no quantity limits on the number of prescriptions per month for the following non-Medicare enrollees only: adults age 21 and older enrolled in CHOICES 1 or CHOICES 2; adults age 21 and older enrolled in ECF CHOICES who meet nursing facility level of care or transitioned from a Section 1915(c) waiver into ECF CHOICES and granted an exception by TennCare based on ICF/IID level of care; non-Medicare PACE enrollees; and persons receiving TennCare-reimbursed services in an Intermediate Care Facility for Individuals with Intellectual Disabilities or a Home and Community Based Services Waiver for Individuals with Intellectual Disabilities.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
		(D) For hospice patients, drugs used for the relief of pain and symptom control related to their terminal illness are covered as part of the hospice benefit. If the patient is not a Medicare beneficiary, pharmacy services needed for conditions unrelated to the terminal illness are covered by TennCare. There are no quantity limits on the number of prescriptions per month covered by TennCare if the hospice patient is receiving TennCare-reimbursed room and board in a Nursing Facility. If the patient is receiving hospice services at home or in a residential hospice, coverage of pharmacy services is as described in sections (C) and (E). (E) Subject to (C) and (D) above, pharmacy services for Medicaid adults age 21 and older are limited to five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. Additional drugs for individuals in (E) shall not be covered. (F) Prescriptions shall be counted beginning on the first day of each calendar month. Each prescription and/or refill counts as one (1). A prescription or refill can be for no more than a thirty-one (31) day supply. (G) The Bureau of TennCare shall maintain an Automatic Exception List of medications which shall not count against such limit. The Bureau of TennCare may modify the Automatic Exception List at its discretion. The most current version of the Automatic Exception List will be made available to enrollees via the internet from the TennCare website and upon request by mail through the DHS Family Assistance Service Center. Only medications that are specified on the current version of the Automatic Exception List that is available on the TennCare website located on the World Wide Web at www.tn.gov/tenncare on the date of service shall be considered exempt from applicable prescription limits.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
		(H) The Bureau of TennCare shall also maintain a Prescriber Attestation List of medications available when the prescriber attests to an urgent need. The State may include certain drugs or categories of drugs on the list, and may maintain, and make available to physicians, providers, pharmacists, and the public, a list that shall indicate the drugs or types of drugs the State has determined to so include. The Prescriber Attestation List drugs may be approved for enrollees who have already met an applicable benefit limit only if the prescribing professional seeks and obtains a Special exemption. In order to obtain a special exemption, the prescribing provider must submit an attestation as directed by TennCare regarding the urgent need for the drug. TennCare will approve the prescribing provider's determination that the criteria for the special exemption are met, without further review, within 24 hours of receipt. Enrollees will not be entitled to a hearing regarding their eligibility for a special exemption if (i) the prescribing provider has not submitted the required attestation, or (ii) the requested drug is not on the Prescriber Attestation List. (I) Pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) are brand name drugs, are non-covered services, unless (a) each excess drug is specified on the current version of the Prescriber Attestation List and a completed Prescriber Attestation is on file for each listed drug as of the date of the pharmacy service, or (b) the excess drug is specified on the Automatic Exception List of medications which shall not count against such limit. (J) Over-the-counter (OTC) drugs for TennCare adults are not covered even if the enrollee has a prescription for such service, unless the drug is listed on the "Covered OTC Drug List" that is available on the TennCare website located at www.tn.gov/tenncare on the date of service.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
26. Physical Therapy [defined at 42 C.F.R. § 440.110(a)].	Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, stabilize or ameliorate impaired functions,	Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions.
27. Physician Inpatient Services [defined at 42 C.F.R. § 440.50].	Covered as medically necessary.	Covered as medically necessary.
28. Physician Outpatient Services/Community Health Clinics/Other Clinic Services [defined at 42 C.F.R. § 440.20(b), 42 C.F.R. § 440.50, and 42 C.F.R. § 440.90].	Covered as medically necessary. Services provided by a Primary Care Provider when the enrollee has a primary behavioral health diagnosis (ICD-9-CM 290.xx-319.xx) are the responsibility of the MCO. Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room provider to establish a primary behavioral health diagnosis are the responsibility of the MCO.	Covered as medically necessary, except see “Methadone Clinic Services.” Services provided by a Primary Care Provider when the enrollee has a primary behavioral health diagnosis (ICD-9-CM 290.xx-319.xx) are the responsibility of the MCO. Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room provider to establish a primary behavioral health diagnosis are the responsibility of the MCO.
29. Private Duty Nursing [defined at 42 C.F.R. § 440.80 and at Rule 1200-13-13-.01].	Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01, when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Prior authorization required, as described in Paragraph (6) of this rule.	Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-13-.01, when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Private duty nursing services are limited to services that support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Prior authorization required, as described in Paragraph (6) of this rule.
30. Psychiatric Inpatient Facility Services [defined at 42 C.F.R. § 441, Subparts C and D and including services for persons of all ages].	Covered as medically necessary, Preadmission and concurrent reviews by the MCC are allowed.	Covered as medically necessary, Preadmission and concurrent reviews by the MCC are allowed.
31. Psychiatric Pharmacy.	See “Pharmacy Services.”	See “Pharmacy Services.”
32. Psychiatric Rehabilitation Services [defined as psychiatric services delivered in accordance with 42 C.F.R. § 440.130(d)].	Covered as medically necessary.	Covered as medically necessary.
33. Psychiatric	Covered as medically necessary.	Covered as medically necessary.

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
Physician Inpatient Services [defined at 42 C.F.R. § 440.50].		
34. Psychiatric Physician Outpatient Services.	See "Outpatient Mental Health Services."	See "Outpatient Mental Health Services."
35. Psychiatric Residential Treatment Services [defined at 42 C.F.R. § 483.352] and including services for persons of all ages].	Covered as medically necessary.	Covered as medically necessary.
36. Reconstructive Breast Surgery [defined in accordance with Tenn. Code Ann. § 56-7-2507].	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
37. Rehabilitation Services.	See "Occupational Therapy," and "Physical Therapy," and "Speech Therapy," and "Inpatient Rehabilitation Facility Services."	See "Occupational Therapy," "Physical Therapy," and "Speech Therapy."
38. Renal Dialysis Clinic Services [defined at 42 C.F.R. § 440.90].	Covered as medically necessary. Generally limited to the beginning ninety (90) day period prior to the enrollee's becoming eligible for coverage by the Medicare program.	Covered as medically necessary. Generally limited to the beginning ninety (90) day period prior to the enrollee's becoming eligible for coverage by the Medicare program.
39. Speech Therapy [defined at 42 C.F.R. § 440.110(c)].	Covered as medically necessary, by a Licensed Speech Therapist to restore, improve, stabilize or ameliorate impaired functions.	Covered as medically necessary, as long as there is continued medical progress, by a Licensed Speech Therapist to restore speech after a loss or impairment.
40. Transportation.	See "Emergency Air and Ground Transportation," "Non-Emergency Ambulance Transportation," and "Non-Emergency Transportation."	See "Emergency Air and Ground Transportation," "Non-Emergency Ambulance Transportation," and "Non-Emergency Transportation."
41. Vision Services [defined as services to treat conditions of the eyes].	Preventive, diagnostic, and treatment services (including eyeglasses) covered as medically necessary.	Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of the

(Rule 1200-13-13-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
		refractive state) is covered. Routine, periodic assessment, evaluation or screening of normal eyes, and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.

(c) Pharmacy

TennCare is permitted under the terms and conditions of the demonstration project approved by the federal government to restrict coverage of prescription and non-prescription drugs to a TennCare-approved list of drugs known as a drug formulary. TennCare must make this list of covered drugs available to the public. Through the use of a formulary, the following drugs or classes of drugs, or their medical uses, shall be excluded from coverage or otherwise restricted by TennCare as described in Section 1927 of the Social Security Act [42 U.S.C. § 1396r-8]:

1. Agents for weight loss or weight gain.

2. Agents to promote fertility or for the treatment of impotence or infertility or for the reversal of sterilization.

3. Agents for cosmetic purposes or hair growth.

4. Agents for symptomatic relief of coughs and colds.

5. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

6. Nonprescription drugs.

7. Covered outpatient drugs, which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or his designee.

8. TennCare shall not cover drugs considered by the FDA to be Less Than Effective (LTE) and DESI drugs, or drugs considered to be Identical, Related and Similar (IRS) to DESI and LTE drugs or any other pharmacy services for which federal financial participation (FFP) is not available. The exclusion of drugs for which no FFP is available extends to all TennCare enrollees regardless of the enrollee's age. TennCare shall not cover experimental or investigational drugs which have not received final approval from the FDA.

9. Buprenorphine products for opiate addiction treatment for persons aged 21 and older are restricted as follows:

   (i) Dosage shall not exceed sixteen milligrams (16 mg) per day for a period of up to six (6) months from the initiation of therapy.

(Rule 1200-13-13-.04, continued)

(ii) For enrollees who are pregnant while receiving the sixteen milligrams (16 mg) per day dosage, the six-month period does not begin until the enrollee is no longer pregnant.

(iii) At the end of the six-month period described in subparts (i) and (ii), the covered dosage amount shall not exceed eight milligrams (8 mg) per day.

10. Sedative hypnotic medications for persons aged 21 and older shall not exceed fourteen (14) pills per month for sedative hypnotic formulations in pill form such as Ambien and Lunesta, one hundred forty milliliters (140 ml) per month of chloral hydrate, or one (1) bottle every sixty (60) days of Zolpimist.

11. Allergy medications.

12. Opioid products for persons aged twenty-one (21) and older are restricted as follows:

(i) "Chronic opioid user" means:

(I) A TennCare enrollee whose TennCare paid claims data demonstrates that he has received at least a ninety (90) day quantity of prescribed opioids in the one hundred eighty (180) day period immediately preceding the opioid's prescription date.

(II) For a TennCare enrollee who has not been enrolled in TennCare long enough to demonstrate that he is a chronic opioid user as defined in Item (I), the enrollee may demonstrate that he has received at least a ninety (90) day quantity of prescribed opioids in the one hundred eighty (180) day period immediately preceding the opioid's prescription date by supplying paid claims data and medical records from his previous healthcare provider(s) or health insurer(s).

(ii) "Non-chronic opioid user" means a TennCare enrollee whose TennCare paid claims data demonstrates he has received less than a ninety (90) day quantity of prescribed opioids in the one hundred eighty (180) day period immediately preceding the opioid's prescription date.

(iii) Non-chronic opioid users shall be eligible to receive covered prescription opioid products as follows:

(I) A maximum of fifteen (15) dosage days in any six (6) month period; and

(II) Daily dosage shall not exceed sixty (60) morphine milligram equivalents (MME) per day.

(iv) The restrictions in Subpart (iii) do not apply for enrollees with severe cancer pain undergoing active or palliative cancer treatment and enrollees in hospice and palliative care.

(v) The following considerations apply for enrollees who experience more frequent or aggressive pain episodes due to these specific clinical disease states:

(I) Enrollees with Sickle Cell may receive up to forty-five (45) days of sixty (60) MME per day in any ninety (90) day period; and

(II) Severe burn victims may receive up to forty-five (45) days of sixty (60) MME per day in any ninety (90) day period.

(vi) Notwithstanding the restrictions in Subpart (iii), enrollees residing in a Medicaid-certified Nursing Facility may receive up to forty-five (45) days of sixty (60) MME per day in any ninety (90) day period.

(d) The MCC shall be allowed to provide cost effective alternative services as defined in paragraph 1200-13-13-.01(29). Cost effective alternative services are not reimbursable in any circumstances other than those described in that paragraph.

(2) Use of Cost Effective Alternative Services.

(a) MCCs shall be allowed, but are not required, to use cost effective alternative services if and only if:

1. These services are listed in the MCC contract and/or in Policy BEN 08-001; or

2. These services are provided under the CHOICES program for individuals enrolled in the CHOICES program in accordance with Rule 1200-13-01-.05 or the ECF CHOICES program for individuals enrolled in the ECF CHOICES program in accordance with Rule 1200-13-01-.31; and

3. They are medically appropriate and cost effective.

(b) Use of approved cost effective alternative services is made at the sole discretion of the MCC.

(3) Emergency Medical Services.

Emergency Medical Services shall be available twenty-four (24) hours per day, seven (7) days per week. Coverage of emergency medical services shall not be subject to prior authorization by the managed care organization but may include a requirement that notice be given to the MCC of use of out-of-plan emergency services. However, such notice requirements shall provide at least a 24-hour time frame after the emergency for notice to be given to the MCC.

(4) Hospital Discharges.

Hospital discharges of mothers and newborn babies following delivery shall take into consideration the following guidelines:

(a) The decision to discharge postpartum mothers and newborns less than 24-48 hours after delivery should be made based upon discharge criteria collaboratively developed and adopted by obstetricians, pediatricians, family practitioners, delivery hospitals, and health plans. The criteria must be contingent upon appropriate preparation, meeting in hospital criteria for both mother and baby, and the planning and implementation of appropriate follow-up. An individualized plan of care must include identification of a primary care provider for both mother and baby and arrangements for follow-up evaluation of the newborn.

Length of hospital stay is only one factor to consider when attempting to optimize patient outcomes for postpartum women and newborns. Excellent outcomes are possible even when length of stay is very brief (less than 24 hours) if perinatal health care is well planned, allows for continuity of care, and patients are well chosen. Some postpartum patients and/or newborns may require extended hospitalization (greater

(Rule 1200-13-13-.04, continued)

than 48-72 hours) despite meticulous care due to medical, obstetric, or neonatal complications. The decision for time of discharge must be individualized and made by the physicians caring for the mother-baby pair. The following guidelines have been developed to aid in the identification of postpartum mothers and newborns who may be candidates for discharge prior to 24-48 hours. The guidelines also provide examples where discharge is inappropriate.

Principles of patient care should be based upon data obtained by clinical research. Regarding the question of postpartum and newborn length of hospitalization, there are inadequate studies available to provide clear direction for clinical decision-making. Clinical guidelines represent an attempt to conceptualize what is, in reality, a dynamic process of health care refinement. Review of these guidelines is desirable and expected.

No provider shall be denied participation, reimbursement or reduction in reimbursement within a network solely related to his/her compliance with the “Guidelines for Discharge of Postpartum Mothers and Newborns.”

(b) Guidelines for Discharge of Postpartum Mothers and Newborns.

1. Discharge Planning.

(i) Discharge planning should occur in a planned and systematic fashion for all postpartum women and newborns in order to enhance care, prevent complications and minimize the need for rehospitalization. Prior to discharge a discussion should be held between the physician or another health care provider and the mother (and father if possible) about any expected perinatal problems and ways to cope with them. Plans for future and immediate care as well as instructions to follow in the event of an emergency or complication should be discussed.

(ii) Follow-up care must be planned for both mother and baby at the time of discharge. For patients leaving the hospital prior to 24-48 hours, contact within 48-72 hours of discharge is recommended and may include appropriate follow-up within 48-72 hours as deemed necessary by the attending provider, depending upon individual patient need. This follow-up visit will be acknowledged as a provider encounter.

(I) Maternal Considerations:

I. Prior to discharge, the patient should be informed of normal postpartum events including but not limited to:

A. Lochial patterns;

B. Range of activity and exercise;

C. Breast care;

D. Bladder care;

E. Dietary needs;

F. Perineal care;

G. Emotional responses;

H. What to report to physician or other health care provider including:

(A) Elevation of temperature,

(B) Chills,

(C) Leg pains, and

(D) Increased vaginal bleeding.

I. Method of contraception;

J. Coitus resumption; and

K. Specific instructions for follow-up (routine and emergent)

(II) Neonatal Considerations:

I. Prior to discharge, the following points should be reviewed with the mother or, preferably, with both parents:

A. Condition of the neonate;

B. Immediate needs of the neonate, (e.g., feeding methods and environmental supports);

C. Instructions to follow in the event of a newborn complication or emergency;

D. Feeding techniques;

E. Skin care, including cord care and genital care;

F. Temperature assessment and measurement with the thermometer; and

G. Assessment of neonatal well-being;

H. Recognition of illness including jaundice;

I. Proper infant safety including use of car seat and sleeping position;

J. Reasonable expectations for the future; and

K. Importance of maintaining immunization begun with initial dose of hepatitis B vaccine.

2. Criteria for Maternal Discharge Less Than 24-48 Hours Following Delivery.

(i) Prior to discharge of the mother, the following should occur:

(Rule 1200-13-13-.04, continued)

(I) The mother should have been observed after delivery for a sufficient time to ensure that her condition is stable, that she has sufficiently recovered and may be safely transferred to outpatient care.

(II) Laboratory evaluations should be obtained and include ABO blood group and Rh typing with appropriate use of Rh immune globulin; and hematocrit or hemoglobin.

(III) The mother should have received adequate preparation for and be able to assume self and immediate neonatal care.

(ii) Factors which may exclude maternal discharge prior to 24-48 hours include:

(I) Abnormal bleeding.

(II) Fever equal to or greater than 100.4 degrees.

(III) Inadequate or no prenatal care.

(IV) Cesarean section.

(V) Untreated or unstable maternal medical condition.

(VI) Uncontrolled hypertension.

(VII) Inability to void.

(VIII) Inability to tolerate solid foods.

(IX) Adolescent mother without adequate support and where appropriate follow-up has not been established. A nurse home visit within 24-48 hours of discharge would act as appropriate follow-up.

(X) All efforts should be made to keep mother and infant together to ensure simultaneous discharge.

(XI) Psychosocial problems (maternal or family) which have been identified prenatally or in hospital. Where appropriate follow-up has not been established, a nurse home visit within 24-48 hours of discharge would act as appropriate follow-up.

3. Criteria for Neonatal Discharge Less than 24-48 Hours Following Delivery.

The nursery stay is planned to allow the identification of early problems and to reinforce instruction in preparation for care of the infant at home. Complications often are not predictable by prenatal and intrapartum events. Because many neonatal problems do not become apparent until several days after birth there is an element of medical risk in early neonatal discharge. Most problems are manifest during the first 12 hours, and discharge at or prior to 24 hours is appropriate for many newborns.

(i) Prior to discharge of the newborn at 24-48 hours, the following should have occurred:

(Rule 1200-13-13-.04, continued)

(I) The course of antepartum, intrapartum, and postpartum care for both mother and fetus should be without problems, which may lead to newborn complications.

(II) The baby is a single birth at 37 to 42 weeks' gestation and the birth weight is appropriate for gestational age according to appropriate intrauterine growth curves.

(III) The baby's vital signs are documented as being normal and stable for the 12 hours preceding discharge, including a respiratory rate below 60/minute, a heart rate of 100 to 160 beats per minute, and an axillary temperature of 36.1 degrees C in an open crib with appropriate clothing.

(IV) The baby has urinated and passed at least one stool.

(V) No evidence of excessive bleeding after circumcision greater than 2 hours.

(VI) The baby has completed at least two successful feedings, with documentation that the baby is able to coordinate sucking, swallowing, and breathing while feeding.

(VII) No evidence of significant jaundice in the first 24 hours of life.

(VIII) The parent's or caretaker's knowledge, ability, and confidence to provide adequate care for her baby are documented.

(IX) Laboratory data are available and reviewed including:

I. Maternal syphilis and hepatitis B surface antigen status.

II. Cord or infant blood type and direct Coomb's test result as clinically indicated.

(X) Screening tests are performed in accordance with state regulations. If the test is performed before 24 hours of milk feeding, a system for repeating the test must be assured during the follow-up visit.

(XI) Initial hepatitis B vaccine is administered or a scheduled appointment for its administration has been made.

(XII) A physician-directed source of continuing medical care for both the mother and the baby is identified. For newborns discharged less than 24-48 hours after delivery, a definitive plan for contact within 48-72 hours after discharge has been made. A nurse home visit within 24-48 hours would be considered appropriate follow-up.

(ii) Maternal factors which may exclude discharge of the newborn prior to 24-48 hours include:

(I) Inadequate or no prenatal care,

(II) Medical conditions that pose a significant risk to the infant,

(III) Group B streptococcus colonization,

(IV) Untreated syphilis,

(V) Suspected active genital herpes,

(VI) HIV,

(VII) Adolescent without adequate support and where appropriate follow-up has not been established (a nurse home visit within 24-48 hours of discharge will act as appropriate follow-up),

(VIII) Mental retardation or psychiatric illness, and

(IX) Requirements for continued maternal hospitalization.

(iii) Newborn factors which may exclude discharge of the newborn prior to 24-48 hours include:

(I) Preterm gestation (less than 37 weeks);

(II) Small for gestational age;

(III) Large for gestational age;

(IV) Abnormal physical exam, vital signs, colors, activity, feeding or stooling;

(V) Significant congenital malformations; and

(VI) Abnormal laboratory finding:

I. Hypoglycemia,

II. Hyperbilirubinemia,

III. Polycythemia,

IV. Anemia, and

V. Rapid plasma reagin positive.

(5) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services for TennCare Medicaid Enrollees under the Age of Twenty-one (21).

The Bureau of TennCare, through its contracts with Managed Care Organizations (MCOs) and other contractors (also referred to collectively as Contractors), operates an EPSDT program to provide health care services as required by 42 C.F.R. Part 441, Subpart B and the "Omnibus Budget Reconciliation Act of 1989" to TennCare Medicaid-eligible enrollees under the age of twenty-one (21).

(a) Responsibilities of the Bureau of TennCare.

1. The Bureau will:

(i) Keep Contractors informed as to changes to the requirements for the operation of the EPSDT program;

(ii) Make changes to TennCare policy when necessary to keep the EPSDT program in compliance with federal and state requirements;

(iii) Provide policy clarification when needed; and

(iv) Oversee the activities of the Contractors to assure compliance with all aspects of the EPSDT program.

2. The Bureau, through local health departments, shall provide information on covered services to adolescent prenatal patients who enter TennCare Medicaid through presumptive eligibility. Assistance will be offered to presumptive eligibles on the day eligibility is determined in making a timely first prenatal appointment. For a woman past her first trimester, this appointment should occur within fifteen (15) days.

3. The Bureau, through the Department of Children's Services, shall inform foster parents and institutions or other residential treatment settings with a number of eligible children, annually or more often when the need arises, including when a change of administrators, social workers, or foster parents occur, of the availability of EPSDT services.

(b) Responsibilities of Contractors.

1. Contractors shall aggressively and effectively inform TennCare Medicaid enrollees of the existence of the EPSDT program, including the availability of specific EPSDT screening and treatment services. Such informing shall occur in a timely manner, generally within sixty (60) days of the MCC's receipt of notification of the child's enrollment in its plan and if no one eligible in the family has utilized EPSDT services, at least annually thereafter.

Contractors shall document to the Bureau the contractor's outreach activities and what efforts were made to inform TennCare Medicaid enrollees and/or the enrollee's responsible party about the availability of EPSDT services and how to access such services. All children, particularly those who have not received complete screenings timely, shall be the target of outreach efforts by the MCOs which are reasonably calculated to insure the child's participation in EPSDT. Failure to timely submit the requested data may result in liquidated damages as described in the contracts between the Bureau of TennCare and the Contractors.

2. Contractors shall use clear and non-technical terms to provide a combination of written and oral information so that the program is clearly and easily understandable.

3. Contractors shall use effective methods (developed through collaboration with agencies which have established procedures for working with such individuals) to inform TennCare Medicaid individuals who are illiterate, blind, deaf, or cannot understand English, about the availability of EPSDT services.

4. Contractors shall design and conduct outreach to inform all TennCare Medicaid-eligible individuals about what services are available under EPSDT, the benefits of preventive health care, where services are available, and how to obtain them; and that necessary transportation and scheduling assistance is available.

(Rule 1200-13-13-.04, continued)

5. Contractors shall create a system so that TennCare Medicaid families can readily access an accurate list of names and phone numbers of contract providers who are currently accepting TennCare.

6. Contractors shall make known and offer to a TennCare Medicaid-covered child and the child's responsible party of the availability for both transportation and scheduling assistance prior to the due date of the TennCare Medicaid child's periodic examination.

7. Contractors shall provide TennCare Medicaid enrollees assistance in scheduling appointments**,** and obtaining transportation prior to the date of each periodic examination as requested and necessary.

8. Contractors shall document services declined by a parent or guardian of a TennCare Medicaid-eligible child or a mature competent child, specifying the particular service declined so that outreach and education for other EPSDT services continues.

9. Contractors shall maintain records of the efforts taken to outreach TennCare Medicaid children who have missed screening appointments when scheduled or who have failed to schedule regular check-ups. These records shall be made available to the Bureau and other parties as directed.

10. Contractors shall treat a TennCare Medicaid-eligible woman's request for EPSDT services during pregnancy as a request for EPSDT services for the child at birth. If the pregnant woman is under age twenty-one (21), she may request EPSDT services for herself.

(c) Compliance.

Contractors must document and maintain records of all outreach efforts made to inform TennCare Medicaid enrollees about the availability of EPSDT services.

(6) Prior Authorization for Home Health Nurse, Home Health Aide, and Private Duty Nursing Services. Prior authorization by the MCC must be obtained in order to establish the medical necessity of all requested home health nurse, home health aide, and private duty nursing services.

(a) The following information must be provided when seeking prior authorization for home health nurse, home health aide, and private duty nursing services:

1. Name of physician prescribing the service(s);

2. Specific information regarding the patient's medical condition and any associated disability that creates the need for the requested service(s); and

3. Specific information regarding the service(s) the nurse or aide is expected to perform, including the frequency with which each service must be performed (e.g., tube feeding patient 7:00 a.m., 12:00 p.m., and 5:00 p.m. daily; bathe patient once per day; administer medications three (3) times per day; catheterize patient as needed from 8:00 a.m. to 5:00 p.m. Monday through Friday; change dressing on wound three (3) times per week). Such information should also include the total period of time that the services are anticipated to be medically necessary by the treating physician (e.g., total number of weeks or months).

(Rule 1200-13-13-.04, continued)

(b) Home health nurses and aides and private duty nurses will never be authorized to personally transport a TennCare enrollee. Home health nurses and aides delivering prior approved home health care services may accompany an enrollee outside the home in accordance with T.C.A. § 71-5-107(a)(12).

(c) Private duty nursing services are limited to services provided in the recipient's own home, with the following two exceptions:

1. A recipient age twenty-one (21) or older who requires eight (8) or more hours of skilled nursing care in a 24-hour period and is authorized to receive private duty nursing services in the home setting may make use of the approved hours outside of that setting in order for the nurse to accompany the recipient to:

(i) Outpatient health care services (including services delivered through a TennCare home and community based services waiver program);

(ii) Public or private secondary school or credit classes at an accredited vocational or technical school or institute of higher education; or,

(iii) Work at his place of employment.

2. A recipient under the age of twenty-one (21) who requires eight (8) or more hours of continuous skilled nursing care in a 24-hour period and is authorized to receive those services in the home setting may make use of the approved hours outside of that setting when normal life activities temporarily take him outside of that setting. Normal life activity for a child under the age of twenty-one (21) means routine work (including work in supported or sheltered work settings); licensed child care; school and school-related activities; religious services and related activities; and outpatient health care services (including services delivered through a TennCare home and community based services waiver program). Normal life activities do not include non-routine or extended home absences.

(d) A private duty nurse may accompany a recipient in the circumstances outlined in subparagraph (c) immediately above, but may not drive.

(e) Private duty nursing services will only be authorized when there are competent family members or caregivers as indicated below:

1. Private duty nursing services include services to teach and train the recipient and the recipient's family or other caregivers how to manage the treatment regimen. Having a caregiver willing to learn the tasks necessary to provide a safe environment and quality in home care is essential to assuring the recipient is properly attended to when a nurse or other paid caregiver is not present, including those times when the recipient chooses to attend community activities to which these rules do not specifically permit the private duty nurse or other paid caregiver to accompany the patient.

2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:

(i) Have a demonstrated understanding, ability, and commitment in the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration and feeding, or in the case of children, other medically necessary skilled nursing functions, as applicable; and

(Rule 1200-13-13-.04, continued)

(ii) Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and

(iii) Are willing and available as needed to meet the recipient's non-nursing support needs.

(iv) In the case of children under the age of 18, the parent or guardian will be expected to fill this role. In the case of an adult age 18 and older, if the health, safety, and welfare of the individual cannot be assured because the recipient does not have such family or caregiver, private duty nursing services may be denied, subject to items (I) and (II) below. However, it shall be the responsibility of the MCO to:

(I) Arrange for the appropriate level of care, which may include nursing facility care, if applicable; and

(II) In the case of a person currently receiving private duty nursing services, facilitate transition to such appropriate level of care prior to termination of the private duty nursing service.

(f) Nursing services (provided as part of home health services or by a private duty nurse) will be approved only if the requested service(s) is of the type that must be provided by a nurse as opposed to an aide, except that the MCO may elect to have a nurse perform home health aide services in addition to nursing services if the MCO determines that this is a less costly alternative than providing the services of both a nurse and an aide. Examples of appropriate nursing services include, but are not limited to, management of ventilator equipment or other life-sustaining medical technology, medication management, and tube feedings.

(g) Home health aide services will only be approved if the requested service(s) meet all medical necessity requirements including the requirements of 1200-13-16-.05(4)(d). Thus, home health aide services will not be approved to provide child care services, prepare meals, perform housework, or generally supervise patients. Examples of appropriate home health aide services include, but are not limited to, patient transfers and bathing.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23, and Public Chapter 473, Acts of 2011.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.04; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Public necessity rule filed September 7, 2005; effective through February 19, 2006. Amendments filed September 29, 2005; effective December 13, 2005. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Public necessity rule filed March 13, 2006; effective through August 25, 2006. Public necessity rules filed May 3, 2006; effective through October 15, 2006. Amendments filed March 31, 2006; effective June 14, 2006. Amendment filed June 12, 2006; effective August 26, 2006. Amendment filed July 28, 2006; effective October 11, 2006. Public necessity rule filed December 1, 2006; expires May 5, 2007. Public necessity rule filed January 26, 2007; expires July 10, 2007. Public necessity rule filed February 2, 2007; effective through July 16, 2007. Amendment filed February 2, 2007; effective April 18, 2007. Amendment filed April 25, 2007; effective July 9, 2007. Amendments filed May 2, 2007; effective July 16, 2007. Public necessity rule filed October 11, 2007; effective through March 24, 2008. Amendment filed January 8, 2008; effective March 23, 2008. Public necessity rule filed September 8, 2008; effective through February 20, 2009. Amendment filed August 19, 2008; effective November 2, 2008. Amendment*

(Rule 1200-13-13-.04, continued)

filed December 5, 2008; effective February 18, 2008. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed June 11, 2009; effective August 25, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Amendments filed September 25, 2009; effective December 24, 2009. Amendments filed September 30, 2009; effective December 29, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendment filed October 26, 2010; effective January 24, 2011. Emergency rules filed July 1, 2011; effective through December 28, 2011. Emergency rule filed August 2, 2011; effective through January 29, 2012. Amendments filed September 23, 2011; effective December 22, 2011. Amendment filed October 28, 2011; effective January 26, 2012. Amendment filed August 10, 2011; effective January 29, 2012. Amendment filed April 25, 2012; effective September 28, 2012. Emergency rule filed September 27, 2013; effective through March 26, 2014. Amendments filed July 1, 2013; effective September 29, 2013. Amendment filed August 7, 2013; effective November 5, 2013. Amendment filed September 27, 2013; effective December 26, 2013. Amendment filed December 17, 2013; effective March 17, 2014. Emergency rule filed September 30, 2015; effective through March 28, 2016. Amendments filed December 29, 2015; effective March 28, 2016. Emergency rules filed June 24, 2016; effective through December 21, 2016. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 13, 2016; effective December 12, 2016. Amendments filed September 30, 2016; effective December 29, 2016. Emergency rules filed January 16, 2018; effective through July 15, 2018. Amendments filed April 9, 2018; effective July 8, 2018.

1200-13-13-.05 ENROLLEE COST SHARING.

(1) TennCare Medicaid enrollees do not have cost sharing responsibilities for TennCare coverage and covered services, except TennCare Medicaid adults (age 21 and older) who receive pharmacy services have nominal copays for the pharmacy services. The copays are $3.00 (three dollars) for each covered branded drug and $1.50 (one dollar and fifty cents) for each covered generic drug. Branded drugs which exceed the limit of two (2) prescriptions or refills per enrollee per month are not covered. Generic drugs and covered branded drugs which exceed the limit of five (5) prescriptions or refills per enrollee per month are not covered. Family planning drugs and emergency services are exempt from copay. Enrollees may not be denied a service for inability to pay a copay. There is no Out-of-Pocket Maximum on copays.

(2) The following adult groups are exempt from copay:

(a) Individuals receiving hospice services who provide verbal notification of such to the pharmacy provider at the point of service;

(b) Individuals who are pregnant who provide verbal notification of such to the pharmacy provider at the point of service; and

(c) Individuals who are receiving services in a Nursing Facility, an Intermediate Care Facility for Individuals with Intellectual Disabilities, CHOICES Group 2, or a Home and Community Based Services waiver for individuals with intellectual disabilities.

(d) Adults age 21 and older enrolled in ECF CHOICES who meet nursing facility level of care or transitioned from a Section 1915(c) waiver into ECF CHOICES and granted an exception by TennCare based on ICF/IID level of care.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, Acts of 2003, Public Chapter 412, §1(c), and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.05; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment by Acts of 2003, Public Chapter 412, §1(c) filed and effective June 25, 2003. Public necessity rule filed July 1, 2005; effective through*

(Rule 1200-13-13-.05, continued)

December 13, 2005. Amendment filed September 26, 2005; effective December 10, 2005. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rule filed September 26, 2013; effective through March 25, 2014. Amendment filed December 17, 2013; effective March 17, 2014. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.

1200-13-13-.06 MANAGED CARE ORGANIZATIONS.

Managed Care Organizations participating in TennCare will be limited to Health Maintenance Organizations that are appropriately licensed to operate within the state of Tennessee to provide medical, behavioral, and long-term care services in the TennCare program. Managed Care Organizations shall have a fully executed contract with the Tennessee Department of Finance and Administration. MCOs, DBMs and PBMs shall agree to comply with all applicable rules, policies, and contract requirements as specified by the Tennessee Department of Finance and Administration as applicable. Managed Care Organizations must continually demonstrate a sufficient provider network based on the standards set by the Bureau of TennCare to remain in the program and must reasonably meet all quality of care requirements established by the Bureau of TennCare.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.06; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment filed September 25, 2009; effective December 24, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010.*

1200-13-13-.07 MANAGED CARE ORGANIZATION PAYMENT.

Managed care organizations will be paid pursuant to the contract the MCO has fully executed with the Tennessee Department of Finance and Administration.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.07; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003.*

1200-13-13-.08 PROVIDERS.

(1) Payment in full.

(a) All Participating Providers, as defined in this Chapter, must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.

(b) Any Non-Participating Providers who provide TennCare Program covered services by authorization from an MCC must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.

(c) Any Non-Participating Provider, as defined in this Chapter, who provides TennCare Program covered non-emergency services to TennCare enrollees without authorization from the enrollee's MCC does so at his own risk. He may not bill the patient for such services except as provided for in Rule 1200-13-13-.08(5).

(Rule 1200-13-13-.08, continued)

(d) Any Out-of-State Emergency Provider, as defined in this Chapter, who provides covered emergency services to TennCare enrollees in accordance with this Chapter must accept as payment in full the amounts paid by the MCC plus any copayment required by the TennCare Program.

(2) Non-Participating Providers.

(a) In situations where a MCC authorizes a service to be rendered by a provider who is not a Participating Provider with the MCC, as defined in this Chapter, payment to the provider shall be no less than eighty percent (80%) of the lowest rate paid by the MCC to equivalent participating network providers for the same service.

(b) Covered medically necessary outpatient emergency services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(D) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(D)), shall be reimbursed at seventy-four percent (74%) of the 2006 Medicare rates for these services. Emergency care to enrollees shall not require preauthorization.

(c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(B) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(B)), shall be reimbursed at 57 percent of the 2008 Medicare Diagnostic Related Groups (DRG) rates (excluding Medical Education and Disproportionate Share components) determined in accordance with 42 C.F.R. § 412 for those services. For DRG codes that are adopted after 2008, 57 percent of the rate from the year of adoption will apply. Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a contract hospital or to another contract service, whichever comes first.

(d) Non-Participating Providers who furnish covered CHOICES services are reimbursed in accordance with Rule 1200-13-01-.05.

(e) Non-Participating Providers who furnish covered ECF CHOICES services are reimbursed in accordance with Rule 1200-13-01-.31.

(3) Participation in the TennCare program will be limited to providers who:

(a) Accept, as payment in full, the amounts paid by the managed care contractor, including copays from the enrollee, or the amounts paid in lieu of the managed care contractor by a third party (Medicare, insurance, etc.);

(b) Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the TDMHDD, if appropriate;

(c) Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);

(d) Agree to maintain and provide access to TennCare and/or its agent all TennCare enrollee medical records for five (5) years from the date of service or upon written authorization from TennCare following an audit, whichever is shorter;

(e) Provide medical assistance at or above recognized standards of practice; and

(Rule 1200-13-13-.08, continued)

(f) Comply with all contractual terms between the provider and the managed care contractor and TennCare policies as outlined in federal and state rules and regulations and TennCare provider manuals and bulletins.

(g) Failure to comply with any of the above provisions (a) through (f) may subject a provider to the following actions:

1. Sanctions set out in T.C.A. § 71-5-118. In addition, the provider may be subject to stringent review/audit procedures, which may include clinical evaluation of services and a prepayment requirement for documentation and justification for each claim.

2. The Bureau of TennCare may withhold or recover payments to managed care contractors in cases of provider fraud, willful misrepresentation, or flagrant non-compliance with contractual requirements and/or TennCare policies.

3. The Bureau of TennCare may refuse to approve or may suspend provider participation with a provider if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the US Title XX Services Program.

4. The Bureau of TennCare may refuse to approve or may suspend provider participation if it determines that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the US Title XX Services Program since the inception of these programs.

5. The Bureau of TennCare shall refuse to approve or shall suspend provider participation if the appropriate State Board of Licensing or Certification fails to license or certify the provider at any time for any reason or suspends or revokes a license or certification.

6. The Bureau of TennCare shall refuse to approve or shall suspend provider participation upon notification by the US Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare or Medicaid for federal financial participation.

7. The Bureau of TennCare may recover from a managed care contractor any payments made by an enrollee and/or his family for a covered service, in total or in part, except as permitted. If a provider knowingly bills an enrollee and/or his family for a covered service, in total or in part, except as permitted, the Bureau of TennCare may terminate the provider's participation in TennCare.

(4) Solicitations and Referrals.

(a) Managed care contractors and providers shall not solicit TennCare enrollees by any method offering as enticements other goods and services (free or otherwise) for the opportunity of providing the enrollee with TennCare covered services that are not medically necessary and/or that overutilize the TennCare program.

(b) A managed care contractor may request a waiver from this restriction in writing to TennCare. TennCare shall determine the value of a waiver request based upon the

(Rule 1200-13-13-.08, continued)

medical necessity and need for the solicitation. The managed care contractor may implement the solicitation only upon receipt of a written waiver approval from TennCare. This waiver is not transferable and may be canceled by TennCare upon written notice.

(c) TennCare payments for services related to a non-waivered solicitation enticement shall be considered by TennCare as a non-covered service and recouped. Neither the managed care contractor nor the provider may bill the enrollee for non-covered services recouped under this authority.

(d) A provider shall not offer or receive remuneration in any form related to the volume or value of referrals made or received from or to another provider.

(5) Providers may seek payment from a TennCare enrollee only under the following circumstances. These circumstances apply to all TennCare providers, as defined in this Chapter, including those who are Out-of-Network Providers in a particular enrollee's MCC. These circumstances include situations where the enrollee may choose to seek an out-of-network provider for a specific covered service.

(a) If the services are not covered by the TennCare program and, prior to providing the services, the provider informed the enrollee that the services were not covered; or

(b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:

1. The provider determines effective on the date of service that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and the service will not be paid for by TennCare. The source of the provider's information must be a database listed on the TennCare website as approved by TennCare on the date of the provider's inquiry.

2. The provider has information in his/her own records to support the fact that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by TennCare. This information may include:

(i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to the benefit limit is still in effect; or

(ii) That the provider had previously examined the database referenced in part 1. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect; or

(iii) That the provider had personally provided services to the enrollee in excess of his/her benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit period is still in effect; or

(iv) The enrollee's MCO has provided confirmation to the provider that the enrollee has reached his/her benefit limit for the applicable service.

3. The provider submits a claim for service to the appropriate managed care contractor (MCC) and receives a written denial of that claim on the basis that the

service exceeds the enrollee's benefit limit. Thereafter, following informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee for services within that same exhausted benefit category without having to submit, for repeated MCC denial, claims for those subsequent services. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by TennCare, the provider may bill the enrollee for that service.

4. The provider had previously taken the steps in parts 1., 2. or 3. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to the benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by TennCare.

(c) If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the enrollee that the services are not covered, the enrollee may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.

(6) Providers may not seek payment from a TennCare enrollee under the following conditions:

(a) The provider knew or should have known about the patient's TennCare eligibility or pending eligibility prior to providing services.

(b) The claim(s) submitted to TennCare or the enrollee's managed care contractor for payment was/were denied due to provider billing error or a TennCare claim processing error.

(c) The provider accepted TennCare assignment on a claim and it is determined that another payer paid an amount equal to or greater than the TennCare allowable amount.

(d) The provider failed to comply with TennCare policies and procedures or provided a service which lacks medical necessity or justification.

(e) The provider failed to submit or resubmit claims for payment within the time periods required by the managed care contractor or TennCare.

(f) The provider failed to ascertain the existence of TennCare eligibility or pending eligibility prior to providing non-emergency services. Even if the enrollee presents another form of insurance, the provider must determine whether the patient is covered under TennCare.

(g) The provider failed to inform the enrollee prior to providing a service not covered by TennCare that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement. Notwithstanding this exemption, providers shall remain obligated to provide notice to enrollees who have exceeded benefit limits in accordance with rule 1200-13-13-.11.

(h) The enrollee failed to keep a scheduled appointment(s).

(Rule 1200-13-13-.08, continued)

(i) The provider is a TennCare Provider, as defined in this Chapter, but is not participating with a particular enrollee's MCC and is seeking to bill the enrollee as though the provider were a Non-TennCare Provider, as defined in this Chapter.

(7) Providers may seek payment from a person whose TennCare eligibility is pending at the time services are provided if the provider informs the person that TennCare assignment will not be accepted whether or not eligibility is established retroactively.

(8) Providers may seek payment from a person whose TennCare eligibility is pending at the time services are provided. Providers may bill such persons at the provider's usual and customary rate for the services rendered. However, all monies collected for TennCare-covered services rendered during a period of TennCare eligibility must be refunded when a claim is submitted to TennCare if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established.

(9) Providers of inpatient hospital services, outpatient hospital services, skilled nursing facility services, independent laboratory and x-ray services, hospice services, and home health agencies must be approved for Title XVIII-Medicare in order to be certified as providers under the TennCare Program; in the case of hospitals, the hospital must meet state licensure requirements and be approved by TennCare as an acute care hospital as of the date of enrollment in TennCare. Children's hospitals and State mental hospitals may participate in TennCare without having been Medicare approved; however, the hospital must be approved by the Joint Commission for Accreditation of Health Care Organizations as a condition of participation.

(10) Pharmacy providers may not waive pharmacy copayments for TennCare Standard enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.

(11) Providers shall not deny services for a Medicaid enrollee's failure to make copayments.

(12) All claims must be filed in accordance with the following:

(a) Claims filed with an MCC must be submitted in accordance with the requirements and timeframes set forth in the MCC's contract.

(b) All other fee-for-service claims for services delivered outside of the TennCare managed care program must be filed with the Bureau of TennCare as follows:

1. All claims must be filed within one (1) year of the date of service except in the following circumstances:

(i) Recipient eligibility was determined retroactively to the extent that filing within one (1) year was not possible. In such situations, claims must be filed within one (1) year after final determination of eligibility.

(ii) If a claim filed with Medicare on a timely basis does not automatically cross over from the Medicare carrier to The Bureau, a TennCare claim may be filed within six (6) months of notification of payment or denial from Medicare.

2. Should an original claim be denied, any resubmission or follow-up of the initial claim must be received within six (6) months from the date the original claim was filed. The Bureau will not process submissions received after the six (6) month

(Rule 1200-13-13-.08, continued)

time limit. The one exception is those claims returned due to available third party coverage. These claims must be submitted within sixty (60) days of notice from the third party resource.

3. Should a correction document involving a suspended claim be sent to the provider, the claim will be denied if the correction document is not completed by the provider and returned to the Bureau within ninety (90) days from the date on the document.

4. If claim is not filed within the above timeframes, no reimbursement may be made.

5. Claims will be paid on a first claim approved - first claim paid basis.

6. The Bureau will not reimburse providers for services for which there is no Federal Financial Participation.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, 71-5-134, Acts of 2003, Public Chapter 412, §1(c), and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.08; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment by Acts of 2003, Public Chapter 412, §1(c) filed and effective June 25, 2003. Amendment filed October 12, 2004; effective December 26, 2004. Public necessity rule filed July 29, 2005; effective through January 10, 2006. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendment filed October 27, 2005; effective January 10, 2006. Amendment filed March 31, 2006; effective June 14, 2006. Public necessity rule filed September 8, 2008; effective through February 20, 2009. Amendment filed December 5, 2008; effective February 18, 2009. Amendment filed February 25, 2009; effective May 11, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rule filed September 3, 2010; effective through March 2, 2011. Amendment filed December 2, 2010 to have been effective March 2, 2011 was stayed by the Government Operations Committee on March 2, 2011; new effective date March 29, 2011. Emergency rules filed July 1, 2016; effective December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.*

1200-13-13-.09 THIRD PARTY RESOURCES.

(1) Individuals applying for TennCare Medicaid or TennCare Standard coverage shall disclose the availability of any third party health care coverage to the agency responsible for determining the individual's eligibility for TennCare.

(2) An individual enrolled in TennCare Medicaid or TennCare Standard shall disclose access to third party resources to his/her specified Managed Care Contractors as soon as s/he becomes aware of the existence of any third party resources.

(3) Managed Care Contractors under contract with the Tennessee Departments of Finance and Administration or Mental Health and Developmental Disabilities shall provide all third party resource information obtained from the plan's enrollees to the Bureau of TennCare on a regular basis as required by their contracts.

(4) Managed Care Contractors shall enforce TennCare subrogation rights pursuant to T.C.A. § 71-5-117.

(5) Managed Care Contractors may pay health insurance premiums for their enrollees if such payments are determined by the Bureau to be cost effective.

(Rule 1200-13-13-.09, continued)

(6) TennCare shall be the payor of last resort, except where contrary to federal or state law.

(7) Asset Disregards for Qualifying Long Term Care Insurance Policies:

(a) Individuals who purchase a qualified long term care insurance policy may have certain assets disregarded in the determination of eligibility for TennCare Medicaid. The Department of Human Services (DHS) shall disregard an individual's assets up to the amount of payments made by the individual's qualifying long-term care insurance policy for services covered under the policy at the time of TennCare application.

(b) The amount of the individual's assets properly disregarded under these provisions shall continue to be disregarded through the lifetime of the individual.

(c) Assets which were disregarded for purposes of Medicaid eligibility determination during the person's lifetime are also protected from estate recovery. When the amount of assets disregarded during the person's lifetime was less than total benefits paid by the qualified long term care insurance policy, additional assets may be protected in the estate recovery process up to the amount of payments made by the individual's qualifying long term care policy for services covered under the policy. If no assets were disregarded during the person's lifetime, the personal representative may designate assets to protect from estate recovery up to the lesser of the two options specified above, even if a qualified long term care policy's benefits were not completely exhausted.

(8) Upon enrollment in TennCare Medicaid or TennCare Standard an individual assigns to the Bureau any rights to third party insurance benefits to which the individual may be entitled.

(9) Upon accepting medical assistance, an enrollee in TennCare Medicaid or TennCare Standard shall be deemed to have made an assignment to the Bureau of the right to third party insurance benefits to which the enrollee may be entitled.

(10) The Bureau shall utilize direct billing when it is determined that a previously paid service may have been covered by a third party.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, 71-5-117, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.09; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment filed February 18; effective May 4, 2009. Amendment filed January 15, 2013; effective April 15, 2013.*

1200-13-13-.10 EXCLUSIONS.

(1) General exclusions. The following items and services shall not be considered covered services by TennCare:

(a) Provision of medical assistance which is outside the scope of benefits as defined in these rules.

(b) Provision of services to persons who are not enrolled in TennCare, either on the date the services are delivered or retroactively to the date the services are delivered.

(c) Services for which there is no Federal Financial Participation (FFP).

(d) Services provided outside the United States or its territories.

(Rule 1200-13-13-.10, continued)

(e) Services provided outside the geographic borders of Tennessee, including transportation to return to Tennessee to receive medical care except in the following circumstances:

1. Emergency medical services are needed because of an emergency medical condition;

2. Non-emergency urgent care services are requested because the recipient's health would be endangered if he were required to travel, but only upon the explicit prior authorization of the MCC;

3. The covered medical service would not be readily available within Tennessee if the enrollee was physically located in Tennessee at the time of need and the covered service is explicitly prior authorized by the enrollee's TennCare MCC; or

4. The out-of-state provider is participating in the enrollee's MCC network.

(f) Investigative or experimental services or procedures including, but not limited to:

1. Drug or device that lacks FDA approval except when medically necessary as defined by TennCare;

2. Drug or device that lacks approval of facility's Institutional Review Board;

3. Requested treatment that is the subject of Phase I or Phase II clinical trials or the investigational arm of Phase III clinical trials; or

4. A requested service about which prevailing opinion among experts is that further study is required to determine safety, efficacy, or long-term clinical outcomes of requested service.

(g) Services which are delivered in connection with, or required by, an item or service not covered by TennCare, including the transportation to receive such non-covered services, except that treatment of conditions resulting from the provision of non-covered services may be covered if medically necessary, notwithstanding the exclusions set out herein.

(h) Items or services furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.

(i) Non-emergency services that are ordered or furnished by an out-of-network provider and that have not been approved by the enrollee's MCC. An exception exists for dually eligible enrollees. In-network care ordered by out-of-network providers is covered for dually eligible enrollees unless the MCO has informed such enrollee in advance of a request for a service that the specific service requires prior authorization and an order from an in-network provider.

(j) Services that are free to the public, with the exception of services delivered in the schools pursuant to the Individuals with Disabilities in Education Act (IDEA).

(k) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that has been excluded from participation in the Medicaid program under the authority of the United States Department of Health and Human Services or the Bureau of TennCare.

(Rule 1200-13-13-.10, continued)

(l) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that is not licensed by the appropriate licensing board.

(m) Items or services outside the scope and/or authority of a provider's specialty and/or area of practice.

(n) Items or services to the extent that Medicare or a third party payer is legally responsible to pay or would have been legally responsible to pay except for the enrollee's or the treating provider's failure to comply with the requirements for coverage of such services.

(o) Medical services for inmates confined in a local, state, or federal prison, jail, or other penal or correctional facility, including a furlough from such facility.

(p) Services delivered by a specific provider, even a provider who is an in-network provider with the enrollee's managed care plan, when the managed care plan has offered the enrollee the services of a qualified provider who is available to provide the needed services.

(q) Items or services that are not covered by Medicare or a third party payer for an individual enrollee because the item or service is essentially equivalent to a Medicare or third party payer service that is being covered (e.g., home health services for individuals receiving hospice care).

(2) Exception to General and Specific Exclusions: COST EFFECTIVE ALTERNATIVE. As approved by CMS and/or authorized by Policy BEN 08-001, each MCC has sole discretionary authority to provide certain cost effective alternatives when providing appropriate medically necessary care. These services are otherwise excluded and are not covered services unless the MCC has followed the procedures set forth in Policy BEN 08-001 and opts at its sole discretion to provide such requested item or service.

(3) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115 waiver program unless excepted by paragraph (2) herein. Some of these services may be covered under the CHOICES or ECF CHOICES programs or outside the managed care program under a Section 1915(c) Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with the appropriate approved TennCare Home and Community Based Services waiver.

(a) Services, products, and supplies that are specifically excluded from coverage except as medically necessary for children under the age of 21

1. Audiological therapy or training

2. Augmentative communication devices

3. Beds and bedding equipment as follows:

(i) Powered air flotation beds, air fluidized beds (including Clinitron beds), water pressure mattress, or gel mattress

For persons age 21 and older: Not covered unless a member has both severely impaired mobility (i.e., unable to make independent changes in body position to alleviate pain or pressure) and any stage pressure ulcer on the trunk or pelvis combined with at least one of the following: impaired

nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status.

(ii) Bead beds, or similar devices

(iii) Bed boards

(iv) Bedding and bed casings

(v) Ortho-prone beds

(vi) Oscillating beds

(vii) Springbase beds

(xiii) Vail beds, or similar bed

4. Biofeedback

5. Chiropractor's services

6. Cushions, pads, and mattresses as follows:

(i) Aquamatic K Pads

(ii) Elbow protectors

(iii) Heat and massage foam cushion pads

(iv) Heating pads

(v) Heel protectors

(vi) Lamb's wool pads

(vii) Steam packs

7. Diagnostic tests conducted solely for the purpose of evaluating the need for a service which is excluded from coverage under these rules.

8. Ear plugs

9. Floor standers, meaning stationary devices not attached to a wheelchair base and not built into the operating system of a power wheelchair that are designed to hold in an upright position an Enrollee who uses a wheelchair and who has limited or no ability to stand on his own

10. Food supplements and substitutes including formulas

For persons 21 years of age and older: Not covered, except that Parenteral Nutrition formulas, Enteral Nutrition formulas for tube feedings and phenylalanine-free formulas (not foods) used to treat PKU, as required by T.C.A. § 56-7-2505, are covered for adults. In addition, oral liquid nutrition may be covered when medically necessary for adults with swallowing or breathing disorders who are severely underweight (BMI<15 kg/m^2) and physically incapable

(Rule 1200-13-13-.10, continued)

of otherwise consuming a sufficient intake of food to meet basic nutritional requirements.

11. Hearing services, including the prescribing, fitting, or changing of hearing aids

12. Humidifiers (central or room) and dehumidifiers

13. Inpatient rehabilitation facility services

14. Medical supplies, over-the-counter, as follows:

    (i) Alcohol, rubbing

    (ii) Band-aids

    (iii) Cotton balls

    (iv) Eyewash

    (v) Peroxide

    (vi) Q-tips or cotton swabs

15. Methadone clinic services

16. Nutritional supplements and vitamins, over-the-counter, except that prenatal vitamins for pregnant women and folic acid for women of childbearing age are covered

17. Orthodontic services, except as defined in Rule 1200-13-13-.04(1)(b)5. or 1200-13-14-.04(1)(b)5.

18. Certain pharmacy items as follows:

    (i) Agents when used for anorexia or weight loss

    (ii) Agents when used to promote fertility

    (iii) Agents when used for cosmetic purposes or hair growth

    (iv) Agents when used for the symptomatic relief of cough and colds

    (v) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

    (vi) Nonprescription drugs

    (vii) Buprenorphine-containing products used for treatment of opiate addiction in excess of the covered amounts listed below:

        (I) Dosage of sixteen milligrams (16 mg) per day for a period of up to six (6) months (183 days) from the initiation of therapy or from the conclusion of pregnancy, if the enrollee is pregnant during this initial maximum dosage therapy; and

(Rule 1200-13-13-.10, continued)

(II) Dosage of eight milligrams (8 mg) per day after the sixth (6^{th}) month (183^{rd} day) of therapy.

(viii) Sedative hypnotic medications in dosage amounts that exceed the dosage amounts listed below:

(I) Fourteen (14) pills per month for sedative hypnotic formulations in pill form such as Ambien and Lunesta;

(II) One hundred forty milliliters (140 ml) per month of chloral hydrate; or

(III) One (1) bottle every sixty (60) days of Zolpimist.

(ix) Allergy medications

(x) Opioid products are restricted as set out in Rule .04(1)(c)12.

19. Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of enrollee abuse

20. Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:

(i) Explanation of continuing medical necessity for the item, and

(ii) Explanation that the item was stolen or destroyed, and

(iii) Copy of police, fire department, or insurance report if applicable

21. Radial keratotomy

22. Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME) item that is stolen or destroyed

23. Repair of DME items not covered by TennCare

24. Repair of DME items covered under the provider's or manufacturer's warranty

25. Repair of a rented DME item

26. Speech, language, and hearing services to address speech problems caused by mental, psychoneurotic, or personality disorders

27. Standing tables

28. Vision services for persons 21 years of age and older that are not needed to treat a systemic disease process including, but not limited to:

(i) Eyeglasses, sunglasses, and/or contact lenses for persons aged 21 and older, including eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, sunglasses, and/or contact lenses; procedures performed to determine the refractive state of the eye(s); one pair of cataract glasses or lenses is covered for adults following cataract surgery

(ii) LASIK

(Rule 1200-13-13-.10, continued)

(iii) Orthoptics

(iv) Vision perception training

(v) Vision therapy

(b) Services, products, and supplies that are specifically excluded from coverage under the TennCare program.

1. Air cleaners, purifiers, or HEPA filters

2. Alcoholic beverages

3. Animal therapy including, but not limited to:

(i) Dolphin therapy

(ii) Equine therapy

(iii) Hippo therapy

(iv) Pet therapy

4. Art therapy

5. Autopsy

6. Bathtub equipment and supplies as follows:

(i) Paraffin baths

(ii) Sauna baths

7. Beds and bedding equipment as follows:

(i) Adjust-a-Beds, lounge beds, or similar devices

(ii) Pillows

(iii) Waterbeds

8. Bioenergetic therapy

9. Body adornment and enhancement services including, but not limited to:

(i) Body piercing

(ii) Breast augmentation

(iii) Breast capsulectomy

(iv) Breast implant removal that is not medically indicated

(v) Ear piercing

(vi) Hair transplantation, and agents for hair growth

(vii) Tattoos or removal of tattoos

(viii) Tongue splitting or repair of tongue splitting

(ix) Wigs or hairpieces

10. Breathing equipment as follows:

(i) Intrapulmonary Percussive Ventilators (IPVs)

(ii) Spirometers, except for peak flow meters for medical management of asthma and incentive spirometers

(iii) Vaporizers

11. Carbon dioxide therapy

12. Care facilities or services, the primary purpose of which is non-medical, including, but not limited to:

(i) Day care

(ii) Evening care centers

(iii) Respite care, except as a component of Mental Health Crisis Services benefits or Hospice Care benefits as provided at Rule 1200-13-13-.04(1)(b).

(iv) Rest cures

(v) Social or diversion services related to the judicial system

13. Carotid body tumor, excision of, as treatment for asthma

14. Chelation therapy, except for the treatment of heavy metal poisoning or secondary hemochromatosis in selected settings. Chelation therapy for treatment of arteriosclerosis or autism is not covered. Chelation therapy for asymptomatic individuals is not covered. In the case of lead poisoning, the lead levels must be extremely high. For children, a minimum level of 45 ug/dl is recommended. Because chelation therapy and its after-effects must be continuously monitored for possible adverse reactions, chelation therapy is covered only in inpatient or outpatient hospital settings, renal dialysis facilities, and skilled nursing facilities. It is not covered in an office setting, an ambulatory surgical center, or a home setting.

15. Clothing, including adaptive clothing

16. Cold therapy devices

17. Comfort and convenience items including, but not limited to:

(i) Corn plasters

(ii) Garter belts

(Rule 1200-13-13-.10, continued)

(iii) Incontinence products (diapers/liners/underpads) not needed for a medical condition; not covered for children age 3 and younger

(iv) Support stockings, when light or medium weight or prescribed for relief of tired or aching legs or treatment of spider/varicose veins. Surgical weight stockings prescribed by a doctor or other qualified licensed health care practitioner for the treatment of chronic foot/ankle swelling, venous insufficiencies, or other medical conditions and thrombo-embolic deterrent support stockings for pre- and post-surgical procedures are covered as medically necessary.

18. Computers, personal, and peripherals including, but not limited to printers, modems, monitors, scanners, and software, including their use in conjunction with an Augmentative Communication Device

19. Convalescent care.

20. Cosmetic dentistry, cosmetic oral surgery, and cosmetic orthodontic services

21. Cosmetic prosthetic devices

22. Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem, including scar revision. The following services are not considered cosmetic services:

(i) Reconstructive surgery to correct the results of an injury or disease

(ii) Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function

(iii) Surgery to reconstruct a breast after mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure

(iv) In accordance with Tennessee law, surgery of the non-diseased breast following mastectomy and reconstruction to create symmetrical appearance

(v) Surgery for the improvement of the functioning of a malformed body member

(vi) Reduction mammoplasty, when the minimum amount of breast material to be removed is equal to or greater than the 22nd percentile of the Schnur Sliding Scale based on the individual's body surface area.

23. Dance therapy

24. Dental services for adults age 21 and older

25. Services provided solely or primarily for educational purposes, including, but not limited to:

(i) Academic performance testing

(ii) Educational tests and training programs

(Rule 1200-13-13-.10, continued)

(iii) Habilitation

(iv) Job training

(v) Lamaze classes

(vi) Lovaas therapy

(vii) Picture illustrations

(viii) Remedial education

(ix) Sign language instruction

(x) Special education

(xi) Tutors

26. Encounter groups or workshops

27. Environmental modifications including, but not limited to:

(i) Air conditioners, central or unit

(ii) Micronaire environmentals, and similar devices

(iii) Pollen extractors

(iv) Portable room heaters

(v) Vacuum systems for dust filtering

(vi) Water purifiers

(vii) Water softeners

28. Exercise equipment including, but not limited to:

(i) Exercise equipment

(ii) Exercycles (including cardiac use)

(iii) Functional electrical stimulation

(iv) Gravitronic traction devices

(v) Gravity guidance inversion boots

(vi) Parallel bars

(vii) Pulse tachometers

(viii) Tilt tables when used for inversion

(ix) Training balls

(Rule 1200-13-13-.10, continued)

(x) Treadmill exercisers

(xi) Weighted quad boots

29. Food and food products (distinct from food supplements or substitutes, as defined in Rule 1200-13-13-.10(3)(a)10.), including but not limited to specialty food items for use in diets such as:

(i) Low-phenylalanine or phenylalanine-free

(ii) Gluten-free

(iii) Casein-free

(iv) Ketogenic

30. Generators and auxiliary power equipment that may be used to provide power for covered medical equipment or for any purpose

31. Grooming services including, but not limited to:

(i) Barber services

(ii) Beauty services

(iii) Electrolysis

(iv) Hairpieces or wigs

(v) Manicures

(vi) Pedicures

32. Hair analysis

33. Home health aide services or services from any other individual or agency that are for the primary purpose of safety monitoring

34. Home modifications and items for use in the home

(i) Decks

(ii) Enlarged doorways

(iii) Environmental accessibility modifications such as grab bars and ramps

(iv) Fences

(v) Furniture, indoor or outdoor

(vi) Handrails

(vii) Meals

(viii) Overbed tables

(Rule 1200-13-13-.10, continued)

(ix) Patios, sidewalks, driveways, and concrete slabs

(x) Plexiglass

(xi) Plumbing repairs

(xii) Porch gliders

(xiii) Rollabout chairs

(xiv) Room additions and room expansions

(xv) Telephone alert systems

(xvi) Telephone arms

(xvii) Telephone service in home

(xviii) Televisions

(xix) Tilt tables when used for inversion

(xx) Toilet trainers and potty chairs. Positioning commodes and toilet supports are covered as medically necessary.

(xxi) Utilities (gas, electric, water, etc.)

35. Homemaker services

36. Hospital inpatient items that are not directly related to the treatment of an injury or illness (such as radios, TVs, movies, telephones, massage, guest beds, haircuts, hair styling, guest trays, etc.)

37. Hotel charges, unless pre-approved in conjunction with a transplant or as part of a non-emergency transportation service

38. Hypnosis or hypnotherapy

39. Infant/child car seats, except that adaptive car seats may be covered for a person with disabilities such as severe cerebral palsy, spina bifida, muscular dystrophy, and similar disorders who meets all of the following conditions:

(i) Cannot sit upright unassisted, and

(ii) Infant/child care seats are too small or do not provide adequate support, and

(iii) Safe automobile transport is not otherwise possible.

40. Infertility or impotence services including, but not limited to:

(i) Artificial insemination services

(ii) Purchase of donor sperm and any charges for the storage of sperm

(Rule 1200-13-13-.10, continued)

(iii) Purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers of gestational carriers

(iv) Cryopreservation and storage of cryopreserved embryos

(v) Services associated with a gestational carrier program (surrogate parenting) for the recipient or the gestational carrier

(vi) Fertility drugs

(vii) Home ovulation prediction kits

(viii) Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal

(ix) Reversal of sterilization procedures

(x) Any other service or procedure intended to create a pregnancy

(xi) Testing and/or treatment, including therapy, supplies, and counseling, for frigidity or impotence

41. Injections for the treatment of pain such as:

(i) Facet/medial branch injections for therapeutic purposes

(ii) Medial branch injections for diagnostic purposes in excess of four (4) injections in a calendar year

(iii) Trigger point injections in excess of four (4) injections per muscle trigger point during any period of six (6) consecutive months

(iv) Epidural steroid injections in excess of three (3) injections during any period of six (6) consecutive months, except epidural injections associated with childbirth

42. Lamps such as:

(i) Heating lamps

(ii) Lava lamps

(iii) Sunlamps

(iv) Ultraviolet lamps

43. Lifts as follows:

(i) Automobile van lifts

(ii) Electric powered recliner, elevating seats, and lift chairs

(iii) Elevators

(iv) Overhead or ceiling lifts, ceiling track system lifts, or wall mounted lifts when installation would require significant structural modification and/or

(Rule 1200-13-13-.10, continued)

renovation to the dwelling (e.g., moving walls, enlarging passageways, strengthening ceilings and supports). The request for prior authorization must include a specific breakdown of equipment and installation costs, specifying all required structural modifications (however minor) and the cost associated thereto.

(v) Stairway lifts, stair glides, and platform lifts, including but not limited to Wheel-O-Vators

44. Ligation of mammary arteries, unilateral or bilateral

45. Megavitamin therapy

46. Motor vehicle parts and services including, but not limited to:

(i) Automobile controls

(ii) Automobile repairs or modifications

47. Music therapy

48. Nail analysis

49. Naturopathic services

50. Necropsy

51. Organ and tissue transplants that have been determined experimental or investigational

52. Organ and tissue donor services provided in connection with organ or tissue transplants covered pursuant to Rule 1200-13-13-.04(1)(b)22., including, but not limited to:

(i) Transplants from a donor who is a living TennCare enrollee and the transplant is to a non-TennCare enrollee

(ii) Donor services other than the direct services related to organ procurement (such as, hospitalization, physician services, anesthesia)

(iii) Hotels, meals, or similar items provided outside the hospital setting for the donor

(iv) Any costs incurred by the next of kin of the donor

(v) Any services provided outside of any “bundled rates” after the donor is discharged from the hospital

53. Oxygen, except when provided under the order of a physician and administered under the direction of a physician

54. Oxygen, preset system (flow rate not adjustable)

55. Certain pharmacy items as follows: DESI, LTE, and IRS drugs

56. Play therapy

(Rule 1200-13-13-.10, continued)

57. Primal therapy

58. Prophylactic use of stainless steel crowns

59. Psychodrama

60. Psychogenic sexual dysfunction or transformation services

61. Purging

62. Recertification of patients in Level 1 and Level II Nursing Facilities

63. Recreational therapy

64. Religious counseling

65. Retreats for mental disorders

66. Rolfing

67. Routine health services which may be required by an employer; or by a facility where an individual lives, goes to school, or works; or by the enrollee's intent to travel

    (i) Drug screenings

    (ii) Employment and pre-employment physicals

    (iii) Fitness to duty examinations

    (iv) Immunizations related to travel or work

    (v) Insurance physicals

    (vi) Job related illness or injury covered by workers' compensation

68. Sensitivity training or workshops

69. Sensory integration therapy and equipment used in sensory integration therapy including, but not limited to:

    (i) Ankle weights

    (ii) Floor mats

    (iii) Mini-trampolines

    (iv) Poof chairs

    (v) Sensory balls

    (vi) Sky chairs

    (vii) Suspension swings

(Rule 1200-13-13-.10, continued)

(viii) Trampolines

(ix) Therapy balls

(x) Weighted blankets or weighted vests

70. Sensory stimulation services

71. Services provided by immediate relatives, i.e., a spouse, parent, grandparent, stepparent, child, grandchild, brother, sister, half brother, half sister, a spouse's parents or stepparents, or members of the recipient's household

72. Sex change or transformation surgery

73. Sexual dysfunction or inadequacy services and medicine, including drugs for erectile dysfunctions and penile implant devices

74. Sitter Services.

75. Speech devices as follows:

(i) Phone mirror handivoice

(ii) Speech software

(iii) Speech teaching machines

76. Sphygmomanometers (blood pressure cuffs)

77. Stethoscopes

78. Supports

(i) Cervical pillows

(ii) Orthotrac pneumatic vests

79. TENS (transcutaneous electrical nerve stimulation) units for the treatment of chronic lower back pain

80. Thermograms

81. Thermography

82. Time involved in completing necessary forms, claims, or reports

83. Tinnitus maskers

84. Toy equipment such as: Flash switches (for toys)

85. Transportation costs as follows:

(i) Transportation to a provider who is outside the geographical access standards that the MCC is required to meet when a network provider is available within such geographical access standards or, in the case of Medicare beneficiaries, transportation to Medicare providers who are

(Rule 1200-13-13-.10, continued)

outside the geographical access standards of the TennCare program when there are Medicare providers available within those standards

(ii) Mileage reimbursement, car rental fees, or other reimbursement for use of a private vehicle unless prior authorized by the MCC in lieu of contracted transportation services

(iii) Transportation back to Tennessee from vacation or other travel out-of-state in order to access non-emergency covered services (unless authorized by the MCC)

(iv) Any non-emergency out-of-state transportation, including airfare, that has not been prior authorized by the MCC. This includes the costs of transportation to obtain out-of-state care that has been authorized by the MCC. Out-of-state transportation must be prior authorized independently of out-of-state care.

86. Transsexual surgery

87. Urine drug screens in excess of twelve (12), four (4) confirmation urine screens and two (2) specific assay tests during a calendar year.

88. Vagus nerve stimulators, except after conventional therapy has failed in treating partial onset of seizures.

89. Weight loss or weight gain and physical fitness programs including, but not limited to:

(i) Dietary programs of weight loss programs, including, but not limited to, Optifast, Nutrisystem, and other similar programs or exercise programs. Food supplements will not be authorized for use in weight loss programs or for weight gain.

(ii) Health clubs, membership fees (e.g., YMCA)

(iii) Marathons, activity and entry fees

(iv) Swimming pools

90. Wheelchairs and wheelchair accessories as follows:

(i) Wheelchairs defined by CMS as power operated vehicles (POVs), namely, scooters and devices with three (3) or four (4) wheels that have tiller steering and limited seat modification capabilities (i.e. provide little or no back support).

(ii) Standing wheelchairs. However a power standing system is covered as set out in the definition of Power Seating Accessories in Rule 1200-13-13-.01.

(iii) Stair climbing wheelchairs.

(iv) Recreational wheelchairs.

91. Whirlpools and whirlpool equipment such as:

(i) Action bath hydro massage

(Rule 1200-13-13-.10, continued)

(ii) Aero massage

(iii) Aqua whirl

(iv) Aquasage pump, or similar devices

(v) Hand-D-Jets, or similar devices

(vi) Jacuzzis, or similar devices

(vii) Turbojets

(viii) Whirlpool bath equipment

(ix) Whirlpool pumps

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-109, 71-5-113, 42 C.F.R. Part 431 Subpart E, 42 C.F.R. Part 438 Subpart F, Executive Order No. 23, and Public Chapter 473, Acts of 2011.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.10; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Repeal and new rule filed October 27, 2005; effective January 10, 2006. Public necessity rules filed May 3, 2006; effective through October 15, 2006. Public necessity rule filed May 3, 2006; effective through October 15, 2006. Amendment filed July 28, 2006; effective October 11, 2006. Public necessity rule filed February 2, 2007; effective through July 16, 2007. Amendment filed January 30, 2007; effective April 15, 2007. Amendment filed May 2, 2007; effective July 16, 2007. Amendment filed June 27, 2007; effective Sept 10, 2007. Amendment filed February 8, 2008; effective April 23, 2008. Amendment filed February 11, 2008; effective April 26, 2008. Amendment filed April 2, 2008; effective June 16, 2008. Amendments filed August 19, 2008; effective November 2, 2008. Amendment filed July 28, 2009; effective October 26, 2009. Amendment filed November 9, 2009; effective February 7, 2010. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Amendment filed October 26, 2010; effective January 24, 2011. Amendment filed December 14, 2010; effective May 31, 2011. Emergency rule filed July 1, 2011; effective through December 28, 2011. Emergency rule filed August 2, 2011; effective through January 29, 2012. Amendment filed September 23, 2011; effective December 22, 2011. Amendment filed October 28, 2011; effective January 26, 2012. Emergency rule filed September 27, 2013; effective through March 26, 2014. Amendment filed July 1, 2013; effective September 29, 2013. Amendment filed September 27, 2013; effective December 26, 2013. Amendment filed December 17, 2013; effective March 17, 2014. Amendments filed December 23, 2014; effective March 23, 2015. Emergency rule filed September 30, 2015; effective through March 28, 2016. Amendments filed December 29, 2015; effective March 28, 2016. Amendments filed December 30, 2015; effective March 29, 2016. Emergency rules filed June 24, 2016; effective through December 21, 2016. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 13, 2016; effective December 12, 2016. Amendments filed September 30, 2016; effective December 29, 2016. Amendments filed September 25, 2017; effective December 24, 2017. Emergency rules filed January 16, 2018; effective through July 15, 2018. Amendments filed April 9, 2018; effective July 8, 2018.*

1200-13-13-.11 APPEAL OF ADVERSE BENEFIT DETERMINATIONS.

(1) Notice Requirements.

(a) When Written Notice is Required.

1. A written notice shall be given to an enrollee by his/her MCC of any adverse benefit determination.

2. A written notice shall be given to an enrollee of any MCC-initiated reduction, termination or suspension of inpatient hospital care.

3. A written notice shall be given to an enrollee of any provider-initiated reduction, termination or suspension.

4. Appropriate notice shall be given to an enrollee by the State or MCC when a claim for service or reimbursement is denied because an enrollee has exceeded a benefit limit. Such notice shall not be subject to the requirements of rule 1200-13-13-.11(1)(c)1. During the applicable time period for each benefit limit, such notice shall only be provided the first time a claim is denied because an enrollee has exceeded a benefit limit. The State or MCC will not be required to provide any notice when an enrollee is approaching or reaches a benefit limit.

5. Appropriate notice shall be given to an enrollee by a provider when an enrollee exceeds a non-pharmacy benefit limit in the following circumstances:

   (i) The provider denies the request for a non-pharmacy service because an enrollee has exceeded the applicable benefit limit; or

   (ii) The provider informs an enrollee that the non-pharmacy service will not be covered by TennCare because he/she has exceeded the applicable benefit limit and the enrollee chooses not to receive the service.

During the applicable time period for each non-pharmacy benefit limit, providers shall only be required to issue this notice the first time an enrollee does not receive a non-pharmacy service from the provider because he/she has exceeded the applicable benefit limit. Such notice shall not be subject to the requirements of rule 1200-13-13-.11(1)(c)1. Providers will not be required to issue any notice when an enrollee is approaching or reaches a non-pharmacy benefit limit.

(b) Timing of Written Notice.

1. Written notice of MCC-initiated reduction, termination or suspension of medical assistance must be provided to an enrollee within the time frames required by 42 C.F.R. §§ 431.210 - 431.214 (usually ten (10) days in advance). However, in instances of MCC-initiated reduction, termination or suspension of inpatient hospital treatment, the notice may be provided to an enrollee the same day of the proposed action. Where applicable and not in conflict with this rule, the exceptions set out at 42 C.F.R. §§ 431.211 - 431.214 permit or require reduction of the time frames within which advance notice must be provided.

2. An MCC must notify an enrollee of its decision in response to a request by or on behalf of an enrollee for prior authorization for medical or related services as set out in 42 C.F.R. § 438.210(d).

3. Written notice of delay of covered medical assistance must be provided to an enrollee immediately upon an MCC's receipt of information leading it to expect that such delay will occur.

4. Written notice of provider-initiated reduction, termination or suspension of services must be provided to an enrollee in compliance with 42 C.F.R. §§ 431.211, 431.213 and 431.214.

(Rule 1200-13-13-.11, continued)

5. Written notice is deemed to be provided to an enrollee upon deposit with the US Postal Service or other commercial mail carrier, or upon hand-delivery to an enrollee or his/her representative.

(c) Notice Contents.

1. Whenever this rule requires that a TennCare enrollee receive written notice of an adverse benefit determination, the notice must be readable and must comply with the requirements of 42 C.F.R. §§ 431.210 and 438.404.

2. Remedying of Notice. If a notice of adverse benefit determination provided to an enrollee does not meet the notice content requirements of rule 1200-13-13-.11(1)(c)1., TennCare or the MCC may cure any such deficiencies by providing one corrected notice to enrollees. If a corrected notice is provided to an enrollee, the reviewing authority shall consider only the factual reasons and legal authorities cited in the corrected notice, except that additional evidence beneficial to the enrollee may be considered on appeal.

(2) Appeal Rights of Enrollees. Enrollees have the following rights:

(a) To appeal adverse benefit determinations.

(b) An enrollee's request for appeal, including oral or written expressions by the enrollee, or on his behalf, of dissatisfaction or disagreement with adverse benefit determinations that have been made or are proposed to be made, may not be denied.

(c) To have the appeal rights that are prescribed by 42 C.F.R. Part 431, Subpart E and Tennessee Code Annotated §§ 4-5-301, et seq.

(d) To be allowed sixty (60) days from receipt of written notice or, if no notice is provided, from the time the enrollee becomes aware of an adverse benefit determination, to appeal any adverse benefit determination.

(e) To appeal in person, by telephone, or in writing. Reasonable accommodations shall be made for any person with disabilities who requires assistance with his/her appeal, such as an appeal by TDD services or other communication device for people with disabilities. Written requests for appeals made at county TDHS offices shall be stamped and immediately forwarded to the TennCare Bureau for processing and entry in the central registry.

(f) For ongoing services, have the right to continuation or reinstatement of services, pursuant to 42 C.F.R. §§ 431.230 and 431.231 as modified by this rule, pending resolution of the appeal when the enrollee submits a timely appeal and timely request for COB. When an enrollee is so entitled to continuation or reinstatement of services, this right may not be denied for any reason, including:

1. An MCC's failure to inform an enrollee of the availability of such continued services;

2. An MCC's failure to reimburse providers for delivering services pending appeal; or

3. An MCC's failure to provide such services when timely requested.

(g) To an appeals process. But for initial reconsideration by an MCC as permitted by this rule, no person who is an employee, agent or representative of an MCC may participate

(Rule 1200-13-13-.11, continued)

in deciding the outcome of a SFH. No state official who was directly involved in the initial determination of the action in question may participate in deciding the outcome of an enrollee's appeal.

(3) Special Provisions Relating to Appeals.

(a) Individualized Decisions Required. Neither the TennCare program nor its MCCs may employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his or her medical history.

(b) Medical Evidence.

1. Appeal decisions must be based on an evaluation of pertinent medical evidence. TennCare and the MCCs shall elicit from enrollees and their treating providers all pertinent medical records that support an appeal; and

2. Medical opinions shall be evaluated pursuant to TennCare Medical Necessity rule 1200-13-16. Reliance upon insurance industry guidelines or utilization control criteria of general application, without consideration of the individual enrollee's medical history, does not satisfy this requirement and cannot be relied upon to support an adverse benefit determination.

(c) Record on Review. When TennCare receives an appeal from an enrollee regarding an adverse benefit determination, TennCare is responsible for obtaining from the MCC any and all records or documents pertaining to the MCC's decision to take the contested action. TennCare shall correct any violation of this rule that is evident from a review of those records.

(d) Valid Factual Disputes. When TennCare receives an appeal from an enrollee, TennCare will dismiss this appeal unless the enrollee has established a valid factual dispute relating to an adverse benefit determination.

1. Processing of Appeals. TennCare shall screen all appeals submitted by TennCare enrollees to determine if the enrollees have presented a valid factual dispute. If TennCare determines that an enrollee failed to present a valid factual dispute, TennCare will immediately provide the enrollee with a notice, informing him/her that the enrollee must provide additional information as identified in the notice. If the enrollee does not provide this information, the appeal shall be dismissed without the opportunity for a state fair hearing within ten (10) days of the date of the notice. If the enrollee adequately responds to this notice, TennCare shall inform the enrollee that the appeal will proceed to a hearing. If the enrollee responds but fails to provide adequate information, TennCare will provide a notice to the enrollee, informing him/her that the appeal is dismissed without the opportunity for a state fair hearing. If the enrollee does not respond, the appeal will be dismissed without the opportunity for a state fair hearing, without further notice to the enrollee.

2. Information Required to Establish Valid Factual Disputes. In order to establish a valid factual dispute, TennCare enrollees must provide the following information: Enrollee's name; member SSN or TennCare ID#; address and phone; identification of the service or item that is the subject of the adverse benefit determination; and the reason for the appeal, including any factual error the enrollee believes TennCare or the MCC has made. For reimbursement and billing appeals, enrollees must also provide the date the service was provided, the

(Rule 1200-13-13-.11, continued)

name of the provider, copies of receipts which prove that the enrollee paid for the services or copies of a bill for the services, whichever is applicable.

(e) Appeals When Enrollees Lack a Prescription. When a TennCare enrollee attempts to lodge an appeal for a benefit for which the enrollee lacks a prescription, TennCare may require the enrollee to exhaust the following administrative process before an appeal can proceed:

1. TennCare will provide appropriate notice to the enrollee informing him/her that he/she will be required to complete an administrative process. Such administrative process requires the enrollee to contact the MCC to make an appointment with a provider to evaluate the request for the service. The MCC shall be required to make such appointment for the enrollee within a 3-week period or forty-eight (48) hours for urgent care from the date the enrollee contacts the MCC. Appeal timeframes will be tolled during this administrative process.

2. In order for this appeal to continue, the enrollee shall be required to contact TennCare after attending the appointment with a physician and demonstrate that he/she remains without a prescription for the service. If the enrollee fails to contact TennCare within sixty (60) days from the date of the notice described in subparagraph (e)1., TennCare will dismiss the appeal without providing an opportunity for a hearing for the enrollee.

(f) Appeals When No Adverse Benefit Determination Has Been Made. Enrollees shall not possess the right to appeal when no adverse benefit determination has been made. If enrollees request a hearing in this circumstance, their request shall be denied by the TennCare bureau without the opportunity for a hearing. Such circumstances include but are not limited to when enrollees appeal and no request for services had previously been denied.

(4) Hearing Rights of Enrollees.

(a) TennCare shall inform enrollees of their state fair hearing rights;

(b) Enrollees shall be entitled to a hearing before a hearing officer that affords each enrollee the right to:

1. Representation at the hearing by anyone of his/her choice, including a lawyer;

2. Review information and facts relied on for the decisions by the MCC and the TennCare Bureau before the hearing;

3. Cross-examine adverse witnesses;

4. Present evidence, including the right to compel attendance of witnesses at hearings;

5. Review and present information from his/her medical records;

6. Present evidence at the hearing challenging the adverse decision by his/her MCC;

7. Ask for an independent medical opinion, at no expense to the enrollee;

8. Continue or reinstate ongoing services pending a hearing decision, as specified in this rule;

9. A written decision setting out the hearing officer's rulings on findings of fact and conclusions of law; and

10. Resolution, including a hearing before a hearing officer if the case has not been previously resolved in favor of the enrollee, pursuant to 42 C.F.R. § 431.244.

(c) TennCare shall not impair the ability of an enrollee to appeal an adverse hearing decision by requiring that the enrollee bear the expense of purchasing a hearing transcript when such purchase would be a financial hardship for the enrollee.

(d) Parties to an Appeal. Under this rule, the parties to a state fair hearing are limited to the enrollee and TennCare, permitted by federal regulations as modified by CMS letter dated June 5, 2017. The purpose of the hearing is to focus on the enrollee's medical needs.

(e) Consistent with the Code of Judicial Conduct, hearing officers shall assist pro se enrollees in developing the factual record and shall have authority to order second medical opinions at no expense to the enrollee.

(f) Review of Hearing Decisions.

1. Hearing officers shall promptly issue an Order of their decision. Any Order delivered orally from the bench in an expedited hearing by a hearing officer shall be effective immediately as to the provision or denial of benefits. In accordance with 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F, the hearing officer shall enter a written order as soon as practicable and shall provide the parties with copies of such Orders. The time for appealing any oral Order shall not begin to run until entry of the written Order.

2. The TennCare Bureau shall have the opportunity to review all decisions of hearing officers, in accordance with T.C.A. §§ 4-5-314 and 4-5-315, to determine whether such decisions are contrary to applicable law, regulations or policy interpretations, which shall include but not be limited to decisions regarding the defined package of covered benefits, determinations of medical necessity and decisions based on the application of this chapter and 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F.

(i) If TennCare modifies or overturns the decision of the hearing officer, TennCare shall issue a written decision that will be provided to the enrollee and the hearing officer. TennCare's decision shall constitute final agency action.

(ii) If TennCare does not modify or overturn the decision of the hearing officer, the hearing officer's decision shall constitute final agency action without additional notice to the enrollee.

(iii) Review of final agency action shall be available to enrollees pursuant to T.C.A. § 4-5-322.

(iv) A hearing officer's decision in an enrollee's appeal shall not be deemed precedent for future appeals.

(g) Continuation or Reinstatement of TennCare Services.

(Rule 1200-13-13-.11, continued)

1. As permitted under 42 C.F.R. §§ 431.230, 431.231 and 438.420, if required or if the enrollee requests, TennCare services shall continue or be reinstated until the earlier of dismissal of the appeal through the valid factual dispute process, enrollee's withdrawal of the appeal, or an initial hearing decision adverse to the enrollee.

2. In the case of a timely request for continuation or reinstatement of the TennCare services described in paragraph (4)(g)1 above, the services shall continue or be reinstated only if and to the extent prescribed by the enrollee's treating clinician.

3. Notwithstanding the requirements of this part, TennCare enrollees are not entitled to continuation or reinstatement of services pending an appeal related to the following:

(i) When a service is denied because the enrollee has exceeded the benefit limit applicable to that service;

(ii) When a request for prior authorization is denied for a prescription drug, with the exception of:

(I) Pharmacists shall provide a single 72-hour interim supply in emergency situations for the non-authorized drug, unless such supply would exceed applicable pharmacy benefit limits; or

(II) When the drug has been prescribed on an ongoing basis or with unlimited refills and becomes subject to prior authorization requirements.

(iii) When coverage of a prescription drug or service is denied because the requested drug or service is not a category or class of drugs or services covered by TennCare;

(iv) When coverage for a prescription drug is denied because the enrollee has been locked into one pharmacy and the enrollee seeks to fill a prescription at another pharmacy;

(v) When a request for reimbursement is denied and the enrollee appeals this denial;

(vi) When a physician has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested; or

(vii) If TennCare had not paid for the type and amount of service for which continuation or reinstatement is requested prior to the appeal.

(h) Reserved.

(5) Reserved.

(6) Release of Enrollees' Medical Records.

(a) When a request is made, by or on behalf of a TennCare enrollee, for approval of a TennCare service or for an appeal of an adverse benefit determination, the enrollee is deemed to have consented to release of his/her relevant medical records to his/her MCC and the TennCare Bureau for the purposes of acting upon the enrollee's request.

(Rule 1200-13-13-.11, continued)

(b) Providers shall promptly provide copies of an enrollee's medical records to the enrollee's MCC(s) and to the TennCare Bureau upon being informed by the MCC(s) or TennCare Bureau that the records have been requested for the purpose of acting upon an enrollee's request for approval of a TennCare service or an enrollee's appeal of an adverse benefit determination.

(c) An enrollee's consent to release of his/her medical records may be evidenced by his signature (or his provider's or authorized representative's signature) upon the enrollee's initial application for TennCare, upon his TennCare appeal form or other written request for authorization or appeal, or, in the event of an appeal by telephone, by a TennCare Bureau employee's signing of an appeal form on behalf of an enrollee with documentation of consent to do so.

(d) The medical records obtained by MCCs and the TennCare Bureau under this rule remain confidential. MCCs and the TennCare Bureau may use and disclose the records only as necessary in their consideration of the enrollee's request for approval of a TennCare service or the enrollee's appeal of an adverse benefit determination.

(7) Time Requirements.

(a) MCCs must act upon a request for prior authorization as provided in 42 C.F.R. § 438.210.

(b) MCCs must complete reconsideration of standard appeals within fourteen (14) calendar days of the request from TennCare. MCCs must complete reconsideration of expedited appeals within seventy-two (72) hours of the request for SFH.

(c) All standard and expedited appeals not previously resolved in favor of the enrollee during reconsideration, shall be set for hearing before a hearing officer, and shall be resolved pursuant to the timeframes set forth in 42 C.F.R. § 431.244. In accordance with 42 C.F.R. § 438.410(a) and 42 C.F.R. § 431.244(f)(2), SFH requests which are approved for expedited resolution and which are not resolved in the enrollee's favor during MCC's reconsideration, shall be resolved by TennCare within three (3) working days from the date of the MCC's reconsideration determination. TennCare is not charged with any delays attributable to the enrollee.

(d) In no circumstance will a directive be issued by the TennCare Bureau or a hearing officer to provide a service to an enrollee if, when the appeal is resolved, the service is no longer covered by TennCare for the enrollee. A directive also will not be issued by the TennCare Bureau if the service cannot reasonably be provided to the enrollee before the date when the service is no longer covered by TennCare for the enrollee.

(8) Reserved.

(9) Special Provisions Relating to Children in State Custody. Children in the custody of the State have the rights and protections established by 42 C.F.R. Part 431, Subpart E regarding TennCare services and benefits.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-109, 71-5-113, 42 C.F.R. Part 431 Subpart E, 42 C.F.R. Part 438 Subpart F, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.11; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed May 5, 2005; effective through October 17, 2005. Public necessity rule filed July 29, 2006; effective through January 10, 2006. Amendments filed July 28, 2005; effective October 11, 2005. Public necessity rule filed*

(Rule 1200-13-13-.11, continued)

December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendments filed October 27, 2005; effective January 10, 2006. However, Notice of Withdrawal of permanent rule amendments (1)(d)3., (1)(d)4., (4)(g)6., (5)(a)5., (5)(e), (5)(f), and (7)(h) filed and effective January 6, 2006 (to have been effective January 10, 2006). Public necessity rule filed May 17, 2006; effective through October 29, 2006. Amendments filed March 31, 2006; effective June 14, 2006. Amendment filed August 14, 2006; effective October 28, 2006. Public necessity rule filed December 1, 2006; effective through May 15, 2007. Amendment filed March 1, 2007; effective May 15, 2007. Amendment filed August 19, 2008; effective November 2, 2008. Amendment filed September 30, 2009; effective December 29, 2009. Amendment filed October 26, 2010; effective January 24, 2011. Emergency rule filed July 1, 2011; effective through December 28, 2011. Amendment filed September 23, 2011; effective December 22, 2011. Amendments filed September 27, 2013; effective December 26, 2013. Amendments filed September 25, 2017; effective December 24, 2017.

1200-13-13-.12 OTHER APPEALS BY TENNCARE APPLICANTS AND ENROLLEES.

Notwithstanding Rule 1200-13-19-.01, or any rule to the contrary, appeals by applicants and enrollees of all non-medical eligibility matters are removed to Rule Chapter 1200-13-19, effective upon expiration of the TDHS contract to determine eligibility matters.

Authority: *T.C.A. §§ 4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-113, 42 C.F.R. Part 431 Subpart E, 42 C.F.R. Part 438 Subpart F, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.12; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed June 8, 2005; effective through November 20, 2005. Amendment to public necessity rule filed July 6, 2005; effective through November 20, 2005. Amendment filed September 6, 2005; effective November 20, 2005. Amendments filed September 25, 2017; effective December 24, 2017.*

1200-13-13-.13 MEMBER ABUSE OR OVERUTILIZATION OF THE TENNCARE PHARMACY PROGRAM.

(1) The Bureau is authorized to implement and maintain a pharmacy lock-in program designed to address member abuse or overutilization. Activities which may indicate abuse or overutilization justifying placement on lock-in or prior approval status include but are not limited to the following:

(a) Forging or altering a prescription for drugs.

(b) Selling TennCare paid prescription drugs.

(c) Failing to control pharmacy overutilization activity while on lock-in status.

(d) Visiting multiple prescribers or pharmacies to obtain controlled substances.

(e) Trading, swapping or selling a TennCare card.

(f) Failing to promptly report the loss or theft of a TennCare card.

(g) Forging or altering a TennCare card.

(h) Knowingly providing false, incomplete, inaccurate or erroneous information to provider(s) in order to receive covered services for which the member is ineligible.

(i) Permitting the use of a TennCare card by anyone other than the member to whom the card is assigned in order to receive or attempt to receive services.

(Rule 1200-13-13-.13, continued)

(2) The TennCare pharmacy lock-in program shall be administered by the Bureau. Monitoring of enrollee activities listed in Paragraph (1) shall be conducted by the Bureau, the MCCs, including the PBM, and the TennCare Office of Inspector General (OIG). When an enrollee has been identified as having participatedin any abuse or overutilization activities, including but not limited to the activities listed in Paragraph (1), the enrollee's name shall be referred to the Bureau as appropriate or potentially appropriate for the lock-in program as follows:

(a) Appropriate for the lock-in program:

1. Any enrollee who has been identified by the OIG as having been convicted of TennCare fraud or a drug-related offense.

2. Any enrollee who has used buprenorphine-containing products for office based opioid addiction treatment within the previous six (6) months.

(b) Potentially appropriate for the lock-in program:

1. Any enrollee who has been arrested for TennCare fraud.

2. Any enrollee who has been arrested for a drug-related offense.

3. Any enrollee who has obtained multiple controlled substance prescriptions over a 90-day period that meet one of the following conditions:

(i) The prescriptions were filled at three (3) or more pharmacies and written by three (3) or more prescribers.

(ii) The prescriptions were filled at one (1) or more targeted pharmacies and written by two (2) or more prescribers.

(iii) The prescriptions were filled at two (2) or more targeted pharmacies and written by one (1) or more prescribers.

(iv) The prescriptions were filled at one (1) or more targeted pharmacies and written by one (1) or more targeted prescribers.

(v) The prescriptions were filled at two (2) or more pharmacies and written during three (3) or more emergency room visits.

(3) Pharmacy lock-in procedures shall include:

(a) A determination to place an enrollee who has been referred as appropriate or potentially appropriate for the lock-in program on lock-in status shall be made by the TennCare Pharmacy Director or designee after the enrollee's relevant pharmacy claims data has been reviewed by clinical staff.

(b) Any enrollee determined to be appropriate for the lock-in program shall be notified by the Bureau or the MCC prior to the imposition of lock-in status. The notice shall include a brief explanation of the lock-in program, the reason for the determination to place the enrollee on lock-in status, the date the lock-in will become effective, and the information necessary for the enrollee to appeal the decision of the Bureau, pursuant to Rule 1200-13-13-.11.

(c) If an enrollee fails to appeal placement in the lock-in program or an appeal is not resolved in his favor, the enrollee will be provided TennCare pharmacy services only at the lock-in provider to which the enrollee is assigned.

(4) Lock-in provider selection. A pharmacy will qualify for and may be selected by the enrollee as a lock-in provider only if it meets all the following criteria:

(a) It is enrolled in the TennCare Pharmacy Network;

(b) It is within the State of Tennessee;

(c) It is a full-service pharmacy that carries all medications normally carried by pharmacies;

(d) It is not a mail order or specialty pharmacy;

(e) It is not a targeted pharmacy;

(f) It is a single pharmacy location at a specific address. A chain pharmacy may be selected but only the specific named location may be used, not multiple locations or outlets of the chain; and

(g) It is in proximity to the enrollee's residence, which must be the current address on file with the Bureau.

(5) After twelve (12) months a member may request a change of lock-in provider once each year. Additional changes are limited to the following reasons:

(a) The member has moved and his new address is at least fifteen (15) miles from the lock-in pharmacy and he has updated his address with the Bureau.

(b) The member's lock-in pharmacy has permanently closed.

(c) The member's lock-in pharmacy has voluntarily dismissed the enrollee from its practice and has notified the Bureau and the PBM.

(d) The Bureau may, at its sole discretion, determine that there is a compelling need to change the member's lock-in pharmacy.

(6) Review of lock-in status. The Bureau or the MCC shall periodically review the claims information of members on lock-in status to determine the need for continued lock-in or escalation to prior approval status.

(a) Lock-in status will be discontinued if the Bureau determines that a member has met all of the following criteria for at least six (6) consecutive months:

1. Has not paid cash for any controlled substance prescriptions covered by TennCare.

2. Has not received any narcotic medications while on buprenorphine-containing products for addiction.

3. Has received TennCare reimbursed controlled substance prescriptions from only one (1) provider.

4. Has received TennCare reimbursed prescriptions from only one (1) pharmacy.

(b) If a member is removed from lock-in status, the Bureau or the MCC will monitor the member for changes in utilization patterns and return him to lock-in status if appropriate.

(Rule 1200-13-13-.13, continued)

(7) Prior approval status.

(a) A member against whom criminal process alleging TennCare fraud has been issued or who has been convicted of TennCare fraud shall automatically be placed on prior approval status.

(b) Lock-in status shall be escalated to prior approval status if a member on lock-in status meets three (3) of the following criteria over a 90 day period:

1. Has paid cash for three (3) or more controlled substance prescriptions covered by TennCare.

2. Has filled prescriptions for controlled substances at two (2) or more pharmacies.

3. Has received controlled substance prescriptions from two (2) or more prescribers.

4. Has received a narcotic prescription while receiving buprenorphine-containing products for addiction.

(c) A member who has been treated in a hospital emergency department for an overdose of a controlled substance (as identified in the most recently available TennCare data) or an illicit substance identified by toxicology shall automatically be placed on prior approval status.

(8) Emergency pharmacy services may be obtained with a TennCare or MCC override of a member's lock-in status. The PBM has clinical staff available at all times to respond to emergency situations. The PBM must verify that a genuine emergency exists, such as documented proof from the lock-in pharmacy that it is temporarily out of stock of a needed medication. A lock-in override will not be provided simply because a pharmacy is closed for the day unless a true medical emergency exists.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, 71-5-146, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.13; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Repeal and new rule filed March 31, 2006; effective June 14, 2006. Amendment filed October 3, 2013; effective January 1, 2014. Amendments filed December 29, 2015; effective March 28, 2016.*

1200-13-13-.14 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-13-.14; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule (repeal) filed August 18, 2005; effective through January 30, 2006. Repeal filed November 15, 2005; effective January 29, 2006.*

RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-14
TENNCARE STANDARD

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1200-13-14-.01 DEFINITIONS.

(1) ABUSE shall mean enrollee practices, or enrollee involvement in practices, including overutilization, waste or fraudulent use/misuse of a TennCare Program that results in cost or utilization which is not medically necessary or medically justified. Abuse of a TennCare Pharmacy Program justifies placement on lock-in or prior approval status for all enrollees involved. Activities or practices which may evidence abuse of the TennCare Pharmacy Program include, but are not limited to, the following: forging or altering drug prescriptions, selling TennCare paid prescription drugs, failure to control pharmacy overutilization activity while on lock-in status and visiting multiple prescribers or pharmacies to obtain prescriptions that are not medically necessary.

(2) ACCESS TO HEALTH INSURANCE shall mean the opportunity an individual has to obtain group health insurance as defined elsewhere in these rules. If a person could have enrolled in work-related or other group health insurance during an employer's or group's open enrollment period and chose not to enroll (or had the choice made for him by a family member) that person shall not be considered to lack access to insurance upon closure of the open enrollment period. Neither the cost of an insurance policy or health plan nor the fact that an insurance policy is not as comprehensive as that of the TennCare Program shall be considered in determining eligibility to enroll in any TennCare category where being uninsured is an eligibility prerequisite.

(3) ADVERSE BENEFIT DETERMINATION shall mean, but is not limited to, a delay, denial, reduction, suspension or termination of TennCare benefits. See 42 C.F.R. § 438.400.

(4) Aggregate Cost-Sharing Cap. The maximum amount a family may pay out-of-pocket for TennCare covered services during a calendar quarter (January 1 through March 31, April 1 through June 30, July 1 through September 30, October 1 through December 31). Amounts paid for non-covered services, including payments for services that exceed a benefit limit, are not counted in the aggregate cost-sharing cap. Amounts paid by the family for third party insurance are not counted in the aggregate cost-sharing cap.

(5) APPLICATION PERIOD shall mean a specific period of time determined by the Bureau of TennCare during which the Bureau will accept applications for the TennCare Standard Spend Down category as described in the Bureau's rules at 1200-13-14-.02.

(6) BENEFITS shall mean the health care package of services developed by the Bureau of TennCare and which define the covered services available to TennCare enrollees. Additional

(Rule 1200-13-14-.01, continued)

benefits are available through the TennCare CHOICES program, as described in Rule 1200-13-01-.05, and the ECF CHOICES program, as described in Rule 1200-13-01-.31. CHOICES benefits are available only to persons who qualify for and are enrolled in the CHOICES program. ECF CHOICES benefits are available only to persons who qualify for and are enrolled in the ECF CHOICES program.

(7) BUREAU OF TENNCARE (BUREAU) shall mean the administrative unit of TennCare which is responsible for the administration of TennCare as defined elsewhere in these rules.

(8) CALL-IN LINE shall mean the toll-free telephone line used as the single point of entry during an open application period to accept new applications for the Standard Spend Down Program.

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

(10) CAPITATION RATE shall mean the amount established by the State for the purpose of providing payment to participating managed care contractors operating under a risk-based contract.

(11) CARETAKER RELATIVE shall mean that individual as defined at Tennessee Code Annotated § 71-3-153.

(12) CATEGORICALLY NEEDY shall mean that category of TennCare Medicaid-eligibles as defined at 1240-03-02-.02 of the rules of the Tennessee Department of Human Services - Division of Medical Services.

(13) CHOICES. See “TennCare CHOICES in Long-Term Care.”

(14) CHOICES 1 and 2 Carryover Group. See definition in Rule 1200-13-01-.02.

(15) CHOICES At-Risk Demonstration Group. See definition in Rule 1200-13-01-.02.

(16) CHOICES 217-Like Group. See definition in Rule 1200-13-01-.02.

(17) CHOICES Group 1. See definition in Rule 1200-13-01-.02.

(18) CHOICES Group 2. See definition in Rule 1200-13-01-.02.

(19) CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) (formerly known as HCFA) shall mean the agency within the United States Department of Health and Human Services that is responsible for administering Title XVIII, Title XIX, and Title XXI of the Social Security Act.

(20) COBRA shall mean health insurance coverage provided pursuant to the Consolidated Omnibus Budget Reconciliation Act.

(21) CODE OF FEDERAL REGULATIONS (C.F.R.) shall mean Federal regulations promulgated to explain specific requirements of Federal law.

(22) COMMENCEMENT OF SERVICES shall mean the time at which the first covered service(s) is/are rendered to a TennCare member for each individual medical condition.

(23) COMMISSIONER shall mean the chief administrative officer of the Tennessee Department where the TennCare Bureau is administratively located, or the Commissioner’s designee.

(Rule 1200-13-14-.01, continued)

(24) COMPLETED APPLICATION is an application where:

(a) All required fields have been completed;

(b) It is signed and dated by the applicant or the applicant's parent or guardian;

(c) It includes all supporting documentation required by the TDHS or the Bureau to determine TennCare eligibility, technical and financial requirements as set out in these rules; and

(d) It includes all supporting documentation required to prove TennCare Standard medical eligibility as set out in these rules.

(25) CONTINUATION OR REINSTATEMENT OF BENEFITS (COB) shall mean the circumstances under which an enrollee may keep receiving, or, in the case of reinstatement, get back and keep receiving, the benefit under appeal until the appeal is resolved. See 42 C.F.R. §§ 431.230, 431.231 and 438.420.

(26) CONTINUOUS ENROLLMENT shall refer to the ability of certain individuals determined eligible for the TennCare Program to enroll at any time during the year. Continuous enrollment is limited to persons in the following two groups:

(a) TennCare Medicaid enrollees as defined in rule 1200-13-13-.02.

(b) Individuals who are losing their Medicaid, who are uninsured, who are under nineteen (19) years of age, and who meet the qualification for TennCare Standard as "Medicaid Rollovers," in accordance with the provisions of Rule 1200-13-14-.02.

(27) CONTRACT PROVIDER shall have the same meaning as Participating Provider.

(28) CONTRACTOR shall mean an organization approved by the Tennessee Department of Finance and Administration to provide TennCare-covered benefits to eligible enrollees in the TennCare Medicaid and TennCare Standard programs.

(29) CONTRACTOR RISK AGREEMENT (CRA) shall mean the document delineating the terms of the agreement entered into by the Bureau of TennCare and the Managed Care Contractors.

(30) CONTROLLED SUBSTANCE. A drug, substance, or immediate precursor identified by the U.S. Department of Justice, Drug Enforcement Administration or by the Tennessee Drug Control Act as having the potential for abuse and the likelihood of physical or psychological dependence if used incorrectly.

(31) COPAY. A fixed fee that is charged to certain TennCare enrollees for certain TennCare services.

(32) CORE MEDICAID POPULATON shall mean individuals eligible under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq., with the exception of the following groups: individuals receiving SSI benefits as determined by the Social Security Administration; individuals eligible under a Refugee status; individuals eligible for emergency services as an illegal or undocumented alien; individuals receiving interim Medicaid benefits with a pending Medicaid disability determination; individuals with forty-five (45) days of presumptive eligibility; and children in DCS custody.

(33) COST-EFFECTIVE ALTERNATIVE SERVICE shall mean a service that is not a covered service but that is approved by TennCare and CMS and provided at an MCC's discretion.

(Rule 1200-13-14-.01, continued)

TennCare enrollees are not entitled to receive these services. Cost-effective alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in the MCC's judgment, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the MCC's judgment, would require more costly treatment in the future. Cost-effective alternative services need not be determined medically necessary except to the extent that they are provided as an alternative to covered Medicaid services. Even if medically necessary, cost effective alternative services are not covered services and are provided only at an MCC's discretion.

(34) COST SHARING shall mean the amounts that certain enrollees in TennCare are required to pay for their TennCare coverage and covered services. Cost sharing includes copayments.

(35) COVERED SERVICES shall mean the services and benefits that:

(a) TennCare contracted MCCs cover, as set out elsewhere in this Chapter and in Rule 1200-13-01-.05; or

(b) In the instance of enrollees who are eligible for and enrolled in federal Medicaid waivers under Section 1915(c) of the Social Security Act, the services and benefits that are covered under the terms and conditions of such waivers.

(36) CPT4 CODES are descriptive terms contained in the Physician's Current Procedural Terminology, used to identify medical services and procedures performed by physicians or other licensed health professionals.

(37) DBM (DENTAL BENEFITS MANAGER) shall mean a contractor approved by the Tennessee Department of Finance and Administration to provide dental benefits to enrollees in the TennCare Program to the extent such services are covered by TennCare.

(38) DEDUCTIBLE. A specified amount of money paid each year by an insured person for benefits before his health plan starts paying claims.

(39) DELAY shall mean any failure to provide timely receipt of TennCare services, and no specific waiting period may be required before the enrollee can appeal.

(40) DEMAND LETTER shall mean a letter sent by TennCare to a TennCare Standard enrollee with premium obligations notifying the enrollee that he is at least 60 days delinquent in his premium payments.

(41) DISCONTINUED DEMONSTRATION GROUP shall mean the group of non-Medicaid eligible individuals who were enrolled in TennCare Standard on April 29, 2005, when the categories in which they were enrolled were terminated, and who have not yet been enrolled in TennCare Medicaid or disenrolled from the TennCare program.

(42) DISENROLLMENT shall mean the discontinuance of an individual's enrollment in TennCare.

(43) DURABLE MEDICAL EQUIPMENT (DME) shall mean equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, is suitable for use in any non-institutional setting in which everyday life activities take place, and is related to the patient's physical disorder. Orthotics and prosthetic devices, and artificial limbs and eyes are considered DME. Non-institutional settings do not include a hospital or nursing facility (NF). Routine DME items, including but not limited to wheelchairs (except as defined below), walkers, hospital beds, canes, commodes, traction equipment, suction machines, patient lifts, weight scales, and other items provided to a member receiving services in a NF that are within the scope of per diem reimbursement for NF services shall not be covered or reimbursable under the Medicaid

(Rule 1200-13-14-.01, continued)

program separate and apart from payment for the NF service. Customized orthotics, prosthetics, wheelchairs, wheelchair seating systems, and other items that are beyond the scope of Medicaid reimbursement for NF services shall be covered by the member's managed care organization, so long as such items:

(a) Are medically necessary for the continuous care of a member; and

(b) Must be custom-made or modified or may be commercially available, but must be individually measured and selected to address the member's unique and permanent medical need for positioning, support or mobility; and

(c) Are solely for the use of that member and not for other NF residents.

(44) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) Services, a covered benefit for TennCare Medicaid-enrolled children only, shall mean:

(a) Screening in accordance with professional standards, and interperiodic, diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare Medicaid enrollees under age twenty-one (21); and

(b) Health care, treatment, and other measures, described in 42 U.S.C. § 1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.

(45) ELIGIBLE shall mean a person who has been determined to meet the eligibility criteria of TennCare Medicaid or TennCare Standard.

(46) Employment and Community First (ECF) CHOICES shall mean the program defined in Rule 1200-13-01-.02 and described in Rule 1200-13-01-.31.

(47) ENROLLEE shall mean an individual eligible for and enrolled in the TennCare program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the US Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act. As concerns MCC compliance with these rules, the term only applies to those individuals for whom the MCC has received at least one day's prior written or electronic notice from the TennCare Bureau of the individual's assignment to the MCC.

(48) ENROLLMENT shall mean the process by which a TennCare-eligible person becomes enrolled in TennCare.

(49) ESCORT shall mean an individual who accompanies an enrollee to receive a medically necessary service. For the purpose of determining whether an individual may qualify as an escort who may be transported without cost to the enrollee as a covered TennCare benefit, the following criteria apply:

(a) Any person over the age of twelve (12) selected by the enrollee;

(b) Any person under the age of twelve (12) is presumed to be too young to serve as an escort. At the time of request for transportation, this presumption can be overcome by specific facts provided by the enrollee, which would demonstrate to a reasonable person that the proposed escort could in fact be of assistance to the enrollee; and

(c) Any person under the age of six (6) is excluded in all cases from the role of escort.

(Rule 1200-13-14-.01, continued)

(50) FAMILY shall mean that as defined in the rules of the Tennessee Department of Human Services found at 1240-01-03 and 1240-01-04, Family Assistance Division, and 1240-03-03, Division of Medical Services.

(51) FEDERAL FINANCIAL PARTICIPATION (FFP) shall mean the Federal Government's share of a state's expenditure under the Title XIX Medicaid Program.

(52) FINAL AGENCY ACTION shall mean the resolution of an appeal by the TennCare Bureau or an initial decision on the merits of an appeal by an administrative judge or hearing officer when such initial decision is not modified or overturned by the TennCare Bureau. Final agency action shall be treated as binding for purposes of these rules.

(53) FRAUD shall mean an intentional deception or misrepresentation made by a person who knows or should have known that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(54) GRAND DIVISIONS shall mean the three (3) distinct geographic areas of the State of Tennessee, known as Eastern, Middle, and Western, as designated in Tennessee Code Annotated § 4-1-201.

(55) GROUP HEALTH INSURANCE shall mean an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly through insurance reimbursement mechanism. This definition includes those types of health insurance found in the Health Insurance Portability And Accountability Act of 1996, as amended, definition of creditable coverage (with the exception that the 50 or more participants criteria does not apply), which includes Medicare and TRICARE. Health insurance benefits obtained through COBRA are included in this definition. It also covers group health insurance available to an individual through membership in a professional organization or a school.

(56) HANDICAPPING MALOCCLUSION shall mean a malocclusion which causes one of the following medical conditions:

(a) A nutritional deficiency that has proven non-responsive to medical treatment without orthodontic treatment. The nutritional deficiency must have been diagnosed by a qualified treating physician and must have been documented in the qualified treating physician's progress notes. The progress notes that document the nutritional deficiency must predate the treating orthodontist's prior authorization request for orthodontics.

(b) A speech pathology that has proven non-responsive to speech therapy without orthodontic treatment. The speech pathology must have been diagnosed by a qualified speech therapist and must have been documented in the qualified speech therapist's progress notes. The progress notes that document the speech pathology must predate the treating orthodontist's prior authorization request for orthodontics.

(c) Laceration of soft tissue caused by a deep impinging overbite. Occasional cheek biting does not constitute laceration of soft tissue. Laceration of the soft tissue must be documented in the treating orthodontist's progress notes and must predate the treating orthodontist's prior authorization request for orthodontics.

Anecdotal information is insufficient to document the presence of a handicapping malocclusion. The presence of a handicapping malocclusion must be supported by the treating professional's progress notes and patient record.

(57) HEALTH INSURANCE, for the purposes of determining eligibility under these regulations:

(Rule 1200-13-14-.01, continued)

(a) Shall mean:

1. Any hospital and medical expense-incurred policy;

2. Medicare;

3. TRICARE;

4. COBRA;

5. Medicaid;

6. State health risk pool;

7. Nonprofit health care service plan contract;

8. Health maintenance organization subscriber contracts;

9. An employee welfare benefit plan to the extent that the plan provides medical care to an employee or his/her dependents (as defined under the terms of the plan) directly through insurance, any form of self insurance, or a reimbursement mechanism;

10. Coverage available to an individual through membership in a professional organization or a school;

11. Coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between the individual and the insurance company;

12. Any of the above types of policies where:

(i) The policy contains a type of benefit (such as mental health benefits) which has been completely exhausted;

(ii) The policy contains a type of benefit (such as pharmacy) for which an annual limitation has been reached;

(iii) The policy has a specific exclusion or rider of non-coverage based on a specific prior existing condition or an existing condition or treatment of such a condition; or

13. Any of the types of policies listed above will be considered health insurance even if one or more of the following circumstances exists:

(i) The policy contains fewer benefits than TennCare;

(ii) The policy costs more than TennCare; or

(iii) The policy is one the individual could have bought during a specified period of time (such as COBRA) but chose not to do so.

(b) Shall not mean:

1. Short-term coverage;

2. Accident coverage;

3. Fixed indemnity insurance;

4. Long-term care insurance;

5. Disability income contracts;

6. Limited benefits policies as defined elsewhere in these rules;

7. Credit insurance;

8. School-sponsored sports-related injury coverage;

9. Coverage issued as a supplemental to liability insurance;

10. Automobile medical payment insurance;

11. Insurance under which benefits are payable with or without regard to fault and which are statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

12. A medical care program of the Indian Health Services (IHS) or a tribal organization;

13. Benefits received through the Veteran's Administration; or

14. Health care provided through a government clinic or program such as, but not limited to, vaccinations, flu shots, mammograms, and care or services received through a disease- or condition-specific program such as, but not limited to, the Ryan White Care Act.

(58) HEALTH PLAN shall mean a Managed Care Organization authorized by the Tennessee Department of Finance and Administration to provide medical and behavioral services to enrollees in the TennCare Program.

(59) HEALTH MAINTENANCE ORGANIZATION (HMO) shall mean an entity licensed by the Tennessee Department of Commerce and Insurance under applicable provisions of Tennessee Code Annotated (T.C.A.) Title 56, Chapter 32 to provide health care services.

(60) HEARING OFFICER shall mean an administrative judge or hearing officer who is not an employee, agent or representative of the MCC or who did not participate in, nor was consulted about, any TennCare Bureau review prior to the State Fair Hearing (SFH).

(61) HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

(62) HOME HEALTH SERVICES shall mean:

(a) Any of the services identified in 42 C.F.R. § 440.70 and delivered in accordance with the provisions of 42 C.F.R. § 440.70. "Part-time or intermittent nursing services" and "home health aide services" are covered only as defined specifically in these rules.

1. Part-time or intermittent nursing services.

(Rule 1200-13-14-.01, continued)

(i) To be considered "part-time or intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, and no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide services combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

(ii) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on a p.r.n. (as needed) basis. Nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period. If there is more than one person in the household who is determined to require TennCare-reimbursed home health nursing services, it is not necessary to have multiple nurses providing the services. A single nurse may provide services to multiple enrollees in the same home and during the same hours, as long as he can provide these services safely and appropriately to each enrollee.

(iii) The above limits may be exceeded when medically necessary for children under the age of 21.

2. Home health aide services.

(i) Home health aide services must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. If there is more than one person in a household who is determined to require TennCare-reimbursed home health aide services, it is not necessary to have multiple home health aides providing the services. A single home health aide may provide services to multiple enrollees in the same home and during the same hours, as long as he can provide these services safely and appropriately to each enrollee.

(ii) The above limits may be exceeded when medically necessary for children under the age of 21.

(b) Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:

1. The child is non-ambulatory; and

2. The child has no or extremely limited ability to interact with caregivers; and

(Rule 1200-13-14-.01, continued)

3. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g. the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and

4. No other children requiring adult care or supervision shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult, unless these children meet all the criteria stated above and are also receiving TennCare-reimbursed home health services.

(63) INCOME shall mean that definition of income in rule 1240-01-04 of the Tennessee Department of Human Services - Family Assistance Division.

(64) INDIVIDUAL HEALTH INSURANCE shall mean health insurance coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between that person and the insurance company.

(65) INITIATING PROVIDER shall mean the provider who renders the first covered service to a TennCare member whose current medical condition requires the services of more than one (1) provider.

(66) INMATE shall mean an individual confined in a local, state, or federal prison, jail, youth development center, or other penal or correctional facility, including a furlough from such facility.

(67) IN-NETWORK PROVIDER shall have the same meaning as Participating Provider.

(68) Inpatient Rehabilitation Facilities shall mean rehabilitation hospitals and distinct parts of hospitals that are designated as 'IRFs' by Medicare.

(69) LICENSED MENTAL HEALTH PROFESSIONAL shall mean a Board eligible or a Board certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy with a current valid license by the Tennessee Licensing Board for the Healing Arts.

(70) LIMITED BENEFITS POLICY shall mean a policy of health coverage for a specific disease (e.g., cancer), or an accident occurring while engaged in a specified activity (e.g., school-based sports), or which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (e.g., hospital indemnity).

(71) LOCK-IN PROVIDER. A provider, pharmacy or physician, chosen by an enrollee on pharmacy lock-in status to whom the enrollee is assigned by TennCare for the purpose of receiving covered pharmacy services.

(72) LOCK-IN STATUS. The restriction of an enrollee to a specified physician, or to a specified pharmacy provider at a specified single location.

(73) LONG-TERM CARE shall mean programs and services described under Rule 1200-13-01-.01.

(74) MCC (MANAGED CARE CONTRACTOR) shall mean:

(Rule 1200-13-14-.01, continued)

(a) A Managed Care Organization, Pharmacy Benefits Manager and/or a Dental Benefits Manager which has signed a TennCare Contractor Risk Agreement with the State and operates a provider network and provides covered health services to TennCare enrollees; or

(b) A Pharmacy Benefits Manager, Behavioral Health Organization or Dental Benefits Manager which subcontracts with a Managed Care Organization to provide services; or

(c) A State government agency that contracts with TennCare for the provision of services.

(75) MCO (Managed Care Organization) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical, behavioral, and long-term care services in the TennCare Program.

(76) MEDICAID shall mean the federal- and state-financed, state-run program of medical assistance pursuant to Title XIX of the Social Security Act. Medicaid eligibility in Tennessee is determined by the Tennessee Department of Human Services, under contract to the Tennessee Department of Finance and Administration. Tennessee residents determined eligible for SSI benefits by the Social Security Administration are also enrolled in Tennessee's TennCare Medicaid program.

(77) MEDICAID "ROLLOVER" ENROLLEE shall mean a TennCare Medicaid enrollee who no longer meets technical eligibility requirements for Medicaid and will be afforded an opportunity to enroll in TennCare Standard in accordance with the provisions of these rules.

(78) MEDICAL ASSISTANCE shall mean health care, services and supplies furnished to an enrollee and funded in whole or in part under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq. and Tennessee Code Annotated §§ 71-5-101, et seq. Medical assistance includes the payment of the cost of care, services, drugs and supplies. Such care, services, drugs, and supplies shall include services of qualified providers who have contracted with an MCC or are otherwise authorized to provide services to TennCare enrollees (i.e., emergency services provided out-of-network or medically necessary services obtained out-of-network because of an MCC's failure to provide adequate access to services in-network).

(79) MEDICAL RECORD shall mean all medical histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; x-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical documentation in written or electronic format; and analyses of such information.

(80) MEDICAL SUPPLIES shall mean covered medical supplies that are deemed medically necessary and appropriate and are prescribed for use in the diagnosis and treatment of medical conditions. Medically necessary medical supplies not included as part of institutional services shall be covered only when provided by or through a licensed home health agency, by or through a licensed medical vendor supplier or by or through a licensed pharmacist.

(81) MEDICALLY ELIGIBLE shall mean a person who has met the medical eligibility criteria for the TennCare Standard program through a mechanism permitted under the provisions of these rules.

(82) MEDICALLY NECESSARY is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in these rules, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any

(Rule 1200-13-14-.01, continued)

items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in the Medical Necessity rule chapter at 1200-13-16.

(83) MEDICALLY NEEDY shall mean that category of TennCare Medicaid-eligibles as defined in rule 1240-03-02-.03 of the Tennessee Department of Human Services - Division of Medical Services.

(84) MEDICARE shall mean the program administered through the Social Security Administration pursuant to Title XVIII, available to most individuals upon attaining age sixty-five (65), to some disabled individuals under age sixty-five (65), and to individuals having End Stage Renal Disease (ESRD).

(85) MEMBER shall mean a TennCare Medicaid- or TennCare Standard-eligible individual who is enrolled in a managed care organization.

(86) NON-CONTRACT PROVIDER shall have the same meaning as Non-Participating Provider.

(87) NON-PARTICIPATING PROVIDER shall mean a TennCare provider, as defined in this Rule, who is not contracted with a particular enrollee's MCO. This term may include TennCare providers who furnish services outside the managed care program on a fee-for-service basis, as well as TennCare providers who receive Medicare crossover payments from TennCare.

(88) NON-TENNCARE PROVIDER shall mean a provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.

(89) OPEN ENROLLMENT shall mean a designated period of time, determined by the Bureau of TennCare, during which persons who are not currently TennCare eligible may apply for the Standard Spend Down program.

(90) OPEN MEDICAID CATEGORIES shall mean those Medicaid eligibility categories for which enrollment has not been closed pursuant to authority granted by CMS as part of the TennCare demonstration project.

(91) OUT-OF-NETWORK PROVIDER shall have the same meaning as Non-Participating Provider.

(92) OUT-OF-STATE EMERGENCY PROVIDER shall mean a provider outside the State of Tennessee who does not participate in TennCare in any way except to bill for emergency services, as defined in this Chapter, provided out-of-state to a particular MCC's enrollee. An Out-of-State Emergency Provider is not required to enroll with TennCare, but for the episode for which he is recognized as an Out-of-State Emergency Provider, he must abide by all TennCare rules and regulations, including those concerning provider billing of enrollees as found in Rule 1200-13-14-.08. In order to receive payment from TennCare, Out-of-State Emergency Providers must be appropriately licensed in the state in which the emergency services were delivered, and they must not be excluded from participation in Medicare or Medicaid.

(93) OVERUTILIZATION shall mean any of the following:

(a) The enrollee initiated use of TennCare services or supplies at a frequency or amount that is not medically necessary or medically justified.

(b) Overutilization, or attempted overutilization, of the TennCare Pharmacy Program which justifies placement on lock-in status for all enrollees involved.

(Rule 1200-13-14-.01, continued)

(c) Activities or practices which may evidence overutilization of the TennCare Pharmacy Program including, but not limited to, the following:

1. Treatment by several physicians for the same diagnosis;

2. Obtaining the same or similar controlled substances from several physicians;

3. Obtaining controlled substances in excess of the maximum recommended dose;

4. Receiving combinations of drugs which act synergistically or belong to the same class;

5. Frequent treatment for diagnoses which are highly susceptible to abuse;

6. Receiving services and/or drugs from numerous providers;

7. Obtaining the same or similar drugs on the same day or at frequent intervals; or

8. Frequent use of the emergency room in non-emergency situations in order to obtain prescription drugs.

(94) PACE Carryover Group. See definition in Rule 1200-13-01-.02.

(95) PARTICIPATING PROVIDER shall mean a TennCare provider, as defined in this Rule, who has entered into a contract with an enrollee's Managed Care Contractor.

(96) PBM (PHARMACY BENEFITS MANAGER) shall mean an organization approved by the Tennessee Department of Finance and Administration to administer pharmacy benefits to enrollees to the extent such services are covered by the TennCare Program. A PBM may have a signed TennCare Contractor Risk Agreement with the State, or may be a subcontractor to an MCO.

(97) PERSONAL CARE SERVICES shall refer to an optional Medicaid benefit defined at 42 C.F.R. § 440.167 that, per the Tennessee Medicaid State Plan, Tennessee has not elected to include in the TennCare benefit package. To the extent that such services are available to children under the age of 21 when medically necessary under the provisions of EPSDT, the Bureau of TennCare designates home health aides as the providers qualified to deliver such services. When medically necessary, personal care services may be authorized outside of the home setting when normal life activities temporarily take the recipient outside of that setting. Normal life activity for a child under the age of 21 means routine work (including work in supported or sheltered work settings); licensed child care; school and school-related activities; religious services and related activities; and outpatient health care services (including services delivered through a TennCare home and community based services waiver program). The home health aide providing personal care services may accompany the recipient but may not drive. Normal life activities do not include non-routine or extended home absences.

(98) PHYSICIAN shall mean a person licensed pursuant to chapter 6 or 9 of title 63 of the Tennessee Code Annotated.

(99) POVERTY LEVEL shall mean the poverty level established by the Federal Government.

(100) POWER SEATING ACCESSORIES. Accessories available to modify a power wheelchair base are covered by TennCare when all listed criteria are met as follows:

(a) Power Seat Elevation System.

(Rule 1200-13-14-.01, continued)

1. It is ordered by the Enrollee's treating physician.

2. An assessment conducted by a licensed physical therapist or licensed occupational therapist establishes that:

(i) The Enrollee has the cognitive ability and enough upper extremity function to carry out mobility-related activities of daily living such as feeding, grooming, dressing, and transferring; and

(ii) The activities for which the accessory will be used are conducted primarily in the enrollee's home.

(b) Power Standing System.

1. It is ordered by the Enrollee's treating physician.

2. An assessment conducted by a licensed physical therapist or licensed occupational therapist establishes that the Enrollee:

(i) Has a chronic condition that causes him to have limited or no ability to stand; and

(ii) Has a physical condition that allows him to stand, when supported, for meaningful periods of time, i.e., he will not suffer loss of blood pressure or have problems with bowel or urine retention; and

(iii) Has the cognitive ability and enough upper extremity function to carry out mobility-related activities of daily living such as feeding, grooming, dressing, and transferring; and

(iv) Meets at least one other complex rehabilitation criterion for a power seat accessory such as a tilt seat and also qualifies for a Group 3 base Power Wheelchair.

(101) POWER WHEELCHAIR ACCESSORIES. All powered wheelchair accessories not defined in this rule as Power Seating Accessories are excluded from TennCare coverage but may be provided by an MCO as a cost effective alternative service as defined in this rule.

(102) PREMIUM. A specified amount of money that an insured person is required to pay on a regular basis in order to participate in a health plan.

(103) PRESCRIBER. An individual authorized by law to prescribe drugs.

(104) PRIMARY CARE PHYSICIAN shall mean a physician responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/ Gynecologist, or Family Practitioner.

(105) PRIMARY CARE PROVIDER shall mean health care professional capable of providing a wide variety of basic health services. Primary care providers include practitioners of family, general, or internal medicine; pediatricians and obstetricians; nurse practitioners; midwives; and physician's assistant in general or family practice.

(Rule 1200-13-14-.01, continued)

(106) PRIOR APPROVAL STATUS shall mean the restriction of an enrollee to a procedure wherein services, except in emergency situations, must be approved by the TennCare Bureau or the MCC prior to the delivery of services.

(107) PRIOR AUTHORIZATION shall mean the process under which services, except in emergency situations, must be approved by the TennCare Bureau or the MCC prior to the delivery in order for such services to be covered by the TennCare program.

(108) PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period.

(a) A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members. If there is more than one person in a household who is determined to require TennCare-reimbursed private duty nursing services, it is not necessary to have multiple nurses providing the services. A single nurse may provide services to multiple enrollees in the same home and during the same hours, as long as he can provide these services safely and appropriately to each enrollee.

(b) If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home, that determines whether the nursing services are continuous or intermittent.

(c) Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:

1. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

2. Is ventilator dependent with a progressive neuromuscular disorder or spinal cord injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least 12 hours each day in order to avoid or delay tracheostomy (requires medical review); or

3. Has a functioning tracheostomy:

(i) Requiring suctioning; and

(ii) Oxygen supplementation; and

(iii) Receiving nebulizer treatments or requiring the use of Cough Assist/ in-exsufflator devices; and

(iv) In addition, at least one subitem from each of the following items (I and II) must be met:

(I) Medication:

(Rule 1200-13-14-.01, continued)

I. Receiving medication via a gastrostomy tube (G-tube); or

II. Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port; and

(II) Nutrition:

I. Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube); or

II. Receiving total parenteral nutrition.

(d) Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.

(e) A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of these rules may receive medically necessary nursing care as an intermittent service under home health.

(f) General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have non-medical care needs which must be met, to the extent that private duty nursing services are provided to a person or persons under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

1. The child is non-ambulatory; and

2. The child has no or extremely limited ability to interact with caregivers; and

3. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse is present in the home without the presence of another responsible adult; and

4. No other children shall be present in the home during the time the private duty nurse is present in the home without the presence of another responsible adult, unless these children meet all of the criteria stated above and are also receiving TennCare-reimbursed private duty nursing services.

(109) Provider shall mean an appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services. Providers are categorized as either TennCare Providers or Non-TennCare Providers. TennCare Providers may be further categorized as being one of the following:

(a) Participating Providers or In-Network Providers

(b) Non-Participating Providers or Out-of-Network Providers

(Rule 1200-13-14-.01, continued)

(c) Out-of-State Emergency Providers

Definitions of each of these terms are contained in this Rule.

(110) PROVIDER-INITIATED REDUCTION, TERMINATION OR SUSPENSION OF SERVICES shall mean a decision to reduce, terminate, or suspend an enrollee's TennCare services which is initiated by the enrollee's provider, rather than by the MCC.

(111) PROVIDER WITH PRESCRIBING AUTHORITY shall mean, in the context of TennCare pharmacy services, a health care professional authorized by law or regulation to order prescription medications for his/her patients, and who:

(a) Participates in the provider network of the MCC in which the enrollee is enrolled; or

(b) Has received a referral of the enrollee, approved by the MCC, authorizing her to treat the enrollee; or

(c) In the case of a TennCare enrollee who is also enrolled in Medicare, is authorized to treat Medicare patients.

(112) PRUDENT LAY PERSON shall mean a reasonable person who possesses an average knowledge of health and medicine.

(113) QUALIFYING MEDICAL CONDITION shall mean a medical condition which is included among a list of conditions established by the Bureau and which will render a qualified uninsured applicant medically eligible.

(114) QUALIFIED UNINSURED PERSON shall mean an uninsured person who meets the technical, financial, and insurance requirements for the TennCare Standard Program.

(115) READABLE shall mean easily understood language and format. See 42 C.F.R. § 438.10.

(116) REASSIGNMENT shall mean the process by which the Bureau of TennCare transfers an enrollee from one MCO to another as described in these rules.

(117) RECEIPT OF MAILED NOTICES shall mean that receipt of mailed notices is presumed to occur within five (5) days of mailing.

(118) RECERTIFICATION shall have the same meaning as Redetermination.

(119) RECONSIDERATION shall mean the mandatory process, triggered by an enrollee's request for a SFH, by which an MCC reviews and renders a decision affirming or reversing the MCC's adverse benefit determination. An MCC satisfies the plan-level requirements of 42 C.F.R. Part 438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a physician other than the original reviewing physician; and produces a timely written finding. See June 5, 2017, CMS letter from Jackie Glaze to Wendy Long, M.D., M.P.H.

(120) REDETERMINATION shall mean the process by which DHS evaluates the ongoing eligibility status of TennCare Medicaid and TennCare Standard enrollees. This is a periodic process that is conducted at specified intervals or when an enrollee's circumstances change. The process is conducted in accordance with TennCare's, or its designee's, policies and procedures.

(Rule 1200-13-14-.01, continued)

(121) RESPONSIBLE PARTY(IES) shall mean the following individuals, who are representatives and/or relatives of recipients of medical assistance who are not financially eligible to receive benefits: parents, spouses, children, and guardians; as defined at Tennessee Code Annotated § 71-5-103(10).

(122) SSI (SUPPLEMENTAL SECURITY INCOME) BENEFITS shall mean the benefits provided through a program administered by the Social Security Administration for those meeting program eligibility requirements. Tennessee residents determined eligible for SSI benefits are automatically enrolled in TennCare Medicaid.

(123) STANDARD SPEND DOWN (SSD) shall mean the demonstration eligibility category composed of adults age twenty-one (21) and older who have been found to meet the criteria in Rule 1200-13-14-.02.

(124) STATE FAIR HEARING (SFH) shall mean an evidentiary hearing requested by or on behalf of an enrollee to allow the enrollee to appeal an adverse benefit determination, which is conducted in accordance with 42 C.F.R. Part 431 Subpart E and the Tennessee Uniform Administrative Procedures Act, T.C.A. §§ 4-5-301, et seq. An initial order under T.C.A. § 4-5-314 shall be entered when an evidentiary hearing is held before a hearing officer. If any party appeals the initial order under T.C.A. § 4-5-315, the Commissioner may render a final order.

(125) TARGETED PHARMACY. A pharmacy meeting one of the following criteria:

(a) It is located outside the State of Tennessee.

(b) It has had previous controlled substance violations with the Tennessee State Board of Pharmacy.

(c) It appears to be an outlier to the norm in its dispensing of controlled substances.

(d) It has filled controlled substance prescriptions that are covered by TennCare for members locked in to a different pharmacy after being notified that the member was locked in to a different pharmacy.

(126) TARGETED PRESCRIBER. A prescriber with prescribing authority who is ranked as a top prescriber of controlled substances based on multiple factors which may include but are not limited to any of the following:

(a) The percentage of controlled substances prescribed.

(b) The percentage of Schedule II controlled substances prescribed.

(c) The percentage of Schedule III controlled substances prescribed.

(d) The percentage of short acting single ingredient opiates prescribed.

(e) The percentage of short acting combination product opiates prescribed.

(f) The percentage of long acting opiates prescribed.

(g) The average morphine equivalents per day prescribed.

(h) The percentage of rejected claims of controlled substances.

(127) TECHNICAL ELIGIBILITY REQUIREMENTS shall mean the eligibility requirements applicable to the appropriate category of medical assistance as discussed in Chapter 1240-03-03-.03 of

(Rule 1200-13-14-.01, continued)

the rules of the TDHS - Division of Medical Services, and the additional eligibility requirements set forth in these rules.

(128) TennCare shall mean 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.

(129) TENNCARE APPEAL FORM shall mean the TennCare form(s) which are completed by an enrollee or by a person authorized by the enrollee to do so, when an enrollee appeals an adverse benefit determination.

(130) TENNCARE CHOICES in Long-Term Care shall mean the program described in Rule 1200-13-01-.05.

(131) TennCare MEDICAID shall mean that part of the TennCare program, which covers persons eligible for Medicaid under Tennessee's Title XIX State Plan for Medical Assistance. The following persons are eligible for TennCare Medicaid:

(a) Tennessee residents determined to be eligible for Medicaid in accordance with 1240-03-03 of the rules of the Tennessee Department of Human Services - Division of Medical Services.

(b) Individuals who qualify as dually eligible for Medicare and Medicaid are enrolled in TennCare Medicaid.

(c) A Tennessee resident who is an uninsured woman, under age sixty-five (65), a US citizen or qualified alien, is not eligible for any other category of Medicaid, has been diagnosed as the result of a screening at a Centers for Disease Control and Prevention (CDC) site with breast or cervical cancer, including pre-cancerous conditions.

(d) Tennessee residents determined eligible for SSI benefits by the Social Security Administration are automatically enrolled in TennCare Medicaid.

(132) TENNCARE MEDICAID ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to close enrollment into TennCare Medicaid for non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance and to disenroll non-pregnant adults age twenty-one (21) or older who qualify as Medically Needy under Tennessee's Title XIX State Plan for Medical Assistance after completion of their twelve (12) months of eligibility.

(133) TENNCARE PHARMACY PROGRAMS shall mean any TennCare pharmacy carve-outs, including, but not limited to, enrollees with dual eligibility and all pharmacy services provided by the TennCare Managed Care Organizations (MCOs).

(134) TENNCARE PROVIDER shall mean a provider who accepts as payment in full for furnishing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with an MCC or TennCare. Such payment may include copayments from the enrollee or the enrollee's responsible party. Except in the case of Out-of-State Emergency Providers, as defined in this Rule, a TennCare provider must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including requirements regarding provider billing of patients as found in Rule 1200-13-14-.08. TennCare Providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in Medicare or Medicaid.

(Rule 1200-13-14-.01, continued)

(135) TennCare SELECT shall mean a state self-insured HMO established by the Bureau of TennCare and administered by a contractor to provide medical services to certain eligible enrollees.

(136) TENNCARE SERVICES OR BENEFITS for purposes of this rule shall mean any medical assistance that is administered by the Bureau of TennCare or its contactors and which is funded wholly or in part with federal funds under the Medicaid Act or any waiver thereof, but excluding:

(a) Medical assistance that can be appealed through an appeal of a pre-admission evaluation (PAE) determination;and

(b) Medicare cost sharing services that do not involve utilization review by the Bureau of TennCare or its contractors.

(137) TENNCARE STANDARD shall mean that part of the TennCare Program which provides health coverage for Tennessee residents who are not eligible for Medicaid and who meet the eligibility criteria found in rule 1200-13-14-.02.

(138) TENNCARE STANDARD ELIGIBILITY REFORMS shall mean the amendments to the TennCare demonstration project approved by CMS on March 24, 2005, to terminate coverage for adults aged 19 and older in TennCare Standard eligibility groups.

(139) TENNderCARE shall mean the name given to the preventive health care program for TennCare children.

(140) TERMINATION shall mean the discontinuance of an enrollee's coverage under the TennCare Medicaid or TennCare standard program.

(141) THIRD PARTY shall mean any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or a part of the costs of medical care of the enrollee.

(142) TRANSITION GROUP shall mean existing Medically Needy adults age twenty-one (21) or older enrolled as of October 5, 2007, who have not yet been assessed for transition to the Standard Spend Down Demonstration population for non-pregnant adults age twenty-one (21) or older.

(143) TREATING PHYSICIAN (OR CLINICIAN) shall mean a health care provider who has provided diagnostic or treatment services for an enrollee (whether or not those services were covered by TennCare), for purposes of treating, or supporting the treatment of, a known or suspected medical condition. The term excludes providers who have evaluated an enrollee's medical condition primarily or exclusively for the purposes of supporting or participating in a decision regarding TennCare coverage.

(144) UNINSURED shall mean any person who does not have health insurance directly or indirectly through another family member, or who does not have access to group health insurance. For purposes of the Medicaid eligibility category of women under 65 requiring treatment for breast or cervical cancer, "Uninsured" shall mean any person who does not have health insurance or access to health insurance which covers treatment for breast or cervical cancer.

(145) VALID FACTUAL DISPUTE shall mean a dispute which, if resolved in favor of the enrollee, would result in the proposed action not being taken.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, 71-5-113, 71-5-134, 71-5-146, 42 C.F.R. Part 431 Subpart E, 42 C.F.R. Part 438 Subpart F, and Executive Order No. 23.* ***Administrative***

(Rule 1200-13-14-.01, continued)

History: *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.01; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment filed April 9, 2003; effective June 23, 2003. Public necessity rule filed May 5, 2005; effective through October 17, 2005. Public necessity rule filed June 3, 2005; effective through November 15, 2005. Amendment filed July 14, 2005; effective September 27, 2005. Amendment filed July 20, 2005; effective October 3, 2005. Amendment filed July 28, 2005; effective October 11, 2005. Amendment filed September 1, 2005; effective November 15, 2005. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendments filed March 31, 2006; effective June 14, 2006. Public Necessity rule filed December 1, 2006; effective through May 15, 2007. Public necessity rule filed February 1, 2007; effective through July 16, 2007. Public necessity rule filed March 21, 2007; effective through September 2, 2007. Amendment filed January 26, 2007; effective April 11, 2007. Amendments filed May 2, 2007; effective July 16, 2007. Amendments filed June 11, 2007; effective August 25, 2007. Public necessity rule filed October 11, 2007; effective through March 24, 2008. Public necessity rule filed February 8, 2008; effective through July 22, 2008. Amendments filed May 7, 2008; effective July 21, 2008. Public necessity rule filed September 8, 2008; effective through February 20, 2009. Amendment filed December 5, 2008; effective February 18, 2009. Amendments filed September 25, 2009; effective December 24, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendments filed January 15, 2013; effective April 15, 2013. Amendment filed July 1, 2013; effective September 29, 2013. Amendments filed October 3, 2013; effective January 1, 2014. Amendment filed December 23, 2014; effective March 23, 2015. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendment filed June 30, 2016; effective September 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016. Amendments filed July 3, 2017; effective October 1, 2017. Amendments filed September 25, 2017; effective December 24, 2017.*

1200-13-14-.02 ELIGIBILITY.

(1) Delineation of agency roles and responsibilities.

(a) The Tennessee Department of Finance and Administration (F&A) is the lead State agency for the TennCare Program.

(b) The Bureau of TennCare (Bureau) is the administrative unit within F&A with the responsibility for day-to-day operations of the TennCare Program. The Bureau is responsible for establishing policy and procedural requirements and criteria for TennCare.

1. With respect to the eligibility of children applying for TennCare as medically eligible persons, the Bureau is responsible for determining the presence of a qualifying medical condition under TennCare Standard.

2. With respect to the eligibility of individuals applying for the TennCare CHOICES program, the Bureau is responsible for determining that the individual meets level of care eligibility criteria for the long-term care services or reimbursement requested. For enrollment into CHOICES Group 2, the Bureau is also responsible for determining the state's ability to provide appropriate Home and Community Based Services (HCBS) as determined by the availability of slots under the established enrollment target in accordance with Rule 1200-13-01-.05 and for confirming a determination by an Area Agency on Aging and Disability or TennCare Managed Care Organization that:

(i) The individual is an adult aged sixty-five (65) or older, or an adult aged twenty-one (21) or older with physical disabilities; and

(Rule 1200-13-14-.02, continued)

(ii) Such individual can be safely and appropriately served in the community and at a cost that does not exceed the individual's cost neutrality cap pursuant to Rule 1200-13-01-.05.

3. With respect to the eligibility of individuals applying for the ECF CHOICES program, the Bureau is responsible for determining that the individual meets all applicable eligibility and enrollment criteria, including target population, medical or level of care eligibility, categorical and financial eligibility, the state's ability to provide appropriate ECF HCBS (as defined in Rule 1200-13-01-.02) as determined by the availability of slots under the established enrollment target for each ECF CHOICES Group in accordance with Rule 1200-13-01-.31 and pursuant to intake and enrollment policies and processes described in 1200-13-01-.31 and in TennCare policies and protocols, and for confirming a determination by a TennCare Managed Care Organization that the individual can be safely and appropriately served in the community and at a cost that does not exceed the individual's expenditure cap pursuant to Rule 1200-13-01-.31.

(c) The Tennessee Department of Human Services (DHS) is under contract with the Bureau to determine initial eligibility for TennCare Medicaid and TennCare Standard, as well as to redetermine, at regular intervals, whether eligibility should be continued. DHS is not responsible for making decisions about the presence of a qualifying medical condition for those applying as medically eligible persons under TennCare Standard.

(d) The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) Program. Tennessee residents determined eligible for SSI benefits are automatically eligible for and enrolled in TennCare Medicaid.

(e) The Tennessee Department of Health (DOH) determines presumptive eligibility under TennCare Medicaid for pregnant women and for women diagnosed with breast or cervical cancer through administration of the Breast and Cervical Cancer Screening Program.

(2) Delineation of TennCare enrollee's responsibilities.

(a) It is the responsibility of each TennCare enrollee to report to the DHS any material change affecting any information given by the applicant/enrollee to DHS at the time of application or redetermination of his eligibility. This information includes, but is not limited to, changes in address, income, family size, employment, or access to insurance. The applicant/enrollee shall mail, or present in person, documentation of any such change to the DHS county office where the enrollee resides. This documentation must be presented within the time frame established by Tennessee Code Annotated § 71-5-110 for reporting changes.

(b) It is the responsibility of each TennCare enrollee to report to his provider that he is a TennCare enrollee.

(3) Technical and financial eligibility requirements for TennCare Standard.

To be eligible for TennCare Standard, each individual must:

(a) Not be eligible for Medicaid as determined by DHS.

(b) Provide a statement from his employer, if employed, concerning the availability of group health insurance. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or any CHOICES or ECF CHOICES demonstration category.)

(Rule 1200-13-14-.02, continued)

(c) Be a U.S. citizen, lawfully admitted alien, or an alien permanently residing in the U.S. under color of law.

(d) Be a Tennessee resident as described under federal and state law.

(e) Present a Social Security number or proof of having applied for one, or assist the DHS caseworker in applying for a Social Security number, for each person applying for TennCare Standard.

(f) Not be an inmate as defined in these rules.

(g) Not be eligible for or have purchased other health insurance as defined at Rule 1200-13-14-.01, except for persons in the category of uninsured children under the age of nineteen (19) whose family income is below two hundred percent (200%) of poverty and who have been continuously enrolled in TennCare Standard since at least December 31, 2001. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or any CHOICES or ECF CHOICES demonstration category.)

(h) Not be enrolled in, or eligible for participation in, Medicare. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or any CHOICES or ECF CHOICES demonstration category.)

(4) General application requirements.

(a) By applying for TennCare, an applicant grants permission and authorizes release of information to the Bureau, or its designee, to investigate any and all information provided, or any information not provided if it could affect eligibility, to determine TennCare eligibility; and if approved, what cost sharing, if any, may be required of the applicant as found in these rules. Information may be verified through, but not limited to, the following sources:

1. The United States Internal Revenue Service (IRS);

2. State income tax records for Tennessee or any other state where income is earned;

3. The Tennessee Department of Labor and Work Force Development, and other Employment Security offices within any state where the applicant may have received wages or been employed;

4. Credit bureaus;

5. Insurance companies; or,

6. Any other governmental agency or public or private source of information where such information may impact an applicant's eligibility or cost sharing requirements for the TennCare Program.

(b) By applying for TennCare, an applicant understands it is a felony offense, pursuant to Tennessee Code Annotated § 71-5-2601, to obtain TennCare coverage under false means or to help anyone get on TennCare under false means.

(5) TennCare Standard: Uninsured and medically eligible children.

(Rule 1200-13-14-.02, continued)

(a) Coverage groups:

1. Group 1: Uninsured children under age nineteen (19) who are losing eligibility for Medicaid, who have family incomes below two hundred percent (200%) of poverty, and who do not have access to insurance.

2. Group 2: Uninsured children under age nineteen (19) who are losing eligibility for Medicaid, who have family incomes that equal or exceed two hundred percent (200%) of poverty, who do not have access to insurance, and who have been determined medically eligible in accordance with these rules.

3. Group 3: Uninsured children under age nineteen (19) who have been continuously enrolled in TennCare Standard since December 31, 2001, who have family incomes below two hundred percent (200%) of poverty, and who have not purchased insurance even if they have access to it. This is a "grandfathered" eligibility category. At such time as a person loses eligibility in this category, he will not be able to re-enroll in it.

4. TennCare Standard is closed to new enrollment for children, except those children identified in (5)(a)1. and (5)(a)2. above.

(b) Eligibility criteria:

1. The individual must be under nineteen (19) years of age.

2. The individual must lack access to insurance, except those individuals in Group 3, defined in part (a)3. above. Individuals in Group 3 must not have purchased insurance that may be available to them.

3. For persons in Groups 1 and 3 defined in parts (a)1. and 3. above, have family incomes that do not exceed two hundred percent (200%) of poverty.

4. For persons in Group 2 defined in part (a)2. above, have been determined medically eligible in accordance with these rules.

(c) Application procedures:

1. Uninsured children.

An individual who is losing eligibility for TennCare Medicaid and who is under the age of nineteen (19) may be approved for TennCare Standard as a Medicaid "Rollover" Enrollee according to the following process:

(i) At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send the enrollee a Request for Information in accordance with rule 1200-13-13-.02(6)(b). The Request for Information will include a form to be completed with information needed to determine eligibility.

(ii) Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to DHS and to provide DHS with the necessary verifications to determine eligibility. When the individual returns a completed Request for Information form, he will first be screened for TennCare Medicaid eligibility. If the individual is no longer TennCare Medicaid eligible, he will be screened for eligibility as a Medicaid

(Rule 1200-13-14-.02, continued)

"Rollover" Enrollee in accordance with TennCare Standard eligibility criteria under rule 1200-13-14-.02.

(iii) If DHS makes a determination that the enrollee is not eligible for any open Medicaid or Standard categories, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

2. Medically eligible children.

(i) Applicants have two (2) options for proving medical eligibility:

(I) Option 1: A completed medical eligibility application and medical records to support any medical condition listed on the application, with a signed release for medical records in the event additional medical records are needed.

(II) Option 2: Have a current CRG 1, 2, 3/TPG 2 assessment on file with the Bureau.

(ii) If a Medicaid enrollee under age nineteen (19) whose Medicaid eligibility is ending is determined to otherwise meet technical eligibility requirements for TennCare Standard, but is not eligible as uninsured because his income is above two hundred percent (200%) of poverty, he will be sent a letter denying TennCare Standard coverage as uninsured and notifying the enrollee that he may qualify as medically eligible. The enrollee will have forty (40) days (inclusive of mail time) to appeal the denial of TennCare Standard as uninsured.

(iii) When DHS makes the determination that the enrollee does not qualify for TennCare Standard as uninsured, TennCare will be notified and will send the enrollee a medical eligibility packet with an explanation regarding how to apply for TennCare Standard as a medically eligible person. The enrollee will have sixty (60) days from the date of the letter (inclusive of mail time) to submit his medical eligibility packet. If the individual is determined to qualify as medically eligible, coverage will be provided throughout the eligibility determination period and will continue with no break.

(iv) The required medical eligibility application information must be returned to the address specified within sixty (60) days from the date of the letter included in the packet. A medical eligibility form and documentation received after that time will not be processed as it exceeds the timely filing requirement. Packets which are not completed by the sixtieth (60th) day will be denied with a notice of appeal rights and the "good cause" reasons for not completing the process timely, which include:

(I) The applicant was sick.

(II) A member of the applicant's immediate family was very sick.

(III) The applicant had a family emergency or tragedy.

(IV) The applicant could not get the medical records he needed from a provider. It was not his fault.

(V) The applicant asked for help because he had a disability. Neither the Bureau nor DHS gave the help the applicant needed.

(VI) The applicant asked for help because he does not speak English. Neither the Bureau nor DHS gave the help the applicant needed.

(v) The Bureau of TennCare will review the completed medical eligibility packet. Evaluation of completed packets will be made within thirty (30) days of receipt from the applicant. Medical Reviewers will assess the records submitted against TennCare medical insurance underwriting guidelines. Applicants who are not determined to be medically eligible by the Bureau will not be eligible for TennCare Standard. They will receive a termination notice which contains appeal rights including the right to appeal within forty (40) days from the receipt of the termination notice. Appeals received by the Bureau after forty (40) days will be considered untimely and will not be forwarded to hearing.

(vi) Applicants deemed medically eligible by the Bureau of TennCare will be approved for TennCare Standard. The Bureau will send the applicant an approval notice of coverage. The eligibility period for medically eligible individuals is twelve (12) months. At the end of twelve (12) months, the enrollee must complete the redetermination/reapplication process.

(vii) The effective date of coverage will be the date of application.

(6) TennCare Standard: Standard Spend Down (SSD) Program.

(a) Coverage group.

Non pregnant adults, age 21 and older, who have been determined to meet criteria patterned after the Medically Needy requirements, as outlined in DHS rule 1240-03-02-.03 and who are age 65 or older, blind, disabled, or caretaker relatives of Medicaid-eligible children.

(b) Eligibility criteria:

1. Must be age twenty-one (21) or older.

2. Must not be pregnant.

3. Must meet one of the following criteria:

(i) Be sixty-five (65) years of age or older; or

(ii) Be blind, as defined in DHS rule 1240-03-03-.02; or

(iii) Be disabled, as defined in DHS rule 1240-03-03-.02; or

(iv) Be a caretaker relative, as defined at T.C.A. § 71-3-153.

4. Must meet the financial eligibility criteria, including income and resource limitations that apply to Medically Needy pregnant women and children eligible under the State plan. These criteria are found at DHS rules 1240-03-03-.05 and 1240-03-03-.06.

5. Must be enrolled in accordance with an enrollment target of 100,000 Tennessee residents who have been determined to be eligible for the Standard Spend Down

(Rule 1200-13-14-.02, continued)

(SSD) Program; with a maximum of 105,000 persons to be enrolled at any given time.

(c) Application procedures:

1. SSD categories.

(i) Category 1. Individuals who are not eligible for Medicaid at the time the SSD program is implemented and who meet the criteria for the new SSD program.

Category 1 applicants will be processed for eligibility only through a single toll-free telephone point of entry (the Call-in Line) initiated in periods of open enrollment. In each such period, the State will determine a specified number of calls that it will accept through the Call-in Line based on the number of Category 1 applications that the State estimates it can process within Federal timeliness standards. The number of calls to be accepted in these periods will be based on the number of remaining slots available under the enrollment target of 100,000 persons. The State will not accept or track calls received outside of these periods.

(ii) Category 2. Individuals in the Transition Group who, at the time the SSD program is implemented, are eligible for Medicaid in a non-pregnant adult Medically Needy category, who have completed their twelve (12) months of Medicaid eligibility, have been found to be ineligible for any other Medicaid category, and have been determined to meet the criteria of the SSD program.

For Category 2 individuals, the State will determine their SSD eligibility on a rolling basis in conjunction with their termination from Medicaid, and shall reserve sufficient slots within the enrollment target to ensure that all such persons who are eligible may be accepted in the SSD category.

Termination procedures for Category 2 individuals who are not eligible for Medicaid or for SSD will be conducted in accordance with those outlined in Paragraph (7)(b) of this rule.

Upon implementation of the SSD program, the State will review all Category 2 individuals for either eligibility in a new Medicaid category or approval as a Standard Spend Down eligible. After the review of all Category 2 individuals is complete and it is determined how many additional enrollees can be added to the SSD program without exceeding the enrollment cap, the State will begin enrolling persons in Category 1.

2. Initial application period for Category 1.

The State will establish an initial target enrollment figure based on its determination of the minimum number of applications the State estimates it can process in a timely manner in accordance with Federal standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions. A toll-free Call-in Line to receive requests for applications will be established and requests will be processed as follows:

(i) Callers to the Call-in Line will be asked for basic demographic information and will be assigned a unique identifier.

(ii) A match will be conducted to verify that callers are not already eligible in a TennCare Medicaid category. Those callers who are already eligible in a TennCare Medicaid category will be sent letters advising them that they currently have benefits and need not apply for Standard Spend Down.

(iii) For those callers who are not Medicaid eligible, the State will send a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within thirty (30) days.

(iv) Completed, signed applications received by the State by the thirty (30)-day deadline will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the State. If the State does not receive an application by the deadline, the State will send the individual a letter advising him that since no application was received, the State will not make an eligibility determination for him, but the individual is free to apply for SSD during any subsequent open application period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he did submit a signed, written application within the deadline.

(v) Since all SSD applications received during an open application period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open application period will be carried forward to future open application periods. The State will determine SSD eligibility within the timeframes specified by Federal regulations at 42 C.F.R. § 435.911; such time frames will begin on the date a signed written application is received by the State.

3. New application periods after the SSD enrollment target has been reached.

Once the State has reached its targeted enrollment of 100,000 persons, new application periods will be scheduled when the number of approved eligibles in the SSD program drops to ninety percent (90%) of target enrollment, or 90,000 persons. Any subsequent application periods will remain open until a predetermined number of calls to the Call-in Line have been received. The number of calls to be received will be based on the State's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the state estimates it can process in a timely manner in accordance with Federal standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions.

4. Period of eligibility.

All enrollees in the SSD demonstration category will have an eligibility period of twelve (12) months from the effective date of eligibility. At the end of the twelve (12)-month period each enrollee must have his eligibility redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for Medically Needy pregnant women and children in TennCare Medicaid.

5. Effective date of eligibility for SSD enrollees.

The effective date of SSD eligibility for an individual whose application for SSD eligibility is initiated through the Call-in Line and who submits a timely signed application will be the later of:

(i) The date his call was received by the Call-in Line; or

(ii) The date spend-down is met (which must be no later than the end of the one (1)-month budget period – in this case, the end of the month of the original call to the Call-in Line).

(iii) The effective date of SSD eligibility for an individual whose eligibility is being redetermined is the application date.

(iv) For Category 2 individuals the effective date will be determined in accordance with DHS rule 1240-03-02-.04.

(7) TennCare Standard: CHOICES 217-Like Group

(a) Coverage group. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the Nursing Facility (NF) level of care criteria, who could have been eligible for HCBS under 42 C.F.R. § 435.217 had the state continued its 1915(c) HCBS Waiver for persons who are elderly and/or physically disabled, and who need and are receiving HCBS as an alternative to Nursing Facility (NF) care. This group exists only in the Grand Divisions of the state where the CHOICES program has been implemented, and participation is subject to the enrollment target for CHOICES Group 2.

(b) Eligibility criteria:

1. Must be aged sixty-five (65) and older or aged twenty-one (21) and older with physical disabilities as defined in Rule 1200-13-01-.02;

2. Must meet the Nursing Facility level of care requirements;

3. Must have a current determination by an Area Agency on Aging and Disability or the TennCare MCO to which the individual is assigned, that he is able to be safely and appropriately served in the community and within his individual cost neutrality cap as defined in Rule 1200-13-01-.05;

4. May be enrolled in accordance with requirements pertaining to the enrollment target for CHOICES Group 2, as described in Rule 1200-13-01-.05;

5. Will be enrolled and begin receiving Home and Community Based Services (HCBS) upon determination of financial eligibility by DHS and continue to receive HCBS as a CHOICES Group 2 participant. Qualifying for enrollment into CHOICES Group 2 (HCBS) is not sufficient to establish eligibility in the CHOICES 217-Like Group if the person will not actually be enrolled and receiving HCBS; and

6. Would be eligible 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-d), if the Home and Community Based Services (HCBS) were provided under a section 1915(c) waiver.

(Rule 1200-13-14-.02, continued)

(c) Application procedures

1. To be eligible for the CHOICES 217-Like Group, each individual must meet all technical and financial requirements applicable to this category as described in DHS Rule Chapter 1240-03-03.

2. The effective date of eligibility in the CHOICES 217-Like Group shall be the date the application is approved by DHS. In no instance shall the effective date of eligibility precede the date the application was filed with DHS.

(8) TennCare Standard: ECF CHOICES 217-Like Group.

(a) Coverage group. Individuals with I/DD of all ages who meet the NF LOC criteria who need and are receiving HCBS, and who would be eligible in the same manner as specified under Section 1902(a) of the Social Security Act and 42 C.F.R. § 435.217, if the HCBS were provided under a Section 1915(c) waiver. Enrollment in this group shall be subject to the enrollment targets established for each applicable ECF CHOICES benefit group. An Applicant may qualify in the ECF CHOICES 217-Like Group only when there is an available slot for enrollment into an ECF CHOICES benefit group for which the Applicant meets all eligibility and enrollment criteria, including prioritization criteria for enrollment into ECF CHOICES as established in these Rules, and when the Applicant upon approval of financial eligibility, will be enrolled by TennCare into such ECF CHOICES group.

(b) Eligibility criteria:

1. Must have an intellectual or developmental disability as defined in Rule 1200-13-01-.02;

2. Must meet the Nursing Facility level of care requirements;

3. Must have a current determination by the TennCare MCO to which the individual is assigned, that he is able to be safely and appropriately served in the community and within his expenditure cap as defined in Rule 1200-13-01-.31, except in instances where the Applicant is not eligible for TennCare at the time of ECF CHOICES application, in which case, such determination shall be made by the MCO upon enrollment into ECF CHOICES;

4. May be enrolled in accordance with requirements pertaining to the enrollment target for each ECF CHOICES Group, including prioritization criteria for enrollment into ECF CHOICES, as described in Rule 1200-13-01-.31;

5. Will be enrolled and begin receiving Home and Community Based Services (HCBS) upon determination of financial eligibility by TennCare and continue to receive HCBS as an ECF CHOICES participant. Qualifying for enrollment into ECF CHOICES is not sufficient to establish eligibility in the ECF CHOICES 217-Like Group if the person will not actually be enrolled and receiving HCBS; and

6. Would be eligible in the same manner as specified under Section 1902(a) of the Social Security Act and 42 C.F.R. § 435.217, if the Home and Community Based Services (HCBS) were provided under a section 1915(c) waiver.

(c) Application procedures:

(Rule 1200-13-14-.02, continued)

1. To be eligible for the ECF CHOICES 217-Like Group, each individual must meet all technical and financial requirements applicable to this category as described in Rule Chapter 1200-13-20.

2. The effective date of eligibility in the ECF CHOICES 217-Like Group shall be the date the application is approved by TennCare. In no instance shall the effective date of eligibility precede the date the application was filed with TennCare.

(9) TennCare Standard: Interim ECF CHOICES At-Risk Group.

(a) Coverage group. Individuals who have an intellectual or developmental disability as defined in Rule 1200-13-01.-02 who meet the financial eligibility standards for the ECF CHOICES 217-Like Group; do not meet the Nursing Facility (NF) level of care criteria, but in the absence of ECF CHOICES HCBS, are At Risk for Institutionalization as defined in Rule 1200-13-01-.02; and who need and are receiving ECF CHOICES HCBS. The Interim ECF CHOICES At-Risk Demonstration Group will open to new enrollment only until such time that the Employment and Community First CHOICES At-Risk Demonstration Group (with income up to one hundred and fifty percent (150%) of the FPL) and the Employment and Community First CHOICES Working Disabled Demonstration Groups can be established. Persons enrolled in the Interim ECF CHOICES At-Risk Demonstration Group as of the date new enrollment into the group closes may continue to qualify in the group as long as they continue to meet nursing facility financial eligibility standards and are At-Risk for Institutionalization as defined in Rule 1200-13-01-.02, and remain continuously eligible and enrolled in the Interim ECF CHOICES At-Risk Demonstration Group. Enrollment in this group shall be subject to the enrollment targets established for each applicable ECF CHOICES benefit group. An Applicant may qualify in the Interim ECF CHOICES At-Risk Group only when there is an available slot for enrollment into an ECF CHOICES benefit group for which the Applicant meets all eligibility and enrollment criteria, including prioritization criteria for enrollment into ECF CHOICES as established in Rule 1200-13-01-.31, and when the Applicant, upon approval of financial eligibility, will be enrolled by TennCare into such ECF CHOICES group.

(b) Eligibility criteria:

1. Must have an intellectual or developmental disability as defined in Rule 1200-13-01-.02;

2. Must meet the financial eligibility standards for the ECF CHOICES 217-Like Group;

3. Do not meet the Nursing Facility level of care, but in the absence of ECF CHOICES HCBS, are At Risk for Institutionalization as defined in Rule 1200-13-01-.02;

4. Must have a current determination by the TennCare MCO to which the individual is assigned, that he is able to be safely and appropriately served in the community and within his expenditure cap as defined in Rule 1200-13-01-.31, except in instances where the Applicant is not eligible for TennCare at the time of ECF CHOICES application, in which case, such determination shall be made by the MCO upon enrollment into ECF CHOICES; and

5. May be enrolled in accordance with requirements pertaining to the enrollment target for each ECF CHOICES Group, including prioritization criteria for enrollment into ECF CHOICES as described in Rule 1200-13-01-.31; and

(Rule 1200-13-14-.02, continued)

6. Will be enrolled and begin receiving Home and Community Based Services (HCBS) upon determination of financial eligibility by TennCare and continue to receive HCBS as an ECF CHOICES participant. Qualifying for enrollment into ECF CHOICES is not sufficient to establish eligibility in the Interim ECF CHOICES At-Risk Group if the person will not actually be enrolled and receiving ECF CHOICES HCBS.

(c) Application procedures:

1. To be eligible for the Interim ECF CHOICES At-Risk Group, each individual must meet all technical and financial requirements applicable to this category as described in Rule Chapter 1200-13-20.

2. The effective date of eligibility in the Interim ECF CHOICES At-Risk Group shall be the date the application is approved by TennCare. In no instance shall the effective date of eligibility precede the date the application was filed with TennCare.

(10) Redetermination of eligibility in TennCare Standard (other than CHOICES 217-Like Group, ECF CHOICES 217-Like Group, and Interim ECF CHOICES At-Risk Group).

(a) All enrollees must reapply and have their TennCare coverage redetermined based on the approved policies and procedures in effect at the time of their next scheduled redetermination/reapplication process. TennCare Standard enrollees shall have their eligibility redetermined in accordance with the following process:

1. Ex Parte Review.

DHS will conduct an ex parte review of eligibility for open Medicaid and Standard categories for all TennCare Standard enrollees due for redetermination. Such ex parte reviews shall be conducted in accordance with federal requirements set forth by CMS in the Special Terms and Conditions of the TennCare demonstration project.

2. Request for Information.

(i) At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of TennCare will send a Request for Information to all TennCare Standard enrollees. The Request for Information will include a form to be completed with the information needed to determine eligibility for open Medicaid and Standard categories, as well as a list of the types of proof needed to verify certain information.

(ii) Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed from to DHS and provide DHS with the necessary verifications to determine eligibility for open Medicaid and Standard categories.

(iii) Enrollees with a health problem, mental health problem, learning problem, or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.

(iv) Enrollees will be given an opportunity until the date of termination to request one (1) extension for good cause of the thirty (30) day time frame for

(Rule 1200-13-14-.02, continued)

responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or who, as a result of a health problem, mental health problem, learning problem, disability, or limited English proficiency, are unable to respond timely. The good cause exception does not confer entitlement upon enrollees and the application of this exception will be within the discretion of DHS. Only one (1) thirty (30) day good cause extension can be granted to each enrollee. Good cause is determined by DHS eligibility staff. Good cause is not requested nor determined through filing an appeal. Requests for an extension of the thirty (30) day time frame to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. DHS will not accept a request for extension of the thirty (30) day time frame submitted by a family member, advocate, provider, or CMHC, acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his whereabouts are unknown. All such requests for good cause extension must be made prior to termination of TennCare eligibility. A good cause extension will be granted if DHS determines that a health problem, mental health problem, learning problem, disability, or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to DHS prior to termination of TennCare eligibility and DHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion of DHS and if granted shall provide the enrollee with an additional thirty (30) days inclusive of mail time from the date of DHS's decision to grant the good cause extension. DHS will send the enrollee a letter granting or denying the request for good cause extension. DHS's decisions with respect to good cause extensions shall not be appealable.

(v) If an enrollee provides some but not all of the necessary information to DHS to determine his eligibility for open Medicaid categories or continuation in TennCare Standard during the thirty (30) day period following the Request for Information, DHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day time frame for responding to the Verification Request.

(vi) Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by DHS shall retain their eligibility for TennCare Standard (subject to any changes in covered services generally applicable to enrollees in their TennCare Standard category) while DHS reviews their eligibility.

(vii) DHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or Verification Request to determine whether the enrollee is eligible for any open Medicaid categories or whether the enrollee is eligible to remain

(Rule 1200-13-14-.02, continued)

in TennCare Standard. If DHS makes a determination that the enrollee is eligible for an open Medicaid category or to remain in TennCare Standard, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare category. When the enrollee is enrolled in TennCare Medicaid, his TennCare Standard eligibility shall be terminated without additional notice. If DHS makes a determination that the enrollee is not eligible for any TennCare category or if the enrollee does not respond to the Request for Information within the requisite thirty (30) day time frame or any extension of such period granted by DHS, the TennCare Bureau will send the enrollee a twenty- (20) day advance Termination Notice.

(viii) DHS shall, pursuant to the rules, policies, and procedures of DHS and the Bureau of TennCare applicable to new applicants for TennCare coverage, review all information and verifications provided by an enrollee after the thirty (30) day period following the Request for Information or after any extension of such period granted by DHS, but the enrollee shall not be entitled to retain eligibility for TennCare Standard pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of his application, or (b) the date spend down eligibility is met as defined in Department of Human Services rule 1240-03-02-.04.

3. Notice of termination.

(i) The TennCare Bureau will send Termination Notices to all TennCare Standard enrollees being terminated who are not determined to be eligible for open Medicaid or Standard categories pursuant to the Ex Parte Review or Request for Information processes described in this subparagraph.

(ii) Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.

(iii) Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and will inform enrollees how they may request a hearing.

(iv) Enrollees with a health problem, mental health problem, learning problem, or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

(v) Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day time frame in which to request a hearing.

(b) A TennCare Standard enrollee shall be required to have his eligibility redetermined for TennCare Standard prior to the expiration date of the current period of coverage as instructed by the DHS. The enrollee’s continued eligibility for TennCare Standard is determined as of the date of the redetermination appointment or a later date if the enrollee does not submit all required documentation at the initial appointment. (The later date must be before the date of expiration of coverage.)

(c) Information to be recertified includes changes in address, income, employment, family size, and access to health insurance (access to insurance is not considered in determining eligibility in the Standard Spend Down category). Redetermination

(Rule 1200-13-14-.02, continued)

appointments must be scheduled and kept regardless of whether any changes have occurred. It is the responsibility of the enrollee to furnish all information requested. The notice reminding the enrollee that he must have his eligibility redetermined will inform the enrollee of the documentation to be brought to the appointment.

(d) The enrollee must complete the entire redetermination process prior to the expiration date of his coverage. Failure to do so will result in coverage lapsing as of the expiration date. The enrollee will not be permitted to appeal the expiration of his coverage in this situation. However, he may appeal on the grounds that:

1. He did, in fact, complete the redetermination process but an administrative error on the part of the State resulted in his coverage expiring; or

2. He was prevented from completing the redetermination process by specific acts or omissions of state employees. However, this ground for appeal does not include challenges to relevant TennCare rules, policies or timeframes.

The individual will receive a notice of the expiration of his coverage and his right to appeal, as set out above, within ten (10) days. There will be no continuation or reinstatement of coverage pending appeal.

(e) Enrollees approved for TennCare Standard as medically eligible persons may also be required to submit proof of continued medical eligibility. Documentation shall be that as required elsewhere in these rules. If as a result of the redetermination appointment it is determined that any enrollee no longer meets the technical eligibility requirements set out at rule 1200-13-14-.02, the enrollee will be disenrolled from TennCare Standard. The enrollee will be sent a notice of termination, and the enrollee has the right to appeal the decision within forty (40) calendar days of the receipt of the letter informing the enrollee of the loss of eligibility. The enrollee's right to appeal is set out at rule 1200-13-14-.12.

(11) Redetermination of eligibility in the CHOICES 217-Like Group.

An enrollee who qualifies for TennCare through DHS shall have his TennCare eligibility redetermined by DHS as required by the appropriate category of medical assistance. Prior to termination, eligibility will be reviewed in accordance with the following process:

(a) At least thirty (30) days prior to the expiration of his current eligibility period, the Bureau of TennCare will send a Request for Information to the enrollee. The Request for Information will include a form to be completed with information needed to verify continued eligibility in the CHOICES 217-Like Group.

(b) Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to DHS and to provide DHS with the necessary verifications to determine continued eligibility for the CHOICES 217-Like Group.

(c) Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.

(d) If an enrollee provides some but not all of the necessary information to DHS to verify his continued eligibility for the CHOICES 217-Like Group during the thirty (30) day period following the Request for Information, DHS will send the enrollee a Verification

(Rule 1200-13-14-.02, continued)

Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request.

(e) Enrollees who respond to the Request for Information within the thirty (30) day period shall retain their eligibility for TennCare (subject to any changes in covered services generally applicable to enrollees in their eligibility category) while DHS reviews their eligibility in the CHOICES 217-Like Group.

(f) Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices but before the date of termination shall retain their eligibility for TennCare while DHS reviews their eligibility in the CHOICES 217-Like Group. If DHS determines that the enrollee remains eligible for his current CHOICES 217-Like category, the enrollee will remain enrolled in such category. If DHS makes a determination that the enrollee is not eligible for continued enrollment in the CHOICES 217-Like Group, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

(g) Individuals may provide the information and verifications specified in the Request for Information after termination of eligibility. DHS shall review all such information pursuant to the rules, policies and procedures of DHS and the Bureau of TennCare applicable to new applicants for TennCare coverage.

(12) Losing eligibility for TennCare Standard.

(a) Eligibility for TennCare Standard shall cease when it has been determined that the enrollee, as the result of one of the following events, no longer meets the criteria for the program. Eligibility for TennCare Standard shall end if:

1. The enrollee becomes eligible for participation in a group health insurance plan, as defined in this Chapter, either directly or indirectly through a family member. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or any CHOICES or ECF CHOICES demonstration category);

2. The enrollee becomes eligible for Medicare. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or any CHOICES or ECF CHOICES demonstration category);

3. The enrollee is determined eligible for Medicaid (this does not apply to the CHOICES 1 and 2 Carryover Group or the PACE Carryover Group; does not apply to the CHOICES 217-Like Group, CHOICES At-Risk Demonstration Group or any ECF CHOICES demonstration category unless the enrollee begins receiving SSI);

4. The enrollee purchases an individual health insurance plan as defined by this Chapter. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or any CHOICES or ECF CHOICES demonstration category);

5. The enrollee fails to comply with TennCare Program requirements, subject to federal and state laws and regulations;

6. The enrollee dies;

7. It is determined that any of the technical eligibility requirements found in this Rule are no longer met;

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8. The enrollee has failed to respond to a redetermination process requirement, as described in this Rule, to assure that the enrollee and other family members, as appropriate, remain eligible for TennCare Standard;

9. The enrollee sends a voluntary written request for termination of eligibility for TennCare Standard to the DHS county office in the county in which he resides;

10. The enrollee no longer qualifies as a resident of Tennessee under federal and state law;

11. The enrollee fails to complete the redetermination process within the timeframes specified within this Rule;

12. The enrollee becomes incarcerated as an inmate;

13. The Bureau determines that the enrollee does not actually have the medical condition(s) which rendered him "medically eligible" for TennCare Standard;

14. The enrollee attains the age of nineteen (19) and has not been determined eligible in an open Medicaid category; or

15. An enrollee in any CHOICES or ECF CHOICES demonstration category no longer satisfies one or more of the eligibility criteria applicable for the category as specified in this Rule.

(b) TennCare Standard enrollees who are disenrolled from TennCare pursuant to this Rule shall be allowed to re-enroll in the TennCare program at any time if they become TennCare Medicaid-eligible or eligible in a CHOICES or ECF CHOICES demonstration category for which enrollment remains open, in accordance with this Rule, and shall not be required to pay arrearages as a condition of re-enrollment. However, nothing in this provision shall eliminate the enrollee's responsibility for unpaid premiums or copayments incurred under any previous period of eligibility.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.02; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rules filed April 29, 2005; effective through October 11, 2005. Public necessity rules filed June 3, 2005; effective through November 15, 2005. Amendments filed July 28, 2005; effective October 11, 2005. Amendments filed September 1, 2005; effective November 15, 2005. Amendment filed January 26, 2007; effective April 11, 2007. Public necessity rule filed February 8, 2008; effective through July 22, 2008. Repeal and new rule filed May 7, 2008; effective July 21, 2008. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Amendment filed October 4, 2012; effective January 2, 2013. Amendments filed September 26, 2013; effective December 25, 2013. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.*

1200-13-14-.03 ENROLLMENT, REASSIGNMENT, AND DISENROLLMENT WITH MANAGED CARE CONTRACTORS (MCCS).

(1) Enrollment.

There are three (3) different types of managed care entities that provide services to TennCare enrollees. Enrollment procedures differ according to the type of managed care entity, the

(Rule 1200-13-14-.03, continued)

geographic area, and the number of managed care entities operating in each geographic area. Enrollment procedures also differ for ECF CHOICES, as described in subparagraph (c) below.

(a) TennCare Managed Care Organizations (MCOs) other than TennCare Select.

1. Except as provided in subparagraph (c), individuals or families determined eligible for TennCare shall select a health plan (Managed Care Organization/MCO) at the time of application. The health plan must be available in the Grand Division of the State in which the enrollee lives. All family members living in the same household and enrolled in TennCare must be assigned to the same MCO except children determined by the Bureau to be eligible to enroll in TennCare Select. An enrollee is given his choice of MCOs when possible. If the requested MCO cannot accept new enrollees, the Bureau will assign each enrollee to an MCO that is accepting new enrollees. If no MCO is available to enroll new members in the enrollee's Grand Division, the enrollee will be assigned to TennCare Select until such time as another MCO becomes available. The Bureau may also assign TennCare children with special health care needs to TennCare Select.

2. Except as provided in subparagraph (c), a TennCare enrollee may change MCOs one (1) time within the initial forty-five (45) calendar days (inclusive of mail time) from the date of the letter informing him of his MCO assignment, if there is another MCO in the enrollee's Grand Division that is currently permitted by the Bureau to accept new enrollees. No additional changes will be allowed except as otherwise specified in these rules. An enrollee shall remain a member of the designated plan until he is given an opportunity to change once each year during an annual change period. The annual change period will occur each year in March for enrollees in West Tennessee, in May for enrollees in Middle Tennessee, and in July for enrollees in East Tennessee. Thereafter, an MCO change is permitted only during an annual change period, unless the Bureau authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment as specified in paragraph (2)(b) below. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until he is enrolled in the requested MCO.

3. Each MCO shall offer its enrollees, to the extent possible, freedom of choice among participating providers. If after notification of enrollment the enrollee has not chosen a primary care provider, one will be selected for him by the MCO. The period during which an enrollee may choose his primary care provider shall not be less than fifteen (15) calendar days.

4. In the event a pregnant woman entering an MCO's plan is receiving medically necessary prenatal care the day before enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the MCO's provider network until such time as the MCO can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health.

   In the event a pregnant woman entering the MCO's plan is in her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period. Reimbursement to an out-of-network provider shall be as set out in rule 1200-13-14-.08.

(Rule 1200-13-14-.03, continued)

(b) TennCare Select.

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

1. The TennCare populations included in the TennCare Select delivery system are as follows:

(i) Children under the age of twenty-one (21) years who are eligible for Supplemental Security Income.

(ii) Children in state custody and children leaving state custody for six (6) months post-custody as long as the child remains eligible.

(iii) Children under the age of twenty-one (21) years in an institutional eligibility category who are receiving care in a Nursing Facility or an Intermediate Care Facility for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded) (ICF/MR), and children and adults in a Home and Community Based Services 1915(c) waiver for individuals with mental retardation.

(iv) Enrollees living in areas where there is insufficient MCO capacity to serve them.

After being assigned to TennCare Select, persons in categories (i) and (iii) above may choose to disenroll from TennCare Select and enroll in another MCO if one is available. Persons in categories (ii) and (iv) must remain in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

2. TennCare Select also provides the following functions:

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

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

(iii) It is also the only entity responsible for payment of the services described in 42 C.F.R. § 440.255, emergency services for certain aliens.

(c) TennCare Managed Care Organizations (MCOs) for ECF CHOICES. Individuals enrolled in ECF CHOICES may select from only the MCOs participating in ECF CHOICES.

1. If an individual enrolled in an MCO other than an ECF CHOICES participating MCO wants to enroll in the ECF CHOICES program, the individual must choose to enroll in an ECF CHOICES participating MCO in order to enroll in ECF CHOICES.

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2. If an individual enrolled in the ECF CHOICES program elects to transition to an MCO that is not participating in ECF CHOICES, the individual is choosing to voluntarily disenroll from ECF CHOICES. Because this is a voluntary decision, advance notice and the right to a fair hearing shall not be provided. However, the individual may elect to transition back to an ECF CHOICES participating MCO in order to resume enrollment in ECF CHOICES.

(d) TennCare Dental Benefits Manager (DBM).

TennCare children shall be assigned to the Dental Benefits Manager (DBM) under contract with the Bureau to provide dental benefits through the TennCare Program. TennCare adults age 21 and older enrolled in ECF CHOICES shall be assigned to the DBM under contract with the Bureau to provide Adult Dental Services through the ECF CHOICES program as defined in 1200-13-01-.02.

(e) TennCare Pharmacy Benefits Manager (PBM).

TennCare enrollees who are eligible to receive pharmacy services shall be assigned to the Pharmacy Benefits Manager (PBM) under contract with the Bureau to provide pharmacy benefits for both medical and behavioral health services through the TennCare Program.

(2) Reassignment.

(a) Reassignment to an MCO other than the current MCO in which the TennCare enrollee is enrolled is subject to another MCO's capacity to accept new enrollees and must be approved by the Bureau of TennCare in accordance with one of the following:

1. During the initial forty-five (45) day period following notification of MCO assignment as described at rule 1200-13-14-.03, a TennCare Standard enrollee may request a change of MCOs.

2. A TennCare enrollee must change MCOs if he moves outside the MCO's Grand Division, and that MCO is not authorized to operate in the enrollee's new place of residence. Until the TennCare enrollee selects or is assigned to a new MCO and his enrollment is deemed complete, his medical care will remain the responsibility of the original MCO.

3. If an enrollee's MCO withdraws from participation in the TennCare Program, TennCare will assign him to a MCO operating in his Grand Division, if one is available. The enrollee will be provided notice of the change and will have forty-five (45) days to select another MCO in his Grand Division. If no MCO is available to accept enrollees from an exiting plan, the enrollees will be assigned to TennCare Select until such time as another MCO becomes available.

4. An enrollee shall be given an opportunity to change MCOs once each year during an annual change period. Only one (1) MCO change is permitted every twelve (12) months, unless the Bureau authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until enrolled in the requested MCO. If an enrollee changes MCOs during an annual change period, all family members living in the same household and enrolled in TennCare shall also be changed except children enrolled in TennCare Select.

(Rule 1200-13-14-.03, continued)

(b) A TennCare enrollee may change MCOs if the TennCare Bureau has granted a request for a change in MCOs or an appeal of a denial of a request for a change in MCOs has been resolved in his favor based on hardship criteria.

1. The following situations will not be determined to be “hardships”:

(i) The enrollee is unhappy with the current MCO or primary care provider (PCP), but there is no hardship medical situation (as stated in Part 2 below);

(ii) The enrollee claims lack of access to services but the plan meets the state’s access standard;

(iii) The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;

(iv) The enrollee is concerned that a current provider might drop out of the plan in the future;

(v) The enrollee is a Medicare beneficiary who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation; or

(vi) The enrollee’s PCP is no longer in the MCO’s network, the enrollee wants to continue to see the current PCP and has refused alternative PCP or provider choices offered by the MCO.

2. Requests for hardship MCO reassignments must meet all of the following six (6) hardship criteria for reassignment. Determinations will be made on an individual basis.

(i) A member has a medical condition that requires complex, extensive, and ongoing care; and

(ii) The member’s specialist has stopped participating in the member’s current MCO network and has refused continuation of care to the member in his current MCO assignment; and

(iii) The ongoing medical condition of the member is such that another physician or provider with appropriate expertise would be unable to take over his care without significant and negative impact on his care; and

(iv) The current MCO has been unable to negotiate continued care for this member with the current specialist; and

(v) The current provider of services is in the network of one or more alternative MCOs; and

(vi) An alternative MCO is available to enrolled members (i.e., has not given notice of withdrawal from the TennCare Program, is not in receivership, and is not at member capacity for the member’s region).

Requests to change MCOs submitted by TennCare enrollees shall be evaluated in accordance with the hardship criteria referenced above. If an enrollee’s request to change MCOs is granted due to hardship, all family members living in the same household and enrolled in TennCare will be assigned to the new MCO except children determined by the Bureau to be eligible to enroll in TennCare Select. Upon denial of a

(Rule 1200-13-14-.03, continued)

request to change MCOs, enrollees shall be provided notice and appeal rights as described in applicable provisions of rule 1200-13-14-.11.

(c) Members receiving long-term services and supports.

1. In the event that a CHOICES member is determined, based on an assessment of needs, to require a long-term care service that is not currently available under the MCO in which he is currently enrolled, but that is available through another MCO, the Bureau shall work with the current MCO to arrange for provision of the required service, which may involve providing such service out-of-network. It shall be considered to be a hardship reason to change MCO assignment only if the current MCO, after working with the Bureau, is unable to provide the required service. In such cases, the MCO that is unable to provide the required service after working with the Bureau may be subject to sanctions.

2. A CHOICES or ECF CHOICES member may request and shall have cause to change MCO assignment if all of the following are met:

(i) The member receives institutional, residential, or employment support services in the MLTSS program in which he is enrolled;

(ii) The member's institutional, residential, or employment support services provider has stopped participating in the member's MCO network and has refused continuation of care to the member in his current MCO assignment;

(iii) The member's current MCO has been unable to negotiate continued services for the member with the current provider;

(iv) The member would have to change his residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO;

(v) As a result, the member would experience a disruption in his residence or employment;

(vi) The current institutional, residential, or employment support services provider is in the network of one or more alternative MCOs; and

(vii) The alternative MCO the member has selected is available to enroll members (i.e., has not given notice of withdrawal from the TennCare Program, is not in receivership, and is not at member capacity for the member's region).

(d) Enrollees who are out-of-state on a temporary basis, but maintain their status as a Tennessee resident under federal and state laws, shall be reassigned to TennCare Select for the period they are out-of-state.

(e) TennCare shall only accept a request to change MCO assignment from the affected enrollee, his parent, guardian, spouse, child over age eighteen (18) or responsible party as defined in Rule 1200-13-14-.01.

(3) Disenrollment.

(a) When it has been determined that an individual no longer meets the criteria for TennCare eligibility, that individual shall be disenrolled from the TennCare Program,

(Rule 1200-13-14-.03, continued)

including the CHOICES and ECF CHOICES program, as applicable. Services provided by the TennCare MCO in which the individual has been enrolled, as well as the PBM and DBM, if applicable, shall be terminated upon disenrollment. Such disenrollment action will be accompanied by appropriate due process procedures as described elsewhere in this Chapter. Disenrollment from the CHOICES program shall proceed as described in Rule 1200-13-01-.05. Disenrollment from the ECF CHOICES program shall proceed as described in Rule 1200-13-01-.31.

(b) Coverage shall cease at 12:00 midnight, local time, on the date that an individual is disenrolled from TennCare.

(c) TennCare may reassign individuals from a designated MCO and place them in another MCO as described elsewhere in these rules. A TennCare MCO may not reassign an enrollee without the permission of TennCare. A TennCare MCO shall not request the reassignment of a TennCare enrollee for any of the following reasons:

1. Adverse changes in the enrollee's health;

2. Pre-existing medical conditions; or

3. High cost medical bills.

Coverage by a particular MCO shall cease at 12:00 midnight local time on the date that an individual has been reassigned by TennCare from one MCO and placed in another plan. Coverage by the new MCO will begin when coverage by the old MCO ends.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.03; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendment filed March 31, 2006; effective June 14, 2006. Amendment filed August 14, 2006; effective October 28, 2006. Amendment filed January 26, 2007; effective April 11, 2007. Amendment filed September 13, 2007; effective November 27, 2007. Public necessity rule filed February 8, 2008; effective through July 22, 2008. Repeal and new rule filed May 7, 2008; effective July 21, 2008. Amendments filed September 25, 2009; effective December 24, 2009. Amendment filed November 30, 2009; effective February 28, 2010. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Amendments filed October 26, 2010; effective January 24, 2011. Amendments filed June 18, 2012; effective September 16, 2012. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016. Amendments filed September 25, 2017; effective December 24, 2017.*

1200-13-14-.04 COVERED SERVICES.

(1) Benefits covered under the managed care program

(a) TennCare MCCs shall cover the following services and benefits subject to any applicable limitations described in this Chapter. TennCare MCCs shall cover TennCare CHOICES services and benefits for individuals enrolled in the TennCare CHOICES program in accordance with Rule 1200-13-01-.05 and ECF CHOICES services and benefits for individuals enrolled in the ECF CHOICES program in accordance with Rule 1200-13-01-.31.

(Rule 1200-13-14-.04, continued)

1. Any and all medically necessary services may require prior authorization or approval by the MCC, except where prohibited by law.

2. An MCC shall not refuse to pay for a service solely because of a lack of prior authorization as follows:

   (i) Preventive, diagnostic, and treatment services for persons under age 21. MCCs shall provide all medically necessary, covered services regardless of whether the need for such services was identified by a provider whose services had received prior authorization from the MCC or by an in-network provider.

   (ii) Emergency services. MCCs shall not require prior authorization or approval for covered services rendered in the event of an emergency, as defined in these rules. Such emergency services may be reviewed on the basis of medical necessity or other MCC administrator requirements, but cannot be denied solely because the provider did not obtain prior authorization or approval from the enrollee's MCC.

3. MCCs shall not impose any service limitations that are more restrictive than those described herein; however, this shall not limit the MCC's ability to establish procedures for the determination of medical necessity.

4. Services for which there is no federal financial participation (FFP) are not covered.

5. Non-covered services are non-covered regardless of medical necessity.

(b) The following physical health and mental health benefits are covered under the TennCare managed care program. Benefits offered under the TennCare CHOICES program are also covered under the TennCare managed care program, as described in Rule 1200-13-01-.05. Benefits offered under the ECF CHOICES program are also covered under the TennCare managed care program, as described in Rule 1200-13-01-.31. There are some exclusions to the benefits listed below. The exclusions are listed in this rule and in Rule 1200-13-14-.10.

SERVICE	**BENEFIT FOR PERSONS UNDER AGE 21**	**BENEFIT FOR PERSONS AGED 21 AND OLDER**
1. Ambulance Sevices.	See "Emergency Air and Ground Transportation" and "Non-Emergency Ambulance Transportation."	See "Emergency Air and Ground Transportation" and "Non-Emergency Ambulance Transportation."
2. Bariatric Surgery, defined as surgery to induce weight loss.	Covered as medically necessary.	Covered as medically necessary.
3. Chiropractic Services [defined at 42 C.F.R. § 440.60(b)].	Covered as medically necessary.	Not covered.
4. Community Health Services, [defined at 42 C.F.R. §440.20(b) and (c) and 42 C.F.R. § 440.90].	Covered as medically necessary.	Covered as medically necessary.
5. Dental Services	Preventive, diagnostic, and	Not covered.

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
[defined at 42 C.F.R. § 440.100].	treatment services covered as medically necessary. Dental services under EPSDT are provided in accordance with the state's periodicity schedule as determined after consultation with recognized dental organizations and at other intervals as medically necessary. Orthodontic services must be prior authorized by the Dental Benefits Manager (DBM). Orthodontic services are only covered for individuals under age 21. Effective October 1, 2013, TennCare reimbursement for orthodontic treatment approved and begun before age 21 will end on the individual's 21st birthday. For individuals receiving treatment prior to October 1, 2013, such treatment may continue until completion as long as the enrollee remains eligible for TennCare. Orthodontic treatment is not covered unless it is medically necessary to treat a handicapping malocclusion. Cleft palate, hemifacial microsomia, or mandibulofacial dysostosis shall be considered handicapping malocclusions. A TennCare-approved Malocclusion Severity Assessment (MSA) will be conducted to measure the severity of the malocclusion. An MSA score of 28 or higher, as determined by the DBM's dentist reviewer(s), will be used for making orthodontic treatment determinations of medical necessity. However, an MSA score alone cannot be used to deny orthodontic treatment. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for	

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	TennCare. The MCO is responsible for the provision of transportation to and from covered dental services, as well as the medical and anesthesia services related to the covered dental services.	
6. Durable Medical Equipment [defined at 42 C.F.R. § 440.70(b)(3) and 42 C.F.R. § 440.120(c)].	Covered as medically necessary.	Covered as medically necessary.
7. Emergency Air and Ground Transportation [defined at 42 C.F.R. § 440.170(a)(1) and (3)].	Covered as medically necessary.	Covered as medically necessary.
8. Preventive, Diagnostic, and Treatment Services for Persons Under Age 21.	Screening and interperiodic screening covered in accordance with federal regulations. (Interperiodic screens are screens in between regular checkups which are covered if a parent or caregiver suspects there may be a problem.) Diagnostic and follow-up treatment services covered as medically necessary and in accordance with federal regulations. The periodicity schedule for child health screens is that set forth in the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care." All components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care."	Not applicable.
9. Home Health Care [defined at 42 C.F.R. § 440.70(a), (b), (c), and (e) and at Rule 1200-13-14-.01].	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-14-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (7) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-14-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (7) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 C.F.R. § 440.70.

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	C.F.R. § 440.70.	
10. Hospice Care [defined at 42 C.F.R., Part 418].	Covered as medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.	Covered as medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
11. Inpatient and Outpatient Substance Abuse Benefits [defined as services for the treatment of substance abuse that are provided (a) in an inpatient hospital (as defined at 42 C.F.R. § 440.10) or (b) as outpatient hospital services (see 42 C.F.R. § 440.20(a)].	Covered as medically necessary.	Covered as medically necessary.
12. Inpatient Hospital Services [defined at 42 C.F.R. § 440.10].	Covered as medically necessary. Preadmission and concurrent reviews allowed.	Covered as medically necessary. Preadmission and concurrent reviews allowed.
13. Inpatient Rehabilitation Facility Services	See “Inpatient Hospital Services.”	Not covered.
14. Lab and X-ray Services [defined at 42 C.F.R. § 440.30].	Covered as medically necessary.	Covered as medically necessary.
15. Medical Supplies [defined at 42 C.F.R. § 440.70(b)(3)].	Covered as medically necessary.	Covered as medically necessary.
16. Mental Health Case Management Services [defined as services rendered to support outpatient mental health clinical services].	Covered as medically necessary.	Covered as medically necessary.
17. Mental Health Crisis Services [defined as services rendered to alleviate a psychiatric emergency].	Covered as medically necessary.	Covered as medically necessary.
18. Methadone Clinic Services [defined as services provided by a methadone clinic].	Covered as medically necessary.	Not covered.

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
19. Non-Emergency Ambulance Transportation, [defined at 42 C.F.R. § 440.170(a)(1) and (3)].	Covered as medically necessary.	Covered as medically necessary.
20. Non-Emergency Transportation [defined at 42 C.F.R. § 440.170(a)(1) and (3)].	Covered as necessary for enrollees lacking accessible transportation for covered services. Emphasis shall be placed on the utilization of fixed route and/or public transportation where appropriate and available. The travel to access primary care and dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCC is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether the enrollee has access to transportation. If the enrollee is a minor child, transportation must be provided for the child and an accompanying adult. However, transportation for a minor child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. Any decision to deny transportation of a minor child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeals process. Tennessee recognizes the "mature minor exception" to permission for medical treatment. The provision of transportation to and from covered dental services is	Covered as necessary for enrollees lacking accessible transportation for covered services. Emphasis shall be placed on the utilization of fixed route and/or public transportation where appropriate and available. The travel to access primary care and dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCC is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether the enrollee has access to transportation. For persons dually eligible for Medicare and Medicaid, non-emergency transportation to access medical services covered by Medicare is provided, as long as these services would be covered by TennCare for the enrollee if he did not have Medicare. The Medicare provider of the medical service does not have to participate in TennCare. Transportation to these medical services is covered within the same access standards as those applicable for TennCare enrollees who are not also Medicare beneficiaries. One escort is allowed per enrollee if the enrollee requires assistance. Assistance is defined for purposes of this rule as help provided to the enrollee that enables the enrollee to receive a medically necessary service. Examples of assistance are: physical assistance such as holding doors or pushing wheelchairs; language assistance such as interpreter services or reading for someone who is illiterate; or decision making assistance. See rule 1200-13-14-.01 for a definition of who may be an escort.

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	the responsibility of the MCO. For persons dually eligible for Medicare and Medicaid, non-emergency transportation to access medical services covered by Medicare is provided, as long as these services would be covered by TennCare for the enrollee if he did not have Medicare. The Medicare provider of the medical services does not have to participate in TennCare. Transportation to these medical services is covered within the same access standards as those applicable for TennCare enrollees who are not also Medicare beneficiaries. One escort is allowed per enrollee if the enrollee requires assistance. Assistance is defined for purposes of this rule as help provided to the enrollee that enables the enrollee to receive a medically necessary service. Examples of assistance are: physical assistance such as holding doors or pushing wheelchairs; language assistance such as interpreter services or reading for someone who is illiterate; or decision making assistance. See rule 1200-13-14-.01 for a definition of who may be an escort.	
21. Occupational Therapy [defined at 42 C.F.R. § 440.110(b)].	Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, stabilize or ameliorate impaired functions.	Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.
22. Organ and Tissue Transplant Services and Donor Organ/Tissue Procurement Services [defined as the transfer of an organ or tissue from an individual to a TennCare enrollee].	Covered as medically necessary. Experimental or investigational transplants are not covered.	Covered as medically necessary when coverable by Medicare. Experimental or investigational transplants are not covered.
23. Outpatient Hospital Services [defined at 42 C.F.R. § 440.20(a)].	Covered as medically necessary.	Covered as medically necessary.

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
24. Outpatient Mental Health Services (including Physician Services), [defined at 42 C.F.R. § 440.20(a), 42 C.F.R. § 440.50, and 42 C.F.R. § 440.90].	Covered as medically necessary.	Covered as medically necessary.
25. Pharmacy Services [defined at 42 C.F.R. § 440.120(a) and obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy, or those administered to a long-term care facility (nursing facility) resident].	Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office, which are the responsibility of the MCO. For TennCare Standard children under age 21 who are Medicare beneficiaries, TennCare pays for medically necessary outpatient prescription drugs when they are covered by TennCare but not by Medicare Part D. Pharmaceuticals supplied and administered in a doctor's office to persons under age 21 are the responsibility of the MCO if not covered by Medicare.	(A) Covered as follows, subject to the limitations set out below. Certain drugs known as DESI, LTE or IRS drugs are excluded from coverage. Persons dually eligible for TennCare Standard and Medicare will receive their pharmacy services through Medicare Part D. (B) Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in the doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are not covered by TennCare. (C) For non-Medicare enrollees in the CHOICES 217-Like Group, the CHOICES 1 and 2 Carryover Group, adults age 21 and older enrolled in ECF CHOICES who meet nursing facility level of care or transitioned from a Section 1915(c) waiver into ECF CHOICES and granted an exception by TennCare based on ICF/IID level of care, and the PACE Carryover Group, covered with no quantity limits on the number of prescriptions per month. (D) For hospice patients, drugs used for the relief of pain and symptom control related to their terminal illness are covered as part of the hospice benefit. If the patient is not a Medicare beneficiary, pharmacy services needed for conditions unrelated to the terminal illness are covered by TennCare. There are no quantity limits on the number of prescriptions per month covered by TennCare if the hospice patient is receiving TennCare-reimbursed room and board in a Nursing Facility. If the patient is receiving

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
		hospice services at home or in a residential hospice, coverage of pharmacy services is as described in sections (C) and (E). (E) For all other non-Medicare enrollees, coverage is limited to five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. Additional drugs for these enrollees shall not be covered. (F) Prescriptions shall be counted beginning on the first day of each calendar month. Each prescription and/or refill counts as one (1). A prescription or refill can be for no more than a thirty-one (31) day supply. (G) The Bureau of TennCare shall maintain an Automatic Exception List of medications which shall not count against such limit. The Bureau of TennCare may modify the Automatic Exception List at its discretion. The most current version of the Automatic Exception List will be made available to enrollees via the internet from the TennCare website and upon request by mail through the DHS Family Assistance Service Center. Only medications that are specified on the current version of the Automatic Exception List that is available on the TennCare website located on the World Wide Web at www.tn.gov/tenncare on the date of service shall be considered exempt from applicable prescription limits. (H) The Bureau of TennCare shall also maintain a Prescriber Attestation List of medications available when the prescriber attests to an urgent need. The State may include certain drugs or categories of drugs on the list, and may maintain and make available to physicians, providers, pharmacists and the public, a list that shall indicate the drugs or types of drugs the State has determined to include. Drugs on the Prescriber Attestation List may be approved for enrollees who have already met an applicable benefit limit only if the prescribing professional seeks and obtains a special exemption. In order to obtain a special exemption, the prescribing provider must submit an attestation as directed by TennCare regarding the urgent need for the

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
		drug. TennCare will approve the prescribing provider's determination that the criteria for the special exemption are met, without further review, within 24 hours of receipt. Enrollees will not be entitled to a hearing regarding their eligibility for a special exemption if (i) the prescribing provider has not submitted the required attestation, or (ii) the requested drug is not on the Prescriber Attestation List. (I) Pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) are brand name drugs, are non-covered services, unless: (a) each excess drug is specified on the current version of the Prescriber Attestation List and a completed Prescriber Attestation is on file for each listed drug as of the date of the pharmacy service; or (b) the excess drug is specified on the Automatic Exception List of medications which shall not count against such limit. (J) Over-the-counter (OTC) drugs for TennCare adults are not covered even if the enrollee has a prescription for such service, unless the drug is listed on the "Covered OTC Drug List" that is available on the TennCare website located at www.tn.gov/tenncare on the date of service.
26. Physical Therapy [defined at 42 C.F.R. § 440.110(a)].	Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, stabilize or ameliorate impaired functions,	Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions.
27. Physician Inpatient Services [defined at 42 C.F.R. § 440.50].	Covered as medically necessary.	Covered as medically necessary.
28. Physician Outpatient Services/Community Health Clinics/Other Clinic Services [defined at 42 C.F.R. §440.20(b), 42 C.F.R. § 440.50, and 42 C.F.R. § 440.90].	Covered as medically necessary. Services provided by a Primary Care Provider when the enrollee has a primary behavioral health diagnosis (ICD-9-CM 290.xx-319.xx) are the responsibility of the MCO. Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room	Covered as medically necessary, except see "Methadone Clinic Services." Services provided by a Primary Care Provider when the enrollee has a primary behavioral health diagnosis (ICD-9-CM 290.xx-319.xx) are the responsibility of the MCO. Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room provider to

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
	provider to establish a primary behavioral health diagnosis are the responsibility of the MCO.	establish a primary behavioral health diagnosis are the responsibility of the MCO.
29. Private Duty Nursing [defined at 42 C.F.R. § 440.80 and at Rule 1200-13-14-.01].	Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-14-.01, when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Prior authorization required, as described in Paragraph (7) of this rule.	Covered as medically necessary in accordance with the definition of Private Duty Nursing at Rule 1200-13-14-.01, when prescribed by an attending physician for treatment and services rendered by a Registered Nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not an immediate relative. Private duty nursing services are limited to services that support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Prior authorization required, as described in Paragraph (7) of this rule.
30. Psychiatric Inpatient Facility Services [defined at 42 C.F.R. § 441, Subparts C and D and including services for persons of all ages].	Covered as medically necessary, Preadmission and concurrent reviews by the MCC are allowed.	Covered as medically necessary, Preadmission and concurrent reviews by the MCC are allowed.
31. Psychiatric Pharmacy.	See “Pharmacy Services.”	See “Pharmacy Services.”
32. Psychiatric Rehabilitation Services [defined as psychiatric services delivered in accordance with 42 C.F.R. § 440.130(d)].	Covered as medically necessary.	Covered as medically necessary.
33. Psychiatric Physician Inpatient Services [defined at 42 C.F.R. § 440.50].	Covered as medically necessary.	Covered as medically necessary.
34. Psychiatric Physician Outpatient Services.	See “Outpatient Mental Health Services.”	See “Outpatient Mental Health Services.”
35. Psychiatric Residential Treatment Services [defined at 42 C.F.R. § 483.352] and including services for persons of all ages].	Covered as medically necessary.	Covered as medically necessary.
36. Reconstructive Breast Surgery	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage

(Rule 1200-13-14-.04, continued)

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
[defined in accordance with Tenn. Code Ann. § 56-7-2507].	requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.	of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
37. Rehabilitation services	See "Occupational Therapy," "Physical Therapy," and "Speech Therapy," and "Inpatient Rehabilitation Facility Services"	See "Occupational Therapy," "Physical Therapy," and "Speech Therapy."
38. Renal Dialysis Clinic Services [defined at 42 C.F.R. § 440.90].	Covered as medically necessary. Generally limited to the beginning ninety (90) day period prior to the enrollee's becoming eligible for coverage by the Medicare program.	Covered as medically necessary. Generally limited to the beginning ninety (90) day period prior to the enrollee's becoming eligible for coverage by the Medicare program.
39. Speech Therapy [defined at 42 C.F.R. § 440.110(c)].	Covered as medically necessary, by a Licensed Speech Therapist to restore, improve, stabilize or ameliorate impaired functions.	Covered as medically necessary, as long as there is continued medical progress, by a Licensed Speech Therapist to restore speech after a loss or impairment.
40. Transportation.	See "Emergency Air and Ground Transportation," "Non-Emergency Ambulance Transportation," and "Non-Emergency Transportation."	See "Emergency Air and Ground Transportation," "Non-Emergency Ambulance Transportation," and "Non-Emergency Transportation."
41. Vision Services [defined as services to treat conditions of the eyes].	Preventive, diagnostic, and treatment services (including eyeglasses) covered as medically necessary.	Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of the refractive state) is covered. Routine, periodic assessment, evaluation or screening of normal eyes, and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.

(c) Pharmacy

(Rule 1200-13-14-.04, continued)

TennCare is permitted under the terms and conditions of the demonstration project approved by the federal government to restrict coverage of prescription and non-prescription drugs to a TennCare-approved list of drugs known as a drug formulary. TennCare must make this list of covered drugs available to the public. Through the use of a formulary, the following drugs or classes of drugs, or their medical uses, shall be excluded from coverage or otherwise restricted by TennCare as described in Section 1927 of the Social Security Act [42 U.S.C. § 1396r-8]:

1. Agents for weight loss or weight gain.

2. Agents to promote fertility or for the treatment of impotence or infertility or for the reversal of sterilization.

3. Agents for cosmetic purposes or hair growth.

4. Agents for symptomatic relief of coughs and colds.

5. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

6. Nonprescription drugs.

7. Covered outpatient drugs, which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or his designee.

8. TennCare shall not cover drugs considered by the FDA to be Less Than Effective (LTE) and DESI drugs, or drugs considered to be Identical, Related and Similar (IRS) to DESI and LTE drugs or any other pharmacy services for which federal financial participation (FFP) is not available. The exclusion of drugs for which no FFP is available extends to all TennCare enrollees regardless of the enrollee's age. TennCare shall not cover experimental or investigational drugs which have not received final approval from the FDA.

9. Buprenorphine products for opiate addiction treatment for persons aged 21 and older are restricted as follows:

   (i) Dosage shall not exceed sixteen milligrams (16 mg) per day for a period of up to six (6) months from the initiation of therapy.

   (ii) For enrollees who are pregnant while receiving the sixteen milligrams (16 mg) per day dosage, the six-month period does not begin until the enrollee is no longer pregnant.

   (iii) At the end of the six-month period described in subparts (i) and (ii), the covered dosage amount shall not exceed eight milligrams (8 mg) per day.

10. Sedative hypnotic medications for persons aged 21 and older shall not exceed fourteen (14) pills per month for sedative hypnotic formulations in pill form such as Ambien and Lunesta, one hundred forty milliliters (140 ml) per month of chloral hydrate, or one (1) bottle every sixty (60) days of Zolpimist.

11. Allergy medications.

12. Opioid products for persons aged twenty-one (21) and older are restricted as follows:

(Rule 1200-13-14-.04, continued)

(i) "Chronic opioid user" means:

(I) A TennCare enrollee whose TennCare paid claims data demonstrates that he has received at least a ninety (90) day quantity of prescribed opioids in the one hundred eighty (180) day period immediately preceding the opioid's prescription date.

(II) For a TennCare enrollee who has not been enrolled in TennCare long enough to demonstrate that he is a chronic opioid user as defined in Item (I), the enrollee may demonstrate that he has received at least a ninety (90) day quantity of prescribed opioids in the one hundred eighty (180) day period immediately preceding the opioid's prescription date by supplying paid claims data and medical records from his previous healthcare provider(s) or health insurer(s).

(ii) "Non-chronic opioid user" means a TennCare enrollee whose TennCare paid claims data demonstrates he has received less than a ninety (90) day quantity of prescribed opioids in the one hundred eighty (180) day period immediately preceding the opioid's prescription date.

(iii) Non-chronic opioid users shall be eligible to receive covered prescription opioid products as follows:

(I) A maximum of fifteen (15) dosage days in any six (6) month period; and

(II) Daily dosage shall not exceed sixty (60) morphine milligram equivalents (MME) per day.

(iv) The restrictions in Subpart (iii) do not apply for enrollees with severe cancer pain undergoing active or palliative cancer treatment and enrollees in hospice and palliative care.

(v) The following considerations apply for enrollees who experience more frequent or aggressive pain episodes due to these specific clinical disease states:

(I) Enrollees with Sickle Cell may receive up to forty-five (45) days of sixty (60) MME per day in any ninety (90) day period; and

(II) Severe burn victims may receive up to forty-five (45) days of sixty (60) MME per day in any ninety (90) day period.

(vi) Notwithstanding the restrictions in Subpart (iii), enrollees residing in a Medicaid-certified Nursing Facility may receive up to forty-five (45) days of sixty (60) MME per day in any ninety (90) day period.

(d) The MCC shall be allowed to provide cost effective alternative services as defined in paragraph 1200-13-14-.01(33). Cost effective alternative services are not reimbursable in any circumstances other than those described in that paragraph.

(2) Use of Cost Effective Alternative Services.

(a) MCCs shall be allowed, but are not required, to use cost effective alternative services if and only if:

(Rule 1200-13-14-.04, continued)

1. These services are listed in the MCC contract and/or in Policy BEN 08-001; or

2. These services are provided under the CHOICES program for individuals enrolled in the CHOICES program in accordance with Rule 1200-13-01-.05 or the ECF CHOICES program for individuals enrolled in the ECF CHOICES program in accordance with Rule 1200-13-01-.31; and

3. They are medically appropriate and cost effective.

(b) Use of approved cost effective alternative services is made at the sole discretion of the MCC.

(3) Emergency Medical Services.

Emergency medical services shall be available twenty-four (24) hours per day, seven (7) days per week. Coverage of emergency medical services shall not be subject to prior authorization by the MCC but may include a requirement that notice be given to the MCC of use of out-of-plan emergency services. However, such requirements shall provide at least a twenty-four (24) hour time frame after the emergency for notice to be given to the MCC.

(4) Preventive, Diagnostic and Treatment Services for Individuals Under Twenty-One (21).

The Bureau of TennCare, through its contracts with Managed Care Organizations (MCOs) and other contractors (also referred to collectively as Contractors), operates an EPSDT program to provide health care services as required by 42 C.F.R. Part 441, Subpart B and the "Omnibus Budget Reconciliation Act of 1989" to eligible enrollees under the age of 21.

(a) Responsibilities of the Bureau of TennCare

1. The Bureau will:

(i) Keep Contractors informed as to changes to the requirements for the operation of the EPSDT program;

(ii) Make changes to the rules of TennCare when necessary to keep the EPSDT program in compliance with federal and state requirements;

(iii) Provide policy clarification when needed; and

(iv) Oversee the activities of the Contractors to assure compliance with all aspects of the EPSDT program.

2. The Bureau, through local health departments, shall inform families of uninsured children who are enrolled in TennCare, of the benefits covered under TennCare and the importance of accessing preventive services.

3. The Bureau, through local health departments, shall provide information on covered services to adolescent prenatal patients who enter TennCare through presumptive eligibility. Assistance will be offered to presumptive eligibles on the day eligibility is determined in making a timely first prenatal appointment; for a woman past her first trimester, this appointment should occur within fifteen (15) days.

4. The Bureau, through the Department of Children's Services, shall inform foster parents and institutions or other residential treatment settings with a number of eligible children, annually or more often when the need arises, including when a

(Rule 1200-13-14-.04, continued)

change of administrators, social workers, or foster parents occur, of the availability of EPSDT services.

(b) Responsibilities of Contractors

1. Contractors shall aggressively and effectively inform enrollees of the existence of the EPSDT program, including the availability of specific EPSDT screening and treatment services. Such informing shall occur in a timely manner, generally within sixty (60) days of the MCO's receipt of notification of the child's enrollment in its plan and if no one eligible in the family has utilized EPSDT services, at least annually thereafter.

   Contractors shall document to the Bureau the contractor's outreach activities and what efforts were made to inform enrollees and/or the enrollee's responsible party about the availability of EPSDT services and how to access such services. Failure to timely submit the requested data may result in liquidated damages as described in the contracts between the Bureau of TennCare and the Contractors.

2. Contractors shall use clear and non-technical terms to provide a combination of written and oral information so that the program is clearly and easily understandable.

3. Contractors shall use effective methods (developed through collaboration with agencies which have established procedures for working with such individuals) to inform individuals who are illiterate, blind, deaf, or cannot understand English, about the availability of EPSDT services.

4. Contractors shall design and conduct outreach to inform all eligible individuals about what services are available under EPSDT, the benefits of preventive health care, where services are available, and how to obtain them; and that necessary transportation and scheduling assistance is available.

5. Contractors shall create a system so that families can readily access an accurate list of names and phone numbers of contract providers who are currently accepting TennCare.

6. Contractors shall offer both transportation and scheduling assistance prior to the due date of the child's periodic examination.

7. Contractors shall provide enrollees assistance in scheduling appointments and obtaining transportation prior to the date of each periodic examination as requested and necessary.

8. Contractors shall document services declined by a parent or guardian or a mature competent child, specifying the particular service declined so that outreach and education for other EPSDT services continues.

9. Contractors shall maintain records of the efforts taken to outreach children who have missed screening appointments when scheduled or who have failed to schedule regular check-ups. These records shall be made available to the Bureau and other parties as directed by TennCare.

10. Contractors shall inform families of the costs, if any, of EPSDT services.

11. Contractors shall treat a TennCare-eligible woman's request for EPSDT services during pregnancy as a request for EPSDT services for the child at birth.

(Rule 1200-13-14-.04, continued)

(c) Compliance

Contractors must document and maintain records of all outreach efforts made to inform enrollees about the availability of EPSDT services.

(5) Preventive Medical Services. The following services (identified by applicable CPT procedure codes) shall be covered subject to any limitations described herein, within the scope of standard medical practice, without copay.

(a) Office Visits

1. New Patient

99381 - Initial evaluation

99382 - ages 1 through 4 years

99383 - ages 5 through 11 years

99384 - ages 12 through 17 years

99385 - ages 18 through 39 years

99386 - ages 40 through 64 years

99387 - ages 65 years and older

2. Established Patient

99391 - Periodic evaluation

99392 - ages 1 through 4 years

99393 - ages 5 through 11 years

99394 - ages 12 through 17 years

99395 - ages 18 through 39 years

99396 - ages 40 through 64 years

99397 - ages 65 years and older

(b) Counseling and Risk Factor Reduction Intervention

1. Individual

99401 - approximately 15 minutes

99402 - approximately 30 minutes

99403 - approximately 45 minutes

99404 - approximately 60 minutes

(Rule 1200-13-14-.04, continued)

2. Group

99411 - approximately 30 minutes

99412 - approximately 60 minutes

(c) Family Planning Services, if not part of a preventive services office visit, should be billed by using the codes in (b)1. above.

(d) Mental health case management services including T1016 and H0004.

(e) Vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP).

(f) Any other covered service assigned a rating of A or B by the US Preventative Services Task Force (USPSTF).

(6) Hospital Discharges.

Hospital discharges of mothers and newborn babies following delivery shall take into consideration the following guidelines:

(a) The decision to discharge postpartum mothers and newborns less than 24-48 hours after delivery should be made based upon discharge criteria collaboratively developed and adopted by obstetricians, pediatricians, family practitioners, delivery hospitals, and health plans. The criteria must be contingent upon appropriate preparation, meeting in hospital criteria for both mother and baby, and the planning and implementation of appropriate follow-up. An individualized plan of care must include identification of a primary care provider for both mother and baby and arrangements for follow-up evaluation of the newborn.

Length of hospital stay is only one factor to consider when attempting to optimize patient outcomes for postpartum women and newborns. Excellent outcomes are possible even when length of stay is very brief (less than 24 hours) if perinatal health care is well planned, allows for continuity of care, and patients are well chosen. Some postpartum patients and/or newborns may require extended hospitalization (greater than 48-72 hours) despite meticulous care due to medical, obstetric, or neonatal complications. The decision for time of discharge must be individualized and made by the physicians caring for the mother-baby pair. The following guidelines have been developed to aid in the identification of postpartum mothers and newborns who may be candidates for discharge prior to 24-48 hours. The guidelines also provide examples where discharge is inappropriate.

Principles of patient care should be based upon data obtained by clinical research. Regarding the question of postpartum and newborn length of hospitalization, there are inadequate studies available to provide clear direction for clinical decision-making. Clinical guidelines represent an attempt to conceptualize what is, in reality, a dynamic process of health care refinement. Review of these guidelines is desirable and expected.

No provider shall be denied participation, reimbursement or reduction in reimbursement within a network solely related to his/her compliance with the “Guidelines for Discharge of Postpartum Mothers and Newborns.”

(b) Guidelines for Discharge of Postpartum Mothers and Newborns

(Rule 1200-13-14-.04, continued)

1. Discharge Planning.

(i) Discharge planning should occur in a planned and systematic fashion for all postpartum women and newborns in order to enhance care, prevent complications and minimize the need for rehospitalization. Prior to discharge a discussion should be held between the physician or another health care provider and the mother (and father if possible) about any expected perinatal problems and ways to cope with them. Plans for future and immediate care as well as instructions to follow in the event of an emergency or complication should be discussed.

Follow-up care must be planned for both mother and baby at the time of discharge. For patients leaving the hospital prior to 24-48 hours, contact within 48-72 hours of discharge is recommended and may include appropriate follow-up within 48-72 hours as deemed necessary by the attending provider, depending upon individual patient need. This follow-up visit will be acknowledged as a provider encounter.

(I) Maternal Considerations:

I. Prior to discharge, the patient should be informed of normal postpartum events including but not limited to:

A. Lochial patterns;

B. Range of activity and exercise;

C. Breast care;

D. Bladder care;

E. Dietary needs;

F. Perineal care;

G. Emotional responses;

H. What to report to physician or other health care provider including:

(A) Elevation of temperature,

(B) Chills,

(C) Leg pains, and

(D) Increased vaginal bleeding.

I. Method of contraception;

J. Coitus resumption; and

K. Specific instructions for follow-up (routine and emergent)

(II) Neonatal Considerations:

(Rule 1200-13-14-.04, continued)

I. Prior to discharge, the following points should be reviewed with the mother or, preferably, with both parents:

A. Condition of the neonate;

B. Immediate needs of the neonate; (e.g., feeding methods and environmental supports);

C. Instructions to follow in the event of a newborn complication or emergency;

D. Feeding techniques: skin care, including cord care and genital care; temperature assessment and measurement with the thermometer; and assessment of neonatal well-being; recognition of illness including jaundice; proper infant safety including use of car seat and sleeping position;

E. Reasonable expectations for the future; and

F. Importance of maintaining immunization begun with initial dose of hepatitis B vaccine.

2. Criteria for Maternal Discharge Less Than 24-48 Hours Following Delivery.

(i) Prior to discharge of the mother, the following should occur:

(I) The mother should have been observed after delivery for a sufficient time to ensure that her condition is stable, that she has sufficiently recovered and may be safely transferred to outpatient care.

(II) Laboratory evaluations should be obtained and include ABO blood group and Rh typing with appropriate use of Rh immune globulin; and hematocrit or hemoglobin.

(III) The mother should have received adequate preparation for and be able to assume self and immediate neonatal care.

(ii) Factors which may exclude maternal discharge prior to 24-48 hours include:

(I) Abnormal bleeding.

(II) Fever equal to or greater than 100.4 degrees.

(III) Inadequate or no prenatal care.

(IV) Cesarean section.

(V) Untreated or unstable maternal medical condition.

(VI) Uncontrolled hypertension.

(VII) Inability to void.

(VIII) Inability to tolerate solid foods.

(IX) Adolescent mother without adequate support and where appropriate follow-up has not been established. A nurse home visit within 24-48 hours of discharge would act as appropriate follow-up.

(X) All efforts should be made to keep mother and infant together to ensure simultaneous discharge.

(XI) Psychosocial problems (maternal or family) which have been identified prenatally or in hospital. Where appropriate follow-up has not been established, a nurse home visit within 24-48 hours of discharge would act as appropriate follow-up.

3. Criteria for Neonatal, Discharge Less than 24-48 Hours Following Delivery.

(i) The nursery stay is planned to allow the identification of early problems and to reinforce instruction in preparation for care of the infant at home. Complications often are not predictable by prenatal and intrapartum events. Because many neonatal problems do not become apparent until several days after birth there is an element of medical risk in early neonatal discharge. Most problems are manifest during the first twelve (12) hours, and discharge at or prior to twenty-four (24) hours is appropriate for many newborns.

(I) Prior to discharge of the newborn at 24-48 hours, the following should have occurred:

I. The course of antepartum, intrapartum, and postpartum care for both mother and fetus should be without problems, which may lead to newborn complications.

II. The baby is a single birth at 37 to 42 weeks' gestation and the birth weight is appropriate for gestational age according to appropriate intrauterine growth curves.

III. The baby's vital signs are documented as being normal and stable for the twelve (12) hours preceding discharge, including a respiratory rate below 60/minute, a heart rate of 100 to 160 beats per minute, and an axillary temperature of 36.1 degrees C in an open crib with appropriate clothing.

IV. The baby has urinated and passed at least one stool.

V. No evidence of excessive bleeding after circumcision greater than two (2) hours.

VI. The baby has completed at least two successful feedings, with documentation that the baby is able to coordinate sucking, swallowing, and breathing while feeding.

VII. No evidence of significant jaundice in the first twenty-four (24) hours of life.

VIII. The parent's or caretaker's knowledge, ability, and confidence to provide adequate care for her baby are documented.

(Rule 1200-13-14-.04, continued)

IX. Laboratory data are available and reviewed including:

A. Maternal syphilis and hepatitis B surface antigen status.

B. Cord or infant blood type and direct Coomb's test result as clinically indicated.

X. Screening tests are performed in accordance with state regulations. If the test is performed before twenty-four (24) hours of milk feeding, a system for repeating the test must be assured during the follow-up visit.

XI. Initial hepatitis B vaccine is administered or a scheduled appointment for its administration has been made.

XII. A physician-directed source of continuing medical care for both the mother and the baby is identified. For newborns discharged less than 24-48 hours after delivery, a definitive plan for contact within 48-72 hours after discharge has been made. A nurse home visit within 24-48 hours would be considered appropriate follow-up.

(II) Maternal factors which may exclude discharge of the newborn prior to 24-48 hours include:

I. Inadequate or no prenatal care,

II. Medical conditions that pose a significant risk to the infant,

III. Group B streptococcus colonization,

IV. Untreated syphilis,

V. Suspected active genital herpes,

VI. HIV,

VII. Adolescent without adequate support and where appropriate follow-up has not been established (a nurse home visit within 24-48 hours of discharge will act as appropriate follow-up),

VIII. Mental retardation or psychiatric illness, and

IX. Requirements for continued maternal hospitalization.

(III) Newborn factors which may exclude discharge of the newborn prior to 24-48 hours include:

I. Preterm gestation (less than 37 weeks);

II. Small for gestational age;

III. Large for gestational age;

IV. Abnormal physical exam, vital signs, color, activity, feeding or stooling;

V. Significant congenital malformations; and

VI. Abnormal laboratory finding:

A. Hypoglycemia,

B. Hyperbilirubinemia,

C. Polycythemia,

D. Anemia, and

E. Rapid plasma reagin positive.

(7) Prior Authorization for Home Health Nurse, Home Health Aide, and Private Duty Nursing Services. Prior authorization by the MCC must be obtained in order to establish the medical necessity of all requested home health nurse, home health aide, and private duty nursing services.

(a) The following information must be provided when seeking prior authorization for home health nurse, home health aide, and private duty nursing services:

1. Name of physician prescribing the service(s);

2. Specific information regarding the patient's medical condition and any associated disability that creates the need for the requested service(s); and

3. Specific information regarding the service(s) the nurse or aide is expected to perform, including the frequency with which each service must be performed (e.g., tube feeding patient 7:00 a.m., 12:00 p.m., and 5:00 p.m. daily; bathe patient once per day; administer medications three (3) times per day; catheterize patient as needed from 8:00 a.m. to 5:00 p.m. Monday through Friday; change dressing on wound three (3) times per week). Such information should also include the total period of time that the services are anticipated to be medically necessary by the treating physician (e.g., total number of weeks or months).

(b) Home health nurses and aides and private duty nurses will never be authorized to personally transport a TennCare enrollee. Home health nurses and aides delivering prior approved home health care services may accompany an enrollee outside the home in accordance with T.C.A. § 71-5-107(a)(12).

(c) Private duty nursing services are limited to services provided in the recipient's own home, with the following two exceptions:

1. A recipient age twenty-one (21) or older who requires eight (8) or more hours of skilled nursing care in a 24-hour period and is authorized to receive private duty nursing services in the home setting may make use of the approved hours outside of that setting in order for the nurse to accompany the recipient to:

(i) Outpatient health care services (including services delivered through a TennCare home and community based services waiver program);

(ii) Public or private secondary school or credit classes at an accredited vocational or technical school or institute of higher education; or,

(Rule 1200-13-14-.04, continued)

(iii) Work at his place of employment.

2. A recipient under the age of twenty-one (21) who requires eight (8) or more hours of continuous skilled nursing care in a 24-hour period and is authorized to receive those services in the home setting may make use of the approved hours outside of that setting when normal life activities temporarily take him outside of that setting. Normal life activity for a child under the age of twenty-one (21) means routine work (including work in supported or sheltered work settings); licensed child care; school and school-related activities; religious services and related activities; and outpatient health care services (including services delivered through a TennCare home and community based services waiver program). Normal life activities do not include non-routine or extended home absences.

(d) A private duty nurse may accompany a recipient in the circumstances outlined in subparagraph (c) immediately above, but may not drive.

(e) Private duty nursing services will only be authorized when there are competent family members or caregivers as indicated below:

1. Private duty nursing services include services to teach and train the recipient and the recipient's family or other caregivers how to manage the treatment regimen. Having a caregiver willing to learn the tasks necessary to provide a safe environment and quality in home care is essential to assuring the recipient is properly attended to when a nurse or other paid caregiver is not present, including those times when the recipient chooses to attend community activities to which these rules do not specifically permit the private duty nurse or other paid caregiver to accompany the patient.

2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:

(i) Have a demonstrated understanding, ability, and commitment in the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration and feeding, or in the case of children, other medically necessary skilled nursing functions, as applicable; and

(ii) Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and

(iii) Are willing and available as needed to meet the recipient's non-nursing support needs.

(iv) In the case of children under the age of 18, the parent or guardian will be expected to fill this role. In the case of an adult age 18 and older, if the health, safety, and welfare of the individual cannot be assured because the recipient does not have such family or caregiver, private duty nursing services may be denied, subject to items (I) and (II) below. However, it shall be the responsibility of the MCO to:

(I) Arrange for the appropriate level of care, which may include nursing facility care, if applicable; and

(Rule 1200-13-14-.04, continued)

(II) In the case of a person currently receiving private duty nursing services, facilitate transition to such appropriate level of care prior to termination of the private duty nursing service.

(f) Nursing services (provided as part of home health services or by a private duty nurse) will be approved only if the requested service(s) is of the type that must be provided by a nurse as opposed to an aide, except that the MCO may elect to have a nurse perform home health aide services in addition to nursing services if the MCO determines that this is a less costly alternative than providing the services of both a nurse and an aide. Examples of appropriate nursing services include, but are not limited to, management of ventilator equipment or other life-sustaining medical technology, medication management, and tube feedings.

(g) Home health aide services will only be approved if the requested service(s) meet all medical necessity requirements including the requirements of 1200-13-16-.05(4)(d). Thus, home health aide services will not be approved to provide child care services, prepare meals, perform housework, or generally supervise patients. Examples of appropriate home health aide services include, but are not limited to, patient transfers and bathing.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23, and Public Chapter 473, Acts of 2011.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.04; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Amendments filed September 29, 2005; effective December 13, 2005. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Public necessity rule filed March 13, 2006; effective through August 25, 2006. Public necessity rule filed May 3, 2006; effective through October 15, 2006. Amendments filed March 31, 2006; effective June 14, 2006. Amendment filed June 12, 2006; effective August 26, 2006. Amendment filed July 28, 2006; effective October 11, 2006. Public necessity rule filed December 1, 2006; effective through May 15, 2007. Public necessity rule filed February 1, 2007; effective through July 16, 2007. Amendment filed February 2, 2007; effective April 18, 2007. Amendment filed May 2, 2007; effective July 16, 2007. Public necessity rule filed October 11, 2007; effective through March 24, 2008. Public necessity rule filed February 8, 2008; effective through July 22, 2008. Amendment filed May 7, 2008; effective July 21, 2008. Public necessity rule filed September 8, 2008; effective through February 20, 2009. Amendments filed August 19, 2008; effective November 2, 2008. Amendment filed December 5, 2008; effective February 18, 2009. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed June 11, 2009; effective August 25, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Amendments filed September 25, 2009; effective December 24, 2009. Amendments filed September 30, 2009; effective December 29, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendment filed October 26, 2010; effective January 24, 2011. Emergency rules filed July 1, 2011; effective through December 28, 2011. Emergency rule filed August 2, 2011; effective through January 29, 2012. Amendments filed September 23, 2011; effective December 22, 2011. Amendment filed October 28, 2011; effective January 26, 2012. Amendment filed August 10, 2011; effective January 29, 2012. Amendment filed April 25, 2012; effective September 28, 2012. Emergency rule filed September 27, 2013; effective through March 26, 2014. Amendments filed July 1, 2013; effective September 29, 2013. Amendment filed August 7, 2013; effective November 5, 2013. Amendment filed September 27, 2013; effective December 26, 2013. Amendment filed December 17, 2013; effective March 17, 2014. Amendment filed June 17, 2014; effective September 15, 2014. Emergency rule filed September 30, 2015; effective through March 28, 2016. Amendments filed December 29, 2015; effective March 28, 2016. Emergency rules filed June 24, 2016; effective through December 21, 2016. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 13, 2016; effective December 12, 2016. Amendments filed*

(Rule 1200-13-14-.04, continued)

September 30, 2016; effective December 29, 2016. Emergency rules filed January 16, 2018; effective through July 15, 2018. Amendments filed April 9, 2018; effective July 8, 2018.

1200-13-14-.05 ENROLLEE COST SHARING.

(1) Premiums and deductibles.

(a) Enrollees are not required to pay premiums for TennCare.

(b) There are no TennCare deductibles.

(2) Copays.

(a) The following TennCare Standard enrollees are exempt from TennCare copays:

1. Enrollees who are receiving hospice services and who provide verbal notification of such to the provider at the point of service.

2. Enrollees who are pregnant and who provide verbal notification of such to the provider at the point of service.

3. Enrollees who are enrolled in any of the following CHOICES or ECF CHOICES demonstration categories:

(i) The CHOICES 217-Like Group

(ii) The CHOICES 1 and 2 Carryover Group

(iii) The PACE Carryover Group

(iv) The ECF CHOICES 217-Like Group

4. Children who are enrolled in TennCare Standard and who have family incomes below 100% of poverty.

(b) The following TennCare services are exempt from TennCare copays for all enrollees:

1. Emergency services, including the seventy-two (72) hour emergency supply of a medication in an emergency situation, as described in Rule 1200-13-14-.11.

2. Family planning services and supplies.

3. Preventive services as identified in Rule 1200-13-14-.04.

(c) Pharmacy copays. The following TennCare Standard enrollees have pharmacy copays of $3.00 per covered brand name prescription and $1.50 per covered generic prescription:

1. TennCare Standard children with family incomes that are 100% of poverty or greater.

2. Enrollees in the Standard Spend Down program.

3. Enrollees in the CHOICES At-Risk Demonstration Group.

(Rule 1200-13-14-.05, continued)

4. Adults age 21 and older in the Interim ECF CHOICES At-Risk Demonstration Group.

(d) Copays for other TennCare services. The following copays are applicable to TennCare Standard children, except children enrolled in ECF CHOICES.

Benefit	Copay if income is 0%-99% of poverty	Copay if income is 100%-199% of poverty	Copay if income is 200% of poverty or greater
Hospital emergency room use for non-emergency services (waived if admitted)	$0	$10	$50
Primary care provider services other than preventive care	$0	$5	$15
Community Mental Health Agency services other than preventive care	$0	$5	$15
Physician specialists and dentists	$0	$5	$20
Prescription or refill	$0	$3 for covered branded prescriptions and $1.50 for covered generic prescriptions	$3 for covered branded prescriptions and $1.50 for covered generic prescriptions
Inpatient hospital admission	$0	$5	$100

(e) Copays for non-emergency services provided in an emergency department are not required unless the hospital has first provided the enrollee with assistance in gaining access to a non-emergency services provider (a physician's office, health care clinic, community health center, hospital outpatient department, or similar provider). This requirement on the part of the hospital can be met if, before providing non-emergency care subject to copay, the emergency room staff recommends that the enrollee or the enrollee's caretaker call the 24/7 nurse staffed call center for the enrollee's MCO to obtain help in locating an available provider in the community, and offers to assist with placing a call to the call center.

(3) Aggregate cost-sharing cap.

(a) The aggregate cost-sharing cap is applicable only to TennCare copays incurred by TennCare Standard children with incomes at or above 100% of poverty and their TennCare family members.

(b) The aggregate cost-sharing cap is calculated by combining the TennCare cost sharing for all TennCare family members who have TennCare cost-sharing obligations, and may not exceed 5 percent of the family's annual income, prorated to a quarterly equivalent. Family income will be calculated using the same methodology used to calculate income for the determination of eligibility, and the family will be assigned to the corresponding income band to determine the standardized aggregate cap, which is based on the lower end of the income band. The following income bands and the corresponding aggregate annual caps will be used:

Income Bands	Poverty levels	Standardized Annual Aggregate Cap

(Rule 1200-13-14-.05, continued)

1	0% - 99%	Not applicable
2	100% - 149%	5% of the amount that corresponds to 100% FPL
3	150% - 199%	5% of the amount that corresponds to 150% FPL
4	200% - 249%	5% of the amount that corresponds to 200% FPL
5	250% - 299%	5% of the amount that corresponds to 250% FPL
6	300% - 349%	5% of the amount that corresponds to 300% FPL
7	350% - 399%	5% of the amount that corresponds to 350% FPL
8	400% - 499%	5% of the amount that corresponds to 400% FPL
9	500% - 599%	5% of the amount that corresponds to 500% FPL
10	600% and over	5% of the amount that corresponds to 600% FPL

(c) Families of applicable TennCare Standard children are responsible for tracking their own incurred cost sharing obligations, including keeping copies of receipts and similar documentation, and notifying the Bureau of TennCare when they believe they have reached their aggregate cost-sharing cap for a particular calendar quarter.

(d) After receiving the information described in subparagraph (c), TennCare will notify families of applicable TennCare Standard children of the date when it has been determined that the aggregate cost-sharing cap, as prorated for the quarter, has been reached. When that occurs, there are no further TennCare cost-sharing obligations required for the remainder of the calendar quarter. Any TennCare copays that are paid by the family during the quarter after the family's aggregate cost-sharing cap, as pro-rated for that quarter, has been reached will be refunded to the family by TennCare.

(4) This paragraph applies to all TennCare Managed Care Contractors and providers.

(a) In accordance with 42 C.F.R. § 447.53(e), providers may not refuse to deliver a covered service to an enrollee because of the enrollee's inability to make his copay.

(b) Managed care contractors participating in the TennCare program shall be specifically prohibited from waiving or discouraging TennCare enrollees from paying any applicable cost-sharing amounts.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.05; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rules filed June 3, 2005; effective through November 15, 2005. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Amendments filed September 1, 2005; effective November 15, 2005. Amendments filed September 26, 2005; effective December 10, 2005. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendment filed March 31, 2006; effective June 14, 2006. Public necessity rule filed March 21, 2007; effective through September 2, 2007. Amendment filed June 11, 2007; effective August 25, 2007. Public necessity rules filed November 30, 2007; effective through May 13, 2008. Amendment filed February 14, 2008; effective April 29, 2008. Emergency rule filed March 1, 2010; effective through August 28, 2010. Emergency rule filed July 26, 2010; effective through January*

(Rule 1200-13-14-.05, continued)

22, 2011. Amendment filed May 27, 2010; effective August 25, 2010. Amendment filed October 20, 2010; effective January 18, 2011. Repeal and new rule filed January 15, 2013; effective April 15, 2013. Emergency rules filed September 26, 2013; effective through March 25, 2014. Amendment filed December 17, 2013; effective March 17, 2014. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.

1200-13-14-.06 MANAGED CARE ORGANIZATIONS.

Managed Care Organizations participating in TennCare will be limited to Health Maintenance Organizations that are appropriately licensed to operate within the state of Tennessee to provide medical, behavioral, and long-term care services in the TennCare program. Managed Care Organizations shall have a fully executed contract with the Tennessee Department of Finance and Administration. MCOs, DBMs and PBMs shall agree to comply with all applicable rules, policies, and contract requirements as specified by the Tennessee Department of Finance and Administration as applicable. Managed Care Organizations must continually demonstrate a sufficient provider network based on the standards set by the Bureau of TennCare to remain in the program and must reasonably meet all quality of care requirements established by the Bureau of TennCare.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.06; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment filed September 25, 2009; effective December 24, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010.*

1200-13-14-.07 MANAGED CARE ORGANIZATION PAYMENT.

Managed care organizations will be paid pursuant to the contract the MCO has fully executed with the Tennessee Department of Finance and Administration.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.07; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003.*

1200-13-14-.08 PROVIDERS.

(1) Payment in full.

(a) All Participating Providers, as defined in this Chapter, must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.

(b) Any Non-Participating Providers who provide TennCare Program covered services by authorization from an MCC must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.

(c) Any Non-Participating Provider, as defined in this Chapter, who provides TennCare Program covered non-emergency services to TennCare enrollees without authorization from the enrollee's MCC does so at his own risk. He may not bill the patient for such services except as provided for in Rule 1200-13-14-.08(5).

(Rule 1200-13-14-.08, continued)

(d) Any Out-of-State Emergency Provider, as defined in this Chapter, who provides covered emergency services to TennCare enrollees in accordance with this Chapter must accept as payment in full the amounts paid by the MCC plus any copayment required by the TennCare Program.

(2) Non-Participating Providers.

(a) In situations where a MCC authorizes a service to be rendered by a provider who is not a Participating Provider with the MCC, as defined in this Chapter, payment to the provider shall be no less than eighty percent (80%) of the lowest rate paid by the MCC to equivalent participating network providers for the same service.

(b) Covered medically necessary outpatient emergency services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(D) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(D)), shall be reimbursed at seventy-four percent (74%) of the 2006 Medicare rates for these services. Emergency care to enrollees shall not require preauthorization.

(c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(B) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(B)), shall be reimbursed at 57 percent of the 2008 Medicare Diagnostic Related Groups (DRG) rates (excluding Medical Education and Disproportionate Share components) determined in accordance with 42 C.F.R. § 412 for those services. For DRG codes that are adopted after 2008, 57 percent of the rate from the year of adoption will apply. Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a contract hospital or to another contract service, whichever comes first.

(d) Non-Participating Providers who furnish covered CHOICES services are reimbursed in accordance with Rule 1200-13-01-.05.

(e) Non-Participating Providers who furnish covered ECF CHOICES services are reimbursed in accordance with Rule 1200-13-01-.31.

(3) Participation in the TennCare program will be limited to providers who:

(a) Accept, as payment in full, the amounts paid by the managed care contractor, including copays from the enrollee, or the amounts paid in lieu of the managed care contractor by a third party (Medicare, insurance, etc.);

(b) Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the TDMHDD, if appropriate;

(c) Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);

(d) Agree to maintain and provide access to TennCare and/or its agent all TennCare enrollee medical records for five (5) years from the date of service or upon written authorization from TennCare following an audit, whichever is shorter;

(e) Provide medical assistance at or above recognized standards of practice; and

(Rule 1200-13-14-.08, continued)

(f) Comply with all contractual terms between the provider and the managed care contractor and TennCare policies as outlined in federal and state rules and regulations and TennCare provider manuals and bulletins.

(g) Failure to comply with any of the above provisions (a) through (f) may subject a provider to the following actions:

1. Sanctions set out in T.C.A. § 71-5-118. In addition, the provider may be subject to stringent review/audit procedures, which may include clinical evaluation of services and a prepayment requirement for documentation and justification for each claim.

2. The Bureau of TennCare may withhold or recover payments to managed care contractors in cases of provider fraud, willful misrepresentation, or flagrant non-compliance with contractual requirements and/or TennCare policies.

3. The Bureau of TennCare may refuse to approve or may suspend provider participation with a provider if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the US Title XX Services Program.

4. The Bureau of TennCare may refuse to approve or may suspend provider participation if it determines that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the US Title XX Services Program since the inception of these programs.

5. The Bureau of TennCare shall refuse to approve or shall suspend provider participation if the appropriate State Board of Licensing or Certification fails to license or certify the provider at any time for any reason or suspends or revokes a license or certification.

6. The Bureau of TennCare shall refuse to approve or shall suspend provider participation upon notification by the US Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare or Medicaid for federal financial participation.

7. The Bureau of TennCare may recover from a managed care contractor any payments made by an enrollee and/or his family for a covered service, in total or in part, except as permitted. If a provider knowingly bills an enrollee and/or his family for a covered service, in total or in part, except as permitted, the Bureau of TennCare may terminate the provider's participation in TennCare.

(4) Solicitations and Referrals.

(a) Managed care contractors and providers shall not solicit TennCare enrollees by any method offering as enticements other goods and services (free or otherwise) for the opportunity of providing the enrollee with TennCare covered services that are not medically necessary and/or that overutilize the TennCare program.

(b) A managed care contractor may request a waiver from this restriction in writing to TennCare. TennCare shall determine the value of a waiver request based upon the

medical necessity and need for the solicitation. The managed care contractor may implement the solicitation only upon receipt of a written waiver approval from TennCare. This waiver is not transferable and may be canceled by TennCare upon written notice.

(c) TennCare payments for services related to a non-waivered solicitation enticement shall be considered by TennCare as a non-covered service and recouped. Neither the managed care contractor nor the provider may bill the enrollee for non-covered services recouped under this authority.

(d) A provider shall not offer or receive remuneration in any form related to the volume or value of referrals made or received from or to another provider.

(5) Providers may seek payment from a TennCare enrollee only under the following circumstances. These circumstances apply to all TennCare providers, as defined in this Chapter, including those who are Out-of-Network Providers in a particular enrollee's MCC. These circumstances include situations where the enrollee may choose to seek an out-of-network provider for a specific covered service.

(a) If the services are not covered by the TennCare program and, prior to providing the services, the provider informed the enrollee that the services were not covered; or

(b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:

1. The provider determines effective on the date of service that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and the service will not be paid for by TennCare. The source of the provider's information must be a database listed on the TennCare website as approved by TennCare on the date of the provider's inquiry.

2. The provider has information in his/her own records to support the fact that the enrollee has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by TennCare. This information may include:

(i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to the benefit limit is still in effect; or

(ii) That the provider had previously examined the database referenced in part 1. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect; or

(iii) That the provider had personally provided services to the enrollee in excess of his/her benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit period is still in effect; or

(iv) The enrollee's MCO has provided confirmation to the provider that the enrollee has reached his/her benefit limit for the applicable service.

3. The provider submits a claim for service to the appropriate managed care contractor (MCC) and receives a written denial of that claim on the basis that the

service exceeds the enrollee's benefit limit. Thereafter, following informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee for services within that same exhausted benefit category without having to submit, for repeated MCC denial, claims for those subsequent services. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by TennCare, the provider may bill the enrollee for that service.

4. The provider had previously taken the steps in parts 1., 2. or 3. above and determined that the enrollee had reached his/her benefit limit for the particular service being requested, if the time period applicable to the benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by TennCare.

(c) If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the enrollee that the services are not covered, the enrollee may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.

(6) Providers may not seek payment from a TennCare enrollee under the following conditions:

(a) The provider knew or should have known about the patient's TennCare eligibility or pending eligibility prior to providing services.

(b) The claim(s) submitted to TennCare or the enrollee's managed care contractor for payment was denied due to provider billing error or a TennCare claim processing error.

(c) The provider accepted TennCare assignment on a claim and it is determined that another payer paid an amount equal to or greater than the TennCare allowable amount.

(d) The provider failed to comply with TennCare policies and procedures or provided a service which lacks medical necessity or justification.

(e) The provider failed to submit or resubmit claims for payment within the time periods required by the managed care contractor or TennCare.

(f) The provider failed to ascertain the existence of TennCare eligibility or pending eligibility prior to providing non-emergency services. Even if the enrollee presents another form of insurance, the provider must determine whether the patient is covered under TennCare.

(g) The provider failed to inform the enrollee prior to providing a service not covered by TennCare that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement. Notwithstanding this exemption, providers shall remain obligated to provide notice to enrollees who have exceeded benefit limits in accordance with rule 1200-13-14-.11.

(h) The enrollee failed to keep a scheduled appointment(s).

(i) The provider is a TennCare provider, as defined in this Chapter, but is not participating with a particular enrollee's MCC and is seeking to bill the enrollee as though the provider were a Non-TennCare Provider, as defined in this Chapter.

(Rule 1200-13-14-.08, continued)

(7) Providers may seek payment from a person whose TennCare eligibility is pending at the time services are provided if the provider informs the person that TennCare assignment will not be accepted whether or not eligibility is established retroactively.

(8) Providers may seek payment from a person whose TennCare eligibility is pending at the time services are provided. Providers may bill such persons at the provider's usual and customary rate for the services rendered. However, all monies collected for TennCare-covered services rendered during a period of TennCare eligibility must be refunded when a claim is submitted to TennCare if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established.

(9) Providers of inpatient hospital services, outpatient hospital services, skilled nursing facility services, independent laboratory and x-ray services, hospice services, and home health agencies must be approved for Title XVIII-Medicare in order to be certified as providers under the TennCare Program; in the case of hospitals, the hospital must meet state licensure requirements and be approved by TennCare as an acute care hospital as of the date of enrollment in TennCare. Children's hospitals and State mental hospitals may participate in TennCare without having been Medicare approved; however, the hospital must be approved by the Joint Commission for Accreditation of Health Care Organizations as a condition of participation.

(10) Pharmacy providers may not waive pharmacy copayments for TennCare Medicaid or TennCare Standard enrollees as a means of attracting business to their establishment. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.

(11) Providers shall not deny services for Medicaid enrollee failure to make copayments.

(12) All claims must be filed in accordance with the following:

(a) Claims filed with an MCC must be submitted in accordance with the requirements and timeframes set forth in the MCC's contract.

(b) All other fee-for-service claims for services delivered outside of the TennCare managed care program must be filed with the Bureau of TennCare as follows:

1. All claims must be filed within one (1) year of the date of service except in the following circumstances:

(i) Recipient eligibility was determined retroactively to the extent that filing within one (1) year was not possible. In such situations, claims must be filed within one (1) year after final determination of eligibility.

(ii) If a claim filed with Medicare on a timely basis does not automatically cross over from the Medicare carrier to the Bureau, a TennCare claim may be filed within six (6) months of notification of payment or denial from Medicare.

2. Should an original claim be denied, any resubmission or follow-up of the initial claim must be received within six (6) months from the date the original claim was filed. The Bureau will not process submissions received after the six (6) month time limit. The one exception is those claims returned due to available third party coverage. These claims must be submitted within sixty (60) days of notice from the third party resource.

(Rule 1200-13-14-.08, continued)

3. Should a correction document involving a suspended claim be sent to the provider, the claim will be denied if the correction document is not completed by the provider and returned to the Bureau within ninety (90) days from the date on the document.

4. If claim is not filed within the above timeframes, no reimbursement may be made.

5. Claims will be paid on a first claim approved - first claim paid basis.

6. The Bureau will not reimburse providers for services for which there is no Federal Financial Participation.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, 71-5-134, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.08; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed January 2, 2003; effective through June 16, 2003. Amendment filed October 12, 2004; effective December 26, 2004. Public necessity rule filed July 29, 2005; effective through January 10, 2006. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendment filed October 27, 2005; effective January 10, 2006. Amendment filed March 31, 2006; effective June 14, 2006. Public necessity rule filed September 8, 2008; effective through February 20, 2009. Amendment filed December 5, 2008; effective February 18, 2009. Amendment filed February 25, 2009; effective May 11, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Emergency rule filed September 3, 2010; effective through March 2, 2011. Amendment filed December 2, 2010; to have been effective March 2, 2011, was stayed 28 days by the Government Operations Committee; new effective date March 29, 2011. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 30, 2016; effective December 29, 2016.*

1200-13-14-.09 THIRD PARTY RESOURCES.

(1) Individuals applying for TennCare Medicaid or TennCare Standard coverage shall disclose the availability of any third party health care coverage to the agency responsible for determining the individual's eligibility for TennCare.

(2) An individual enrolled in TennCare Medicaid or TennCare Standard shall disclose access to third party resources to his/her specified Managed Care Contractors as soon as s/he becomes aware of the existence of any third party resources.

(3) Managed Care Contractors under contract with the Tennessee Departments of Finance and Administration or Mental Health and Developmental Disabilities shall provide all third party resource information obtained from the plan's enrollees to the Bureau of TennCare on a regular basis as required by their contracts.

(4) Managed Care Contractors shall enforce TennCare subrogation rights pursuant to T.C.A. § 71-5-117.

(5) Managed Care Contractors may pay health insurance premiums for their enrollees if such payments are determined by the Bureau to be cost effective.

(6) TennCare shall be the payor of last resort, except where contrary to federal or state law.

(7) Upon enrollment in TennCare Medicaid or TennCare Standard an individual assigns to the Bureau any rights to third party insurance benefits to which the individual may be entitled.

(Rule 1200-13-14-.09, continued)

(8) Upon accepting medical assistance, an enrollee in TennCare Medicaid or TennCare Standard shall be deemed to have made an assignment to the Bureau of the right to third party insurance benefits to which the enrollee may be entitled.

(9) The Bureau shall utilize direct billing when it is determined that a previously paid service may have been covered by a third party.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, 71-5-117, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.09; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Amendment filed January 15, 2013; effective April 15, 2013.*

1200-13-14-.10 EXCLUSIONS.

(1) General exclusions. The following items and services shall not be considered covered services by TennCare:

(a) Provision of medical assistance which is outside the scope of benefits as defined in these rules.

(b) Provision of services to persons who are not enrolled in TennCare, either on the date the services are delivered or retroactively to the date the services are delivered.

(c) Services for which there is no Federal Financial Participation (FFP).

(d) Services provided outside the United States or its territories.

(e) Services provided outside the geographic borders of Tennessee, including transportation to return to Tennessee to receive medical care except in the following circumstances:

1. Emergency medical services are needed because of an emergency medical condition;

2. Non-emergency urgent care services are requested because the recipient's health would be endangered if he were required to travel, but only upon the explicit prior authorization of the MCC;

3. The covered medical service would not be readily available within Tennessee if the enrollee was physically located in Tennessee at the time of need and the covered service is explicitly prior authorized by the enrollee's TennCare MCC; or

4. The out-of-state provider is participating in the enrollee's MCC network.

(f) Investigative or experimental services or procedures including, but not limited to:

1. Drug or device that lacks FDA approval except when medically necessary as defined by TennCare;

2. Drug or device that lacks approval of facility's Institutional Review Board;

3. Requested treatment that is the subject of Phase I or Phase II clinical trials or the investigational arm of Phase III clinical trials; or

4. A requested service about which prevailing opinion among experts is that further study is required to determine safety, efficacy, or long-term clinical outcomes of requested service.

(g) Services which are delivered in connection with, or required by, an item or service not covered by TennCare, including the transportation to receive such non-covered services, except that treatment of conditions resulting from the provision of non-covered services may be covered if medically necessary, notwithstanding the exclusions set out herein.

(h) Items or services furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.

(i) Non-emergency services that are ordered or furnished by an out-of-network provider and that have not been approved by the enrollee's MCC. An exception exists for dually eligible enrollees. In-network care ordered by out-of-network providers is covered for dually eligible enrollees unless the MCO has informed such enrollee in advance of a request for a service that the specific service requires prior authorization and an order from an in-network provider.

(j) Services that are free to the public, with the exception of services delivered in the schools pursuant to the Individuals with Disabilities in Education Act (IDEA).

(k) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that has been excluded from participation in the Medicaid program under the authority of the United States Department of Health and Human Services or the Bureau of TennCare.

(l) Items or services ordered, prescribed, administered, supplied, or provided by an individual or entity that is not licensed by the appropriate licensing board.

(m) Items or services outside the scope and/or authority of a provider's specialty and/or area of practice.

(n) Items or services to the extent that Medicare or a third party payer is legally responsible to pay or would have been legally responsible to pay except for the enrollee's or the treating provider's failure to comply with the requirements for coverage of such services.

(o) Medical services for inmates confined in a local, state, or federal prison, jail, or other penal or correctional facility, including a furlough from such facility.

(p) Services delivered by a specific provider, even a provider who is an in-network provider with the enrollee's managed care plan, when the managed care plan has offered the enrollee the services of a qualified provider who is available to provide the needed services.

(q) Items or services that are not covered by Medicare or a third party payer for an individual enrollee because the item or service is essentially equivalent to a Medicare or third party payer service that is being covered (e.g., home health services for individuals receiving hospice care).

(2) Exception to General and Specific Exclusions: COST EFFECTIVE ALTERNATIVE. As approved by CMS and/or authorized by Policy BEN 08-001, each MCC has sole discretionary authority to provide certain cost effective alternatives when providing appropriate medically

(Rule 1200-13-14-.10, continued)

necessary care. These services are otherwise excluded and are not covered services unless the MCC has followed the procedures set forth in Policy BEN 08-001 and opts at its sole discretion to provide such requested item or service.

(3) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115 waiver program unless excepted by paragraph (2) herein. Some of these services may be covered under the CHOICES or ECF CHOICES programs or outside the managed care program under a Section 1915(c) Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with the appropriate approved TennCare Home and Community Based Services waiver.

(a) Services, products, and supplies that are specifically excluded from coverage except as medically necessary for children under the age of 21.

1. Audiological therapy or training

2. Augmentative communication devices

3. Beds and bedding equipment as follows:

(i) Powered air flotation beds, air fluidized beds (including Clinitron beds), water pressure mattress, or gel mattress

For persons age 21 and older: Not covered unless a member has both severely impaired mobility (i.e., unable to make independent changes in body position to alleviate pain or pressure) and any stage pressure ulcer on the trunk or pelvis combined with at least one of the following: impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status.

(ii) Bead beds, or similar devices

(iii) Bed boards

(iv) Bedding and bed casings

(v) Ortho-prone beds

(vi) Oscillating beds

(vii) Springbase beds

(viii) Vail beds, or similar bed

4. Biofeedback

5. Chiropractor’s services

6. Cushions, pads, and mattresses as follows:

(i) Aquamatic K Pads

(ii) Elbow protectors

(iii) Heat and massage foam cushion pads

(iv) Heating pads

(v) Heel protectors

(vi) Lamb's wool pads

(vii) Steam packs

7. Diagnostic tests conducted solely for the purpose of evaluating the need for a service which is excluded from coverage under these rules.

8. Ear plugs

9. Floor standers, meaning stationary devices not attached to a wheelchair base and not built into the operating system of a power wheelchair that are designed to hold in an upright position an Enrollee who uses a wheelchair and who has limited or no ability to stand on his own

10. Food supplements and substitutes including formulas

    For persons 21 years of age and older: Not covered, except that Parenteral Nutrition formulas, Enteral Nutrition formulas for tube feedings and phenylalanine-free formulas (not foods) used to treat PKU, as required by T.C.A. § 56-7-2505, are covered for adults. In addition, oral liquid nutrition may be covered when medically necessary for adults with swallowing or breathing disorders who are severely underweight (BMI<15 kg/m2) and physically incapable of otherwise consuming a sufficient intake of food to meet basic nutritional requirements.

11. Hearing services, including the prescribing, fitting, or changing of hearing aids

12. Humidifiers (central or room) and dehumidifiers

13. Inpatient rehabilitation facility services

14. Medical supplies, over-the-counter, as follows:

    (i) Alcohol, rubbing

    (ii) Band-aids

    (iii) Cotton balls

    (iv) Eyewash

    (v) Peroxide

    (vi) Q-tips or cotton swabs

15. Methadone clinic services

16. Nutritional supplements and vitamins, over-the-counter, except that prenatal vitamins for pregnant women and folic acid for women of childbearing age are covered

(Rule 1200-13-14-.10, continued)

17. Orthodontic services, except as defined in Rule 1200-13-13-.04(1)(b)5. or 1200-13-14-.04(1)(b)5.

18. Certain pharmacy items as follows:

    (i) Agents when used for anorexia or weight loss

    (ii) Agents when used to promote fertility

    (iii) Agents when used for cosmetic purposes or hair growth

    (iv) Agents when used for the symptomatic relief of cough and colds

    (v) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

    (vi) Nonprescription drugs

    (vii) Buprenorphine-containing products used for treatment of opiate addiction in excess of the covered amounts listed below:

        (I) Dosage of sixteen milligrams (16 mg) per day for a period of up to six (6) months (183 days) from the initiation of therapy or from the conclusion of pregnancy, if the enrollee is pregnant during this initial maximum dosage therapy; and

        (II) Dosage of eight milligrams (8 mg) per day after the sixth (6^{th}) month (183^{rd} day) of therapy.

    (viii) Sedative hypnotic medications in dosage amounts that exceed the dosage amounts listed below:

        (I) Fourteen (14) pills per month for sedative hypnotic formulations in pill form such as Ambien and Lunesta;

        (II) One hundred forty milliliters (140 ml) per month of chloral hydrate; or

        (III) One (1) bottle every sixty (60) days of Zolpimist.

    (ix) Allergy medications

    (x) Opioid products are restricted as set out in Rule .04(1)(c)12.

19. Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of enrollee abuse

20. Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:

    (i) Explanation of continuing medical necessity for the item, and

    (ii) Explanation that the item was stolen or destroyed, and

    (iii) Copy of police, fire department, or insurance report if applicable

(Rule 1200-13-14-.10, continued)

21. Radial keratotomy

22. Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME) item that is stolen or destroyed

23. Repair of DME items not covered by TennCare

24. Repair of DME items covered under the provider's or manufacturer's warranty

25. Repair of a rented DME item

26. Speech, language, and hearing services to address speech problems caused by mental, psychoneurotic, or personality disorders

27. Standing tables

28. Vision services for persons 21 years of age and older that are not needed to treat a systemic disease process including, but not limited to:

    (i) Eyeglasses, sunglasses, and/or contact lenses for persons aged 21 and older, including eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, sunglasses, and/or contact lenses; procedures performed to determine the refractive state of the eye(s); one pair of cataract glasses or lenses is covered for adults following cataract surgery

    (ii) LASIK

    (iii) Orthoptics

    (iv) Vision perception training

    (v) Vision therapy

(b) Services, products, and supplies that are specifically excluded from coverage under the TennCare program.

1. Air cleaners, purifiers, or HEPA filters

2. Alcoholic beverages

3. Animal therapy including, but not limited to:

    (i) Dolphin therapy

    (ii) Equine therapy

    (iii) Hippo therapy

    (iv) Pet therapy

4. Art therapy

5. Autopsy

6. Bathtub equipment and supplies as follows:

(Rule 1200-13-14-.10, continued)

(i) Paraffin baths

(ii) Pillows

(iii) Sauna baths

7. Beds and bedding equipment as follows:

(i) Adjust-a-Beds, lounge beds, or similar devices

(ii) Waterbeds

8. Bioenergetic therapy

9. Body adornment and enhancement services including, but not limited to:

(i) Body piercing

(ii) Breast augmentation

(iii) Breast capsulectomy

(iv) Breast implant removal that is not medically indicated

(v) Ear piercing

(vi) Hair transplantation, and agents for hair growth

(vii) Tattoos or removal of tattoos

(viii) Tongue splitting or repair of tongue splitting

(ix) Wigs or hairpieces

10. Breathing equipment as follows:

(i) Intrapulmonary Percussive Ventilators (IPVs)

(ii) Spirometers, except for peak flow meters for medical management of asthma and incentive spirometers

(iii) Vaporizers

11. Carbon dioxide therapy

12. Care facilities or services, the primary purpose of which is non-medical, including, but not limited to:

(i) Day care

(ii) Evening care centers

(iii) Respite care, except as a component of Mental Health Crisis Services benefits or Hospice Care benefits as provided at Rule 1200-13-14-.04(1)(b).

(Rule 1200-13-14-.10, continued)

(iv) Rest cures

(v) Social or diversion services related to the judicial system

13. Carotid body tumor, excision of, as treatment for asthma

14. Chelation therapy, except for the treatment of heavy metal poisoning or secondary hemochromatosis in selected settings. Chelation therapy for treatment of arteriosclerosis or autism is not covered. Chelation therapy for asymptomatic individuals is not covered. In the case of lead poisoning, the lead levels must be extremely high. For children, a minimum level of 45 ug/dl is recommended. Because chelation therapy and its after-effects must be continuously monitored for possible adverse reactions, chelation therapy is covered only in inpatient or outpatient hospital settings, renal dialysis facilities, and skilled nursing facilities. It is not covered in an office setting, an ambulatory surgical center, or a home setting.

15. Clothing, including adaptive clothing

16. Cold therapy devices

17. Comfort and convenience items including, but not limited to:

(i) Corn plasters

(ii) Garter belts

(iii) Incontinence products (diapers/liners/underpads) not needed for a medical condition; not covered for children age 3 and younger

(iv) Support stockings, when light or medium weight or prescribed for relief of tired or aching legs or treatment of spider/varicose veins. Surgical weight stockings prescribed by a doctor or other qualified licensed health care practitioner for the treatment of chronic foot/ankle swelling, venous insufficiencies, or other medical conditions and thrombo-embolic deterrent support stockings for pre- and post-surgical procedures are covered as medically necessary.

18. Computers, personal, and peripherals including, but not limited to printers, modems, monitors, scanners, and software, including their use in conjunction with an Augmentative Communication Device

19. Convalescent care.

20. Cosmetic dentistry, cosmetic oral surgery, and cosmetic orthodontic services

21. Cosmetic prosthetic devices

22. Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem, including scar revision. The following services are not considered cosmetic services:

(i) Reconstructive surgery to correct the results of an injury or disease

(Rule 1200-13-14-.10, continued)

(ii) Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function

(iii) Surgery to reconstruct a breast after mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure

(iv) In accordance with Tennessee law, surgery of the non-diseased breast following mastectomy and reconstruction to create symmetrical appearance

(v) Surgery for the improvement of the functioning of a malformed body member

(vi) Reduction mammoplasty, when the minimum amount of breast material to be removed is equal to or greater than the 22nd percentile of the Schnur Sliding Scale based on the individual's body surface area.

23. Dance therapy

24. Dental services for adults age 21 and older

25. Services provided solely or primarily for educational purposes, including, but not limited to:

(i) Academic performance testing

(ii) Educational tests and training programs

(iii) Habilitation

(iv) Job training

(v) Lamaze classes

(vi) Lovaas therapy

(vii) Picture illustrations

(viii) Remedial education

(ix) Sign language instruction

(x) Special education

(xi) Tutors

26. Encounter groups or workshops

27. Environmental modifications including, but not limited to:

(i) Air conditioners, central or unit

(ii) Micronaire environmentals, and similar devices

(iii) Pollen extractors

(iv) Portable room heaters

(v) Vacuum systems for dust filtering

(vi) Water purifiers

(vii) Water softeners

28. Exercise equipment including, but not limited to:

(i) Exercise equipment

(ii) Exercycles (including cardiac use)

(iii) Functional electrical stimulation

(iv) Gravitronic traction devices

(v) Gravity guidance inversion boots

(vi) Parallel bars

(vii) Pulse tachometers

(viii) Tilt tables when used for inversion

(ix) Training balls

(x) Treadmill exercisers

(xi) Weighted quad boots

29. Food and food products (distinct from food supplements or substitutes, as defined in Rule 1200-13-14-.10(3)(a)10.), including but not limited to specialty food items for use in diets such as:

(i) Low-phenylalanine or phenylalanine-free

(ii) Gluten-free

(iii) Casein-free

(iv) Ketogenic

30. Generators and auxiliary power equipment that may be used to provide power for covered medical equipment or for any purpose

31. Grooming services including, but not limited to:

(i) Barber services

(ii) Beauty services

(iii) Electrolysis

(iv) Hairpieces or wigs

(Rule 1200-13-14-.10, continued)

(v) Manicures

(vi) Pedicures

32. Hair analysis

33. Home health aide services or services from any other individual or agency that are for the primary purpose of safety monitoring

34. Home modifications and items for use in the home

(i) Decks

(ii) Enlarged doorways

(iii) Environmental accessibility modifications such as grab bars and ramps

(iv) Fences

(v) Furniture, indoor or outdoor

(vi) Handrails

(vii) Meals

(viii) Overbed tables

(ix) Patios, sidewalks, driveways, and concrete slabs

(x) Plexiglass

(xi) Plumbing repairs

(xii) Porch gliders

(xiii) Rollabout chairs

(xiv) Room additions and room expansions

(xv) Telephone alert systems

(xvi) Telephone arms

(xvii) Telephone service in home

(xviii) Televisions

(xix) Tilt tables when used for inversion

(xx) Toilet trainers and potty chairs. Positioning commodes and toilet supports are covered as medically necessary.

(xxi) Utilities (gas, electric, water, etc.)

35. Homemaker services

(Rule 1200-13-14-.10, continued)

36. Hospital inpatient items that are not directly related to the treatment of an injury or illness (such as radios, TVs, movies, telephones, massage, guest beds, haircuts, hair styling, guest trays, etc.)

37. Hotel charges, unless pre-approved in conjunction with a transplant or as part of a non-emergency transportation service

38. Hypnosis or hypnotherapy

39. Infant/child car seats, except that adaptive car seats may be covered for a person with disabilities such as severe cerebral palsy, spina bifida, muscular dystrophy, and similar disorders who meets all of the following conditions:

    (i) Cannot sit upright unassisted, and

    (ii) Infant/child care seats are too small or do not provide adequate support, and

    (iii) Safe automobile transport is not otherwise possible.

40. Infertility or impotence services including, but not limited to:

    (i) Artificial insemination services

    (ii) Purchase of donor sperm and any charges for the storage of sperm

    (iii) Purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers of gestational carriers

    (iv) Cryopreservation and storage of cryopreserved embryos

    (v) Services associated with a gestational carrier program (surrogate parenting) for the recipient or the gestational carrier

    (vi) Fertility drugs

    (vii) Home ovulation prediction kits

    (viii) Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal

    (ix) Reversal of sterilization procedures

    (x) Any other service or procedure intended to create a pregnancy

    (xi) Testing and/or treatment, including therapy, supplies, and counseling, for frigidity or impotence

41. Injections for the treatment of pain such as:

    (i) Facet/medial branch injections for therapeutic purposes

    (ii) Medial branch injections for diagnostic purposes in excess of four (4) injections in a calendar year

(Rule 1200-13-14-.10, continued)

(iii) Trigger point injections in excess of four (4) injections per muscle trigger point during any period of six (6) consecutive months

(iv) Epidural steroid injections in excess of three (3) injections during any period of six (6) consecutive months, except epidural injections associated with childbirth

42. Lamps such as:

(i) Heating lamps

(ii) Lava lamps

(iii) Sunlamps

(iv) Ultraviolet lamps

43. Lifts as follows:

(i) Automobile van lifts

(ii) Electric powered recliner, elevating seats, and lift chairs

(iii) Elevators

(iv) Overhead or ceiling lifts, ceiling track system lifts, or wall mounted lifts when installation would require significant structural modification and/or renovation to the dwelling (e.g., moving walls, enlarging passageways, strengthening ceilings and supports). The request for prior authorization must include a specific breakdown of equipment and installation costs, specifying all required structural modifications (however minor) and the cost associated thereto.

(v) Stairway lifts, stair glides, and platform lifts, including but not limited to Wheel-O-Vators

44. Ligation of mammary arteries, unilateral or bilateral

45. Megavitamin therapy

46. Motor vehicle parts and services including, but not limited to:

(i) Automobile controls

(ii) Automobile repairs or modifications

47. Music therapy

48. Nail analysis

49. Naturopathic services

50. Necropsy

51. Organ and tissue transplants that have been determined experimental or investigational

52. Organ and tissue donor services provided in connection with organ or tissue transplants covered pursuant to Rule 1200-13-14-.04(1)(b)22., including, but not limited to:

    (i) Transplants from a donor who is a living TennCare enrollee and the transplant is to a non-TennCare enrollee

    (ii) Donor services other than the direct services related to organ procurement (such as, hospitalization, physician services, anesthesia)

    (iii) Hotels, meals, or similar items provided outside the hospital setting for the donor

    (iv) Any costs incurred by the next of kin of the donor

    (v) Any services provided outside of any "bundled rates" after the donor is discharged from the hospital

53. Oxygen, except when provided under the order of a physician and administered under the direction of a physician

54. Oxygen, preset system (flow rate not adjustable)

55. Certain pharmacy items as follows: DESI, LTE, and IRS drugs

56. Play therapy

57. Primal therapy

58. Prophylactic use of stainless steel crowns

59. Psychodrama

60. Psychogenic sexual dysfunction or transformation services

61. Purging

62. Recertification of patients in Level 1 and Level II Nursing Facilities

63. Recreational therapy

64. Religious counseling

65. Retreats for mental disorders

66. Rolfing

67. Routine health services which may be required by an employer; or by a facility where an individual lives, goes to school, or works; or by the enrollee's intent to travel

    (i) Drug screenings

    (ii) Employment and pre-employment physicals

(Rule 1200-13-14-.10, continued)

(iii) Fitness to duty examinations

(iv) Immunizations related to travel or work

(v) Insurance physicals

(vi) Job related illness or injury covered by workers' compensation

68. Sensitivity training or workshops

69. Sensory integration therapy and equipment used in sensory integration therapy including, but not limited to:

(i) Ankle weights

(ii) Floor mats

(iii) Mini-trampolines

(iv) Poof chairs

(v) Sensory balls

(vi) Sky chairs

(vii) Suspension swings

(viii) Trampolines

(ix) Therapy balls

(x) Weighted blankets or weighted vests

70. Sensory stimulation services

71. Services provided by immediate relatives, i.e., a spouse, parent, grandparent, stepparent, child, grandchild, brother, sister, half brother, half sister, a spouse's parents or stepparents, or members of the recipient's household

72. Sex change or transformation surgery

73. Sexual dysfunction or inadequacy services and medicine, including drugs for erectile dysfunctions and penile implant devices

74. Sitter services.

75. Speech devices as follows:

(i) Phone mirror handivoice

(ii) Speech software

(iii) Speech teaching machines

76. Sphygmomanometers (blood pressure cuffs)

(Rule 1200-13-14-.10, continued)

77. Stethoscopes

78. Supports

    (i) Cervical pillows

    (ii) Orthotrac pneumatic vests

79. TENS (transcutaneous electrical nerve stimulation) units for the treatment of chronic lower back pain

80. Thermograms

81. Thermography

82. Time involved in completing necessary forms, claims, or reports

83. Tinnitus maskers

84. Toy equipment such as: Flash switches (for toys)

85. Transportation costs as follows:

    (i) Transportation to a provider who is outside the geographical access standards that the MCC is required to meet when a network provider is available within such geographical access standards or, in the case of Medicare beneficiaries, transportation to Medicare providers who are outside the geographical access standards of the TennCare program when there are Medicare providers available within those standards

    (ii) Mileage reimbursement, car rental fees, or other reimbursement for use of a private vehicle unless prior authorized by the MCC in lieu of contracted transportation services

    (iii) Transportation back to Tennessee from vacation or other travel out-of-state in order to access non-emergency covered services (unless authorized by the MCC)

    (iv) Any non-emergency out-of-state transportation, including airfare, that has not been prior authorized by the MCC. This includes the costs of transportation to obtain out-of-state care that has been authorized by the MCC. Out-of-state transportation must be prior authorized independently of out-of-state care.

86. Transsexual surgery

87. Urine drug screens in excess of twelve (12), four (4) confirmation urine screens and two (2) specific assay tests during a calendar year.

88. Vagus nerve stimulators, except after conventional therapy has failed in treating partial onset of seizures.

89. Weight loss or weight gain and physical fitness programs including, but not limited to:

(Rule 1200-13-14-.10, continued)

(i) Dietary programs of weight loss programs, including, but not limited to, Optifast, Nutrisystem, and other similar programs or exercise programs. Food supplements will not be authorized for use in weight loss programs or for weight gain.

(ii) Health clubs, membership fees (e.g., YMCA)

(iii) Marathons, activity and entry fees

(iv) Swimming pools

90. Wheelchairs and wheelchair accessories as follows:

(i) Wheelchairs defined by CMS as power operated vehicles (POVs), namely, scooters and devices with three (3) or four (4) wheels that have tiller steering and limited seat modification capabilities (i.e. provide little or no back support).

(ii) Standing wheelchairs. However a power standing system is covered as set out in the definition of Power Seating Accessories in Rule 1200-13-14-.01.

(iii) Stair climbing wheelchairs.

(iv) Recreational wheelchairs.

91. Whirlpools and whirlpool equipment such as:

(i) Action bath hydro massage

(ii) Aero massage

(iii) Aqua whirl

(iv) Aquasage pump, or similar devices

(v) Hand-D-Jets, or similar devices

(vi) Jacuzzis, or similar devices

(vii) Turbojets

(viii) Whirlpool bath equipment

(ix) Whirlpool pumps

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, 71-5-113, 42 C.F.R. Part 431 Subpart E, 42 C.F.R. Part 438 Subpart F, Executive Order No. 23, and Public Chapter 473, Acts of 2011.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.10; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Repeal and new rule filed October 27, 2005; effective January 10, 2006. Public necessity rule filed May 3, 2006; effective through October 15, 2006. Amendment filed July 28, 2006; effective October 11, 2006. Public necessity rule filed February 1, 2007; effective through July 16, 2007. Amendment filed January 30, 2007; effective April 15, 2007. Amendment filed May 2, 2007; effective July 16, 2007. Amendment filed June 27, 2007; effective September 10, 2007. Amendment filed February 8,*

(Rule 1200-13-14-.10, continued)

2008; effective April 23, 2008. Amendment filed February 11, 2008; effective April 26, 2008. Amendment filed April 2, 2008; effective June 16, 2008. Amendments filed August 19, 2008; effective November 2, 2008. Amendment filed July 28, 2009; effective October 26, 2009. Amendment filed November 9, 2009; effective February 7, 2010. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Amendment filed October 26, 2010; effective January 24, 2011. Amendment filed December 14, 2010; effective May 31, 2011. Emergency rule filed July 1, 2011; effective through December 28, 2011. Emergency rule filed August 2, 2011; effective through January 29, 2012. Amendment filed September 23, 2011; effective December 22, 2011. Amendment filed October 28, 2011; effective January 26, 2012. Emergency rule filed September 27, 2013; effective through March 26, 2014. Amendment filed July 1, 2013; effective September 29, 2013. Amendment filed September 27, 2013; effective December 26, 2013. Amendment filed December 17, 2013; effective March 17, 2014. Amendments filed December 23, 2014; effective March 23, 2015. Emergency rule filed September 30, 2015; effective through March 28, 2016. Amendments filed December 29, 2015; effective March 28, 2016. Amendments filed December 30, 2015; effective March 29, 2016. Emergency rules filed June 24, 2016; effective through December 21, 2016. Emergency rules filed July 1, 2016; effective through December 28, 2016. Amendments filed September 13, 2016; effective December 12, 2016. Amendments filed September 30, 2016; effective December 29, 2016. Amendments filed September 25, 2017; effective December 24, 2017. Emergency rules filed January 16, 2018; effective through July 15, 2018. Amendments filed April 9, 2018; effective July 8, 2018.

1200-13-14-.11 APPEAL OF ADVERSE BENEFIT DETERMINATIONS.

(1) Notice Requirements.

(a) When Written Notice is Required.

1. A written notice shall be given to an enrollee by his/her MCC of any adverse benefit determination.

2. A written notice shall be given to an enrollee of any MCC-initiated reduction, termination or suspension of inpatient hospital care.

3. A written notice shall be given to an enrollee of any provider-initiated reduction, termination or suspension.

4. Appropriate notice shall be given to an enrollee by the State or MCC when a claim for service or reimbursement is denied because an enrollee has exceeded a benefit limit. Such notice shall not be subject to the requirements of rule 1200-13-14-.11(1)(c)1. During the applicable time period for each benefit limit, such notice shall only be provided the first time a claim is denied because an enrollee has exceeded a benefit limit. The State or MCC will not be required to provide any notice when an enrollee is approaching or reaches a benefit limit.

5. Appropriate notice shall be given to an enrollee by a provider when an enrollee exceeds a non-pharmacy benefit limit in the following circumstances:

(i) The provider denies the request for a non-pharmacy service because an enrollee has exceeded the applicable benefit limit; or

(ii) The provider informs an enrollee that the non-pharmacy service will not be covered by TennCare because he/she has exceeded the applicable benefit limit and the enrollee chooses not to receive the service.

During the applicable time period for each non-pharmacy benefit limit, providers shall only be required to issue this notice the first time an enrollee does not receive a non-pharmacy service from the provider because he/she has exceeded

the applicable benefit limit. Such notice shall not be subject to the requirements of rule 1200-13-14-.11(1)(c)1. Providers will not be required to issue any notice when an enrollee is approaching or reaches a non-pharmacy benefit limit.

(b) Timing of Written Notice.

1. Written notice of MCC-initiated reduction, termination or suspension of medical assistance must be provided to an enrollee within the time frames required by 42 C.F.R. §§ 431.210 - 431.214 (usually ten (10) days in advance). However, in instances of MCC-initiated reduction, termination or suspension of inpatient hospital treatment, the notice may be provided to an enrollee the same day of the proposed action. Where applicable and not in conflict with this rule, the exceptions set out at 42 C.F.R. §§ 431.211 - 431.214 permit or require reduction of the time frames within which advance notice must be provided.

2. An MCC must notify an enrollee of its decision in response to a request by or on behalf of an enrollee for prior authorization for medical or related services as set out in 42 C.F.R. § 438.210(d).

3. Written notice of delay of covered medical assistance must be provided to an enrollee immediately upon an MCC's receipt of information leading it to expect that such delay will occur.

4. Written notice of provider-initiated reduction, termination or suspension of services must be provided to an enrollee in compliance with 42 C.F.R. §§ 431.211, 431.213 and 431.214.

5. Written notice is deemed to be provided to an enrollee upon deposit with the US Postal Service or other commercial mail carrier, or upon hand-delivery to an enrollee or his/her representative.

(c) Notice Contents.

1. Whenever this rule requires that a TennCare enrollee receive written notice of an adverse benefit determination, the notice must be readable and must comply with the requirements of 42 C.F.R. §§ 431.210 and 438.404.

2. Remedying of Notice. If a notice of adverse benefit determination provided to an enrollee does not meet the notice content requirements of rule 1200-13-14-.11(1)(c)1., TennCare or the MCC may cure any such deficiencies by providing one corrected notice to enrollees. If a corrected notice is provided to an enrollee, the reviewing authority shall consider only the factual reasons and legal authorities cited in the corrected notice, except that additional evidence beneficial to the enrollee may be considered on appeal.

(2) Appeal Rights of Enrollees. Enrollees have the following rights:

(a) To appeal adverse actions benefit determinations.

(b) An enrollee's request for appeal, including oral or written expressions by the enrollee, or on his behalf, of dissatisfaction or disagreement with adverse benefit determinations that have been made or are proposed to be made, may not be denied.

(c) To have the appeal rights that are prescribed by 42 C.F.R. Part 431, Subpart E and Tennessee Code Annotated §§ 4-5-301, et seq.

(Rule 1200-13-14-.11, continued)

(d) To be allowed sixty (60) days from receipt of written notice or, if no notice is provided, from the time the enrollee becomes aware of an adverse benefit determination, to appeal any adverse benefit determination.

(e) To appeal in person, by telephone, or in writing. Reasonable accommodations shall be made for any person with disabilities who requires assistance with his/her appeal, such as an appeal by TDD services or other communication device for people with disabilities. Written requests for appeals made at county TDHS offices shall be stamped and immediately forwarded to the TennCare Bureau for processing and entry in the central registry.

(f) For ongoing services, have the right to continuation or reinstatement of services, pursuant to 42 C.F.R. §§ 431.230 and 431.231 as modified by this rule, pending resolution of the appeal when the enrollee submits a timely appeal and timely request for COB. When an enrollee is so entitled to continuation or reinstatement of services, this right may not be denied for any reason, including:

1. An MCC's failure to inform an enrollee of the availability of such continued services;

2. An MCC's failure to reimburse providers for delivering services pending appeal; or

3. An MCC's failure to provide such services when timely requested.

(g) To an appeals process. But for initial reconsideration by an MCC as permitted by this rule, no person who is an employee, agent or representative of an MCC may participate in deciding the outcome of a SFH. No state official who was directly involved in the initial determination of the action in question may participate in deciding the outcome of an enrollee's appeal.

(3) Special Provisions Relating to Appeals.

(a) Individualized Decisions Required. Neither the TennCare program nor its MCCs may employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his or her medical history.

(b) Medical Evidence.

1. Appeal decisions must be based on an evaluation of pertinent medical evidence. TennCare and the MCCs shall elicit from enrollees and their treating providers all pertinent medical records that support an appeal; and

2. Medical opinions shall be evaluated pursuant to TennCare Medical Necessity rule 1200-13-16. Reliance upon insurance industry guidelines or utilization control criteria of general application, without consideration of the individual enrollee's medical history, does not satisfy this requirement and cannot be relied upon to support an adverse benefit determination.

(c) Record on Review. When TennCare receives an appeal from an enrollee regarding an adverse benefit determination, TennCare is responsible for obtaining from the MCC any and all records or documents pertaining to the MCC's decision to take the contested action. TennCare shall correct any violation of this rule that is evident from a review of those records.

(Rule 1200-13-14-.11, continued)

(d) Valid Factual Disputes. When TennCare receives an appeal from an enrollee, TennCare will dismiss this appeal unless the enrollee has established a valid factual dispute relating to an adverse benefit determination.

1. Processing of Appeals. TennCare shall screen all appeals submitted by TennCare enrollees to determine if the enrollees have presented a valid factual dispute. If TennCare determines that an enrollee failed to present a valid factual dispute, TennCare will immediately provide the enrollee with a notice, informing him/her that the enrollee must provide additional information as identified in the notice. If the enrollee does not provide this information, the appeal shall be dismissed without the opportunity for a state fair hearing within ten (10) days of the date of the notice. If the enrollee adequately responds to this notice, TennCare shall inform the enrollee that the appeal will proceed to a hearing. If the enrollee responds but fails to provide adequate information, TennCare will provide a notice to the enrollee, informing him/her that the appeal is dismissed without the opportunity for a state fair hearing. If the enrollee does not respond, the appeal will be dismissed without the opportunity for a state fair hearing, without further notice to the enrollee.

2. Information Required to Establish Valid Factual Disputes. In order to establish a valid factual dispute, TennCare enrollees must provide the following information: Enrollee's name; member SSN or TennCare ID#; address and phone; identification of the service or item that is the subject of the adverse benefit determination; and the reason for the appeal, including any factual error the enrollee believes TennCare or the MCC has made. For reimbursement and billing appeals, enrollees must also provide the date the service was provided, the name of the provider, copies of receipts which prove that the enrollee paid for the services or copies of a bill for the services, whichever is applicable.

(e) Appeals When Enrollees Lack a Prescription. When a TennCare enrollee attempts to lodge an appeal for a benefit for which the enrollee lacks a prescription, TennCare may require the enrollee to exhaust the following administrative process before an appeal can proceed:

1. TennCare will provide appropriate notice to the enrollee informing him/her that he/she will be required to complete an administrative process. Such administrative process requires the enrollee to contact the MCC to make an appointment with a provider to evaluate the request for the service. The MCC shall be required to make such appointment for the enrollee within a 3-week period or forty-eight (48) hours for urgent care from the date the enrollee contacts the MCC. Appeal timeframes will be tolled during this administrative process.

2. In order for this appeal to continue, the enrollee shall be required to contact TennCare after attending the appointment with a physician and demonstrate that he/she remains without a prescription for the service. If the enrollee fails to contact TennCare within sixty (60) days from the date of the notice described in subparagraph (e)1., TennCare will dismiss the appeal without providing an opportunity for a hearing for the enrollee.

(f) Appeals When No Adverse Benefit Determination Has Been Made. Enrollees shall not possess the right to appeal when no adverse benefit determination has been made. If enrollees request a hearing in this circumstance, their request shall be denied by the TennCare bureau without the opportunity for a hearing. Such circumstances include but are not limited to when enrollees appeal and no request for services had previously been denied.

(Rule 1200-13-14-.11, continued)

(4) Hearing Rights of Enrollees.

(a) TennCare shall inform enrollees of their state fair hearing rights;

(b) Enrollees shall be entitled to a hearing before a hearing officer that affords each enrollee the right to:

1. Representation at the hearing by anyone of his/her choice, including a lawyer;

2. Review information and facts relied on for the decisions by the MCC and the TennCare Bureau before the hearing;

3. Cross-examine adverse witnesses;

4. Present evidence, including the right to compel attendance of witnesses at hearings;

5. Review and present information from his/her medical records;

6. Present evidence at the hearing challenging the adverse decision by his/her MCC;

7. Ask for an independent medical opinion, at no expense to the enrollee;

8. Continue or reinstate ongoing services pending a hearing decision, as specified in this rule;

9. A written decision setting out the hearing officer's rulings on findings of fact and conclusions of law; and

10. Resolution, including a hearing before a hearing officer if the case has not been previously resolved in favor of the enrollee, pursuant to 42 C.F.R. § 431.244.

(c) TennCare shall not impair the ability of an enrollee to appeal an adverse hearing decision by requiring that the enrollee bear the expense of purchasing a hearing transcript when such purchase would be a financial hardship for the enrollee.

(d) Parties to an Appeal. Under this rule, the parties to a state fair hearing are limited to the enrollee and TennCare, permitted by federal regulations as modified by CMS letter dated June 5, 2017. The purpose of the hearing is to focus on the enrollee's medical needs.

(e) Consistent with the Code of Judicial Conduct, hearing officers shall assist pro se enrollees in developing the factual record and shall have authority to order second medical opinions at no expense to the enrollee.

(f) Review of Hearing Decisions.

1. Hearing officers shall promptly issue an Order of their decision. Any Order delivered orally from the bench in an expedited hearing by a hearing officer shall be effective immediately as to the provision or denial of benefits. In accordance with 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F, the hearing officer shall enter a written order as soon as practicable and shall provide the parties with copies of such Orders. The time for appealing any oral Order shall not begin to run until entry of the written Order.

2. The TennCare Bureau shall have the opportunity to review all decisions of hearing officers, in accordance with T.C.A. §§ 4-5-314 and 4-5-315, to determine whether such decisions are contrary to applicable law, regulations or policy interpretations, which shall include but not be limited to decisions regarding the defined package of covered benefits, determinations of medical necessity and decisions based on the application of this chapter and 42 C.F.R. Part 431 Subpart E and 42 C.F.R. Part 438 Subpart F.

(i) If TennCare modifies or overturns the decision of the hearing officer, TennCare shall issue a written decision that will be provided to the enrollee and the hearing officer. TennCare's decision shall constitute final agency action.

(ii) If TennCare does not modify or overturn the decision of the hearing officer, the hearing officer's decision shall constitute final agency action without additional notice to the enrollee.

(iii) Review of final agency action shall be available to enrollees pursuant to T.C.A. § 4-5-322.

(iv) A hearing officer's decision in an enrollee's appeal shall not be deemed precedent for future appeals.

(g) Continuation or Reinstatement of TennCare Services.

1. As permitted under 42 C.F.R. §§ 431.230, 431.231 and 438.420, if required or if the enrollee requests, TennCare services shall continue or be reinstated until the earlier of dismissal of the appeal through the valid factual dispute process, enrollee's withdrawal of the appeal, or an initial hearing decision adverse to the enrollee.

2. In the case of a timely request for continuation or reinstatement of the TennCare services described in paragraph (4)(g)1. above, the services shall continue or be reinstated only if and to the extent prescribed by the enrollee's treating clinician.

3. Notwithstanding the requirements of this part, TennCare enrollees are not entitled to continuation or reinstatement of services pending an appeal related to the following:

(i) When a service is denied because the enrollee has exceeded the benefit limit applicable to that service;

(ii) When a request for prior authorization is denied for a prescription drug, with the exception of:

(I) Pharmacists shall provide a single 72-hour interim supply in emergency situations for the non-authorized drug unless such supply would exceed applicable pharmacy benefit limits; or

(II) When the drug has been prescribed on an ongoing basis or with unlimited refills and becomes subject to prior authorization requirements.

(Rule 1200-13-14-.11, continued)

(iii) When coverage of a prescription drug or service is denied because the requested drug or service is not a category or class of drugs or services covered by TennCare;

(iv) When coverage for a prescription drug is denied because the enrollee has been locked into one pharmacy and the enrollee seeks to fill a prescription at another pharmacy;

(v) When a request for reimbursement is denied and the enrollee appeals this denial;

(vi) When a physician has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested; or

(vii) If TennCare had not paid for the type and amount of service for which continuation or reinstatement is requested prior to the appeal.

(h) Reserved.

(5) Reserved.

(6) Release of Enrollee's Medical Records.

(a) When a request is made, by or on behalf of a TennCare enrollee, for approval of a TennCare service or for an appeal of an adverse benefit determination, the enrollee is deemed to have consented to release of his/her relevant medical records to his/her MCC and the TennCare Bureau for the purposes of acting upon the enrollee's request.

(b) Providers shall promptly provide copies of an enrollee's medical records to the enrollee's MCC(s) and to the TennCare Bureau upon being informed by the MCC(s) or TennCare Bureau that the records have been requested for the purpose of acting upon an enrollee's request for approval of a TennCare service or an enrollee's appeal of an adverse benefit determination.

(c) An enrollee's consent to release of his/her medical records may be evidenced by his signature (or his provider's or authorized representative's signature) upon the enrollee's initial application for TennCare, upon his TennCare appeal form or other written request for authorization or appeal, or, in the event of an appeal by telephone, by a TennCare Bureau employee's signing of an appeal form on behalf of an enrollee with documentation of consent to do so.

(d) The medical records obtained by MCCs and the TennCare Bureau under this rule remain confidential. MCCs and the TennCare Bureau may use and disclose the records only as necessary in their consideration of the enrollee's request for approval of a TennCare service or the enrollee's appeal of an adverse benefit determination.

(7) Time Requirements.

(a) MCCs must act upon a request for prior authorization as provided in 42 C.F.R. § 438.210.

(b) MCCs must complete reconsideration of standard appeals within fourteen (14) calendar days of the request from TennCare. MCCs must complete reconsideration of expedited appeals within seventy-two (72) hours of the request for SFH.

(Rule 1200-13-14-.11, continued)

(c) All standard and expedited appeals not previously resolved in favor of the enrollee during reconsideration, shall be set for hearing before a hearing officer, and shall be resolved pursuant to the timeframes set forth in 42 C.F.R. § 431.244. In accordance with 42 C.F.R. § 438.410(a) and 42 C.F.R. § 431.244(f)(2), SFH requests which are approved for expedited resolution and which are not resolved in the enrollee's favor during MCC's reconsideration, shall be resolved by TennCare within three (3) working days from the date of the MCC's reconsideration determination. TennCare is not charged with any delays attributable to the enrollee.

(d) In no circumstance will a directive be issued by the TennCare Bureau or a hearing officer to provide a service to an enrollee if, when the appeal is resolved, the service is no longer covered by TennCare for the enrollee. A directive also will not be issued by the TennCare Bureau if the service cannot reasonably be provided to the enrollee before the date when the service is no longer covered by TennCare for the enrollee.

(8) Reserved.

(9) Special Provisions Relating to Children in State Custody. Children in the custody of the State have the rights and protections established by 42 C.F.R. Part 431, Subpart E regarding TennCare services and benefits.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-109, 71-5-113, 42 C.F.R. Part 431 Subpart E, 42 C.F.R. Part 438 Subpart F, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.11; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed May 5, 2005; effective through October 17, 2005. Public necessity rule filed July 29, 2005; effective through January 10, 2006. Amendments filed July 28, 2005; effective October 11, 2005. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Amendments filed October 27, 2005; effective January 10, 2006. However, Notice of Withdrawal of permanent rule amendments (1)(d)3., (1)(d)4., (4)(g)6., (5)(a)5., (5)(e), (5)(f), and (7)(h) filed and effective January 6, 2006 (to have been effective January 10, 2006). Public necessity rule filed May 17, 2006; effective through October 29, 2006. Amendments filed March 31, 2006; effective June 14, 2006. Amendment filed August 14, 2006; effective October 28, 2006. Public Necessity rule filed December 1, 2006; effective through May 15, 2007. Amendment filed January 30, 2007; effective April 15, 2007. Amendment filed March 1, 2007; effective May 15, 2007. Amendment filed September 13, 2007; effective November 27, 2007. Amendment filed August 19, 2008; effective November 2, 2008. Amendment filed September 30, 2009; effective December 29, 2009. Amendment filed October 26, 2010; effective January 24, 2011. Amendment filed September 23, 2011; effective December 22, 2011. Amendments filed September 27, 2013; effective December 26, 2013. Amendments filed September 25, 2017; effective December 24, 2017.*

1200-13-14-.12 OTHER APPEALS BY TENNCARE APPLICANTS AND ENROLLEES.

Notwithstanding Rule 1200-13-19-.01, or any rule to the contrary, appeals by applicants and enrollees of all non-medical eligibility matters are removed to Rule Chapter 1200-13-19, effective upon expiration of the TDHS contract to determine eligibility matters.

Authority: *T.C.A. §§ 4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-113, 42 C.F.R. Part 431 Subpart E, 42 C.F.R. Part 438 Subpart F, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.12; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed June 8, 2005; effective through November 20, 2005. Amendment to public necessity rule filed July 6, 2005;*

(Rule 1200-13-14-.12, continued)

effective through November 20, 2005. Amendment filed September 6, 2005; effective November 20, 2005. Amendments filed September 25, 2017; effective December 24, 2017.

1200-13-14-.13 MEMBER ABUSE OR OVERUTILIZATION OF THE TENNCARE PHARMACY PROGRAM.

(1) The Bureau is authorized to implement and maintain a pharmacy lock-in program designed to address member abuse or overutilization. Activities which may indicate abuse or overutilization justifying placement on lock-in or prior approval status include but are not limited to the following:

(a) Forging or altering a prescription for drugs.

(b) Selling TennCare paid prescription drugs.

(c) Failing to control pharmacy overutilization activity while on lock-in status.

(d) Visiting multiple prescribers or pharmacies to obtain controlled substances.

(e) Trading, swapping or selling a TennCare card.

(f) Failing to promptly report the loss or theft of a TennCare card.

(g) Forging or altering a TennCare card.

(h) Knowingly providing false, incomplete, inaccurate or erroneous information to provider(s) in order to receive covered services for which the member is eligible.

(i) Permitting the use of a TennCare card by anyone other than the member to whom the card is assigned in order to receive or attempt to receive services.

(2) The TennCare pharmacy lock-in program shall be administered by the Bureau. Monitoring of enrollee activities listed in Paragraph (1) shall be conducted by the Bureau, the MCCs, including the PBM, and the TennCare Office of Inspector General (OIG). When an enrollee has been identified as having participated in any abuse or overutilization activities, including but not limited to the activities listed in Paragraph (1), the enrollee's name shall be referred to the Bureau as appropriate or potentially appropriate for the lock-in program as follows:

(a) Appropriate for the lock-in program:

1. Any enrollee who has been identified by the OIG as having been convicted of TennCare fraud or a drug-related offense.

2. Any enrollee who has used buprenorphine-containing products for office based opioid addiction treatment within the previous six (6) months.

(b) Potentially appropriate for the lock-in program:

1. Any enrollee who has been arrested for TennCare fraud.

2. Any enrollee who has been arrested for a drug-related offense.

3. Any enrollee who has obtained multiple controlled substance prescriptions over a 90-day period that meet one of the following conditions:

(Rule 1200-13-14-.13, continued)

(i) The prescriptions were filled at three (3) or more pharmacies and written by three (3) or more prescribers.

(ii) The prescriptions were filled at one (1) or more targeted pharmacies and written by two (2) or more prescribers.

(iii) The prescriptions were filled at two (2) or more targeted pharmacies and written by one (1) or more prescribers.

(iv) The prescriptions were filled at one (1) or more targeted pharmacies and written by one (1) or more targeted prescribers.

(v) The prescriptions were filled at two (2) or more pharmacies and written during three (3) or more emergency room visits.

(3) Pharmacy lock-in procedures shall include:

(a) A determination to place an enrollee who has been referred as appropriate or potentially appropriate for the lock-in program on lock-in status shall be made by the TennCare Pharmacy Director or designee after the enrollee's relevant pharmacy claims data has been reviewed by clinical staff.

(b) Any enrollee determined to be appropriate for the lock-in program shall be notified by the Bureau or the MCC prior to the imposition of lock-in status. The notice shall include a brief explanation of the lock-in program, the reason for the determination to place the enrollee on lock-in status, the date the lock-in will become effective, and the information necessary for the enrollee to appeal the decision of the Bureau, pursuant to Rule 1200-13-13-.11.

(c) If an enrollee fails to appeal placement in the lock-in program or an appeal is not resolved in his favor, the enrollee will be provided TennCare pharmacy services only at the lock-in provider to which the enrollee is assigned.

(4) Lock-in provider selection. A pharmacy will qualify for and may be selected by the enrollee as a lock-in provider only if it meets all the following criteria:

(a) It is enrolled in the TennCare Pharmacy Network;

(b) It is within the State of Tennessee;

(c) It is a full-service pharmacy that carries all medications normally carried by pharmacies;

(d) It is not a mail order or specialty pharmacy;

(e) It is not a targeted pharmacy;

(f) It is a single pharmacy location at a specific address. A chain pharmacy may be selected but only the specific named location may be used, not multiple locations or outlets of the chain; and

(g) It is in proximity to the enrollee's residence, which must be the current address on file with the Bureau.

(5) After twelve (12) months a member may request a change of lock-in provider once each year. Additional changes are limited to the following reasons:

(a) The member has moved and his new address is at least fifteen (15) miles from the lock-in pharmacy and he has updated his address with the Bureau.

(b) The member's lock-in pharmacy has permanently closed.

(c) The member's lock-in pharmacy has voluntarily dismissed the enrollee from its practice and has notified the Bureau and the PBM.

(d) The Bureau may, at its sole discretion, determine that there is a compelling need to change the member's lock-in pharmacy.

(6) Review of lock-in status. The Bureau or the MCC shall periodically review the claims information of members on lock-in status to determine the need for continued lock-in or escalation to prior approval status.

(a) Lock-in status will be discontinued if the Bureau determines that a member has met all of the following criteria for at least six (6) consecutive months:

1. Has not paid cash for any controlled substance prescriptions covered by TennCare.

2. Has not received any narcotic medications while on buprenorphine-containing products for addiction.

3. Has received TennCare reimbursed controlled substance prescriptions from only one (1) provider.

4. Has received TennCare reimbursed prescriptions from only one (1) pharmacy.

(b) If a member is removed from lock-in status, the Bureau or the MCC will monitor the member for changes in utilization patterns and return him to lock-in status if appropriate.

(7) Prior approval status.

(a) A member against whom criminal process alleging TennCare fraud has been issued or who has been convicted of TennCare fraud shall automatically be placed on prior approval status.

(b) Lock-in status shall be escalated to prior approval status if a member on lock-in status meets three (3) of the following criteria over a 90 day period:

1. Has paid cash for three (3) or more controlled substance prescriptions covered by TennCare.

2. Has filled prescriptions for controlled substances at two (2) or more pharmacies.

3. Has received controlled substance prescriptions from two (2) or more prescribers.

4. Has received a narcotic prescription while receiving buprenorphine-containing products for addiction.

(c) A member who has been treated in a hospital emergency department for an overdose of a controlled substance (as identified in the most recently available TennCare data) or an illicit substance identified by toxicology shall automatically be placed on prior approval status.

(8) Emergency pharmacy services may be obtained with a TennCare or MCC override of a member's lock-in status. The PBM has clinical staff available at all times to respond to emergency situations. The PBM must verify that a genuine emergency exists, such as

(Rule 1200-13-14-.13, continued)

documented proof from the lock-in pharmacy that it is temporarily out of stock of a needed medication. A lock-in override will not be provided simply because a pharmacy is closed for the day unless a true medical emergency exists.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, 71-5-146, and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed July 1, 2002; effective through December 13, 2002. Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.13; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule filed December 29, 2005; expired June 12, 2006. On June 13, 2006, affected rules reverted to status on December 28, 2005. Repeal and new rule filed March 31, 2006; effective June 14, 2006. Amendment filed October 3, 2013; effective January 1, 2014. Amendments filed December 29, 2015; effective March 28, 2016.*

1200-13-14-.14 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed September 30, 2002; to be effective December 14, 2002; however, on December 9, 2002, the House Government Operations Committee of the General Assembly stayed rule 1200-13-14-.14; new effective date February 12, 2003. Emergency rule filed December 13, 2002; effective through May 27, 2003. Public necessity rule (repeal) filed August 18, 2005; effective through January 30, 2006. Repeal filed November 15, 2005; effective January 29, 2006.*

RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-15
REPEALED

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1200-13-15-.01 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.02 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.03 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.04 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.05 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.06 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.07 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.08 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.09 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.10 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.11 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.12 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.13 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.14 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

1200-13-15-.15 REPEALED.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

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Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed October 29, 2003; effective January 12, 2004. Repeal filed March 4, 2010; effective August 29, 2010.*

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RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION

BUREAU OF TENNCARE

CHAPTER 1200-13-16
MEDICAL NECESSITY

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1200-13-16-.01 DEFINITIONS.

(1) ADEQUATE when applied to a medical item or service shall mean that the item or service, considered as part of a course of diagnosis or treatment, is sufficient, but not in excess of what is needed, for diagnosis or treatment of the particular medical condition. In order for a medical item or service to be determined adequate, such item or service must also satisfy the requirements at rule 1200-13-16-.05(5) regarding "safe and effective" and the requirements at rule 1200-13-16-.05(6) regarding "not experimental or investigational."

(2) BENEFITS shall mean the defined package of health care services, including long term care services, for which an enrollee is eligible under the TennCare Program including applicable limits on such services.

(3) BUREAU OF TENNCARE shall mean the single State Medicaid agency which is responsible for the administration of the TennCare program.

(4) CASE-CONTROL STUDY shall mean a study in which the study and control groups are selected on the basis of whether they have the disease (cases) rather than whether they have been exposed to a risk factor or clinical intervention. The design is therefore observational (as opposed to experimental) and retrospective (as opposed to prospective), with the clinical outcome already known at the outset. Principal disadvantages of this study design are that important confounding variables may be difficult to identify and adjust for, clinical outcome is already known and may influence the measurement and interpretation of data (observer bias), and participants may have difficulty in accurately recalling past medical history and previous exposures (recall bias).

(5) CASE REPORT shall mean an uncontrolled observational study (prospective or retrospective) involving an intervention and an outcome in a single patient.

(6) CASE SERIES shall mean an uncontrolled study (prospective or retrospective) of a succession of consecutive patients who receive a particular intervention and are followed to observe their outcomes.

(7) CLINICAL TRIAL shall mean a study that involves the administration of a test regimen to humans to evaluate its efficacy and safety.

(Rule 1200-13-16-.01, continued)

(8) CONTROL GROUP shall mean a group of patients that serves as the basis of comparison when assessing the effects of the intervention of interest that is given to the patients in the treatment group. Depending upon the circumstances of the trial, a control group may receive no treatment, a "usual" or "standard" treatment, or a placebo. To make the comparison valid, the composition of the control group should resemble that of the treatment group as closely as possible.

(9) CONTROLLED CLINICAL TRIAL shall mean a clinical trial in which a control group (which receives a standard intervention, which may be no treatment) is compared to a study group (which receives the intervention under study) in order to test a research hypothesis. A controlled clinical trial may or may not be randomized.

(10) CONTROLLED COHORT STUDY shall mean an observational study in which outcomes in a group of patients that received an intervention are compared with outcomes in a similar group i.e., the cohort, either contemporary or historical, of patients that did not receive the intervention. Cohort studies are more subject to systematic bias than randomized trials because treatments, risk factors, and other covariables may be chosen by patients or physicians on the basis of important (and often unrecognized) factors that are related to outcome. Therefore, investigators in controlled cohort studies may identify and correct for confounding variables, which are related factors that may be more directly responsible for clinical outcome than the intervention/exposure in question. For example, in an adjusted- (or matched-) cohort study, investigators identify (or make statistical adjustments to provide) a cohort group that has characteristics (e.g., age, gender, disease severity) that are as similar as possible to the group that experienced the intervention.

(11) CONVENIENCE shall mean the degree to which an item or service is designed or recommended for the personal comfort or ease of an enrollee, caregiver, or provider. Alleviation of pain is not considered a matter of convenience.

(12) COST EFFECTIVE when applied to a medical item or service shall mean that the benefits associated with the item or service, considered as part of diagnosis or treatment, outweigh the costs associated with the item or service. When appropriate, such analysis may include assessment of aggregate, population-level data related to the costs or benefits of a medical item or service.

(13) COST-EFFECTIVE ALTERNATIVE SERVICE shall mean a service that is not a covered service but that is approved by TennCare and CMS and provided at an MCC's discretion. TennCare enrollees are not entitled to receive these services. Cost-effective alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in the MCC's judgment, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the MCC's judgment, would require more costly treatment in the future. Cost-effective alternative services need not be determined medically necessary except to the extent that they are provided as an alternative to covered Medicaid services. Even if medically necessary, a cost effective alternative service is not a covered service and is provided only at an MCC's discretion.

(14) COVERED SERVICES shall mean medical items and services that are within an enrollee's scope of defined benefits, and not in excess of any applicable limits on such items or services. Covered services include long term care services for those enrollees eligible for long term care. With the exception of cost-effective alternative services and even in cases of emergency, only a covered service can be determined to be medically necessary for reimbursement purposes under the program.

(15) DIAGNOSIS shall mean the act or process of identifying or determining the nature and cause of a medical problem or condition through evaluation of patient history, examination, and review of laboratory data and other pertinent information. Diagnosis may include cost

(Rule 1200-13-16-.01, continued)

effective screening services provided in accordance with nationally accepted standards or guidelines developed or endorsed by respected medical organizations, such as the Centers for Disease Control and Prevention.

(16) EFFECTIVE describes the use of a medical item or service that produces the intended result and where the benefit of the medical item or service outweighs the adverse medical risks or consequences.

(17) ELIGIBLE describes a person who has been determined to meet the eligibility criteria for the TennCare program.

(18) ENROLLEE shall mean an individual who is eligible for and enrolled in the TennCare program.

(19) EVIDENCE-BASED shall mean the ordered and explicit use of the best medical evidence available when making health care decisions.

(20) EXPERIMENTAL STUDY shall mean a randomized controlled clinical trial.

(21) HIERARCHY OF EVIDENCE shall mean a ranking of the weight given to medical evidence depending on objective indicators of its validity and reliability including the nature and source of the medical evidence, the empirical characteristics of the studies or trials upon which the medical evidence is based, and the consistency of the outcome with comparable studies. The hierarchy in descending order, with Type I given the greatest weight is:

(a) Type I: Meta-analysis done with multiple, well-designed controlled clinical trials;

(b) Type II: One or more well-designed experimental studies;

(c) Type III: Well-designed, quasi-experimental studies;

(d) Type IV: Well-designed, non-experimental studies; and

(e) Type V: Other medical evidence defined as evidence-based

1. Clinical guidelines, standards or recommendations from respected medical organizations or governmental health agencies;

2. Analyses from independent health technology assessment organizations; or

3. Policies of other health plans.

(22) HOME HEALTH SERVICES shall mean those services as defined at 1200-13-13-.01 and 1200-13-14-.01.

(23) INSTITUTIONAL REVIEW BOARD shall mean a specifically constituted review body established or designated by an entity to protect the welfare of human subjects recruited to participate in biomedical or behavioral research.

(24) LONG TERM CARE shall mean institutional services of a nursing facility, an intermediate care facility for the mentally retarded, or services provided through a Home and Community Based Services (HCBS) waiver program.

(25) MCC (MANAGED CARE CONTRACTOR) shall mean:

(Rule 1200-13-16-.01, continued)

(a) A managed care organization, pharmacy benefits manager, and/or a dental benefits manager which has signed a TennCare Contract with the State and operates a provider network and provides covered health services to TennCare enrollees; or

(b) A pharmacy benefits manager, dental benefits manager, or behavioral health organization which subcontracts with a managed care organization to provide services; or

(c) A State government agency (i.e., Department of Children's Services and Division of Mental Retardation Services) that contracts with TennCare for the provision of services.

(26) MCO (MANAGED CARE ORGANIZATION) shall mean an appropriately licensed Health Maintenance Organization (HMO) contracted with the Bureau of TennCare to manage the delivery, provide for access, contain the cost, and ensure the quality of specified covered medical and behavioral benefits to TennCare enrollee-members through a network of qualified providers.

(27) MEDICAID shall mean the federal- and state-financed, state-run program of medical assistance pursuant to Title XIX of the Social Security Act.

(28) MEDICAL CONDITION shall mean a disorder or an abnormal condition of the body and/or mind.

(29) MEDICAL EVIDENCE shall mean Type I-IV analyses and studies and/or Type V evidence defined herein at "HIERARCHY OF EVIDENCE".

(30) MEDICAL ITEM OR SERVICE shall mean an item or service that is provided, ordered, or prescribed by a licensed health care provider and is primarily intended for a medical and/or behavioral purpose and designed to achieve that medical and/or behavioral purpose.

(31) MEDICAL NECESSITY shall mean the quality of being "medically necessary" as defined by Tennessee Code Annotated, Section 71-5-144, and applies to TennCare enrollees. Implementation of the term "medical necessity" is provided for in these rules, consistent with the statutory provisions, which control in case of ambiguity.

(32) MEDICAL NECESSITY DETERMINATION a decision made by the Chief Medical Officer of the Bureau of TennCare or his or her clinical designee or by the Medical Director of one of its Managed Care Contractors or his or her clinical designee regarding whether a requested medical item or service satisfies the definition of medical necessity contained in Tennessee Code Annotated, Section 71-5-144 and these rules as defined herein. Items or services that are not determined medically necessary shall not be paid for by TennCare.

(33) MEDICAL NECESSITY GUIDELINES shall mean evidence-based guidelines approved by the Chief Medical Officer of the Bureau of TennCare for the purpose of guiding medical necessity determinations for particular courses of diagnosis or treatment.

(34) MEDICALLY NECESSARY is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in these rules, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in these rules.

(Rule 1200-13-16-.01, continued)

(35) MEDICAL RECORD shall mean all medical histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; x-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical documentation in written or electronic format; and analyses of such information.

(36) META-ANALYSIS shall mean systematic methods that use statistical techniques for combining results from different studies to obtain a quantitative estimate of the overall effect of a particular intervention or variable on a defined outcome. This combination may produce a stronger conclusion than can be provided by any individual study.

(37) NON-CONTROLLED COHORT STUDY shall mean a longitudinal study in which a group of people who share a common characteristic or experience are tracked over time with observation of outcomes within the group.

(38) NON-COVERED SERVICE shall mean items and services that are not within the scope of defined benefits for which a beneficiary is eligible under TennCare, including cost-effective alternative services and medical items and services that are in excess of any applicable limits on such items or services that might otherwise be covered. With the exception of cost-effective alternative services, non-covered services under TennCare, including medical items and services in excess of benefit limits, are never to be paid for by TennCare, even if they otherwise would qualify as “medically necessary,” regardless of the medical circumstances involved.

(39) NON-EXPERIMENTAL STUDY shall mean a study that is not randomized or controlled. Examples of non-experimental studies include non-controlled cohort studies, case series or case reports.

(40) NON-RANDOMIZED CONTROLLED CLINICAL TRIAL shall mean a controlled clinical trial that assigns patients to intervention and control groups using a method that does not involve randomization, e.g., at the convenience of the investigators or some other technique such as alternate assignment. Controlled trials that are not randomized are subject to a variety of biases, including selection bias, in which persons who volunteer or are assigned by investigators to study groups may differ in characteristics other than the intervention itself.

(41) OFF-LABEL USE shall mean the use of a drug or biological product that has been approved for marketing by the United States Food and Drug Administration (FDA) but is proposed to be used for other than the FDA-approved purpose.

(42) PHYSICIAN shall mean a person licensed pursuant to Chapter 6 or 9 of Title 63 of the Tennessee Code Annotated.

(43) QUASI-EXPERIMENTAL STUDY shall mean a study in which the investigator lacks full control over randomization of subjects (lacks full control over the allocation and/or timing of intervention) but nonetheless conducts the study as if it were an experiment, allocating subjects to groups. Examples of quasi-experimental studies include non-randomized controlled clinical trials, controlled cohort studies, or case-control studies.

(44) RANDOMIZED CONTROLLED CLINICAL TRIAL shall mean a clinical trial in which participants are assigned in a randomized fashion to a study group (which receives the intervention) or a control group (which receives a standard treatment, which may be no intervention or a placebo). Randomization enhances the comparability of the groups and provides a more valid basis for measuring statistical uncertainty. In this manner, differences in outcomes can be attributed to the intervention rather than to differences between the groups. Randomized controlled trials may or may not be blinded. In a blinded trial, the investigators, the subjects, or both (double-blinded study) are not told to which group they have been assigned, so that this knowledge will not influence their assessment of outcome.

(Rule 1200-13-16-.01, continued)

(45) SCREEN shall mean to test for or examine for the presence of a medical problem or condition in the absence of signs and symptoms of disease.

(46) STUDY shall mean a careful examination or analysis applying scientific methodology and published in a peer-reviewed scientific journal or periodical.

(47) TENNCARE shall mean the TennCare waiver demonstration program(s) and/or Tennessee's traditional Medicaid program.

(48) TREATING PHYSICIAN OR OTHER TREATING HEALTH CARE PROVIDER shall mean a licensed physician practicing within the scope of his or her license or other licensed health care provider practicing within the scope of his or her license who has personally examined a particular TennCare enrollee and who has provided diagnostic or treatment services for that particular enrollee (whether or not those services were covered by TennCare) for purposes of treating or supporting the treatment of a known or suspected medical condition of that particular enrollee. The term excludes all other providers, including those who have evaluated a particular enrollee's medical condition primarily or exclusively for the purposes of supporting or participating in a decision regarding TennCare coverage.

(49) TREATMENT shall mean the provision of medical items or services based on the recommendation of a treating physician or other treating health care provider practicing within the scope of his or her license.

Authority: *T.C.A. §§ 4-5-202, 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed December 1, 2006; expires May 15, 2007. Original rule filed March 1, 2007; effective May 15, 2007. Amendment filed October 11, 2007; effective December 25, 2007. Public necessity rule filed September 8, 2008; effective through February 20, 2009. Amendment filed December 5, 2008; effective February 18, 2009. Amendments filed September 25, 2009; effective December 24, 2009.*

1200-13-16-.02 INTRODUCTION.

The medical necessity standard set forth at Tennessee Code Annotated Section 71-5-144 and in these rules shall govern the delivery of all medical items and services to all enrollees or classes of beneficiaries in the TennCare program. The definition of medical necessity will be implemented consistent with federal law, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, and within the state's authority to define what constitutes a medically necessary Medicaid service. The state recognizes that current EPSDT requirements include coverage of "necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illness and conditions discovered by screening services, whether or not such services are covered under the state plan".

Authority: *T.C.A. §§ 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed December 1, 2006; expires May 15, 2007. Original rule filed March 1, 2007; effective May 15, 2007.*

1200-13-16-.03 THE SCOPE OF TENNCARE'S PAYMENT OBLIGATION.

(1) Tennessee has an obligation to provide payment on behalf of TennCare enrollees for and only for (a) covered services (b) that are medically necessary.

(2) No TennCare enrollee is entitled to receive (a) non-covered services including cost effective alternative services or (b) covered services that are not medically necessary.

(3) In the context of prior authorization or concurrent review:

(Rule 1200-13-16-.03, continued)

(a) When a covered service has been designated by the Bureau of TennCare or a managed care contractor as requiring prior approval, no TennCare enrollee is entitled to receive the covered service until the favorable conclusion of the prior approval process.

(b) When a covered service has been designated by the Bureau of TennCare or a managed care contractor as requiring concurrent review, the enrollee may receive covered services until the expiration of any existing authorization for treatment or until a determination that such service is no longer medically necessary. No TennCare enrollee is entitled to receive covered services subject to concurrent review beyond the expiration of any existing authorization for treatment unless such authorization has been extended through the concurrent review process. For TennCare enrollees under age 21, upon receipt of a timely filed request to continue authorization of a service originally prescribed on an ongoing basis, such authorization is automatically extended pending completion of concurrent review. A request to continue authorization shall be timely if received by the MCC prior to the expiration of the current authorization.

Authority: *T.C.A. §§ 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed December 1, 2006; expires May 15, 2007. Original rule filed March 1, 2007; effective May 15, 2007.*

1200-13-16-.04 PRIOR AUTHORIZATION AND CONCURRENT UTILIZATION REVIEW.

(1) The Bureau of TennCare may identify certain items or services that, for purposes of determining medical necessity, shall require prior authorization and/or concurrent review.

(a) Managed care contractors and/or a state agency performing the function of a managed care contractor shall implement prior authorization and/or concurrent review procedures for all items or services specified by the Bureau of TennCare and, at their individual discretion, may require prior authorization and/or concurrent review for additional non-emergency medical items or services not specified by the Bureau of TennCare.

(b) Managed care contractors and/or a state agency performing the function of a managed care contractor will inform their enrollees and their participating providers which medical items or services require prior authorization and/or concurrent review. Such notice need not be individualized in nature. Thus, failure to provide individualized prior authorization notices does not invalidate the requirement for prior authorization and/or concurrent review. Notice to providers shall be in writing and such notice requirement may be satisfied by publishing notice on the internet.

Authority: *T.C.A. §§ 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed December 1, 2006; expires May 15, 2007. Original rule filed March 1, 2007; effective May 15, 2007.*

1200-13-16-.05 MEDICAL NECESSITY CRITERIA.

(1) To be medically necessary, a medical item or service must satisfy each of the following criteria:

(a) It must be recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within the scope of his or her license who is treating the enrollee;

(b) It must be required in order to diagnose or treat an enrollee's medical condition;

(Rule 1200-13-16-.05, continued)

(c) It must be safe and effective;

(d) It must not be experimental or investigational; and

(e) It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

(2) The convenience of an enrollee, the enrollee's family, the enrollee's caregiver, or a provider, shall not be a factor or justification in determining that a medical item or service is medically necessary.

(3) Services required to diagnose an enrollee's medical condition.

(a) Provided that all the other medical necessity criteria are satisfied, services required to diagnose an enrollee's medical condition may include screening services, as appropriate.

(b) Screening services are "appropriate" if they meet one of the following three categories:

1. Services required to achieve compliance with federal statutory or regulatory mandates under the EPSDT program;

2. Newborn testing for metabolic/genetic defects as set forth in Tennessee Code Annotated, Section 68-5-401; or

3. Pap smears, mammograms, prostate cancer screenings, colorectal cancer screenings, and screening for tuberculosis and sexually transmitted diseases, including HIV, in accordance with nationally accepted clinical guidelines adopted by the Bureau of TennCare.

(c) Unless specifically provided for herein, other screening services are "appropriate" only if they satisfy each of the following criteria:

1. The Bureau of TennCare, a managed care contractor, or a state agency performing the functions of a managed care contractor determines that the screening services are cost effective;

2. The screening must have a significant probability of detecting the disease;

3. The disease for which the screening is conducted must have a significant detrimental effect on the health status of the affected person;

4. Tests must be available at a reasonable cost;

5. Evidence-based methods of treatment must be available for treating the disease at the disease stage which the screening is designed to detect; and

6. Treatment in the asymptomatic phase must yield a therapeutic result.

(d) Services required to diagnose an enrollee's medical condition include diagnostic services mandated by EPSDT requirements.

(4) Services required to treat an enrollee's medical condition. Provided that all other elements of medical necessity are satisfied, treatment of an enrollee's medical condition may only include:

(Rule 1200-13-16-.05, continued)

(a) Medical care that is essential in order to treat a diagnosed medical condition, the symptoms of a diagnosed medical condition, or the effects of a diagnosed medical condition and which, if not provided, would have a significant and demonstrable adverse impact on quality or length of life.

(b) Medical care that is essential in order to treat the significant side effects of another medically necessary treatment (*e.g.*, nausea medications for side effects of chemotherapy).

(c) Medical care that is essential, based on an individualized determination of a particular patient's medical condition, to avoid the onset of significant health problems or significant complications that, with reasonable medical probability, will arise from that medical condition in the absence of such care.

(d) Home health services.

1. Home health aide services are necessary to treat an enrollee's medical condition only if such services;

(i) Are of a type that the enrollee cannot perform for himself or herself;

(ii) Are of a type for which there is no caregiver able to provide the services; and

(iii) Consist of hands-on care of the enrollee.

2. All other home health services are necessary to treat an enrollee's medical condition only if they are ordered by the treating physician, are pursuant to a plan of care, and meet the requirements described at subparagraph (a), (b), or (c) immediately above or (f) immediately below. Services that do not meet these requirements, such as general child care services, cleaning services or preparation of meals, are not required to treat an enrollee's medical condition and will not be provided. Because children typically have non-medical care needs which must be met, to the extent that home health services or private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the health care provider) must be present at all times in the home during provision of home health or private duty nursing services unless all of the following criteria are met:

(i) The child is non-ambulatory; and

(ii) The child has no or extremely limited ability to interact with caregivers; and

(iii) The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g. the child has no need for general supervision or meal preparation) during the time the home health provider or private duty nurse is in the home without the presence of another responsible adult; and

(iv) No other children shall be present in the home during the time the home health provider or private duty nurse is present in the home without the presence of another responsible adult.

3. Private Duty Nursing services are separate services from home health services. When private duty nurses are authorized by the MCC to provide home health

(Rule 1200-13-16-.05, continued)

aide services pursuant to rule 1200-13-13-.04(7)(f) or 1200-13-14-.04(8)(f), these services must meet the requirements described at part 1. immediately above.

4. Home health services may not be denied on any of the following grounds:

(i) Because such services are medically necessary on a long term basis or are required for the treatment of a chronic condition;

(ii) Because such services are deemed to be custodial care;

(iii) Because the enrollee is not homebound;

(iv) Because private insurance utilization guidelines, including but not limited to those published by Milliman & Robertson or developed in-house by TennCare managed care contractors, do not authorize such health care as referenced above;

(v) Because the enrollee does not meet coverage criteria for Medicare or some other health insurance program, other than TennCare;

(vi) Because the home health care that is needed does not require or involve a skilled nursing service;

(vii) Because the care that is required involves assistance with activities of daily living;

(viii) Because the home health service that is needed involves home health aide services; or

(ix) Because the enrollee meets the criteria for receiving Medicaid nursing facility services.

(e) Personal Care Services.

1. Personal care services are necessary to treat an enrollee's medical condition only if such services are ordered by the treating physician pursuant to a plan of care to address a medical condition identified as a result of an EPSDT screening. Personal care services must be supervised by a registered nurse and delivered by a home health aide. In addition the services must:

(i) Be of a type that the enrollee cannot perform for himself or herself;

(ii) Be of a type for which there is no caregiver able to provide the services; and

(iii) Consist of hands-on care of the enrollee.

2. Services that do not meet these requirements, such as general child care services, cleaning services or preparation of meals, are not required to treat an enrollee's medical condition and will not be provided. For this reason, to the extent that personal care services are provided to a person under 18 years of age, a responsible adult (other than the home health aide) must be present at all times during provision of personal care services.

(f) The following preventive services:

(Rule 1200-13-16-.05, continued)

1. Prenatal and maternity care delivered in accordance with standards endorsed by the American College of Obstetrics and Gynecology;

2. Family planning services;

3. Age-appropriate childhood immunizations delivered according to guidelines developed by the Advisory Committee on Immunization Practices;

4. Health education services for TennCare-eligible children under age 21 in accordance with 42 U.S.C. Section 1396d;

5. Other preventive services that are required to achieve compliance with federal statutory or regulatory mandates under the EPSDT program; or

6. Other preventive services that have been endorsed by the Bureau of TennCare or a particular managed care contractor as representing a cost effective approach to meeting the medically necessary health care needs of an individual enrollee or group of enrollees.

(5) Safe and effective.

(a) To qualify as being safe and effective, the type, scope, frequency, intensity, and duration of a medical item or service must be consistent with the symptoms or confirmed diagnosis and treatment of the particular medical condition. The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs.

(b) The reasonably anticipated medical benefits of the item or service must outweigh the reasonably anticipated medical risks based on:

1. The enrollee's condition; and

2. The weight of medical evidence as ranked in the hierarchy of evidence in rule 1200-13-16-.01(21) and as applied in rule 1200-13-16-.06(6) and (7).

(6) Not experimental or investigational.

(a) A medical item or service is not experimental or investigational if the weight of medical evidence supports the safety and efficacy of the medical item or service in question as ranked in the hierarchy of evidence in rule 1200-13-16-.01(21) and as applied in rule 1200-13-16-.06(6) and (7). This standard is not satisfied by a provider's subjective clinical judgment on the safety and effectiveness of a medical item or service or by a reasonable medical or clinical hypothesis based on an extrapolation from use in diagnosing or treating another condition. However, extrapolation from one population group to another (e.g. from adults to children) may be appropriate. For example, extrapolation may be appropriate when the item or service has been proven effective, but not yet tested in the population group in question.

(b) Subject to the provisions set forth in subparagraph (c) immediately below, use of adrug or biological product that has not been approved for marketing under a new drug application or abbreviated new drug application by the United States Food and Drug Administration (FDA) is deemed experimental.

(c) Use of a drug or biological product that has been approved for marketing by the FDA but is proposed to be used for other than the FDA-approved purpose (*i.e.*, off-label use) is experimental and not medically necessary unless the off-label use is shown to be

(Rule 1200-13-16-.05, continued)

widespread and all other medical necessity criteria as set forth in rule 1200-13-16-.05(1)(a), (b), (c) and (e) are satisfied.

(d) Items or services provided or performed for research purposes are experimental and not medically necessary. Evidence of such research purposes may include written protocols in which evaluation of the safety and efficacy of the service is a stated objective or when the ability to perform the service is contingent upon approval from an Institutional Review Board, or a similar body.

(e) Unless a proposed diagnosis or treatment independently satisfies the criteria for "not experimental or investigational", and satisfies all other medical necessity criteria, the fact that an experimental/investigational treatment is the only available treatment for a particular medical condition or that the patient has tried other more conventional therapies without success does not qualify the service for coverage.

(7) The least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee.

(a) Where there are less costly alternative courses of diagnosis or treatment that are adequate for the medical condition of the enrollee, more costly alternative courses of diagnosis or treatment are not medically necessary, even if the less costly alternative is a non-covered service under TennCare.

(b) Where there are less costly alternative settings in which a course of diagnosis or treatment can be provided that is adequate for the medical condition of the enrollee, the provision of services in a setting more costly to TennCare is not medically necessary.

(c) If a medical item or service can be safely provided to a person in an outpatient setting for the same or lesser cost than providing the same item or service in an inpatient setting, the provision of such medical item or service in an inpatient setting is not medically necessary and TennCare shall not provide payment for that inpatient service.

(d) An alternative course of diagnosis or treatment may include observation, lifestyle, or behavioral changes or, where appropriate, no treatment at all when such alternative is adequate for the medical condition of the enrollee.

(e) The following is a non-exhaustive illustrative set of circumstances that could fit within the provisions of rule 1200-13-16-.05(7)(d). These examples may or may not be appropriate, depending on an individualized medical assessment of a patient's unique circumstances:

1. Rest, fluids and over-the-counter medication for symptomatic relief might be recommended for a viral respiratory infection, as opposed to a prescription for an antibiotic;

2. Rest, ice packs and/or heat for acute, uncomplicated, mechanical low back pain along with over-the-counter pain medicine, as opposed to x-rays and a prescription for analgesics;

3. Clear liquids and advance diet as tolerated for uncomplicated, acute gastroenteritis, as opposed to prescription antidiarrheals.

(8) The Bureau of TennCare may make limited special exceptions to the medical necessity requirements described at rule 1200-13-16-.05(1) for particular items or services, such as long term care, or such as may be required for compliance with federal law.

(Rule 1200-13-16-.05, continued)

(9) Transportation services that meet the requirements described at rule 1200-13-13-.04 and 1200-13-14-.04 shall be deemed to be medically necessary if provided in connection with medically necessary items or services.

Authority: *T.C.A. §§ 4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-144 and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed December 1, 2006; expires May 15, 2007. Original rule filed March 1, 2007; effective May 15, 2007. Amendment filed October 11, 2007; effective December 25, 2007. Public necessity rule filed September 8, 2008; effective through February 20, 2009. Amendment filed December 5, 2008; effective February 18, 2009. Amendments filed June 17, 2011; effective November 28, 2011.*

1200-13-16-.06 DETERMINATION OF MEDICAL NECESSITY.

(1) The Bureau of TennCare is ultimately responsible for determining whether specific medical items and/or services under TennCare (a) are covered services and (b) are medically necessary. In the vast majority of cases, medical necessity determinations will be made as part of a prior authorization or concurrent review process. However, less frequently such determinations may be made retrospectively in the course of the investigation of unusual billing or practice patterns. The Bureau of TennCare may delegate covered services and/or medical necessity decisions to managed care contractors. All medical necessity decisions must be made by licensed medical staff with appropriate clinical expertise. The Bureau may review such decisions as a part of routine monitoring or as a result of an enrollee appeal or provider complaint and may overturn such decisions if not made in accordance with these rules.

(2) Non-covered services, including medical items and services in excess of benefit limits, are never to be paid for by TennCare, even if they otherwise would qualify as “medically necessary,” regardless of the medical circumstances involved, unless an MCC, in its discretion, provides a cost effective alternative service.

(3) If, after an enrollee is provided the opportunity by the State or managed care contractor to consult with a physician, a medical item or service has not been recommended, ordered or prescribed by a treating physician or other treating health care provider practicing within the scope of his or her license, it is not medically necessary and is not covered under TennCare.

(4) In making a medical necessity determination, TennCare or its designee will consider a recommendation, order, or prescription for a covered medical item or service from a treating physician or other treating health care provider.

(a) A recommendation, order or prescription from a treating physician or other treating health care professional shall be based on a thorough, up-to-date assessment of the enrollee’s medical condition, with careful consideration of all required medical necessity criteria as defined by statute and by these rules.

(b) The managed care contractor will evaluate the information provided by the treating provider in support of a recommendation, order or prescription for a covered service. If the information or opinion of the treating provider deviates significantly from that of the MCC, the MCC will request further explanation from the treating provider. Upon request from the enrollee’s MCC or the Bureau of TennCare for purposes of making an individualized medical necessity determination, the treating physician or other treating health care provider shall provide information and/or documentation supporting the need for the recommended medical item or service in order to diagnose or treat the enrollee’s medical condition.

(Rule 1200-13-16-.06, continued)

(c) In addition, when requested, the treating physician or other treating health care provider will provide a written explanation as to why a less costly alternative proposed by the MCC is not believed to be adequate to address the enrollee's medical condition.

(d) Information/documentation requested by the managed care contractor or the Bureau of TennCare for purposes of making a medical necessity determination will be provided free of charge.

(e) Providers who fail to provide information/documentation requested by the managed care contractor or the Bureau of TennCare for purposes of making a medical necessity determination shall not be entitled to payment for provision of the applicable medical item or service. In such instances, providers may not seek payment from patients or third parties for items or services denied payment.

(5) The treating physician's conclusory statements, without more, are not binding on the State.

(6) In evaluating the request/recommendation of the treating physician or other treating health care provider, a managed care contractor and/or the Bureau of TennCare shall use the hierarchy of evidence to determine if the requested item or service is safe and effective, as referenced at rule1200-13-16-.05(5) and (6)(a), for the enrollee by classifying the item or service as having an A, B, C or D level of supporting evidence, as indicated below. In classifying the item or service as having A, B, C or D level of supporting evidence, extrapolation from one population group to another (e.g. from adults to children) may be appropriate. For example, extrapolation may be appropriate when the item or service has been proven effective, but not yet tested in the population group in question.

(a) "A" level evidence: Shows the requested medical item or service is a proven benefit to the enrollee's condition as demonstrated by strong scientific literature and well-designed clinical trials such as Type I evidence or multiple Type II evidence or combinations of Type II, III, or IV evidence with consistent results. An "A" rating cannot be based on Type III, Type IV, or Type V evidence alone.

(b) "B" level evidence: Shows the requested medical item or service has some proven benefit to the enrollee's condition as demonstrated by:

1. Multiple Type II or III evidence or combinations of Type II, III, or IV evidence with generally consistent findings of effectiveness and safety. A "B" rating cannot be based on Type IV or V evidence alone; or

2. Singular Type II, III, IV, or V evidence when consistent with Bureau of TennCare endorsed or established evidence-based clinical guidelines.

(c) "C" level evidence: Shows only weak and inconclusive evidence regarding safety and/or efficacy for the enrollee's condition such as:

1. Type II, III, or IV evidence with inconsistent findings; or

2. Only Type V evidence is available.

(d) "D" level evidence: Is not supported by any evidence regarding safety and efficacy for the enrollee's condition.

(7) Application of the Hierarchy of Evidence. After classifying the available evidence, the Bureau of TennCare or a managed care contractor will approve items or services in the following manner:

(Rule 1200-13-16-.06, continued)

(a) Medical items or services with supporting “A” and “B” rated evidence will be considered safe and effective if the item or service does not place the enrollee at a greater risk of morbidity and mortality than an equally effective alternative treatment.

(b) Medical items or services with “C” rated evidence or a physician’s clinical judgment that is not supported by objective evidence, will be considered safe and effective only if the provider shows that the requested service is the optimal intervention for meeting the enrollee’s specific condition or treatment needs, and:

1. Does not place the enrollee at greater risk of morbidity or mortality than an equally effective alternative treatment; and

2. Is the next reasonable step for the enrollee in light of the enrollee’s past medical treatment.

(c) Medical items or services with “D” rated evidence will not be considered safe and effective and, therefore, will not be determined medically necessary.

(8) The Bureau of TennCare or the managed care contractor’s classification of available medical evidence as defined at rule 1200-13-16-.01(21) and any resulting approval of items or services as described at rule 1200-13-16-.06(6) and (7) shall be binding on TennCare enrollees and providers.

(9) The managed care contractor or the Bureau of TennCare will rely upon all relevant information in making a medical necessity determination. Such determinations must be individualized and made in the context of medical/behavioral history information included in the enrollee’s medical record.

(10) The fact that a particular medical item or service has been covered in one instance does not make such item or service medically necessary in any other case, even if such case is similar in certain respects to the situation in which the item or service was determined to be medically necessary.

(11) Items or services that are not determined medically necessary, as defined by the statute or by these rules, shall not be paid for by TennCare.

Authority: *T.C.A. §§ 4-5-202, 4-5-209, 71-5-105, 71-5-109, 71-5-144 and Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed December 1, 2006; expires May 15, 2007. Original rule filed March 1, 2007; effective May 15, 2007. Amendment filed June 17, 2011; effective November 28, 2011.*

1200-13-16-.07 DEVELOPMENT OF EVIDENCE-BASED MEDICAL NECESSITY GUIDELINES.

(1) In recognition of the ever-evolving nature of the study and practice of medicine, the growing body of evidence-based medical practice guidelines, the opportunity to achieve cost-containment objectives consistent with quality care, and the existence of practice variability among health care practitioners, the Bureau of TennCare may, on occasion, endorse or establish medical necessity guidelines that shall guide determinations of medical necessity for specific items or services across all managed care contractors and State agencies performing the function of managed care contractors.

(2) Such guidelines shall be established with input from managed care contractors, practicing physicians and other health care providers, shall be evidence-based and shall take into consideration all criteria of the statutory definition of medical necessity.

(Rule 1200-13-16-.07, continued)

(3) The Bureau of TennCare will disseminate approved evidence-based medical necessity guidelines to its contractors and the provider community.

(4) The Bureau of TennCare will implement a continuous medical review process to ensure that approved evidence-based medical necessity guidelines are responsive to advances in medical knowledge and technology.

Authority: *T.C.A. §§ 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed December 1, 2006; expires May 15, 2007. Original rule filed March 1, 2007; effective May 15, 2007.*

1200-13-16-.08 RIGHT TO APPEAL A MEDICAL NECESSITY DETERMINATION.

An enrollee may appeal a determination that a medical item or service that is within the enrollee's scope of covered benefits is not medically necessary. In all such appeals, the burden of proof will rest with the enrollee at all stages.

Authority: *T.C.A. §§ 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.* ***Administrative History:*** *Public necessity rule filed December 1, 2006; expires May 15, 2007. Original rule filed March 1, 2007; effective May 15, 2007.*

RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-17
TENNCARE CROSSOVER PAYMENTS FOR MEDICARE DEDUCTIBLES AND COINSURANCE

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1200-13-17-.01 DEFINITIONS.

(1) COST EFFECTIVE ALTERNATIVE SERVICE is defined at Rule 1200-13-13-.01.

(2) DUAL ELIGIBLE shall mean a person who is a Medicare beneficiary and who is entitled to some form of assistance from TennCare Medicaid.

(3) ENHANCED PAYMENT RATE shall mean the payment rate referred to in 42 U.S.C. § 1396a(a)(13)(C). Enhanced payment rates are made only to primary care providers and to providers of vaccine administration services, as defined in these rules. These rates are applicable only for dates of service between January 1, 2013, and December 31, 2014.

(4) FULL BENEFIT DUAL ELIGIBLE (FBDE) shall mean a Medicare beneficiary who also qualifies for TennCare benefits, except that Waiver Duals are not considered FBDEs.

(5) MANAGED CARE CONTRACTOR (MCC) is defined at Rule 1200-13-13-.01.

(6) MEDICARE ALLOWED AMOUNT shall mean the amount that Medicare considers reasonable for a Medicare-covered service, as defined on the claim for that service.

(7) MEDICARE BENEFITS shall mean the health care services available to Medicare beneficiaries through the Medicare program where payment for the services is either completely the obligation of the Medicare program or in part the obligation of the Medicare program, with the remaining payment (cost sharing) obligations belonging to the beneficiary, some other third party, or TennCare.

(8) MEDICARE COINSURANCE is defined as “Coinsurance” at Rule 1240-03-01-.02(1).

(9) MEDICARE COST-SHARING shall mean TennCare’s obligation for payment of certain Medicare beneficiaries’ Medicare deductibles and coinsurance.

(10) MEDICARE CROSSOVER CLAIM shall mean a claim that has been submitted to the Bureau of TennCare for Medicare cost sharing payments after the claim has been adjudicated by Medicare and paid by Medicare and Medicare has determined the enrollee’s liability. Claims denied by Medicare or not submitted to Medicare are not considered Medicare crossover claims.

(11) MEDICARE DEDUCTIBLE is defined as “Deductible” at Rule 1240-03-01-.02(1).

(Rule 1200-13-17-.01, continued)

(12) MEDICARE PAID AMOUNT is defined as the amount Medicare actually paid on a claim, which is generally a percentage of the Medicare allowed amount. The Medicare paid amount on a Medicare Part C claim is the amount that the Part C plan paid.

(13) MEDICARE PART A is defined at Rule 1240-03-01-.02(1).

(14) MEDICARE PART B is defined at Rule 1240-03-01-.02(1).

(15) MEDICARE PART C refers to the Medicare Advantage program authorized under Part C of Title XVIII of the Social Security Act, through which beneficiaries may choose to enroll in private managed care plans that contract with the Centers for Medicare and Medicaid Services (CMS). These plans may be HMO plans, PPO plans, or private fee-for-service plans. They offer combined coverage of Part A, Part B, and, in most cases, Part D benefits. Some Medicare Advantage plans offer additional benefits not otherwise covered by Medicare.

(16) MEDICARE PREMIUMS shall mean the Medicare Part A and/or Medicare Part B premiums for which TennCare is responsible, depending on the enrollee's eligibility group. TennCare does not pay for Medicare Part C premiums, Medicare Part D premiums, or any other Medicare premiums.

(17) PHARMACY PROVIDERS shall mean providers enrolled with the Medicare program and with Medicaid to provide Medicare Part B pharmacy services.

(18) PHARMACY SERVICES shall mean outpatient prescription drugs provided through Medicare Part B.

(19) PRIMARY CARE PROVIDERS shall mean, for purposes of the enhanced payment rate, as defined in these rules, primary care providers practicing in family medicine, general internal medicine, pediatric medicine, and related subspecialists who meet requirements as described in 42 C.F.R. § 447.400(a). In accordance with policies set forth by the Bureau of TennCare, these providers must adequately demonstrate to an MCO or the Bureau of TennCare that they meet the minimum board certification requirements and/or that 60 percent of the services they provide represent the eligible codes identified in these rules as primary care or vaccine administration services.

(20) PRIMARY CARE SERVICES are services for which enhanced payment rates, as defined in these rules, will be paid for dates of service between January 1, 2013, and December 31, 2014. The procedure codes for these services, as published in the American Medical Association's Current Procedural Terminology (2013 edition), are Evaluation and Management Codes 99201 through 99499, or their successor codes.

(21) PROFESSIONAL SERVICES shall mean the professional/technical component of Medicare services. These services are typically provided by non-institutional providers or suppliers such as physicians, outpatient clinics, and Durable Medical Equipment vendors. They are generally covered under Medicare Part B and billed on a CMS-1500 claim form. Services that are not billed on a CMS-1500 claim form or an ASC X12N 837P claim transaction are not considered part of this definition.

(22) QMB shall mean Qualified Medicare Beneficiary, as defined at Rule 1240-03-02-.02(2).

(Rule 1200-13-17-.01, continued)

(23) SSI shall mean the federal Supplemental Security Income program that provides monthly income to low-income aged, blind, and disabled individuals. An "active" SSI recipient is one who is receiving monthly SSI checks.

(24) TENNCARE ALLOWABLE shall mean the lower of the TennCare maximum fee or 85% of the Medicare allowed amount on the claim.

(25) TENNCARE COVERED SERVICE shall mean any service that is listed as "covered" in Rules 1200-13-13-.04 and 1200-13-14-.04 and that is not listed specifically as an exclusion in Rules 1200-13-13-.10 and 1200-13-14-.10.

(26) TENNCARE MAXIMUM FEE shall mean the maximum amount considered by TennCare for reimbursement of a particular Medicare-covered service. The TennCare maximum fee is 85% of the Cigna Medicare fee schedule amount for participating providers that was in effect on January 1, 2008. For Medicare-covered services that were introduced after January 1, 2008, and that therefore had no Medicare fee schedule amount in effect on that date, the TennCare maximum fee is 85% of the Medicare fee schedule amount for the participating providers that was in effect on the date the service was introduced.

(27) TENNCARE PAYMENT AMOUNT shall mean the net amount paid by TennCare on a Medicare crossover claim. The TennCare payment amount will be the TennCare allowable, less the amount Medicare paid on the claim, less any third party liability. The TennCare payment amount shall not exceed the enrollee's liability on the claim.

(28) TENNCARE PHARMACY ALLOWABLE shall mean, for Medicare Part B pharmacy services provided to FBDEs by pharmacy providers, as defined in these rules, 100% of the Medicare allowed amount on the claim.

(29) TENNCARE PRIMARY CARE ALLOWABLE shall mean 100% of the designated Medicare Cost-Sharing amounts for primary care services provided by primary care providers as defined in these rules during Calendar Years (CY) 2013 and 2014.

(30) TENNCARE VACCINATION ADMINISTRATION ALLOWABLE shall mean 100% of the designated Medicare Cost-Sharing amounts for vaccine administration services provided by primary care providers as defined in these rules during Calendar Years (CY) 2013 and 2014.

(31) VACCINE ADMINISTRATION SERVICES are services for which enhanced payment rates, as defined in these rules, will be paid for dates of service between January 1, 2013, and December 31, 2014. The procedure codes for these services, as published in the American Medical Association's Current Procedural Terminology (2013 edition), are Vaccine Administration Codes 90460, 90461, 90471, 90472, 90473, and 90474 or their successor codes.

(32) WAIVER DUAL shall mean a person who was enrolled in TennCare as of December 31, 2001, as an Uninsured or Uninsurable and who also had Medicare. This category was closed for adults 19 and older on April 29, 2005. Waiver Duals are not considered Full Benefit Dual Eligibles.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, and 71-5-109.* ***Administrative History:*** *Public necessity rule filed July 1, 2008; effective through December 13, 2008. New rule filed September 24, 2008; effective December 8, 2008. Public necessity rules filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective*

(Rule 1200-13-17-.01, continued)
December 10, 2009. Emergency rule filed June 21, 2013; effective through December 18, 2013. Amendment filed August 15, 2013; effective November 13, 2013.

1200-13-17-.02 ELIGIBILITY FOR CROSSOVER PAYMENTS.

(1) The following dual eligibles are eligible for TennCare to make Medicare crossover payments on all Medicare covered services, regardless of whether or not these services are also covered by TennCare:

(a) QMBs;

(b) Non-QMB FBDEs who are under age 21; and

(c) Non-QMB FBDEs who are active SSI beneficiaries.

(2) Non-QMB FBDEs who are age 21 and older and who are not active SSI beneficiaries are eligible for TennCare to make Medicare crossover payments on all Medicare covered services that are also TennCare covered services. They are not eligible for TennCare to make Medicare crossover payments when the service on which the payment is requested is not a TennCare covered service.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Public necessity rule filed July 1, 2008; effective through December 13, 2008. New rule filed September 24, 2008; effective December 8, 2008.*

1200-13-17-.03 THIRD PARTY RESOURCES.

When a TennCare enrollee is covered by other third party payers, in addition to Medicare, TennCare is the payer of last resort. Whether or not Medicare is the primary payer, providers must bill all other third party payers prior to submitting a crossover claim to the Bureau of TennCare.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Public necessity rule filed July 1, 2008; effective through December 13, 2008. New rule filed September 24, 2008; effective December 8, 2008.*

1200-13-17-.04 MEDICARE CROSSOVER PAYMENT METHODOLOGY.

(1) On crossover claims for professional services and procedures with dates of service on or after July 1, 2008, TennCare will pay the lesser of (a) billed charges or (b) the TennCare allowable, as defined in these rules, less the Medicare paid amount, less any third party liability.

(2) On crossover claims for Medicare Part B pharmacy services provided by pharmacy providers, as defined in these rules, to non-FBDEs with dates of service on or after July 1, 2009, TennCare will pay the lesser of (a) billed charges or (b) the TennCare allowable, as defined in these rules, less the Medicare paid amount, less any third party liability.

(3) On crossover claims for Medicare Part B pharmacy services provided by pharmacy providers, as defined in these rules, to FBDEs with dates of service on or after July 1, 2009, TennCare will pay the lesser of (a) billed charges or (b) the TennCare pharmacy allowable, as defined in these rules, less the Medicare paid amount, less any third party liability.

(Rule 1200-13-17-.04, continued)

(4) On crossover claims for primary care services, as defined in these rules, TennCare will pay an enhanced payment rate for dates of service between January 1, 2013, and December 31, 2014. The enhanced payment rate will be the lesser of (a) billed charges or (b) the TennCare primary care allowable, as defined in these rules, less the Medicare paid amount, less any third party liability.

(5) On crossover claims for vaccine administration services, as defined in these rules, TennCare will pay an enhanced payment rate for services between January 1, 2013, and December 31, 2014. The enhanced payment rate will be the lesser of (a) billed charges or (b) the TennCare vaccination administration allowable, as defined in these rules, less the Medicare paid amount, less any third party liability.

(6) In no circumstance will the TennCare payment exceed the enrollee's liability on the Medicare crossover claim.

(7) Medicare crossover payments are normally made by the Bureau of TennCare separately from the Managed Care Contractors. Rules 1200-13-13-.08(12)(b) and 1200-13-14-.08(12)(b) set forth the guidelines for timely filing Medicare crossover claims. However, if an MCC should choose to authorize a non-covered TennCare service as a cost-effective alternative service for a non-QMB FBDE who is age 21 or older and not an SSI recipient, the MCC will be responsible for the Medicare crossover payment on that service. The calculation of this payment should be included by the MCC in its analysis of whether or not the non-covered TennCare service is a cost-effective alternative service.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, and 71-5-109.* ***Administrative History:*** *Public necessity rule filed July 1, 2008; effective through December 13, 2008. New rule filed September 24, 2008; effective December 8, 2008. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rule filed June 21, 2013; effective through December 18, 2013. Amendment filed August 15, 2013; effective November 13, 2013.*

1200-13-17-.05 PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS.

(1) Medicare providers who are licensed professionals and who wish to bill for services provided to Medicare beneficiaries must enroll with the TennCare program and obtain TennCare Medicaid identification numbers.

(2) Participation in the TennCare/Medicare crossover program is limited to providers who maintain current Tennessee medical licenses and/or current licenses in the states in which they practice.

(3) Providers must be licensed and accredited according to the specific laws and regulations that apply to their service type.

(4) Health care providers who are required under Tennessee law to render services under the supervision of other health care providers will not be assigned TennCare identification numbers. These providers' claims must be submitted by the licensed or certified health care providers who supervise them.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, and 71-5-109.* ***Administrative History:*** *Public necessity rule filed July 1, 2008; effective through December 13, 2008. New rule filed September 24, 2008; effective December 8, 2008.*

RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-18
TENNCARE ADMINISTRATIVE ACTIONS AND PROVIDER APPEALS

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1200-13-18-.01 SCOPE AND AUTHORITY.

(1) An approved provider of TennCare services may appeal the following administrative actions:

(a) An administrative action for recovery against a person other than an enrollee, recipient or applicant brought by the Bureau of TennCare upon written request of the Attorney General pursuant to the Tennessee Medicaid False Claims Act;

(b) An action proposed or taken by the Bureau of TennCare or its audit contractor to recover, recoup or withhold payment from a provider, as a result of any audit performed by or on behalf of the Centers for Medicare and Medicaid Services or the Bureau pursuant to state or federal law;

(c) A Bureau of TennCare determination to suspend payments to a provider due to a credible allegation of fraud for which an investigation is pending;

(d) A denial of eligibility for or a determination of the amount of an incentive payment pursuant to the federal Medicaid Electronic Health Record Incentive Program (EHR-IP); or,

(e) Termination of an approved provider's Tennessee Medicaid Provider Number by the Bureau, except when federal law mandates exclusion of the provider.

(2) A provider of services may not appeal the following administrative actions:

(a) An MCC's refusal to contract with the provider;

(b) A decision by the Bureau to decline coverage of prescriptions not written by a provider with prescribing authority; or,

(c) Termination or exclusion from the Program as required by federal law.

(3) In order to exercise the right to a hearing, a provider must submit his appeal and request for a hearing in writing to the Bureau. The notice of the Bureau action shall contain specific instructions concerning the right to appeal and the address for filing an appeal.

(4) Any request for an appeal must be received at the address contained in the notice of action no later than 35 days following the date of the notice.

(Rule 1200-13-18-.01, continued)

(5) Provider appeals shall be conducted as contested case hearings by the Tennessee Department of State, Administrative Procedures Division, pursuant to the Tennessee Uniform Administrative Procedures Act (APA).

(6) The Uniform Rules of Procedure for Hearing Contested Cases Before State Administrative Agencies, Chapter 1360-04-01, promulgated under the APA, are adopted by the Bureau and incorporated by reference herein. The Uniform Rules shall govern the conduct of a provider appeal except where a specific contrary provision is adopted by the Bureau in this Chapter.

(7) For purposes of issuing an initial order, a contested case hearing shall be conducted by an administrative judge hearing the case alone.

Statutory Authority: *T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.* ***Administrative History:*** *Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.*

1200-13-18-.02 DEFINITIONS.

(1) Administrative Judge. An employee or official of the Office of the Secretary of State who is licensed to practice law and authorized by law to conduct contested case proceedings.

(2) Administrative Procedures Act (APA). The Tennessee Uniform Administrative Procedures Act, as amended, codified at T.C.A. §§ 4-5-301, et seq.

(3) Approved Provider. A provider of health care services who has registered with and been approved by the Bureau and has been issued a Tennessee Medicaid Provider Number.

(4) Audit. The systematic process of objectively obtaining and evaluating evidence regarding assertions about economic actions and events to ascertain the degree of correspondence between those assertions and established criteria and communicating the results to interested parties. Audits are conducted in accordance with AICPA (American Institute of Certified Public Accountants) auditing or attestation engagement standards. For purposes of this chapter, audits are conducted of health care provider records, financial information, and statistical data according to principles of cost reimbursement to determine the reasonableness and allowance of costs reimbursable under the Program. Statistically valid random sampling is used to determine actual damages.

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

(6) Civil Penalty. A monetary penalty assessed by the Bureau against a provider in an amount of not less than $1,000 nor more than $5,000 for each violation of the Tennessee Medicaid False Claims Act. T.C.A. § 71-5-183(h)(3).

(7) Claim. Any request or demand for money, property, or services made to any employee, officer, or agent of the state, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded was issued from, or was provided by, the State.

(8) Commissioner. The chief administrative officer of the Tennessee Department where the Bureau is administratively located.

(9) Commissioner's Designee. A person authorized by the Commissioner to review appeals of initial orders and to enter final orders pursuant to T.C.A. § 4-5-315, or to review petitions for stay or reconsideration of final orders.

(Rule 1200-13-18-.02, continued)

(10) Contested Case. An administrative proceeding in which the legal rights, duties or privileges of a party are required by any statute or constitutional provision to be determined by an agency after an opportunity for a hearing.

(11) Credible Allegation of Fraud. Information which has been verified by the Bureau through judicious case-by-case review and found to contain indicia of reliability. This information may be from any source, including but not limited to hotline complaints, claims data mining, patterns identified through provider audits, civil false claims cases, or law enforcement investigations.

(12) Department. The Tennessee Department of Finance and Administration.

(13) Electronic Health Record Incentive Program (EHR-IP). The provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) that provide for incentive payments to eligible professionals (EPs) and eligible hospitals (EHs), including acute care, children's and critical access hospitals (CAHs) participating in Medicare and Medicaid programs that adopt, implement or update a certified system and successfully demonstrate meaningful use of certified electronic health record (EHR) technology as required by federal regulations.

(14) Enrollee. An individual eligible for and enrolled in the TennCare program.

(15) Error Rate. The percentage of claims in a sample population that was not billed properly and is actionable. Error rates can be applied to entire populations if the sample was the result of statically valid random sampling. The use of the term "error" does not indicate the intent of the person or entity submitting the claim.

(16) Findings of Fact. The factual findings issued by the Administrative Judge or Commissioner's Designee following an administrative hearing. The factual findings are enumerated in the initial and/or final order. An order must include a concise and explicit statement of the underlying facts of record to support the findings.

(17) Final Agency Decision. A Final Order.

(18) Final Order. An initial order becomes a final order without further notice if not timely appealed, or if the initial order is appealed pursuant to T.C.A. § 4-5-315, the Commissioner or Commissioner's Designee may render a final order. A statement of the procedures and time limits for seeking reconsideration or judicial review shall be included with the issuance of a final order.

(19) Good Cause Not to Suspend Payment. The Bureau may determine not to suspend payment or not to continue suspension of payment to a provider being investigated due to a credible allegation of fraud if:

(a) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation;

(b) Other available remedies implemented by the State more effectively or quickly protect Program funds;

(c) The Bureau determines, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be removed;

(Rule 1200-13-18-.02, continued)

(d) Enrollee access to items or services would be jeopardized by a payment suspension because the provider is the sole community physician, the sole source of essential specialized services in a community, or serves a large number of enrollees within a HRSA-designated medically underserved area;

(e) Law enforcement declines to certify that a matter continues to be under investigation; or

(f) The Bureau determines that payment suspension is not in the best interests of the Program.

(20) Good Cause to Suspend Payment Only in Part. The Bureau may determine to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to a provider being investigated due to a credible allegation of fraud if:

(a) Enrollee access to items or services would be jeopardized by a payment suspension in whole or part because the provider is the sole community physician, the sole source of essential specialized services in a community, or serves a large number of recipients within a HRSA-designated medically underserved area;

(b) The Bureau determines, based upon the submission of written evidence by the provider that is the subject of a whole payment suspension, that such suspension should be imposed only in part;

(c) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider, and the Bureau determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid;

(d) Law enforcement declines to certify that a matter continues to be under investigation; or

(e) The Bureau determines that payment suspension only in part is in the best interests of the Program.

(21) Hearing. A contested case proceeding.

(22) Indicia of Reliability. Factors which the Bureau will examine in determining whether a credible allegation of fraud exists, requiring the suspension of payments to a provider, including but not limited to:

(a) Firsthand knowledge;

(b) Corroborating witness;

(c) Witness conflict (disgruntled employee);

(d) Prior bad acts;

(e) Pattern of bad acts;

(f) Documentary proof;

(g) Admission by provider;

(h) Expert opinion; or

(Rule 1200-13-18-.02, continued)

(i) Indictment by a court of competent jurisdiction.

(23) Initial Order. The decision issued by the administrative judge following a hearing. The initial order shall contain the decision, findings of fact, conclusions of law, the policy reasons for the decision and the remedy prescribed. It shall include a statement of the procedure for filing an appeal of the initial order as well as a statement of any circumstances under which the initial order may, without further notice, become a final order. A statement of the procedures and time limits for seeking reconsideration or other administrative relief and the time limits for seeking judicial review shall be included.

(24) Notice of Action. The document or letter sent by the Bureau to a provider detailing the action the Bureau intends to take against the provider. The notice shall include a statement of the reasons and authority for the action as well as a statement of the provider's right to appeal the action, if applicable.

(25) Notice of Hearing. The pleading filed with the Administrative Procedures Division by the Bureau upon receipt of an appeal. It shall contain a statement of the time, place, nature of the hearing, and the right to be represented by counsel; a statement of the legal authority and jurisdiction under which the hearing is to be held, referring to the particular statutes and rules involved; and, a short and plain statement of the matters asserted, in compliance with the APA.

(26) Program. See TennCare.

(27) Provider with Prescribing Authority. A health care professional authorized by law or regulation to order prescription medications for her patients and who:

(a) Participates in the provider network of the MCC in which the beneficiary is enrolled; or

(b) Has received a referral of the beneficiary, approved by the MCC, authorizing her to treat the beneficiary; or,

(c) In the case of a TennCare beneficiary who is also enrolled in Medicare, is authorized to treat Medicare patients.

(28) RAT-STATS. A widely accepted statistical software tool designed to assist the user in conducting statistically valid random sampling and evaluating audit results.

(29) Standard of Proof. A preponderance of the evidence.

(30) Statistically Valid Random Sampling. A method for determining error rates in healthcare billings using extrapolation. Typically used for large numbers of suspect claims or patients, a random sample of claims from a chosen population is selected using RAT-STATS or a similar program. That sample is then analyzed for errors. If the sample is the result of statistically valid random sampling, the error rate in the sample can be extrapolated to the entire population of claims.

(31) 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.

(32) Tennessee Medicaid Provider Number. The identifying number issued by the Bureau to an approved provider for the purpose of receiving payment in exchange for rendering services to TennCare enrollees.

(Rule 1200-13-18-.02, continued)

(33) Tennessee Medicaid False Claims Act (Act). T.C.A. §§ 71-5-181, *et seq.*

(34) Termination. The deactivation of a provider's Tennessee Medicaid Provider Number and the cessation of the provider's TennCare billing privileges.

Statutory Authority: *T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.* ***Administrative History:*** *Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011. Amendment filed January 15, 2013; effective April 15, 2013.*

1200-13-18-.03 ADMINISTRATIVE ACTION FOR RECOVERY UNDER THE TENNESSEE MEDICAID FALSE CLAIMS ACT.

(1) The Attorney General, following an investigation of an approved provider's claims, may determine that certain provider actions are appropriate for administrative action by the Bureau, pursuant to the Act. The Attorney General may refer any such matters to the Bureau Director, or his designee, along with the investigative file and a recommendation for action.

(2) The Attorney General shall not refer matters originally brought under T.C.A. § 71-5-183(b) or if any person has the right to participate in or recover from the proceeding pursuant to T.C.A. § 71-5-183(c)(5).

(3) Upon receipt of a written request from the Attorney General, the Bureau may commence a contested case proceeding on behalf of the State for recovery under the Act against any person other than an enrollee, recipient or applicant.

(4) The Bureau may initiate the recovery process by notice of action to the provider setting out:

(a) The assessment of damages, civil penalties and related costs;

(b) The name and contact information of an individual within the Bureau with knowledge of the claim(s) and the assessment who is authorized to discuss the matter with the provider; and

(c) A statement of the right of the provider to appeal the assessment and the manner in which an appeal must be filed.

(5) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.

(6) The Bureau may recover actual damages in an amount no greater than twenty-five thousand dollars ($25,000). The amount of actual damages may be based upon a statistically valid random sample utilizing a software tool such as RAT-STATS.

(7) In addition to and not limited by the amount of actual damages, the Bureau may recover:

(a) Civil penalties of not less than one thousand dollars ($1,000) nor more than five thousand dollars ($5,000) for each claim found to be in violation of the Act;

(b) Costs of the administrative action; and

(c) Treble the amount of actual damages.

(8) Any action for recovery shall not be brought:

(a) More than six (6) years following the date on which the violation of the Act is committed; or

(Rule 1200-13-18-.03, continued)

(b) More than three (3) years after the date when facts material to the right of action are known or reasonably should have been known by the state official charged with responsibility to act in the circumstances, but in no event not more than ten (10) years after the date the violation was committed, whichever occurs last.

(9) A subpoena issued by an administrative judge pursuant to the APA requiring the attendance of a witness at a hearing may be served by certified mail at any place in the United States.

(10) For purposes of rendering a final order pursuant to the APA, the Bureau is designated as the agency to review initial orders and issue final agency decisions. Orders issued by the Bureau shall have the effect of a final order pursuant to the APA.

(11) Judgment. A final order issued by the Bureau under this rule may be enforced as a final judgment, as follows:

(a) A notarized copy of the final order must be filed in the office of the Clerk of the Chancery Court of Davidson County;

(b) Upon filing with the Clerk, a final order shall be considered as a judgment by consent of the parties on the same terms and conditions as those recited in the order;

(c) The judgment shall be promptly entered by the Court;

(d) The judgment shall become final on the date of entry; and

(e) A final judgment shall have the same effect, is subject to the same procedures and may be enforced or satisfied in the same manner as any other judgment of a court of record of the State of Tennessee.

Statutory Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-183.* ***Administrative History:*** *Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011. Amendment filed January 15, 2013; effective April 15, 2013.*

1200-13-18-.04 RECOUPMENT OR WITHHOLD.

(1) The Bureau is required by state and federal law to protect the integrity of the Medicaid program. This is accomplished in part by causing audits of provider claims to be conducted. Audit findings are reported to the Bureau for the purpose of recovering incorrect payments, by recoupment or withhold.

(2) The Bureau shall notify a provider of its intent to recoup or withhold based upon audit findings by issuing a notice of action. Each notice of action sent to a provider shall contain the proposed recovery action and the following information:

(a) The name and contact information of an individual knowledgeable about the audit findings and who is authorized to discuss the proposed recovery action with the provider;

(b) The manner by which the provider may submit additional information to support his disagreement with the proposed recovery action;

(c) A statement that the provider has the right to appeal the proposed recovery action and the manner in which an appeal must be filed.

(3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.

(Rule 1200-13-18-.04, continued)

(4) The audit and the audit findings are not subject to appeal. (See NHC v. Snodgrass, 555 S.W.2d 403 (Tenn. 1977)).

Statutory Authority: *T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.* ***Administrative History:*** *Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.*

1200-13-18-.05 SUSPENSION OF PAYMENT.

(1) Pursuant to 42 C.F.R. § 447.90, the Bureau is prohibited by federal law from receiving federal financial participation (FFP) for payment to a provider of medical items or services with respect to which there is a pending investigation of a credible allegation of fraud, absent good cause not to suspend payment or good cause to suspend payment only in part.

(2) The Bureau must provide written notice to the provider of a suspension of payments:

(a) Five (5) days after suspending payments unless a law enforcement agency has submitted a written request to delay the notice; or

(b) Thirty (30) days after suspending payments when a delay was properly requested by law enforcement, except the delay may be renewed twice in writing not to exceed ninety (90) days.

(3) Written notice of suspension of payment must contain:

(a) A statement that payments are suspended according to this rule and federal regulation;

(b) The general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation;

(c) A statement that the suspension is temporary and the circumstances under which it will be terminated;

(d) If applicable, state the type(s) of TennCare/Medicaid claims to which suspension is effective;

(e) A statement that the provider has the right to submit written evidence for consideration by the Bureau; and

(f) A statement that the provider has the right to appeal the suspension and the manner in which an appeal must be filed.

(4) Any appeal of a notice of suspension of payment shall be conducted according to rule .01 of this chapter.

(5) Any suspension of payment shall be temporary and shall not continue after:

(a) The Bureau or prosecuting authority determines there is insufficient evidence of fraud by the provider; or

(b) Legal proceedings related to the provider's alleged fraud are completed.

(6) The Bureau must document in writing the termination of a suspension of payment. Such document must include any applicable appeal rights available to the provider.

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

(Rule 1200-13-18-.05, continued)
rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.

1200-13-18-.06 ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM (EHR-IP).

(1) An approved provider of TennCare services, upon receipt of a notice of action, may appeal the following issues related to the EHR-IP:

(a) Denial of an incentive payment;

(b) Incentive payment amount;

(c) Determination of eligibility for an incentive payment, including but not limited to measurement of patient volume;

(d) Determination of efforts to adopt, implement or upgrade to certified EHR technology during the first year of the EHR-IP or meaningful use of certified EHR technology in subsequent years;

(e) Whether the provider is hospital-based;

(f) Whether the provider is practicing predominantly in an FQHC or RHC;

(g) Whether a hospital qualifies as an acute care or children's hospital; or,

(h) Whether the provider is already participating in the Medicare incentive program or in the Medicaid incentive program of another state and therefore is ineligible for duplicate TennCare incentive program payments.

(2) Each notice of action sent to a provider of a determination of any matter listed in paragraph (1) shall contain the following:

(a) The contact information to reach an individual knowledgeable about the EHR-IP who is authorized to discuss the determination with which the provider disagrees;

(b) The manner by which the provider may submit additional information to support his disagreement with the determination; and

(c) A statement that the provider has the right to appeal the determination with which he disagrees and the manner in which an appeal must be filed.

(3) Any appeal of a notice of action shall be conducted according to rule .01 of this chapter.

Statutory Authority: *T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.* ***Administrative History:*** *Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.*

1200-13-18-.07 TERMINATION OR EXCLUSION OF A PROVIDER FROM PROGRAM PARTICIPATION.

(1) A provider may be terminated or excluded from participation in the TennCare program.

(2) Federal Mandatory Exclusion. The Bureau is required by federal law to exclude a provider from participation in the TennCare program upon notice from HHS or CMS under the following circumstances:

(Rule 1200-13-18-.07, continued)

(a) Conviction of program-related crimes;

(b) Conviction relating to patient abuse;

(c) Felony conviction relating to health care fraud; or

(d) Felony conviction relating to controlled substance.

(3) Federal Permissive Exclusion. Pursuant to federal law, the Bureau may exclude a provider from participation in the TennCare program under the following circumstances:

(a) Conviction related to fraud;

(b) Conviction related to obstruction of an investigation or audit;

(c) Misdemeanor conviction related to controlled substance;

(d) License revocation or suspension;

(e) Exclusion or suspension under federal or state health care program;

(f) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services;

(g) Fraud, kickbacks, and other prohibited activities;

(h) Entities controlled by a sanctioned individual;

(i) Failure to disclose required information;

(j) Failure to supply requested information on subcontractors and suppliers;

(k) Failure to supply payment information;

(l) Failure to grant immediate access;

(m) Failure to take corrective action;

(n) Default on health education loan or scholarship obligations;

(o) Individuals controlling a sanctioned entity; or

(p) Making false statements or misrepresentation of material facts.

(4) When a provider exclusion is mandatory, the notice of action shall state that the provider has no right to appeal the termination from program participation.

(5) When a provider exclusion is permissive, the notice of action shall include a statement that the provider has the right to appeal the termination from program participation and the manner in which an appeal must be filed.

Statutory Authority: *T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.* ***Administrative History:*** *Emergency rule filed February 18, 2011; effective through August 17, 2011. Original rule filed May 18, 2011; effective August 16, 2011.*

1200-13-18-.08 PROVIDER SANCTIONS.

(1) Pursuant to the authority granted by T.C.A. § 71-5-118 to the Commissioner to impose sanctions against providers, the Commissioner, through the Bureau, may take the following actions against a provider upon a finding that such actions will further the purpose of the Tennessee Medical Assistance Act:

(a) Subject providers to stringent review and audit procedures which may include clinical evaluation of claim services and a prepayment requirement for documentation and for justification of each claim;

(b) Refuse to issue or terminate a Tennessee Medicaid Provider Number if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the U.S. Title XX Services Program;

(c) Refuse to issue or terminate a Tennessee Medicaid Provider Number if a determination is made that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the U.S. Title XX Services Program since the inception of these programs;

(d) Refuse to issue or terminate a Tennessee Medicaid Provider Number if the appropriate State Board of Licensing or Certification fails to license or certify the provider at any time for any reason or suspends or revokes a license or certification;

(e) Refuse to issue or terminate a Tennessee Medicaid Provider Number upon notification by the U.S. Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare or Medicaid for federal financial participation;

(f) Suspend or withhold payments to a provider in cases of fraud, willful misrepresentation, or flagrant noncompliance; or,

(g) Recover from a provider any payments made by a recipient and/or his family for a covered service when evidence of recipient billing by the provider is determined by the Bureau and repayment by the provider to the recipient and/or his family is not made within 30 days of receiving notification from the Bureau to make repayment. If a provider knowingly bills a recipient and/or family for a TennCare covered service, in total or in part, except as otherwise permitted by State rules, the Bureau may terminate the provider from participation in the program.

(2) In addition to the grounds for sanctions set out in T.C.A. § 71-5-118, activities or practices which justify sanctions against a provider and may include recoupment of monies incorrectly paid shall include but not be limited to:

(a) Noncompliance with contractual terms;

(b) Billing for a service in a quantity which is greater than the amount provided;

(c) Billing for a service which is not provided or not documented;

(Rule 1200-13-18-.08, continued)

(d) Knowingly providing incomplete, inaccurate, or erroneous information to TennCare or its agent(s);

(e) Continued provision of poor record keeping or inappropriate or inadequate medical care;

(f) Medical assistance of a quality below recognized standards;

(g) Suspension from the Medicare or Medicaid program(s) by the authorized U.S. enforcement agency;

(h) Partial or total loss (voluntary or otherwise) of a provider's federal Drug Enforcement Agency (DEA) dispensing or prescribing certification;

(i) Restriction to or loss of practice by a state licensing board action;

(j) Acceptance of a pretrial diversion, in state or federal court, from a Medicaid or Medicare fraud charge or evidence from such charge;

(k) Violation of the responsible state licensing board license or certification rules;

(l) Conviction of any felony, any offense under state or federal drug laws, or any offense involving moral turpitude;

(m) Dispensing, prescribing, or otherwise distributing any controlled substance or any other drug not in the course of professional practice, or not in good faith to relieve pain and suffering, or not to cure an ailment, physical or mental infirmity or disease;

(n) Dispensing, prescribing, or otherwise distributing to any person a controlled substance or other drug if such person is addicted to the habit of using controlled substances without making a bona fide effort to cure the habit of such patient;

(o) Dispensing, prescribing or otherwise distributing any controlled substance or other drug to any person in violation of any law of the state or of the United States of America;

(p) Engaging in the provision of medical or dental service when mentally or physically unable to safely do so;

(q) Billing TennCare an amount that is greater than the provider's usual and customary charge to the general public for that service;

(r) Falsifying or causing to be falsified dates of service, dates of certification or recertification or back dating any record which results in or could result in an inappropriate cost to TennCare;

(s) Fragmentation or submitting claims separately on the component parts of a procedure instead of claiming a single procedure code which includes the entire procedure or all component parts, when such approach results in TennCare paying a greater amount for the components than it would for the entire procedure; or,

(t) Submitting claims for a separate procedure which is commonly carried out as a component part of a larger procedure, unless it is performed alone for a medically justified specific purpose.

Statutory Authority*: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.* ***Administrative History:*** *Original rule filed May 18, 2011; effective August 16, 2011.*

RULES
OF THE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-19
APPEALS OF CERTAIN ELIGIBILITY DETERMINATIONS AND TENNCARE DELAY HEARINGS

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1200-13-19-.01 SCOPE AND AUTHORITY. This chapter governs all administrative hearings conducted for the purpose of reviewing eligibility determinations for the following categories which use the MAGI income methodology: Children Under 19, Pregnant Women, Caretaker Relatives, CHIP – Children and Pregnancy (CoverKids/HealthyTNBabies). Eligibility determination appeals for any other eligibility category will not be governed by this chapter. This chapter will govern all delay hearings for all eligibility categories. These rules preempt any other TennCare Rules to the extent that they are in conflict with this chapter.

(1) The Tennessee Medical Assistance Act of 1968 and Executive Order Number 23, dated October 19, 1999, designate the Tennessee Department of Finance and Administration as the single state agency for purposes of administering Title XIX of the Social Security Act (Medicaid).

(2) The CoverKids Act of 2006 authorizes the Tennessee Department of Finance and Administration to establish and administer a program to provide health care coverage to uninsured children under Title XXI of the Social Security Act (State Children's Health Insurance Program).

(3) Titles XIX and XXI of the Social Security Act, TennCare II Medicaid Section 1115 Demonstration Waiver, and 42 CFR Subpart E require the designated state agency to provide for appeals and fair hearings concerning eligibility determinations for applicants and recipients of assistance and services provided through the programs.

(4) The Commissioner of the Department of Finance and Administration has placed responsibility for eligibility determination appeal hearings in the Division of Health Care Finance and Administration (HCFA), except as specifically delegated to the Department of Human Services. HCFA employs Administrative Judges vested with full authority to conduct the hearing process, including authority to schedule and conduct a hearing; administer oaths; issue subpoenas; rule upon offers of proof; regulate the course of the hearing; set the time and place for continued hearings; enter an Initial Order; rule on petitions for reconsideration; and perform duties or actions that are necessary for the fair and timely management of the administrative hearing process.

(Rule 1200-13-19-.01, continued)

(5) Tennessee Code Annotated § 71-5-112 requires any hearing concerning matters of eligibility for medical assistance to be conducted under the Tennessee Uniform Administrative Procedures Act.

(6) Any procedural matter not specifically addressed by these rules is to be resolved by consulting the following authorities in the order listed: the Tennessee Uniform Administrative Procedures Act (UAPA), the Uniform Rules of Procedure For Hearing Contested Cases Before State Administrative Agencies (UAPA Rules), and the Tennessee Rules of Civil Procedure (TRCP).

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.02 DEFINITIONS.

(1) Administrative Judge. An impartial employee of the Agency who has no direct involvement in the action under consideration prior to the filing of the appeal; is licensed to practice law; is authorized to conduct administrative hearings; and, will hear contested cases and will enter Initial Orders as set out in T.C.A. §§ 4-5-301(a)(2) and 314(b).

(2) Agency. The TennCare Bureau or CoverKids, as applicable.

(3) Agency Record. The Agency record will consist solely of: notice of all proceedings; any pre-hearing order; any motions, pleadings, briefs, petitions, requests and intermediate rulings; evidence received or considered; a statement of matters officially noticed; proffers of proof and objections and rulings thereon; proposed findings, requested orders, and exceptions; the tape recording, stenographic notes or symbols, or transcript of the hearing; any Final Order, Initial Order, or order on reconsideration; staff memoranda or data submitted to the Agency unless prepared and submitted by personal assistants and not inconsistent with T.C.A. § 4-5-304(b); and matters placed on the record after an ex parte communication. The Record must be maintained for a period of time not less than three (3) years as required by T.C.A. § 4-5-319(a). This will be the official record for the purposes of T.C.A. § 4-5-322.

(4) Appeal. The process of obtaining an administrative hearing as a result of an Agency action or inaction regarding matters affecting eligibility for TennCare or CoverKids, or the process of obtaining review of an Initial Order by the Commissioner's Designee or judicial review of a Final Order.

(5) Appeal Request. Request for a hearing.

(6) Appellant. An applicant or enrollee whose appeal of an action or inaction of the Agency has been determined to present a valid factual dispute. The Appellant bears the burden of proof in any hearing conducted under this chapter. Also referred to as the Petitioner.

(7) Applicant. An individual who submits an application for TennCare or CoverKids health coverage, or the Medicare Savings Program, or the person who acts as an authorized representative for the applicant.

(8) Burden of Proof. The minimum evidentiary standard required in order to prevail in an administrative hearing is a preponderance of the evidence. A "preponderance of the evidence" means the greater weight of the evidence or that, according to the evidence, the

(Rule 1200-13-19-.02, continued)

conclusion sought by the party with the burden of proof is the more probable conclusion. The Appellant bears the burden of proof in any hearing conducted under this chapter.

(9) Children's Health Insurance Program (CHIP). A program established and administered by a State, jointly funded with the Centers for Medicare and Medicaid Services (CMS), to provide health assistance to uninsured, low-income children through a separate child health program, a Medicaid expansion program, or a combination program.

(10) Clerk's Office. The Agency Appeals Clerk's Office.

(11) Commissioner. The chief administrative officer of the Tennessee department where the Bureau of TennCare is administratively located.

(12) Commissioner's Designee. A person authorized by the Commissioner to review appeals of Initial Orders and to enter Final Orders under T.C.A. § 4-5-315, or to review Petitions for Stay or Reconsideration of Final Orders. Petitions for Reconsideration of an Initial Order will be disposed of by the same person who rendered the Initial Order, if available.

(13) Contested Case Proceeding. See "Hearing".

(14) CoverKids. The Children's Health Insurance Program in Tennessee.

(15) Delay Appeal. An appeal of an application that has been pending for longer than 45 days, or 90 days for CHOICES applications, with the sole purpose of determining whether the delay in processing is unreasonable.

(16) Ex Parte Communication. An exchange of information regarding an issue of fact in a contested case proceeding between one party and the Administrative Judge without including the opposing party. Communication may take place orally or in writing, by telephone, face-to-face, or electronically. Communications between Agency members or their attorneys are not considered to be ex parte. An Administrative Judge, hearing officer, or Agency member may communicate with the Agency regarding any matter pending before the Agency if such persons do not receive ex parte communications of a type that the Administrative Judge, hearing officer, or Agency members would be prohibited from receiving, and do not furnish, augment, diminish, or modify the evidence in the record. Matters of scheduling, dismissal, withdrawal or other administrative issues are not ex parte communications.

(17) Fair Hearing. See "Hearing".

(18) Findings of Fact. The factual findings following the administrative hearing, enumerated in the Initial and Final Order, which include a concise and explicit statement of the underlying facts of record to support the findings.

(19) Final Order. The Initial Order becomes a Final Order in fifteen (15) days without further notice if not appealed. If the Initial Order is reviewed under T.C.A. § 4-5-315, the Commissioner or Commissioner's Designee may render a Final Order. The Final Order is binding upon all parties unless it is stayed, reversed or set aside according to applicable rules. A statement of the procedures and time limits for seeking reconsideration or judicial review must be included.

(20) Good Cause. A legally sufficient reason. In reference to an omission or an untimely action, a reason based on circumstances outside the party's control and despite the party's reasonable efforts.

(Rule 1200-13-19-.02, continued)

(21) Hearing. A contested case proceeding where evidence is heard by an Administrative Judge to render a decision regarding an applicant's or enrollee's delayed adjudication or eligibility appeal, conducted under this Chapter. Also referred to as a Fair Hearing or a Contested Case Proceeding.

(22) Initial Order. The decision of the Administrative Judge following an administrative hearing. The Initial Order must contain the decision, findings of fact, conclusions of law, the policy reasons for the decision and the remedy prescribed. It must include a statement of any circumstances under which the Initial Order may, without further notice, become a Final Order. A statement of the procedures and time limits for seeking reconsideration or other administrative relief and the time limits for seeking judicial review will be included.

(23) Modified Adjusted Gross Income (MAGI). Has the same meaning as is found in 42 C.F.R. § 435.603.

(24) Notice of Hearing. The pleading filed with the TennCare Administrative Hearing Unit by the Agency upon receipt of an appeal. It must contain a statement of the time, place, nature of the hearing, and the right to be represented by counsel or another authorized person of his choice; a statement of the legal authority and jurisdiction under which the hearing is to be held, referring to the particular statutes and rules involved; and a short and plain statement of the matters asserted, in compliance with T.C.A. §4-5-307(b).

(25) Party. Each person or Agency named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party.

(26) Petitioner. See Appellant.

(27) Pleadings. Written statements of the facts and law which constitute a party's position or point of view in a contested case and which, when taken together with the other party's pleadings, will define the issues to be decided in the case. Pleadings may be in legal form, such as a ''Notice of Hearing'', ''Petition for Hearing'' or ''Answer'', or, where not practicable to put them in legal form, letters or other papers may serve as pleadings in a contested case, if necessary to define what the parties' positions are and what the issues in the case will be.

(28) Request for a Hearing. A clear expression by the applicant or beneficiary, or his authorized representative, that he wants the opportunity to present his case to a reviewing authority.

(29) Representative. An individual or organization, including legal counsel, a relative, a friend, or another spokesperson, authorized by an appellant to represent him during an appeal.

(30) Respondent. The party who is responding to the action brought by the petitioner, usually the Agency.

(31) Single State Agency. The Tennessee Department of Finance and Administration, 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 to administer TennCare.

(32) 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.

(33) Valid Factual Dispute. A dispute that, if resolved in favor of the appellant, would prevent the state from taking the action that is the subject of the appeal.

(Rule 1200-13-19-.02, continued)
Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.03 ACCESSIBILITY. Information concerning the availability of language assistance must be provided to applicants and enrollees, including individuals with disabilities or who have limited English proficiency, in plain language and in a manner that is accessible and timely as required by the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.04 NOTICE OF ELIGIBILITY DETERMINATION.

(1) The Agency must send each applicant a written notice of the Agency's decision on his application, and if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of his right to request a hearing.

(2) Before an application is denied for lack of documentation or conflicting information, the Agency will notify the applicant of the type of documentary proof he must submit in order to meet the eligibility requirements set out in 42 C.F.R. Part 435.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.05 APPEAL RIGHTS, NOTICES AND PROCEDURES.

(1) The Agency must grant an opportunity for a hearing to the following:

(a) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness.

(b) Any beneficiary who requests it because he believes the Agency has taken an action erroneously.

(c) Any enrollee who is entitled to a hearing under 42 C.F.R. 438 subpart B.

(2) The Agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries.

(3) When the Agency receives an appeal from an appellant, the Agency will dismiss this appeal unless the appellant has established a valid factual dispute relating to the appeal. The Agency will screen all appeals submitted by appellants to determine if each appellant has presented a valid factual dispute. If the Agency determines that an appellant failed to present a valid factual dispute, the Agency will immediately provide the appellant with a notice informing him that he must provide additional information as identified in the notice. If the appellant does not provide this information within ten (10) days of the date of the notice, the appeal will be dismissed without the opportunity for a fair hearing. If the appellant adequately responds to this notice, the Agency will inform the appellant that the appeal will proceed to a hearing. If the appellant responds but fails to provide adequate information, the Agency will

(Rule 1200-13-19-.05, continued)

provide a notice to the appellant, informing him that the appeal is dismissed without the opportunity for a fair hearing. If the appellant does not respond, the appeal will be dismissed without the opportunity for a fair hearing, without further notice to the appellant.

(4) The Agency must provide notice of his right to a hearing; of the method by which he may obtain a hearing; and that he may represent himself or use a representative at the time:

(a) The individual applies for CoverKids or TennCare; and

(b) Of any action affecting his eligibility.

(5) The notice of appeal rights and procedures must contain:

(a) A statement of what action the Agency intends to take;

(b) The reasons for the intended action;

(c) The specific rules that support, or the change in Federal or State law that requires, the action;

(d) An explanation of:

1. The individual's right to request a hearing; or

2. In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

3. The circumstances under which Medicaid is continued if a hearing is requested.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.06 TIME.

(1) In computing any period of time prescribed or allowed by statute, rule or order, the date of the act, event or default after which the designated period of time begins to run is not to be included. The last day of the time period is to be included unless it is a Saturday, a Sunday or a legal holiday, which extends the period until the end of the next day which is neither a Saturday, a Sunday nor a legal holiday. When the period of time prescribed or allowed is less than seven (7) days, intermediate Saturdays, Sundays and legal holidays are excluded in the computation. The Notice of Hearing shall provide notice of this provision or inform the applicant or recipient of the specific calendar dates by which certain actions must be taken.

(2) Except in regard to petitions for appeal, reconsideration or review under T.C.A. §§ 4-5-315, 4-5-317 and 4-5-322, or where otherwise prohibited by law, when an act is required or allowed to be done at or within a specified time, the Agency or Administrative Judge may, at any time:

(a) With or without motion or notice, order the period enlarged if the request is made before the expiration of the period originally prescribed or as extended by previous order; or

(b) Upon motion made after the expiration of the specified period, permit the act to be done late, where the failure to act was the result of excusable neglect. Nothing in this

(Rule 1200-13-19-.06, continued)

section is to be construed to allow any ex parte communications concerning any issue in the proceeding that would be prohibited by T.C.A. § 4-5-304.

(3) An appeal or request for a hearing must be received by the Agency within forty (40) calendar days (inclusive of mail time) of the date of the Agency notice to the individual regarding the intended action or prior to the date of action specified in the notice, whichever is later, unless good cause can be shown as to why the appeal or request for a hearing could not be filed within the required time limit.

(4) Any communication submitted electronically must be received by midnight of the designated date.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.07 DISMISSAL OF APPEAL OR REQUEST FOR HEARING.

(1) The Agency may close a request for a delay appeal upon making an eligibility determination.

(2) The Agency may dismiss a request for hearing if the appeal request has been withdrawn by the appellant in writing or through electronic or oral notification.

(3) The Agency may dismiss a previously accepted appeal upon evidence presented at a good cause hearing, pre-hearing conference, or in the pleadings that the appeal was not timely filed and that good cause for the untimely filing did not exist.

(4) Upon appropriate proof, the Agency may dismiss an appeal at any point in the hearing process for any of the reasons that the appeal might be denied by the Agency by rule or law, if such facts had been known by the Agency before the appeal was accepted for hearing.

(5) The Agency must dismiss an appeal or request for hearing if the appeal does not present a valid factual dispute and the appellant does not provide additional information or clarification to establish a valid factual dispute within fifteen (15) (inclusive of mail time) days of an Agency request. The Agency decision that an appeal does not raise a valid factual dispute is not appealable.

(6) When the Agency dismisses an appeal it must provide a timely notice of dismissal to the appellant, stating:

(a) The reason for dismissal;

(b) An explanation of the dismissal's effect on the appellant's eligibility; and

(c) An explanation of how the appellant may show good cause why the dismissal should be vacated.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective March 3, 2015.*

1200-13-19-.08 FILING AND SERVICE OF PLEADINGS AND OTHER MATERIALS.

(1) After an appeal is filed, all pleadings and any other materials that are required to be filed by a time certain must be received by the Clerk's Office by the specified time. The materials may be filed by delivering them to the Agency in person, electronically, by mail or by private carrier.

(2) Upon initiation of a contested case, all pleadings and other materials required to be filed or submitted prior to the hearing must be filed with the Clerk's Office, where they will be stamped with the date of receipt.

(3) A petition for appeal of an Initial Order or for reconsideration or stay of an Initial or Final Order must be filed with the Agency.

(4) Discovery materials that are not actually introduced as evidence need not be filed, except as provided in this Chapter.

(5) Copies of all materials filed with the Agency in a contested case shall also be served upon all parties, or upon their counsel, and contain a statement indicating that copies have been served upon all parties. Service may be by mail or equivalent carrier, by hand delivery, or in electronic format.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.09 TELEPHONIC AND ALTERNATE ELECTRONIC METHODS FOR CONDUCTING PREHEARING CONFERENCES AND HEARINGS. In the discretion of the Administrative Judge, and with the concurrence of the parties, any pre-hearing conference or hearing may be conducted by telephone or other electronic means, if each participant in the conference or hearing has an opportunity to fully participate in the entire proceeding while it is taking place.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.10 COMMENCEMENT OF CONTESTED CASE PROCEEDINGS.

(1) The appellant or his representative may request an appeal or a hearing by any clear expression, oral, written, or through other commonly available electronic means.

(2) Upon determination that an appeal or a request for a hearing contains a valid factual dispute, the Agency will issue a notice of hearing as defined in this chapter. The notice of hearing must:

(a) Contain a statement of the date, time, place, and nature of the hearing;

(b) Inform the appellant of the right to be represented by counsel or another authorized person of his choice;

(c) Contain a statement of the legal authority and jurisdiction under which the hearing will be held, including references to the specific statutes and rules involved;

(Rule 1200-13-19-.10, continued)

(d) Contain instructions to the appellant to notify the Agency if he requires a change in the schedule;

(e) Provide a short and plain statement of the matters asserted and define the issues and refer to detailed statements of the matters involved, if available;

(f) Provide information about hearing procedures, including the right to present written evidence and testimony and to bring witnesses and members of his family to the hearing.

(g) Inform the appellant of his right to inspect the Agency file regarding the matter under appeal and to copy from the file.

(3) Service of Notice of Hearing.

(a) The Agency will provide the appellant or his representative with a copy of the notice of hearing by delivering it to the party electronically; by U.S. Mail; by certified mail; FedEx, UPS, or equivalent carrier; or by personal service. The notice will be sent a minimum of ten (10) days in advance of the date of the hearing. Delivery is presumed within five (5) days if sent by regular mail; the day following for expedited or overnighted delivery; the same day for electronic delivery and personal service.

(b) Service of the notice of hearing will be made at the address required to be kept current by the applicant or recipient with the Agency by T.C.A. §§ 71-5-106(l) and 110(c)(1), and at the address provided with the request for hearing, if different from the address on file with the Agency. The Agency must use the best address known to it, whether provided directly by the applicant or recipient or obtained indirectly.

(c) If there is a motion for default and there is no indication of actual service on a party, in determining whether to grant the default the Administrative Judge must consider the following:

1. Whether any other attempts at actual service were made;

2. Whether and to what extent actual service is feasible in any given case;

3. What attempts were made to make contact with the party electronically, by telephone, by regular mail, or otherwise; and

4. Whether the Agency has actual knowledge or reason to know that the party may be located at an address other than the address to which the notice was mailed.

(4) Supplemented Notice. In the event it is impractical or impossible to include every element required for notice in the notice of hearing, elements such as the time and place of the hearing may be supplemented in a later written notice.

(5) Filing of Documents. When a contested case is commenced in which an Administrative Judge will be conducting the proceedings, the Agency will provide all the papers that make up the notice of hearing and all pleadings, motions, and objections, formal or otherwise, that have been provided to or generated by the Agency. Legible copies may be filed in lieu of originals.

(6) Answer. The party may respond to the issues set out in the notice or other original pleading by filing a written answer with the Agency in which the party may:

(Rule 1200-13-19-.10, continued)

(a) Object to the notice upon the ground that it does not state acts or omissions upon which the Agency may proceed;

(b) Object on the basis of lack of jurisdiction over the subject matter;

(c) Object on the basis of lack of jurisdiction over the person;

(d) Object on the basis of insufficiency of the notice;

(e) Object on the basis of insufficiency of service of the notice;

(f) Object on the basis of failure to join an indispensable party;

(g) Generally deny all the allegations contained in the notice or state that he is without knowledge as to each and every allegation, both of which shall be deemed a general denial of all charges;

(h) Admit in part or deny in part allegations in the notice and elaborate on or explain relevant issues of fact in a manner that will simplify the ultimate issues; and

(i) Assert any available defense.

(7) Amendment to Notice. The notice or other original pleading may be amended within two (2) weeks from service of the notice and before an answer is filed, unless it is shown that undue prejudice will result from this amendment. Otherwise the notice or other original pleading may only be amended by written consent of the parties or by leave of the Administrative Judge, and leave shall be freely given when justice so requires. No amendment to the notice may introduce a new statutory or regulatory basis for denial or termination of enrollment without original service and running of times applicable to service of the original notice. The Administrative Judge shall not grant a continuance to amend the notice or original pleading if it would prejudice the right to a hearing and Initial Order within any mandatory time frames.

(8) Amendments to Conform to the Evidence. When issues not raised by the pleadings are tried by express or implied consent of the parties, they will be treated as if they had been raised in the pleadings. Such amendment of the pleadings as may be necessary to cause them to conform to the evidence and to raise these issues may be made upon motion of any party at any time; but failure to amend for this reason does not affect the result of the determination of these issues. If evidence is objected to at the hearing on the ground that it is not within the issues in the pleadings, the Administrative Judge may allow the pleadings to be amended unless the objecting party shows that the admission of such evidence would prejudice his defense. The Administrative Judge may grant a continuance to enable the objecting party to have reasonable notice of the amendments. However, when the individual is not represented by counsel, the burden is on the Administrative Judge to rule on whether to allow additional evidence and the need for continuances to enable the party additional time to address the new grounds.

(9) Pre-hearing Conference.

(a) In any action set for hearing the Administrative Judge, upon his own motion or upon motion of a party or qualified representative, may direct the parties to appear before him for a conference to consider:

1. The simplification of issues;

2. The necessity or desirability of amendments to the pleadings;

(Rule 1200-13-19-.10, continued)

3. The possibility of obtaining admissions of fact and of documents to avoid unnecessary proof;

4. The limitation of the number of expert witnesses; or

5. Other matters that may aid in the disposition of the action.

(b) The Administrative Judge will enter an order reciting the action taken at the conference, the amendments allowed to the pleadings, the agreements made by the parties to the matters considered, and limiting the issues for hearing to those not disposed of by the admissions or agreements of the parties. When entered such order controls the subsequent course of the action, unless modified at the hearing to prevent manifest injustice.

(c) If a pre-hearing conference is not held, the Administrative Judge may issue a pre-hearing order, based on the pleadings, to regulate the conduct of the proceedings.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.11 REPRESENTATION BY COUNSEL.

(1) Any party to a contested case hearing may be advised and represented, at his own expense, by anattorney in good standing and possessing a current license to practice law in the state of Tennessee.

(2) Any party to a contested case hearing may represent himself or be represented by a non-attorney of his choice, such as a relative, friend or another spokesperson. If the party is represented by a non-attorney, he must provide valid written or oral attestation on the record authorizing representation.

(3) The Agency will notify all parties in a contested case hearing of the right to be represented by counsel. An appearance by a party at a hearing without counsel may be deemed a waiver of the right to counsel.

(4) Entry of an appearance by counsel will be made by the filing of pleadings, or of a formal or informal notice of appearance, or appearance as counsel at a pre-hearing conference or a hearing.

(5) After appearance of counsel has been made, all pleadings, motions, and other documents must be served upon counsel. If appearance is by a non-attorney representative, all documents must be served on both the party and the representative.

(6) Counsel wishing to withdraw must give written notice to the Agency and the Administrative Judge.

(7) Out-of-state attorneys shall comply with T.C.A. § 23-3-103(a) and Tenn. Sup. Ct. R. 19, except that the affidavit referred to in Rule 19 and a motion requesting pro hac vice admission shall be filed with the Clerk's Office, and served upon the Board of Professional Responsibility according to Rule 19 not later than the first occasion in which the out-of-state attorney files any pleading or paper with the Clerk's Office or otherwise personally appears.

(Rule 1200-13-19-.11, continued)
Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.12 PRE-HEARING MOTIONS.

(1) Motions. Parties to a contested case are encouraged to resolve matters on an informal basis prior to a contested case hearing. If efforts at informal resolution fail, any party may request relief in the form of a motion by serving a copy on all parties and by filing the motion with the Administrative Judge. The motion must contain a request for the relief sought and the grounds which entitle the moving party to relief. A motion is considered submitted for disposition seven (7) days after it was filed, unless oral argument is requested and granted, or unless a longer or shorter time is set by the Administrative Judge.

(2) Time Limits; Oral Argument. Each opposing party may file a written response to a motion within seven (7) days of the date the motion was filed. If oral argument is requested, the motion may be argued by conference telephone call. A brief memorandum of law submitted with the motion is preferable to oral argument.

(3) Affidavits; Briefs and Supporting Statements.

(a) Motions and responses to motions must be accompanied by supporting affidavits and briefs or supporting statements. Motions and responses to motions must be supported by affidavits for facts relied upon which are not of record or the subject of official notice. Supporting affidavits must contain only facts admissible in evidence under T.C.A. § 4-5-313, and to which the affiants are competent to testify. Properly verified copies of all papers or parts of papers referred to in the affidavits may be attached.

(b) In the discretion of the Administrative Judge, a schedule may be established for submitting briefs or supporting statements.

(4) Disposition of Motions; Drafting the Order. The Administrative Judge must render a decision on a motion by issuing an order or by instructing the prevailing party to prepare and submit an order within seven (7) days of the ruling on the motion, or as otherwise ordered by the Administrative Judge. After signing an order, the Administrative Judge will cause the order to be served upon the parties.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.13 CONTINUANCES.

(1) Continuances may be granted for good cause in any stage of the proceeding. The need for a continuance must be brought to the attention of the Administrative Judge as soon as practicable by the appellant, by the Agency, or by mutual consent of the parties.

(2) If an appellant requests a continuance, any mandatory time limits or deadlines for conducting hearings and issuing Initial Orders by an Administrative Judge may be extended by a like period of time. The applicable time frame will be extended only by the number of days that the appellant delays the proceedings, either by his acts or omissions.

(Rule 1200-13-19-.12, continued)
Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.14 DISCOVERY.

Any party to a contested case proceeding has the right to examine Agency manuals, the Agency case file regarding the matter being contested, and all documents and records used as evidence, at the Agency office during normal State office hours, except that records, the confidentiality of which is protected by law may not be inspected consistent with T.C.A. § 4-5-311. A party or his representative may copy entries or documents to be introduced at the hearing as supporting evidence.

(2) Any party to a contested case proceeding has the right to reasonable discovery under T.C.A. § 4-5-311.

(3) The Administrative Judge will issue subpoenas to require the attendance of witnesses and the production of books, records, papers, or other tangible things necessary and proper for the hearing proceeding, when requested by a party involved in the case. Subpoenas may be served at any place within the State by certified mail in addition to means of service provided by the TRCP.

(4) The Administrative Judge may at or before the time specified in the subpoena for compliance:

(a) Void or modify a subpoena if it is unreasonable and oppressive, or

(b) Tax the party making the request with reasonable costs in the production of books, papers, documents, or other tangible things.

(5) The parties should attempt to achieve discovery informally. Only if such attempts have failed or if the complexity of the case makes informal discovery impracticable shall discovery be sought and conducted under the TRCP.

(6) Upon motion of a party or upon the Administrative Judge's own motion, the Administrative Judge may order that discovery be completed by a certain date.

(7) Any motion to compel discovery, motion to quash, motion for protective order, or other discovery related motion must:

(a) Quote verbatim the interrogatory, request, question, or subpoena at issue, or be accompanied by a copy of the interrogatory, request, subpoena, or excerpt of a deposition which shows the question and objection or response if applicable;

(b) State the reason or reasons supporting the motion; and

(c) Be accompanied by a detailed statement certifying that the moving party or his counsel has made a good faith effort to resolve by agreement the issues raised and that agreement has not been achieved; such efforts must be set out with particularity in the statement.

(8) The Administrative Judge will decide any motion relating to discovery according to the UAPA, the UAPA Rules, or the TRCP.

(Rule 1200-13-19-.14, continued)

(9) Other than as provided in paragraph (7) above, discovery materials need not be filed with the Clerk's Office.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.15 ORDER OF PROCEEDINGS.

(1) Hearings of contested cases, including reconsideration hearings, will be conducted as follows:

(a) The Administrative Judge may confer with the parties prior to a hearing to explain the order of proceedings, admissibility of evidence, number of witnesses and other matters.

(b) The hearing is called to order by the Administrative Judge.

(c) The Administrative Judge introduces himself and gives a very brief statement of the nature of the proceedings, including a statement of his role in making factual and legal rulings.

(d) The Administrative Judge then calls on the petitioner to ask if the petitioner is represented by counsel, and if so, counsel is introduced. The Administrative Judge then introduces the respondent's counsel and any other officials who may be present at the hearing.

(e) The Administrative Judge states what documents the record contains.

(f) The Administrative Judge swears the witnesses.

(g) The parties are asked whether they wish to have all witnesses excluded from the hearing room except during their testimony. If so, all witnesses are instructed not to discuss the case during the pendency of the proceeding and asked to leave the hearing room. Individual parties are permitted to stay in the hearing room, and the State may have one appropriate individual, who may also be a witness, act as its party representative.

(h) Any preliminary motions, stipulations, or agreed orders are heard by the Administrative Judge.

(i) Opening statements are allowed by both parties.

(j) The petitioner, as the moving party, has the burden of proof, calls the first witness and questioning proceeds as follows:

1. Moving party questions.

2. State cross-examines.

3. Moving party redirects.

4. State re-cross-examines.

5. Administrative Judge may ask questions.

(Rule 1200-13-19-.15, continued)

6. Further questions by parties as long as necessary to provide all pertinent testimony.

(k) State calls witnesses and questioning proceeds as follows:

1. State questions.

2. Moving party cross-examines.

3. State redirects.

4. Moving party re-cross-examines.

5. Administrative Judge may ask questions.

6. Further questions by parties as long as necessary to provide all pertinent testimony.

(l) The moving party and the other party are allowed to call appropriate rebuttal and rejoinder witnesses with examination proceeding as outlined above.

(m) Closing arguments are allowed to be presented by both parties.

(n) The Administrative Judge announces the decision or takes the case under advisement.

(2) The parties are informed that an Initial Order will be written and sent to the parties and that the Initial Order will inform the parties of their appeal rights.

(3) Paragraphs (1) and (2) of this rule are intended to be a general outline for the conduct of a contested case proceeding. A departure from the literal form or substance of this outline, in order to expedite or ensure the fairness of proceedings, is not a violation of this rule.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.16 DEFAULT AND UNCONTESTED PROCEEDINGS.

(1) The failure of a party to attend or participate in a pre-hearing conference, hearing or other stage of contested case proceedings after appropriate notice of those actions is cause for holding that party in default under T.C.A. § 4-5-309. Failure to comply with any lawful order of the Administrative Judge, necessary to maintain the orderly conduct of the hearing, may be deemed a failure to participate in a stage of a contested case and is cause for a holding of default.

(2) If a party fails to attend or participate as provided in paragraph (1) above, the Administrative Judge will enter into the record evidence of service of notice to that party and determine whether the service of notice is sufficient as a matter of law, according to this chapter. If the notice is held to be sufficient, the Administrative Judge may do either of the following:

(a) Hold the party failing to attend or to participate in default and, after determining that the party in default has the burden of proof, adjourn the proceedings and enter an order of

(Rule 1200-13-19-.16, continued)

default stating the grounds for the default that will become a Final Order without further notice as provided in this chapter, unless a petition for reconsideration is timely filed; or

(b) Hold the party failing to attend or to participate in default and, after determining that the party not in default has the burden of proof, conduct the proceedings without the participation of the defaulting party and include in the Initial Order a written notice of default stating the grounds for the default. The Initial Order will become a Final Order without further notice as provided in this chapter, unless a petition for reconsideration is timely filed.

(3) The Administrative Judge will serve the written notice of entry of default for failure to appear as provided in paragraph (2) above on all parties. The defaulting party, no later than fifteen (15) days after receipt of a notice of default, may file a petition for reconsideration as provided in this chapter and T.C.A. § 4-5-317, requesting that the default be set aside for good cause shown, and stating the grounds relied upon. The Administrative Judge may rule on the petition or take no action for twenty (20) days after which the petition is deemed denied. T.C.A. § 4-5-317.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.17 EVIDENCE. The Administrative Judge will consider the information used to determine the applicant's eligibility as well as additional relevant information presented as evidence during the course of the appeal. The standard for admissibility of evidence is set out at T.C.A. § 4-5-313.

(1) The testimony of witnesses will be taken in open hearings, except that witnesses may be excluded from the hearing prior to their testimony.

(2) The Administrative Judge will admit and give probative effect to evidence admissible in a court. When necessary to establish facts not reasonably susceptible to proof under the rules of court, evidence may be admitted if it is of a type commonly relied upon by reasonably prudent persons in the conduct of their affairs. The Administrative Judge will give effect to the rules of privilege recognized by law and to state or federal statutes or regulations protecting the confidentiality of certain records and will exclude evidence which in his judgment is irrelevant, immaterial or unduly repetitious.

(3) Documentary evidence otherwise admissible may be received in the form of copies or excerpts, or by incorporation by reference to material already on file with the Agency. Upon request, parties will be given an opportunity to compare the copy with the original, if reasonably available.

(4) Official notice may be taken of:

(a) Any fact that could be judicially noticed in the courts of Tennessee;

(b) The record of other proceedings before the Agency;

(c) Technical or scientific matters within the Administrative Judge's specialized knowledge; and

(d) Codes or standards that have been adopted by an agency of the United States, of Tennessee or of another state, or by a nationally recognized organization or association. Parties will be notified before or during the hearing, or before the issuance

(Rule 1200-13-19-.17, continued)

of any Initial or Final Order that is based in whole or in part on facts or material noticed, of the specific facts or material noticed and the source, including any staff memoranda and data, and be given an opportunity to contest and rebut the facts or material so noticed.

(5) Every party has the right to present evidence, to make arguments, and to confront and cross-examine witnesses.

(6) Any party intending to introduce an affidavit into evidence must deliver a copy of the affidavit along with the notice described below to the opposing party at least ten (10) days prior to a hearing or a continued hearing. The opposing party has seven (7) days after delivery of the affidavit to deliver to the proponent a request to cross-examine the affiant or the right to cross-examination is waived and the affidavit, if introduced in evidence, will be given the same effect as if the affiant had testified orally. If an opportunity to cross-examine an affiant is not provided after a proper request is made, the affidavit will not be admitted into evidence. Delivery means actual receipt, for purposes of this paragraph. The Administrative Judge may admit affidavits not submitted in compliance with this paragraph where necessary to prevent injustice.

(7) The notice required to accompany an affidavit must contain the following information and be substantially in the following form:

The accompanying affidavit of _____ (here insert name of affiant) will be introduced as evidence at the hearing in _____ (here insert title of proceeding). _____ (Here insert name of affiant) will not be called to testify orally and you will not be entitled to question such affiant unless you notify _____ (here insert name of the proponent or the proponent's attorney) at _____ (here insert address) that you wish to cross-examine such affiant. To be effective, your request must be mailed or delivered to _____ (here insert name of proponent or the proponent's attorney) on or before _____ (here insert a date seven (7) days after the date of mailing or delivering the affidavit to the opposing party).

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.18 INITIAL AND FINAL ORDERS.

(1) At the conclusion of the hearing, the Administrative Judge may allow the parties a designated amount of time to submit proposed findings of fact and conclusions of law.

(2) The Administrative Judge will issue an Initial Order which automatically becomes the Final Order fifteen (15) days after it is issued unless the Agency receives a timely filed petition for appeal, petition for reconsideration, or petition for a stay of effectiveness. The effective date of an Initial Order that becomes final by operation of law is its original date of entry. The Final Order is binding upon all parties unless it is stayed, reversed or set aside according to applicable rules.

(3) If the Administrative Judge becomes unavailable for any reason before issuing an Initial Order or Final Order, a substitute will be appointed as provided in T.C.A. § 4-5-302. The substitute must use the existing record and may conduct further proceedings as appropriate in the interest of justice.

(4) Contents of the Order.

(Rule 1200-13-19-.19, continued)

(a) An Initial Order or a Final Order will include findings of fact, conclusions of law, the policy reasons for the decision, the remedy prescribed and, if applicable, the action taken on a petition for stay of effectiveness. The Agency member's experience, technical competence, and specialized knowledge may be utilized to evaluate the evidence.

(b) Findings of fact are concise and explicit statements of the underlying facts of record that support the order and must be based exclusively upon the evidence of record from the hearing and on matters officially noticed in that proceeding.

(c) The Initial Order must include a statement that it will automatically become a Final Order without further notice unless a petition for reconsideration or petition for appeal is filed.

(d) The Initial Order or Final Order must include a statement of the procedures and time limits to request an appeal, reconsideration or stay of the Initial or Final Order and the time limits for seeking judicial review of the Final Order.

(5) The Administrative Judge must cause copies of the Initial Order to be sent to each party at the time the order is entered. If an Initial Order becomes final by operation of law, no further notice shall be provided.

(6) If a Final Order is issued, the Agency must cause copies of the Final Order to be sent to each party at the time the order is entered.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.19 APPEAL OF INITIAL ORDERS.

(1) Written notice of the right to petition for stay, reconsideration, or appeal must accompany the Initial Order sent to the parties.

(2) If an Initial Order is subject to both a timely petition for reconsideration and a petition for appeal, the petition for reconsideration will be disposed of first and a new fifteen (15) day period will start to run.

(3) A petition for appeal from an Initial Order must be addressed to the Commissioner's Designee and filed with the Clerk's Office within fifteen (15) days after entry of an Initial Order and comply with T.C.A. § 4-5-315.

(4) A petition for appeal must state its basis.

(5) The Commissioner's Designee, on his own motion, may review an Initial Order after giving written notice to the parties within fifteen (15) days after entry of an Initial Order.

(6) On appeal the parties will be permitted an opportunity to file briefs. The Agency may provide the parties an opportunity to present oral argument.

(7) The Commissioner's Designee may enter a Final Order disposing of the proceeding or may remand the matter for further proceedings with instructions to the Administrative Judge who

(Rule 1200-13-19-.19, continued)

entered the Initial Order. When remanding a matter, the Commissioner's Designee may order temporary relief if authorized and appropriate.

(8) A Final Order or an order remanding the matter for further proceedings will be entered in writing within sixty (60) days after receipt of briefs and oral argument, unless that period is waived or extended with the written consent of all parties or for good cause shown. The order will identify any differences from the Initial Order and include or incorporate by express reference to the Initial Order, all information required by paragraph .18(4).

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.20 RECONSIDERATION.

(1) Written notice of the right to petition for stay, reconsideration, or appeal must accompany the Initial Order sent to the parties.

(2) If a separate Final Order is entered following the entry of an Initial Order, written notice of the right to petition for reconsideration of the Final Order will accompany the Final Order sent to the parties.

(3) A petition for reconsideration stating in detail the reasons for the request and the relief requested may be addressed to the Administrative Judge and filed with the Clerk's Office by any party within fifteen (15) days after entry of an Initial Order or Final Order.

(4) If an Initial Order is subject to both a timely petition for reconsideration and a petition for appeal, the petition for reconsideration will be disposed of first and a new fifteen (15) day period will start to run.

(5) Filing a petition for reconsideration of the Final Order does not supersede or delay the effective date of the Final Order. The Final Order takes effect on the date entered by the Agency and continues in effect until the petition for reconsideration is granted or until the Final Order is stayed, superseded, modified, or set aside in a manner provided by law. If a change affecting benefits or services occurs while reconsideration is pending, action to implement that change is not delayed pending the decision concerning reconsideration of the Final Order.

(6) Within twenty (20) days of receiving a petition for reconsideration of the Initial or Final Order, the Administrative Judge who entered the Initial or Final Order will enter a written order as set out at T.C.A. § 4-5-317:

Denying the petition;

(b) Granting the petition and setting the matter for further proceedings; or

(c) Granting the petition and issuing a new Initial or Final Order.

(d) If no action is taken on the petition for reconsideration within twenty (20) days, the petition is deemed to be denied.

(7) An order granting a petition for reconsideration and setting the matter for further proceedings will contain:

(Rule 1200-13-19-.20, continued)

(a) A statement of the extent and scope of the proceedings;

(b) A statement limiting the proceedings to argument upon the existing record; and

(c) State that no new evidence will be introduced, unless the party proposing new evidence shows good cause for his failure to introduce the evidence in the original proceeding.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.21 STAY.

(1) Written notice of the right to petition for stay, reconsideration, or appeal must accompany the Initial Order or Final Order sent to the parties.

(2) A petition for stay of effectiveness of an Initial Order or Final Order may be submitted to the Agency within seven (7) days after entry of the order. The Agency may take action on the petition for stay before or after the effective date of the Initial or Final Order.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.22 JUDICIAL REVIEW.

(1) Written notice of the right to seek judicial review of the Final Order and the time within which to file a petition for judicial review of the Final Order must be included with the Initial and Final Order sent to the parties.

(2) Judicial review is initiated by filing a petition for review in a Chancery Court of Tennessee having jurisdiction within sixty (60) days after the Final Order is entered. T.C.A. § 4-5-322 sets out the judicial review information.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.23 CLERICAL MISTAKES. Prior to any appeal being perfected by either party to Chancery Court, clerical mistakes in orders or other parts of the record, and errors of oversight or omission may be corrected by the Administrative Judge or the Commissioner's Designee at any time on his own initiative or on motion of any party and after such notice, if any, as the Administrative Judge or Commissioner's Designee may require. The entry of a corrected order does not affect the dates of the original appeal time period.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.24 AGENCY RECORD.

(1) The agency record as defined in this chapter will remain on file in the Bureau of TennCare for not less than three (3) years and be available to the appellant or his representative at any reasonable time during business hours.

(2) Public access to Final Orders. Hearing decisions will be accessible to the public for inspection and copying, subject to the requirements of safeguarding information which is confidential under any provision of law or rule. Those portions of any record that contain confidential information may be deleted prior to providing access to the Final Order.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

1200-13-19-.25 CODE OF JUDICIAL CONDUCT, DISQUALIFICATION AND SEPARATION OF FUNCTIONS. Administrative Judges must comply with the code of judicial conduct requirements set out in the UAPA Rules and the requirements of T.C.A. §§ 4-5-302 and 4-5-303 concerning disqualification of Administrative Judges and separation of functions. Complaints regarding an individual Administrative Judge's conduct are to be made to the supervising Administrative Judge and complaints regarding the supervising Administrative Judge are to be made to the commissioner.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and 71-5-112; 42 U.S.C. §§ 1396a(a)(3), (5), (8); 42 C.F.R. 431 Subpart E and 42 C.F.R. § 435.912.* ***Administrative History:*** *Emergency rule filed November 7, 2014; effective through May 6, 2015. Original rule filed February 2, 2015; effective May 3, 2015.*

RULES
OF THE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE

CHAPTER 1200-13-20
TENNCARE TECHNICAL AND FINANCIAL ELIGIBILITY

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1200-13-20-.01 SCOPE AND AUTHORITY.

(1) This Chapter governs the processes for determining financial and categorical eligibility for the TennCare and CoverKids programs. This Chapter preempts any other TennCare and CoverKids Rules pertaining to eligibility determination to the extent that they are in conflict.

(2) The Tennessee Medical Assistance Act of 1968 and Executive Order Number 23, dated October 19, 1999, designate the Tennessee Department of Finance and Administration as the Single State Agency for purposes of administering Title XIX of the Social Security Act (Medicaid).

(3) The CoverKids Act of 2006 authorizes the Tennessee Department of Finance and Administration to establish and administer a program to provide health care coverage to uninsured children under Title XXI of the Social Security Act (State Children's Health Insurance Program – CHIP).

(4) Titles XIX and XXI of the Social Security Act, TennCare Medicaid Section 1115 Demonstration Waiver as may be amended, extended, or renewed in the future, and 42 C.F.R. Parts 431 and 435 require the designated State agency to provide for eligibility determinations for applicants for assistance and services provided through the programs.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111, and 71-5-117.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016.*

1200-13-20-.02 DEFINITIONS AND ACRONYMS.

(1) AAAD – Area Agency for Aging and Disability

(2) ABD – Aged, Blind or Disabled

(3) Access to Health Insurance (TennCare). See definition in Rule 1200-13-13-.01. Access to health insurance through the Federally Facilitated Marketplace (FFM) shall not constitute "access to insurance" for purposes of eligibility for TennCare.

(4) Achieving a Better Life Experience (ABLE) Account. An account established under 26 U.S.C.A. § 529A. ABLE accounts or 529A accounts are tax-advantaged savings accounts for individuals with disabilities that are established under a qualified ABLE program.

(5) Active SSI Recipient. An individual who has been found eligible to receive SSI benefits by the SSA.

(Rule 1200-13-20-.02, continued)

(6) AFDC – Aid to Families with Dependent Children

(7) Aged. An individual age sixty-five (65) or older.

(8) Aid to Families With Dependent Children (AFDC). The name of the cash assistance program for families and children prior to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in July 1996.

(9) Annuities. Contracts or agreements that, in exchange for a lump sum payment or series of payments, provide for the payment of income at regular intervals, e.g., monthly, quarterly, annually, etc. Annuities establish a source of income for a future period and are often used in retirement planning.

(10) Applicant. An individual who is seeking an eligibility determination for himself through an application submission or a transfer from another agency or insurance affordability program. For purposes of this Chapter, applicant also includes an individual who is seeking an eligibility determination for himself through an application for Medicare Savings Programs (MSP).

(11) Application. The single, streamlined form developed for use for all insurance affordability programs, as required by 42 C.F.R. § 435.907(b), or the application form used in determining Medicaid eligibility for Long Term Services and Supports (LTSS), Hospice Care, and Medicare Savings Programs (MSP).

(12) Application File Date. See Rule .05(5).

(13) APTC – Advanced Premium Tax Credit

(14) APTC/CSR – Advanced Premium Tax Credit/Cost Sharing Reductions

(15) Authorized Representative. An Authorized Representative as defined at 42 C.F.R. § 435.923.

(16) BCSP – Breast and Cervical Screening Program

(17) Blind. An individual who is determined to be blind by the SSA.

(18) Breast and Cervical Cancer (BCC). The Medicaid eligibility category defined at Section 1902(aa) of the Social Security Act (42 U.S.C. § 1396a(aa)). This eligibility category covers individuals who have been found to have breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program, who are under age sixty-five (65), do not otherwise have creditable coverage (including current enrollment in Medicaid), as the term is used under the Health Insurance Portability and Accountability Act (HIPAA) (§ 2701(c) of the PHS Act (42 U.S.C. § 300gg(c)), are not otherwise eligible for Medicaid or receiving TennCare Standard, and who are currently undergoing treatment for breast or cervical cancer.

(19) Bureau of TennCare (Bureau). See definition in Rule 1200-13-13-.01.

(20) Caretaker Relative. A relative of a dependent child by blood, adoption, or marriage with whom the child lives, assumes primary responsibility for the child's care, and is one of the following:

(a) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece; or

(Rule 1200-13-20-.02, continued)

(b) The spouse of such caretaker relative, even after the marriage is terminated by death or divorce.

(21) CCRC – Continuing Care Retirement Community

(22) CHIP. The Children's Health Insurance Program established by Title XXI of the Social Security Act.

(23) CHOICES. TennCare CHOICES in Long-Term Care, as defined in Rule 1200-13-01-.02.

(24) CMS (Centers for Medicare & Medicaid Services). See definition in Rule 1200-13-13-.01.

(25) Community Spouse. The legal spouse of an institutionalized individual. A community spouse may not reside in a medical institution or nursing facility.

(26) Comprehensive Aggregate Cap Waiver. See definition in Tennessee's 1915(c) Home and Community Based Services Waiver.

(27) Completed Application. An application that meets the following criteria:

(a) All required fields have been completed;

(b) Is signed and dated by the applicant, the applicant's parent or guardian, an individual acting on behalf of the applicant, or an authorized representative;

(c) Includes all supporting documentation required by the Bureau to determine TennCare or CoverKids eligibility, including technical and financial requirements as set out in this Chapter; and

(d) If the application is for the TennCare Standard Medically Eligible category, it includes all supporting documentation required to prove TennCare Standard medical eligibility as set out in this Chapter.

(28) Continuous Eligibility. Enrollment in TennCare or CoverKids with no lapse in coverage.

(29) Core Medicaid Population. Individuals eligible under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq., with the exception of the following groups: active SSI recipients who are receiving benefits as determined by the SSA; individuals eligible for emergency services as an undocumented or ineligible alien; individuals in a presumptive eligibility period; and children in DCS custody, including DCS children who meet the criteria for immediate eligibility and those receiving adoption assistance payments.

(30) CoverKids. The name given to the Children's Health Insurance Program (CHIP) in Tennessee under T.C.A. § 71-3-1101.

(31) CoverKids Pregnant Women/Unborn Children. Provides maternity care coverage for pregnant CoverKids enrollees, including the unborn children of pregnant women with no source of coverage, who meet the CoverKids eligibility requirements.

(32) CSIMA – Community Spouse Income Maintenance Allowance

(33) CSRMA – Community Spouse Resource Maintenance Allowance

(34) DAC – Disabled Adult Child

(35) DCS – Department of Children's Services

(Rule 1200-13-20-.02, continued)

(36) Deemed Newborn. An individual eligible in a Medicaid category authorized by Section 1902(e)(4) of the Social Security Act (42 U.S.C. § 1396a(e)(4)) and 42 C.F.R. § 435.117.

(37) DIMA – Dependent Income Maintenance Allowance

(38) Disabled. An individual who has been determined to be disabled by the SSA. An individual that meets conditions in Rule .08(5)(c).

(39) Disabled Adult Child (DAC). The Medicaid eligibility category defined in Section 1634(c) of the Social Security Act (42 U.S.C. § 1383c(c)).

(40) Effective Date. The first date of eligibility for purposes of health care services coverage and payment.

(41) Eligible. An individual who has been determined to meet the eligibility criteria of TennCare Medicaid, TennCare Standard, or CoverKids.

(42) Enrollee. An individual eligible for and enrolled in the TennCare program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the U. S. Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act or in the CoverKids program. (42 U.S.C. §§ 1315 or 1396n). For purposes of this Chapter, enrollee also includes individuals eligible for and enrolled in the Medicare Savings Programs (MSPs).

(43) Enrollment. The process by which a TennCare or CoverKids eligible individual becomes enrolled in TennCare or CoverKids.

(44) Exchange. A governmental agency or non-profit entity that meets the applicable Federal standards and makes Qualified Health Plans (QHPs), including TennCare and CoverKids, available to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a Small Business Health Options Program (SHOP) serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by the Department of Health and Human Services (HHS).

(45) Extended Medicaid. Medicaid eligibility authorized for enrollees who lose Child Modified Adjusted Gross Income (MAGI), Pregnancy MAGI, or Caretaker Relative MAGI eligibility due to increased receipt of spousal support, whose household income prior to losing eligibility was at or below the current Caretaker Relative MAGI income standard for three (3) of the six (6) months preceding the month of the increase in income.

(46) Families First (FF). Tennessee's Temporary Assistance for Needy Families (TANF) program was created by the PRWORA in 1996. TANF became effective in July 1996 and replaced what was then commonly known as the AFDC program.

(47) Federal Data Services Hub. An electronic service established by the HHS to facilitate sharing of data and other information between federal agencies, State agencies, and other entities involved in administering Insurance Affordability Programs.

(48) Federal Financial Participation (FFP). See definition in Rule 1200-13-13-.01.

(49) Federal Poverty Level (FPL). The poverty level established annually by HHS.

(50) Federally Facilitated Marketplace (FFM). See "Exchange."

(Rule 1200-13-20-.02, continued)

(51) FEMA – Federal Emergency Management Agency

(52) FF – Families First

(53) FFM – Federally Facilitated Marketplace

(54) FFP – Federal Financial Participation

(55) Financially Responsible Relatives (FRR). Principle of financial responsibility between spouses and of parents to their children which is used in determining household composition, income counting and resource counting for certain Medicaid categories.

(56) Former Foster Care Children Under 26. The Medicaid eligibility category defined at Section 1902(a)(10)(A)(i)(IX) of the Social Security Act (42 U.S.C. § 1396a(a)(10)(A)(i)(IX)).

(57) FPL – Federal Poverty Level

(58) FRR – Financially Responsible Relatives

(59) Full-Time Student. A student is defined as a child under age twenty-one (21), unless otherwise specified in this Chapter, attending primary or secondary school, college, university, or a course of vocational or technical training.

(a) A child retains his or her student status during official school vacations and breaks if the requirement prior to the vacation or break was met, and the student plans to return.

(b) A child who is receiving elementary/secondary or equivalent vocational/technical instruction from a homebound teacher meets student requirements.

(c) An elementary school is defined as a State-approved educational institution comprised of grade kindergarten through eighth grade.

(d) Participation in apprenticeships, correspondence courses, other courses of home study and rehabilitation programs other than academic, institutional, vocational or technical training do not qualify a child as a student.

(e) A full-time student for college or university is an individual who is enrolled in at least twelve (12) credit or semester hours per semester. A part-time student is an individual who is enrolled in at least six (6) but less than twelve (12) credit or semester hours per semester. T.C.A. §§ 49-4-902(18) and (29).

(60) Group Health Insurance. An employee benefit plan to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly through an insurance reimbursement mechanism. This definition includes those types of health insurance found in the Health Insurance Portability And Accountability Act of 1996, as amended, definition of creditable coverage (with the exception that the 50-or-more participants criteria do not apply), which includes Medicare and TRICARE. Health insurance benefits obtained through COBRA are included in this definition. It also covers group health insurance available to an individual through membership in a professional organization or a school.

(61) HCBS – Home and Community Based Services

(62) HCFA – Health Care Finance and Administration

(Rule 1200-13-20-.02, continued)

(63) Health Care Finance and Administration (HCFA). The State agency that oversees most of the health care related divisions within the Tennessee Department of Finance and Administration, including the Bureau of TennCare, the Office of eHealth, the Cover Tennessee Programs and the Strategic Planning and Innovation Group.

(64) Health Insurance (for CoverKids).

(a) Health insurance including, but not limited to, basic medical coverage (hospitalization plans), major medical insurance, comprehensive medical insurance, short-term medical policies, mini-medical plans, and high-deductible plans with health savings accounts. For purposes of eligibility, other coverage includes Medicare, TennCare, TRICARE, employer-sponsored coverage.

(b) Health insurance shall not include the following:

1. CoverTN;

2. AccessTN;

3. Catastrophic health insurance plans that only provide medical services after satisfying a deductible in excess of $3,000.00 (or the maximum allowed deductible for a health savings account plan);

4. Dental-only plans;

5. Vision-only plans;

6. Benefits provided by the U.S. Department of Veterans Affairs or the Indian Health Service.

7. Coverage under the State of Tennessee's Children's Special Services program; or

8. Medical insurance that is available to an enrollee pursuant either to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 (29 U.S.C. §§ 1161, et seq.) and which the individual declined, or to T.C.A. §§ 56-7-2312, et seq., and which the individual declined.

(c) Consistent with 42 U.S.C. § 1397jj(b)(2)(B) and 42 C.F.R. §§ 457.301 and 457.310(c)(1)(ii), health insurance shall not include State-administered or other medical coverage offered by means of a family member's employment with a local education agency (LEA) if the LEA does not make more than a nominal contribution (as defined at 42 C.F.R. § 457.310(c)(1)(ii)) to the premium for the dependent, who is applying (or re-applying) for coverage through CoverKids.

(65) Health Insurance (for TennCare).

(a) Health insurance, for purposes of determining eligibility under these Rules, shall mean:

1. Any hospital or medical expense-incurred policy;

2. Medicare;

3. TRICARE;

4. COBRA;

(Rule 1200-13-20-.02, continued)

5. Medicaid;

6. State health high-risk pool;

7. Nonprofit health care service plan contract;

8. Health maintenance organization (HMO) subscriber contracts;

9. Group Health Insurance;

10. Coverage available to an individual through membership in a professional organization or a school;

11. Coverage under a policy covering one individual or all members of a family under a single policy where the contract exists solely between the individual and the insurance company;

12. Any of the above types of policies for which:

(i) The policy contains a type of benefit (such as mental health benefits) which has been completely exhausted;

(ii) The policy contains a type of benefit (such as pharmacy) for which an annual limitation has been reached;

(iii) The policy has a specific exclusion or rider of non-coverage based on a specific prior existing condition or an existing condition or treatment of such a condition.

13. Any of the types of policies listed in part 12. will be considered Health Insurance even if one or more of the following circumstances exists:

(i) The policy contains fewer benefits than TennCare;

(ii) The policy costs more than TennCare; or

(iii) The policy is one the individual could have bought during a specified period of time (such as COBRA) but chose not to do so.

(b) Health insurance, for purposes of determining eligibility under these Rules, shall not mean:

1. Short term coverage;

2. Accident coverage;

3. Fixed indemnity insurance;

4. Long-term care insurance;

5. Disability income contracts;

6. Limited benefits policies as defined elsewhere in these Rules;

7. Credit insurance;

(Rule 1200-13-20-.02, continued)

8. School-sponsored sports-related injury coverage;

9. Coverage issued as a supplement to liability insurance;

10. Automobile medical insurance;

11. Insurance under which benefits are payable with or without regard to fault and which are statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

12. A medical care program of the Indian Health Services (IHS) or a tribal organization;

13. Benefits received through the U.S. Department of Veterans Affairs; or

14. Health care provided through a government clinic or program such as, but not limited to, vaccinations, flu shots, mammograms, and care or services received through a disease- or condition-specific program such as, but not limited to, the Ryan White CARE Act.

(66) Health Insurance Marketplace, a.k.a. “Marketplace”, “Exchange” or “Federally Facilitated Marketplace”. See “Exchange.”

(67) Home and Community Based Services (HCBS). See definition in Rule 1200-13-01-.02.

(68) Household Size. The number of individuals counted as members of an individual’s household for purposes of determining eligibility for TennCare or CoverKids.

(69) ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities

(70) Immediate Eligibility (for DCS children only). An arrangement whereby children in the custody of the State who are presumed to be TennCare-eligible may gain TennCare eligibility while their applications are being processed.

(71) Inactive SSI Enrollee. Individuals whose SSI cash benefits have been terminated by SSA and who remain eligible for TennCare until they have been reviewed for coverage in other eligibility categories. Inactive SSI enrollees are not eligible for CHOICES.

(72) Incarcerated. The state of being confined in a local, State, or federal prison, jail, youth development center, or other penal or correctional facility, including the state of being on furlough from such facility.

(73) Individual Health Insurance. Health insurance coverage under a policy covering one individual or all the members of a family under a single policy where the contract exists solely between that individual and the insurance company.

(74) Infants and Children Under Age 19. The Medicaid eligibility categories defined at Sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) and (d) of the Social Security Act. (42 U.S.C. §§ 1396a(a)(10)(A)(i)(III), (IV), (VI) and (VII); 1396a(a)(10)(A)(ii)(IV) and (IX); and 1396u-1(b) and (d)).

(75) Insurance Affordability Program. A program that is one of the following:

(a) TennCare.

(Rule 1200-13-20-.02, continued)

(b) CoverKids.

(c) APTC/CSR for participation in a QHP available through the FFM.

(76) Institutional Eligibility. The eligibility category defined at Section 1902(a)(10)(A)(ii)(V), (VI) and (VII) of the Social Security Act. (42 U.S.C. § 1396a(a)(10)(A)(ii)(V), (VI) and (VII)).

(77) Institutional Spouse. An institutionalized individual who is the legal spouse of a Community Spouse.

(78) Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). An institution described at 42 C.F.R. Part 483, Subpart I.

(79) IRA – Individual Retirement Account

(80) ITEM D. The term used in Tennessee to refer to the methodology for deducting incurred expenses for necessary medical or remedial care for institutionalized individuals in the post-eligibility phase of income defined at 42 C.F.R. §§ 435.725(c)(4), 435.726(c)(4) and 435.832.

(81) Joint Custody. Legal custody of a child held simultaneously by two (2) or more caretaker relatives. The caretaker relatives must exercise care and control of the child.

(82) Limited Benefits Policy. A policy of health coverage for a specific disease (e.g., cancer), or an accident occurring while engaged in a specified activity (e.g., school-based sports), or which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (e.g., hospital indemnity).

(83) Long-Term Care. See “Long-Term Services and Supports” (LTSS).

(84) Long-Term Services and Supports (LTSS) Program. See definition in Rule 1200-13-01-.02.

(85) LTSS – Long-Term Services and Supports

(86) MAGI – Modified Adjusted Gross Income

(87) Marketplace. See “Exchange.”

(88) Medicaid. See definition in Rule 1200-13-13-.01.

(89) Medicaid Income Cap (MIC). Three hundred percent (300%) of the SSI Federal Benefit Rate.

(90) Medicaid “Rollover” Enrollee. A TennCare Medicaid enrollee under the age of 19 who no longer meets eligibility requirements for Medicaid and who is afforded an opportunity to enroll in TennCare Standard according to the provisions of these Rules.

(91) Medically Needy. The Medicaid eligibility category described at Section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. § 1396a(a)(10)(C)).

(92) Medically Needy Income Standard (MNIS). See definition at 42 C.F.R. § 435.811.

(93) Medicare. The program administered through the SSA pursuant to Title XVIII, available to most individuals upon attaining age sixty-five (65), to some disabled individuals under age sixty-five (65), and to some individuals that have End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

(Rule 1200-13-20-.02, continued)

(94) Medicare Buy-In. The process by which TennCare "buys" Medicare beneficiaries into the Medicare program. The Medicare buy-in consists of paying for some or all of a beneficiary's Medicare premiums, deductibles, and coinsurance.

(95) Medicare Savings Program (MSP). One of the programs under which low-income Medicare beneficiaries can get assistance from Medicaid for paying for some or all of their Medicare premiums, deductibles, and coinsurance. These programs include the Qualified Medicare Beneficiary (QMB) program, the Specified Low Income Medicare Beneficiary (SLMB) program, the Qualifying Individual (QI1) program and the Qualified Disabled and Working Individual (QDWI) program.

(96) Member. See "Enrollee."

(97) MIC – Medicaid Income Cap

(98) Miller Trust. See "Qualified Income Trust."

(99) MNIS – Medically Needy Income Standard

(100) Modified Adjusted Gross Income (MAGI). See definition at 42 C.F.R. § 435.603(e).

(101) MSP – Medicare Savings Program

(102) Newborn Presumptive. The Medicaid eligibility category described at 42 C.F.R. § 435.1102.

(103) Nursing Facility (NF). See definition in Rule 1200-13-01-.02.

(104) PACE – Program of All-Inclusive Care for the Elderly

(105) PACE Carryover Group. See definition in Rule 1200-13-01-.02.

(106) PASS – Plan to Achieve Self Support

(107) Patient Liability. See definition in Rule 1200-13-01-.02.

(108) Payment for Emergency Medical Services. Eligibility authorized by Section 1903(v) of the Social Security Act (42 U.S.C. § 1396b(v)).

(109) Personal Needs Allowance (PNA). See definition in Rule 1200-13-01-.02.

(110) Pickle Passalong. The eligibility category defined at 42 C.F.R. § 435.135.

(111) Pregnant Women. For purposes of the Medicaid program, the Medicaid eligibility category defined at Sections 1902(a)(10)(A)(i)(III), (IV) and (VII); 1902(a)(10)(A)(ii)(I), (IV), and (IX); and 1931(b) and (d) of the Social Security Act, (42 U.S.C. §§ 1396a(a)(10)(A)(i)(III), (IV), and (VII); 1396a(a)(10)(A)(ii)(I), (IV) and (IX); and 1396u-1(b) and (d)); and 42 C.F.R. § 435.116.

(112) Presumptive Eligibility for Individuals with Breast or Cervical Cancer. Individuals presumed to be eligible for coverage under the Medicaid category authorized by Section 1902(aa) of the Social Security Act (42 U.S.C. § 1396a(aa)) based on a determination by the Tennessee Department of Health or other qualified entity.

(113) Presumptive Eligibility for Pregnant Women. Women presumed to be eligible for coverage in the category defined at Sections 1902(a)(10)(A)(i)(III), (IV) and (VII); 1902(a)(10)(A)(ii)(I), (IV), (IX); and 1931(b) and (d) of the Social Security Act, (42 U.S.C. §§ 1396a(a)(10)(A)(i)(III),

(Rule 1200-13-20-.02, continued)

(IV), and (VII); 1396a(a)(10)(A)(ii)(I), (IV) and (IX); and 1396u-1(b) and (d)); and in 42 C.F.R. § 435.1103 by the Tennessee Department of Health or other qualified entity.

(114) Program of All-Inclusive Care for the Elderly (PACE). See definition in Rule 1200-13-01-.02.

(115) QDWI – Qualified Disabled and Working Individual

(116) QHP – Qualified Health Plan

(117) QI1 – Qualifying Individual

(118) QIT – Qualified Income Trust

(119) QMB – Qualified Medicare Beneficiary

(120) Qualified Disabled and Working Individual (QDWI). An individual who is under age sixty-five (65), has lost free Medicare Part A coverage due to substantial gainful activity, has a disabling impairment, has the option to purchase Medicare Part A for an indefinite period of time, and for whom Medicaid pays the Medicare Part A premium, if income is not more than two hundred percent (200%) of the FPL and resources are not more than twice the SSI limit and is not otherwise eligible for Medicaid. Eligibility is authorized by Sections 1905(p)(3)(A)(i) and (s); and 1902(a)(10)(E)(ii) of the Social Security Act, (42 U.S.C. §§ 1396d(p)(3)(A)(i) and (s); and 1396a(a)(10)(E)(ii)).

(121) Qualified Health Plan (QHP). See definition at 42 U.S.C. § 18021.

(122) Qualified Income Trust (QIT). The trust defined at 42 U.S.C. § 1396p(d)(4)(B).

(123) Qualified Long-Term Care Insurance Policy. A long-term care insurance policy issued on or after October 1, 2008, that has been pre-certified by the Tennessee Department of Commerce and Insurance pursuant to Rule 0780-01-61 as:

(a) A policy that meets all applicable Tennessee Long Term Care Partnership requirements; or

(b) A policy that has been issued in another Partnership State and which is covered under a reciprocal agreement between that State and the State of Tennessee.

(124) Qualified Medicare Beneficiary (QMB). An individual who is entitled to and receives Medicare Part A and for whom Medicaid pays the Medicare Part A and Part B premium, coinsurance and deductible for Medicare-covered services, and whose income is not more than one hundred percent (100%) of the FPL. Eligibility is authorized by Sections 1905(p) and 1902(a)(10)(E)(i) of the Social Security Act, (42 U.S.C. §§ 1396d(p) and 1396a(a)(10)(E)(i)).

(125) Qualifying Individual 1 (QI1). An individual who is entitled to and receives Medicare Part A, for whom Medicaid pays Medicare Part B premiums on a first-come, first-served basis, and who has income at least one hundred and twenty percent (120%) of the FPL but not more than one hundred and thirty-five percent (135%) of the FPL. Individuals are not enrolled in TennCare Medicaid or TennCare Standard. Eligibility is authorized by Section 1902(a)(10)(E)(iv) of the Social Security Act, (42 U.S.C. § 1396a(a)(10)(E)(iv)) and 42 U.S.C. § 1396u-3.

(126) Qualifying Medical Condition. A medical condition included on a list of conditions established by the Bureau which will render a qualified uninsured applicant medically eligible.

(Rule 1200-13-20-.02, continued)

(127) Redetermination. The process by which the Bureau evaluates the ongoing eligibility status of TennCare Medicaid enrollees who are considered a part of the Core Medicaid Population, as well as TennCare Standard and CoverKids enrollees. This is a periodic process that is conducted at specified intervals. The process is conducted according to TennCare's, or its designee's, policies and procedures. This is also referred to as "Renewal."

(128) Renewal. See "Redetermination."

(129) Responsible Party(ies). The following individuals, who are representatives and/or relatives of recipients of medical assistance who are not financially eligible to receive benefits: parents, spouses, children, and guardians; as defined at T.C.A. § 71-5-103.

(130) Single State Agency (CoverKids and TennCare). The Department of Finance and Administration.

(131) SLMB – Specified Low Income Medicare Beneficiary

(132) Specified Low-Income Medicare Beneficiary (SLMB). An individual who is eligible for Medicare Part A and for whom Medicaid pays Medicare Part B premiums, if income is at least one hundred percent (100%) but not more than one hundred twenty percent (120%) of the FPL. Eligibility is authorized by Sections 1905(p)(3)(A)(ii) and 1902(a)(10)(E)(iii) of the Social Security Act, (42 U.S.C. §§ 1396d(p)(3)(A)(ii) and 1396a(a)(10)(E)(iii)).

(133) Spend down. The process by which excess income is utilized for recognized medical expenses and which, when depleted, results in a determination of eligibility if all other eligibility factors are met for the Medically Needy categories.

(134) SSA – Social Security Administration

(135) SSI – Supplemental Security Income

(136) SSI – Related Groups. Individuals who have been found eligible in one of the following categories:

(a) Disabled Adult Children (DAC).

(b) Pickle Passalong.

(c) Widow/Widower.

(137) Standard Child Medically Eligible. An uninsured child under age nineteen (19) who is losing eligibility for Medicaid or currently enrolled in TennCare Standard, whose household income exceeds two hundred and eleven percent (211%) of the FPL, who does not have access to health insurance, and who has been determined medically eligible according to these Rules.

(138) Standard Child Uninsured. The TennCare Demonstration category defined as including individuals in the following groups:

(a) Uninsured children under age nineteen (19) who are losing eligibility for Medicaid, or are currently enrolled in TennCare Standard, who have household incomes at or below two hundred and eleven percent (211%) of the FPL, and who do not have access to health insurance; or

(b) Uninsured children under age nineteen (19) who have been continuously enrolled in TennCare Standard since December 31, 2001, who have family incomes at or below two hundred percent (200%) of the FPL, and who have not purchased insurance even

(Rule 1200-13-20-.02, continued)

if they have access to it. This is a "grandfathered" eligibility category. When an individual loses eligibility in this category, he will not be able to re-enroll in it.

(139) Supplemental Security Income (SSI). A federal income supplement program funded by general tax revenues and is designed to help aged, blind and disabled individuals who have little or no income. Applications for SSI benefits are filed at the Social Security office. Individuals who are eligible for SSI are automatically entitled to Medicaid (42 U.S.C. §§ 1382, et seq.).

(140) TANF – Temporary Assistance for Needy Families

(141) Temporary Assistance for Needy Families (TANF). A program created by the PRWORA in 1996. TANF became effective in July 1996 and replaced what was then commonly known as the AFDC program. The name given to Tennessee's TANF program is Families First.

(142) 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.

(143) TennCare CHOICES in Long-Term Services and Supports. The program described in Rule 1200-13-01-.05. CHOICES is a benefit package available to TennCare enrollees who are eligible in the Institutional eligibility category or who are active SSI enrollees and who meet the requirements of the program set out in Chapter 1200-13-01.

(144) TennCare Medicaid. That part of the TennCare program which covers individuals eligible for Medicaid under Tennessee's Title XIX State Plan for Medical Assistance. The following individuals are eligible for TennCare Medicaid:

(a) Tennessee residents determined to be eligible for Medicaid according to this Chapter.

(b) Individuals who qualify as dually eligible for Medicare and Medicaid are enrolled in TennCare Medicaid.

(c) A Tennessee resident who is an uninsured individual, under age sixty-five (65), a US citizen or qualified alien, is not eligible for any other category of Medicaid, and has been diagnosed as the result of a screening at a Centers for Disease Control and Prevention (CDC) site with breast or cervical cancer, including pre-cancerous conditions.

(d) Tennessee residents determined eligible for SSI benefits and TennCare Medicaid by the SSA are automatically enrolled in TennCare Medicaid.

(145) TennCare Standard. That part of the TennCare Program which provides health coverage for Tennessee residents who are not eligible for Medicaid and who meet the eligibility criteria found in this Chapter.

(146) Tennessee Health Connection (TNHC). Working title of the entity contracted with TennCare to provide service center functionality, including a call center and document intake.

(147) Termination. See definition in Rule 1200-13-13-.01. Also means the discontinuance of an enrollee's coverage under the CoverKids program.

(148) Title IV-E. The section of the Social Security Act under which grants are made to States for implementation of foster care and adoption assistance programs. Eligibility is authorized by Section 1902(a)(10)(A)(i)(I) of the Social Security Act (42 U.S.C. § 1396(a)(10)(A)(i)(I)), 42 C.F.R. § 435.115, and 42 C.F.R. § 435.145.

(Rule 1200-13-20-.02, continued)

(149) TNHC – Tennessee Health Connection

(150) Transitional Medicaid. Medicaid authorized for enrollees who lose Child MAGI, Pregnancy MAGI, or Caretaker Relative MAGI eligibility due to increased earnings and whose household income prior to losing eligibility was at or below the current Caretaker Relative MAGI income standard for three (3) of the six (6) months immediately preceding the month of the increase in income.

(151) Uninsured. See definition in Rule 1200-13-13-.01.

(152) Valid Application. Either the single application form for all insurance affordability programs or the application form for LTSS or MSPs. It must include contact information and be signed by the Applicant, a Responsible Party, or the Authorized Representative.

(153) WIA – Workforce Investment Act

(154) Widow/Widower. The eligibility category defined at 42 C.F.R. § 435.138.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111, and 71-5-117.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016.*

1200-13-20-.03 DELINEATION OF ROLES AND RESPONSIBILITIES.

(1) Agencies' Roles and Responsibilities.

(a) The Bureau of TennCare (Bureau) is responsible for determining eligibility for both TennCare and CoverKids and for conducting appeals of eligibility-related decisions, unless otherwise agreed to by the Single State Agency and CMS. The Bureau is also responsible for coordinating the eligibility process for TennCare and CoverKids with the eligibility process for APTC/CSR in the FFM, in compliance with 42 C.F.R. §§ 435.1200 and 1205, unless otherwise agreed to by the Single State Agency and CMS.

(b) The Tennessee Department of Human Services (DHS) is under contract with the Bureau to determine initial eligibility for some TennCare Medicaid and TennCare Standard applicants who have open Supplemental Nutrition Assistance Program (SNAP) cases, as well as to redetermine, at regular intervals, whether eligibility should be continued for some enrollees. DHS is not responsible for making decisions about the presence of a qualifying medical condition for those applying as medically eligible individuals under TennCare Standard.

(c) With respect to the eligibility of children applying for TennCare as medically eligible individuals, the Bureau is responsible for determining the presence of a qualifying medical condition under TennCare Standard.

(d) The Tennessee Department of Children's Services (DCS) is responsible for determining eligibility for Medicaid foster care and adoption assistance categories.

(e) The Tennessee Department of Health (DOH) is responsible for conducting presumptive eligibility determinations for pregnant women and individuals in the BCC category.

(f) The SSA is responsible for determining eligibility for receipt of benefits from the SSI program and for determining TennCare Medicaid eligibility for individuals who are eligible for SSI benefits. 42 U.S.C. § 1383c(a). Individuals determined eligible for SSI

(Rule 1200-13-20-.03, continued)

benefits and TennCare Medicaid by SSA are automatically enrolled in TennCare Medicaid.

(g) The FFM is responsible for making TennCare Medicaid and CoverKids eligibility determinations for categories using MAGI income methodologies, based on an agreement between the State and the FFM. The FFM is also responsible for assessing applicants who may be eligible for other Medicaid eligibility categories and transmitting those applications to the State for full review.

(h) The Bureau is responsible for notifying applicants of recovery for LTSS expenditures. Section 1917 of the Social Security Act (42 U.S.C. § 1396p), 42 C.F.R. §§ 433.36 and 435.700, et seq., and T.C.A. § 71-5-116.

(2) Enrollee Roles and Responsibilities.

(a) Each TennCare enrollee and each CoverKids enrollee is responsible for reporting to HCFA any material change in the information affecting eligibility given by the applicant/enrollee to the Bureau or to the FFM. This information includes, but is not limited to, changes in address, income, household size, employment, or access to insurance. When submitting changes to the State, the applicant/enrollee shall mail, fax, or present in person, any required documentation of any such change to TennCare. When submitting changes to the FFM the applicant/enrollee shall mail or electronically upload any required documentation of any such change to the FFM. General contact information such as phone number and address changes may be updated by phone call to TNHC. Changes must be reported within ten (10) days of the occurrence.

(b) All verifications requested must be furnished within ten (10) days of the notice requesting additional information unless otherwise specified by federal law.

(c) Each TennCare enrollee and each CoverKids enrollee is responsible for reporting to his provider that he is a TennCare or CoverKids enrollee.

(d) By accepting medical assistance through the TennCare program, every enrollee is deemed to assign to the State of Tennessee all third party insurance benefits or other third party sources of medical support or benefits. Individuals applying as Caretaker Relatives under Medicaid (see Rule .07) must cooperate in establishing the paternity of dependent children and obtaining medical support. Failure to cooperate in securing or collecting third party medical insurance, benefits or support is grounds for denying or terminating TennCare eligibility.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111, and 71-5-117.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016.*

1200-13-20-.04 TECHNICAL ELIGIBILITY REQUIREMENTS.

(1) State Residency. Individuals enrolled in TennCare must meet the requirements for State residency established in 42 C.F.R. § 435.403. Individuals applying for CoverKids must also meet the requirements specified at 42 C.F.R. § 457.320(d).

(a) Temporary absence. Individual may be “temporarily absent” from Tennessee but still considered a resident of the State for purposes of TennCare and CoverKids eligibility. An individual who wishes to be considered temporarily absent from the State for continued eligibility purposes must provide the Bureau with an anticipated date of return. The Bureau will assess the continuation of an individual’s temporary absence status ten (10) days after the individual’s anticipated date of return.

(Rule 1200-13-20-.04, continued)

A temporary absence from the State will not preclude continued eligibility under the following circumstances:

1. The absence is for a specific purpose such as a temporary work assignment, visit, hospitalization, participation in an educational or rehabilitation program not available in Tennessee; or

2. The absence is for a child receiving specialized treatment out of State; and

3. The individual indicates his intent to return to Tennessee once the purpose for his absence is accomplished.

(b) Students.

1. Individuals who are dependents of a Tennessee resident and who attend school out of State will be considered Tennessee residents.

2. Individuals aged eighteen (18) to twenty-two (22) who are considered to be dependents of a non-Tennessee resident and who attend school full time in State will not be considered Tennessee residents.

(2) Citizenship. Individuals enrolled in TennCare or CoverKids must meet the requirements for citizenship or qualified non-citizen status established in 42 C.F.R. § 435.406.

(a) Qualified aliens who entered the United States on or after August 22, 1996, are barred from receiving TennCare Medicaid or CoverKids benefits for five (5) years from the date of entering the U.S. before potential eligibility for TennCare or CoverKids unless they meet the exceptions to the five (5) year bar as outlined in 8 U.S.C. § 1613(b).

(b) For CoverKids, unborn children are presumed to be U.S. citizens, regardless of the citizenship or immigration status of the mother.

(3) Social Security Number (SSN).

(a) Individuals enrolled in TennCare or CoverKids must meet the requirements of 42 C.F.R. § 435.910.

(b) Unborn children enrolled in CoverKids Pregnant Women/Unborn Children are not required to have an SSN.

(c) SSNs are not required for members of households who are not applying for TennCare or CoverKids coverage.

(4) Incarceration. Individuals who are incarcerated are eligible for TennCare in a suspended status pursuant to T.C.A. § 71-5-106(r), as long as all eligibility criteria are met. Individuals in a suspended status will be eligible for TennCare payments only for medical institution stays longer than twenty-four (24) hours. All other medical payments while in the suspended status are not subject to TennCare reimbursement. The suspended status will be removed once the State receives notice that the enrollee is no longer incarcerated. See also 42 C.F.R. § 435.1010.

(5) Residents of an Institution for Mental Disease (IMD). Individuals who are residents of an IMD are not eligible for FFP, except for those who are age sixty-five (65) or older and confined to an approved ward, or those who are under age twenty-two (22) and receiving inpatient psychiatric services. Confinement in an IMD does satisfy and establish institutional status for

(Rule 1200-13-20-.04, continued)

individuals under age sixty-five (65) and those confined to unapproved wards who are subsequently admitted to a medical institution. See Section 1905 of the Social Security Act (42 U.S.C. § 1396d).

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111, and 71-5-117.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016.*

1200-13-20-.05 GENERAL APPLICATION REQUIREMENTS.

(1) Right to apply.

(a) Any individual wishing to do so shall have the opportunity to apply for TennCare Medicaid or CoverKids without delay.

(b) Information about the TennCare or CoverKids program administered by HCFA shall be provided to any individual requesting it pursuant to 42 C.F.R. § 435.905.

(c) Applications may be filed by the applicant, an individual listed in Rule .05(3)(b), his Authorized Representative or someone acting responsibly for him. See 42 C.F.R. § 435.923.

(d) Proof of eligibility is not required of an individual prior to filing an application.

(e) The right to file an application shall not be denied to any individual even if it is apparent that eligibility for TennCare or CoverKids does not exist.

(2) Rights and responsibilities.

(a) By applying for TennCare or CoverKids, an applicant grants permission and authorizes release of information to TennCare, or its designee, to investigate any and all information provided, or any information not provided if it could affect eligibility, to determine TennCare or CoverKids eligibility; and if approved, what cost sharing, if any, may be required of the applicant. Information may be verified through, but not limited to, the following sources:

1. The United States Internal Revenue Service (IRS);

2. State income tax records for Tennessee or any other State where income is earned;

3. The Tennessee Department of Labor and Workforce Development, and other Employment Security offices within any State where the applicant may have received wages or been employed;

4. Credit bureaus;

5. Insurance companies; or,

6. Any other governmental agency or public or private source of information where such information may impact an applicant’s eligibility or cost sharing requirements for the TennCare or CoverKids Program. The Federal Data Services Hub, or “electronic service” referred to in 42 C.F.R. § 435.949, is an example of such an information source.

(Rule 1200-13-20-.05, continued)

(b) It is a felony offense, pursuant to T.C.A. § 71-5-2601, to apply for TennCare coverage under false means or to help anyone obtain TennCare under false means.

(c) By applying for TennCare Medicaid, an applicant agrees to provide information to the Bureau, or its designee, about any third party coverage in which the applicant is enrolled.

(3) Submitting an application.

(a) TennCare will accept Valid Applications in compliance with 42 C.F.R. § 435.907 and, for CoverKids applicants, 42 C.F.R. § 457.330, or as otherwise agreed to by the Single State Agency and CMS.

(b) An application can be filed by one of the following individuals, as applicable:

1. Adult applicants or an adult who is in the applicant's household as defined in 42 C.F.R. § 435.603(f);

2. An adult who is in the applicant's family, as defined in the Internal Revenue Code at 26 U.S.C. § 36B(d)(1);

3. Applicants who are over age fourteen (14) but under age eighteen (18) who are emancipated or are considered sufficiently mature to make their own health care decisions;

4. A parent who has primary custody of a minor child;

5. Either parent of a minor child when custody is equally divided between legal parents;

6. The legal guardian or conservator;

7. An Authorized Representative;

8. If the applicant is a minor or incapacitated, someone acting responsibly for the applicant; or

9. A representative of the long term care facility where the individual resides.

(c) Applications received from Tennessee residents living out of State.

1. Applications filed for Tennessee residents who are temporarily out of State may be accepted.

2. The application of someone who is hospitalized in another State and planning to return to Tennessee when discharged may be processed in the usual manner.

(d) Out of State applicants.

1. Applications received from individuals residing in another State and not intending to reside in Tennessee will be denied.

2. Individuals who are in Tennessee for a temporary purpose, such as a visit, who intend to return to their home out of State are not eligible for TennCare or CoverKids.

(Rule 1200-13-20-.05, continued)

3. Applicants must always be given the right to submit an application if they wish to do so and receive a decision on their application.

(4) Assistance with submitting an application. HCFA is required to provide assistance to any individual seeking help with the application or redetermination process in person by Certified Application Counselors (CACs), over the phone, and online in a manner that is accessible to individuals with disabilities and those who have limited English proficiency. Assistance includes, but is not limited to, the following:

(a) Help with form completion;

(b) Help securing a representative, if needed, and/or allowing someone of the applicant's choice to assist with the application and renewal process; and

(c) Help in obtaining necessary information from third parties.

(5) Applications may be filed in any of the following ways:

(a) By mail.

1. LTSS and MSP: Paper LTSS/MSP applications must be submitted to TNHC. The Application File Date for LTSS/MSP applications mailed to TNHC will be the date the application is received at TNHC.

2. All categories of TennCare and CoverKids except MSPs:

(i) Mail paper applications to the FFM. The Application File Date will be the date provided by the FFM.

(ii) Mail an application to TNHC. If an FFM application is mailed to TNHC, the State will forward the application to the FFM to be processed. The Application File Date will be the date provided by the FFM, or as otherwise agreed to by the Single State Agency and CMS.

(b) By phone.

1. LTSS and MSP: Call TNHC or the local AAAD (or MCO if current TennCare enrollee). TNHC will provide a paper application that must be submitted by mail or fax. The Application File Date for LTSS/MSP applications will be the date the application is received at TNHC.

2. All other categories of TennCare and CoverKids except MSPs: Call the FFM. The Application File Date will be the date provided by the FFM.

3. Newborn applicants may call TNHC to either be added as a Deemed Newborn or apply for Newborn Presumptive coverage. The Application File Date for a Newborn Presumptive will be the date of determination by the qualified entity.

(c) By fax.

1. LTSS and MSP or EMS (Emergency Medical Services) applicants: Fax an application to TNHC. The Application File Date for LTSS/MSP/EMS applications faxed to TNHC will be the date the application is received at TNHC.

2. All other categories of TennCare and CoverKids: Fax application to TNHC. If an FFM application is faxed to TNHC, the State will forward the application to the

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FFM to be processed. The Application File Date will be the date provided by the FFM, or as otherwise agreed to by the Single State Agency and CMS.

(d) By online submission of the application through the FFM. The Application File Date will be the date provided to the State by the FFM.

(e) In person at any DHS county office.

1. LTSS and MSP: Submit a paper LTSS/MSP application at the local DHS office. The Application File Date for LTSS/MSP applications submitted to DHS will be the date of receipt at DHS.

2. All categories of TennCare and CoverKids other than MSPs: Complete an online application by using a kiosk at a DHS office or by telephone. Applications filed with the FFM, using the FFM Web site, call center or paper application, are processed by the FFM. Once processed, the federal government transmits the applicant's information to HCFA through an electronic file. The Application File Date will be the date provided to the State by the FFM.

(f) Low Income Subsidy (LIS) applications through the SSA. Application File Date will be the date provided to the State by the SSA.

(6) Processing time. Eligibility will be timely determined in compliance with 42 C.F.R. § 435.912, or as otherwise agreed to by the Single State Agency and CMS.

(7) Disposition.

(a) Eligibility is determined based on information contained on the completed application form as well as information secured during the application process.

(b) All applications will be subject to one (1) of the following actions:

1. Approval. When all eligibility factors are met, the application is approved.

2. Denial. When one or more eligibility factor(s) is not met, the application is denied.

(i) Death is not an appropriate reason to deny a Medicaid application. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion.

(ii) Applicants who do not respond to requests for verifications by the State in a timely manner will be denied for failure to respond to such requests.

(iii) Applicants who do not provide sufficient information in response to requests for verifications by the State will be denied.

(c) Withdrawal. When an applicant decides to withdraw his request for assistance during the application process, it is not necessary to complete any remaining verification and evaluation.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111, and 71-5-117.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016.*

1200-13-20-.06 FINANCIAL ELIGIBILITY DETERMINATIONS.

(1) Modified Adjusted Gross Income (MAGI) Financial Eligibility Determinations.

(a) All applicants for TennCare or CoverKids will have their income calculated for eligibility purposes according to the MAGI-based requirements at 42 C.F.R. § 435.603. The only exceptions are the Medicaid applicants at 42 C.F.R. §§ 435.603(j)(1)-(6).

(b) In compliance with 42 C.F.R. § 435.603(g)(1), there is no resource or asset test for individuals whose income eligibility is required to be determined using MAGI income requirements.

(c) There is no resource or asset test for pregnant women or children enrolled in CoverKids.

(d) In compliance with 42 C.F.R. § 435.603(g)(2), there are no income or expense disregards for individuals whose eligibility is determined according to MAGI requirements, with the exception of those described at 42 C.F.R. §§ 435.603(d)(1) and (4).

(e) Household composition, for financial eligibility determination purposes, for TennCare Medicaid (Child, Pregnant Women and Caretaker Relative categories), TennCare Standard Children Uninsured, TennCare Standard Medically Eligible, and the CoverKids categories will be determined using the MAGI methodology in accordance with 42 C.F.R. § 435.603(f). Household composition for all other categories will be determined according to this Chapter. MAGI household composition methodology is based on federal tax rules and the principles of tax dependency, however the MAGI rules apply to both applicants who expect to file taxes or be claimed as tax dependents, and to those applicants who do not file taxes or are not claimed as tax dependents. Each applicant has his own household size constructed under MAGI rules, and it is permissible for applicants who live in the same household to have different household sizes.

1. Tax Filers.

(i) For applicants who expect to file taxes, the household includes the tax filer and any dependents the tax filer expects to claim.

(ii) For applicants claimed as tax dependents, the household is the same as the tax filer claiming the tax dependent. Tax dependents may include individuals not otherwise eligible for TennCare Medicaid or CoverKids, and who are not applying for benefits. If a non-custodial parent claims a child as a dependent, the dependent child will be included in the non-custodial parent's household size.

(iii) For married couples who live together, each spouse will always be included in the other spouse's household, regardless of the couple's tax filing status.

(iv) There are three exceptions to the tax filer rule for applicants claimed as tax dependents. An applicant who meets any of the following is subject to the non-filer household composition rules:

(I) The tax filer is someone other than the applicant's spouse, or natural, adopted or step parent; or

(Rule 1200-13-20-.06, continued)

(II) The applicant is under age nineteen (19), or twenty-one (21) if a full-time student, and is claimed as a tax dependent by one parent, but his or her parents live together and do not file a joint tax return; or

(III) The applicant is under age nineteen (19), or twenty-one (21) if a full-time student, and expects to be claimed as a tax dependent by a non-custodial parent.

2. Non-Filers. Applicants who do not file taxes are subject to the non-filer household composition rules. The non-filer household includes the applicant and if living with the applicant:

(i) The applicant's spouse;

(ii) The applicant's natural, adopted and step children under age nineteen (19), or twenty-one (21) if a full-time student;

(iii) For applicants under age nineteen (19), or twenty-one (21) if a full-time student, the applicant's natural, adopted or step parent; and

(iv) For applicants under age nineteen (19), or twenty-one (21) if a full-time student, the applicant's natural, adoptive and step siblings who are under age nineteen (19), or (21) if a full-time student.

(f) The household size for a pregnant woman includes the number of children she is expected to deliver (the unborn child(ren)). The household size for other applicants in a pregnant woman's household does not include the unborn child(ren).

(2) AFDC-Related Financial Determinations.

(a) Coverage groups whose financial eligibility is determined according to AFDC-based methodologies are:

1. Medically Needy Children; and

2. Qualified Medically Needy Pregnant Women.

(b) Income Determinations. Income for individuals described in this paragraph is calculated according to the AFDC cash assistance program's income definitions and policies (Rules 1240-01-04-.12 and .14-.19, and 45 C.F.R. § 233.20). Unless otherwise specified below, these individuals are subject to the following income requirements:

1. ABLE Accounts. Contributions and ABLE account earnings are excluded, except that contributions are not deducted from countable income of the individual making the contribution. Distributions from an ABLE account are not income of the designated beneficiary in any month regardless of whether the distribution is for non-housing QDEs, housing QDEs or non-qualified expenses. Distribution from an ABLE account is the conversion of a resource from one form to another.

2. Adoption Subsidies – Countable to the child if intended for general living expenses. Excluded if for reimbursement of child care while the adult responsible for the child is at work or seeking employment, for medical expenses, or from State adoption assistance programs or Title IV-E funds for special needs children.

3. Alimony Received – Countable.

(Rule 1200-13-20-.06, continued)

4. Annuity Payments – If the underlying annuity is an excluded resource, the periodic payments are countable unearned income. If the underlying annuity is a countable resource, payments are excluded.

5. Assistance Payment from another State – Countable.

6. Bonuses – Countable.

7. Cancelled Debts – Excluded.

8. Capital Gains – Countable.

9. Cash Support – Countable, unless excluded as infrequent or irregular income.

10. Census Payments – Excluded.

11. Child Support Payments – Countable, both current payments and arrears.

12. Child/Spousal Support Transferred to IV-D Agency – Payments transferred by the household to DCS as assigned support are excluded.

13. Commissions – Countable.

14. CSIMA – Countable as unearned income only when the institutionalized individual is not in the community spouse's household.

15. Contractual Payments – Countable.

16. Death Benefits – Countable income to an individual if the total amount exceeds the expense of the deceased person's last illness and burial paid by the individual to whom the death benefit is issued.

17. Deferred Wages – Countable when the income would have normally been received if the wages are deferred at the employee's request. Countable when received if the wages are deferred by the employer.

18. DIMA – Countable as unearned income only when the institutionalized individual is not in the dependent's household.

19. Differential Payments – Countable.

20. Domestic Commercial Transportation Tickets – Excluded as long as tickets are not converted to cash.

21. Domestic Volunteer Service Act Payments – Excluded as income if payments are made for supporting services or reimbursements for out-of-pocket expenses.

22. Dwelling-related Assistance – Excluded if housing assistance is provided by HUD or FMHA.

23. Earned Income Tax Credits – Excluded.

24. In-Kind Income: Wages, Food, Shelter or other – Countable.

25. Earned In-Kind Food or Shelter – Countable.

(Rule 1200-13-20-.06, continued)

26. Earned In-Kind Not Food or Shelter – Countable.

27. Earned In-Kind Wages – Countable.

28. Education Income that is Not Work Study – Includes: Pell Grant; SEOG Grant; National Direct Student Loan; Guaranteed Student Loan; State Student Initiative and any financial aid:

    (i) Excluded - if paid directly to the school and unavailable to the student.

    (ii) Countable - as unearned income: Any portion of the grant, scholarship or fellowship that is not used to pay tuition, fees, or other necessary education expenses.

29. FF/TANF Payments – Excluded.

30. Farmer Income – Countable.

31. Farmer/Fishing Income – Countable.

32. Gambling Prizes and Awards – Countable.

33. Gifts – Cash gifts are countable unless excluded as infrequent or irregular income. In-Kind gifts are countable, and the value is equal to the current market value.

34. Income Produced from Resources – Countable.

35. Inheritance Cash – Countable.

36. Interest Bearing Resources – Interest earned on a resource, dividends, royalties and other direct money payments is countable.

37. Interest on Burial Funds and Spaces – Excluded.

38. Irregular or Infrequent Income – Up to $30.00 of unearned or earned income received infrequently or irregularly per quarter is excluded.

39. Jury Duty Pay – Countable unless the income is turned over to an applicant's employer.

40. Low Income Home Energy Assistance Payments (LIHEAP) – Excluded.

41. Military Allotments – The Family Subsistence Supplemental Allowance (FSSA) and the Military Basic Allowance for Housing (BAH) are countable as unearned income.

42. PASS Payments – Excluded.

43. Payments from FEMA – FEMA payments issued as a result of presidentially declared emergency or major disaster are excluded. Payments made by comparable disaster assistance programs by States, local governments and disaster assistance organizations are also excluded. FEMA payments which are made to a household to pay for rent, food and utility assistance when there is no major disaster or emergency declaration are countable.

(Rule 1200-13-20-.06, continued)

44. Pensions – Countable.

45. Protective Payee Payments – Funds received by a protective payee (conservator, authorized representative or representative payee) and used for the care and maintenance of a third party beneficiary (adult or child) who may or may not be a member of the protective payee's household are excluded as income to the protective payee. Any part of the payment that is retained by the protective payee for his or her own use is countable income to the protective payee. Even if the protective payee retains a fee for his or her services, the entire payment issued on behalf of the beneficiary is countable income to the beneficiary.

46. Railroad Retirement Payments – Countable.

47. Rehabilitation Payments – Net rehabilitation payments are countable as unearned income. Deduct allowable expenses from the gross rehabilitation payment.

48. Reimbursements – Reimbursement of expenses an employee incurs in the performance of his duties for items other than normal living expenses are excluded.

49. Rental or Lease Income – Countable as earned income when the individual is actively engaged in producing such income, or bears some responsibility in earning the income. Countable as unearned income when the individual is not actively engaged in producing the income, or bears no responsibility in earning the income. Count the amount of income remaining after expenses related to maintaining the property are applied.

50. Royalties and Honoraria – Countable.

51. Self-Employment – Net earnings are countable.

52. Settlements and Restitutions – The following settlements and restitution payments are excluded as unearned income.

    (i) Agent Orange Settlement Payments. Excluded as unearned income but counted when determining patient liability for institutionalized individuals;

    (ii) Alaska Native Claims Settlement Act exclusions;

    (iii) Criminal Victims Compensation Funds paid to crime victims;

    (iv) Distribution of perpetual judgment funds to Indian tribes under the following;

        (I) Black Feet and Gros Ventre Tribes (P.L. 92-254);

        (II) Grand River Band of Ottawah Indiana in Indian Claims Commission Docket No. 40-K;

        (III) Indian Judgment Funds Distribution (P.L. 93-134);

        (IV) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under P.L. 94-114;

(Rule 1200-13-20-.06, continued)

(V) Tribes of groups under P.L. 93-134; and

(VI) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 94-433).

(v) Filipino Veterans Compensation Fund Payments. Lump sum payments made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;

(vi) German Reparation Payments;

(vii) Japanese-American and Aleutian Restitution Payments;

(viii) Payments made to individuals because of their status as victims of Nazi persecutions;

(ix) Payments to children born of Vietnam veterans diagnosed with spina bifida; and

(x) Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act.

53. Severance – Countable.

54. Sick/Disability Payments – Countable.

55. Social Security Payments – Countable.

56. Social Service Payments – Excluded.

57. SSI Payments – Excluded.

58. Strike Benefits – Countable.

59. Supplemental Nutrition Assistance Program (SNAP) – The value of a SNAP benefit is excluded. The value of free or reduced food under WIC or the National School Lunch Act is also excluded.

60. Temporary Disability Payments – Income is countable as unearned income to the extent it is not a reimbursement for specific costs and is paid directly to the applicant or any member of the applicant's household.

61. Tips – Any amount over $20.00 per month is countable.

62. Trusts – Money withdrawn from the body of a trust or interest and dividends accrued to the trust and paid to the individual is countable.

63. Unemployment Compensation – Countable.

64. U.S. Department of Veterans Affairs Payments – Educational benefits, VA Aid & Attendance, Augmented VA benefits and VA payments from Unusual Medical Expenses are excluded.

65. VISTA Payments – Countable.

(Rule 1200-13-20-.06, continued)

66. Wages – Countable.

67. WIA Payments – Excluded.

68. Work Study Payments – Exclude college work study income up to the amount necessary to pay for tuition and mandatory fees. Income in excess of tuition and fee costs is countable earned income.

69. Workers' Compensation – Countable.

(c) Resource Requirements. Resources for individuals described in this paragraph are calculated according to the AFDC cash assistance program's resource definitions and policies (Rules 1240-01-04-.05, .07, .09 and .10; 42 C.F.R. §§ 435.840 and 435.845; and 45 C.F.R. § 233.20). Individuals described in this paragraph are subject to the following resource requirements:

1. ABLE Accounts. ABLE account balances under $100,000.00 are not a countable resource of the designated beneficiary. Distributions from an ABLE account are countable as a resource when:

(i) Distributions are retained past the month of receipt for a housing-related QDE or are used for or intended to be used for non-qualified disability expenses;

(ii) Distributions are retained past the month of receipt and were previously excluded because intended for a QDE, but used for a non-qualified expense. Count the amount of funds used as a resource the first of the month in which funds were spent; or

(iii) Distributions are retained past the month of receipt, have not been spent, and the intent to use the funds for a QDE has changed. Count the retained funds as a resource the first of the following month.

(iv) Qualified disability expenses (QDE) are expenses related to the blindness or disability of the designated beneficiary and for the benefit of the designated beneficiary. In general, a QDE includes, but is not limited to: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, funeral and burial expenses, and basic living expenses.

2. Annuities. An annuity is a countable resource when it is revocable, assignable, or if it can be sold.

(i) If an annuity is an excluded resource, payments being received from the annuity are countable unearned income. If the annuity is a countable resource, any payments being received from the annuity are excluded.

(ii) The countable resource value of an annuity is its Fair Market Value (FMV). If the applicant is able to provide the FMV of the annuity, verified by two (2) credible sources in the legitimate business of selling and purchasing annuities, accept the verified value.

(iii) If the applicant does not provide two (2) credible statements of FMV, multiply the total annual payment by the period remaining to determine the

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countable value. If the period of the annuity is based on an annuitant's lifetime, the annual payments are multiplied by the annuitant's life expectancy, according to SSA's Period Life Table. If the annuity is a "period certain" annuity, annual payments are multiplied by the annuitant's life expectancy or the period certain, whichever is less. The calculated value of an annuity may be rebutted by providing two (2) credible statements of FMV amounts.

3. Business or Self-Employment – Excluded as essential for the production of earned income. Such excluded resources may include:

   (i) Tools/equipment;

   (ii) Stock or raw materials;

   (iii) Personal property essential for income production;

   (iv) Real property;

   (v) Office equipment;

   (vi) Business loans for the purchase of capital assets;

   (vii) Inventory;

   (viii) Machinery and equipment;

   (ix) Business/commercial checking accounts; and

   (x) Life insurance.

4. Burial Contracts or Policies – Excluded. This does not include pre-paid or pre-need burial agreements.

5. Burial Plot – Exclude the value of burial plots and spaces for all household members.

6. Prepaid Burial Agreements or Burial Trusts – Exclude one burial agreement or burial trust with equity value of $1,500.00 or less per family member.

7. Cash – Countable.

8. Certificate of Deposit (CD) – Countable if held in a personal account. The value of a CD is the net amount that could be received after penalties for early withdrawal, if applicable. Taxes are not deducted in determining value.

9. Checking Account – Personal checking accounts are countable. Other checking accounts may be excluded if designated for burial needs, educational income, Individual Development Accounts, PASS, prorated as income, proceeds from the sale of a home, disaster or settlement funds and retroactive SSA payments.

10. Contract for Deed or Mortgage – The value of a contract for deed or mortgage may be a countable asset depending on the circumstances of the loan, including the individual's role as lender or borrower and the accessibility of the asset:

(Rule 1200-13-20-.06, continued)

(i) When the individual is the lender for a contract for deed, the lender may sell or transfer the instrument to have immediate access to the unpaid principal. The value of the resource equity value is a countable asset. Any subsequent payments to the principal made by the debtor after approval are considered a resource because the unpaid loan principal is a resource. The value of the contract may be excluded from the countable resource if the individual can demonstrate that the contract cannot be sold without his realizing a net loss.

(ii) If the individual is the borrower, the property agreement is not a resource. However, the property purchased may be a countable resource following the month of transaction.

11. Educational Income – All educational income is excluded as a resource, including Title IV, Bureau of Indian Affairs, Department of Veterans Affairs and work study for post-secondary education. The individual must be enrolled in school and attending classes to be considered a student. Grants, scholarships, fellowships and gifts other than those previously listed intended to pay for tuition, fees or education expenses are excluded as a resource.

12. Farm, Business or other Equipment – The equity value of non-self-employment income-producing real property, other than the homestead, is countable. If the property is used for self-employment, it is excluded as Business or Self-Employment.

13. Rental Property – Countable if the individual who owns the property is not 'in the business of renting property. Someone who is in the business of renting property is someone who materially participates in the operation and decision making of the rental business for at least twenty (20) hours per week.

14. Home and Lot – The entire value of the home, whether on land or water, and lot and all adjoining land not separated by property owned by others and any related outbuildings are excluded in determining resource eligibility, as long as the home is the principal place of residence for the applicant/enrollee. Temporary absences from the home do not affect the home's exemption, as long as the individual intends to return home at a specified time.

15. Household Goods and Personal Effects – Excluded.

16. Individual Development Account (IDA) – Funds, including accrued interest, in the account are excluded as a resource as long as the individual complies with the IDA eligibility rules and continues to maintain or make contributions to the account.

17. Income-Producing Resource – Countable if accessible to the individual.

18. Sick and Disability Insurance – Excluded.

19. Burial Insurance – Excluded.

20. Items of Unusual Value – Exclude up to $2,000.00 of all total personal items of unusual value. If the individual's equity value in one or more than one item of unusual value is greater than $2,000.00, the amount that exceeds $2,000.00 is countable towards the resource limit.

21. Life Estates:

(i) Property in which an individual holds a life estate is subject to the same exclusion rules as property the individual owns by title, subject to the following exceptions:

(I) A life estate will be excluded as the home when the property meets the home exemption.

(II) A life estate will be excluded when ownership is necessary for the production of earned income. See Business or Self-Employment in this Subparagraph.

(III) The terms of the life estate contract prevent the holder from selling his or her interest in the property.

(ii) If the life estate is not excluded based on the criteria above, the entire value of the life estate is a countable asset. The life estate value is determined by multiplying the fair market value of the property by the percentage listed in the "Life Estate Interest Table" for the age of the individual on whose lifetime the life estate is based. If more than one person owns the life estate, the value is based on the owner with the longest life expectancy.

22. Life Insurance – Excluded.

23. Livestock – The value of livestock necessary for business or self-employment, as a tool of the trade, or raised for home/personal consumption is an excluded resource. Income received is countable as self-employment income. Livestock that is used as non-business, income-producing property is countable.

24. Oil and Mineral Rights – May be included with land ownership or owned separately. If surface rights of the same property are excluded (for example, as a home) so are oil and mineral rights. Oil and mineral rights are countable when owned for personal use, or when the surface rights of the same property are countable (non-homestead, real property).

(i) If oil or mineral rights are producing income under a lease agreement, the owner may be constrained from selling or otherwise disposing of those rights. If the land is already excluded, then oil and mineral rights are also excluded.

(ii) If oil or mineral rights are producing income to the individual, and he or she is not actively engaged in the production of income, the equity value of the rights is countable.

25. Personal – Countable unless excluded based on the terms of the asset. A personal resource is typically for the use of the individual and/or his family.

26. Personal Consumption – Exclude as a resource the equity value of a non-business property used to produce goods or services essential to daily activities.

27. PASS – Income an SSI recipient places in an approved PASS account is excluded as a resource. The PASS account itself is also excluded. This exclusion expires when the PASS contract expires or ends, or when the individual is no longer an SSI recipient.

(Rule 1200-13-20-.06, continued)

28. Proceeds from the Sale of a Home – Excluded to the extent that the funds are intended to be used to purchase another home subject to the homestead exclusion, and the funds are used for such a purpose within three (3) months of the date of receipt of the proceeds.

29. Promissory Note and Other Loans – A promissory note or other loan given by the household is considered personal property and is countable, unless the note/loan balance is inaccessible or the promissory note is held for reasons other than personal use. The lender holds legal interest and has the legal ability to make available his or her share in the note or loan. The equity value of the note/loan is countable.

30. Prorated as Income – Excluded.

31. Real Property – The equity value in all real property the individual owns individually or jointly is a countable asset with the following exceptions:

    (i) Property excluded as the homestead;

    (ii) The inaccessible equity value of real property;

    (iii) Equity value of income-producing property;

    (iv) Real property necessary for the production of earned income (see Business or Self-Employment in this Subparagraph); and

    (v) Real property excluded under a Conditional Assistance agreement between the individual and the State. The individual must make a bona fide effort to sell the property at its current market value, and repay the State for medical expenses covered by HCFA during the exclusion period with the proceeds of the sale. Exemption of the real property is not to exceed nine (9) months. Only one (1) parcel of property may be excluded under a Conditional Assistance agreement per period of eligibility.

        (I) Repayment of medical expenses covered by HCFA may not exceed the total of the net proceeds. Any proceeds remaining after repayment to the State are considered a resource.

        (II) If the property remains unsold after nine (9) months, the property is considered inaccessible so long as bona fide efforts to sell the property continue.

32. Retirement Accounts and Pension Plans – Excluded up to $20,000.00. Money held in an IRA, 401(K), or Keogh in excess of $20,000.00 is countable, minus any penalty for early withdrawal.

33. Savings Account – Countable if it is characterized by personal use. If the current month's income has been deposited into the account, it must be excluded when determining the current value of the account. A savings account may be excluded if it is used for one of the following purposes:

    (i) Burial funds;

    (ii) Business or Self-Employment;

    (iii) Educational Income;

(Rule 1200-13-20-.06, continued)

(iv) Individual Development Account;

(v) PASS;

(vi) Proceeds from the Sale of a Home (subject to time limits);

(vii) Prorated as Income;

(viii) Settlement or Disaster Payment, if Excluded by Policy; and

(ix) SSI/SSA Retroactive Payment (subject to time limits).

34. Settlement or Disaster Payment – Payments or benefits provided under certain Federal statutes are excluded, if payments are not commingled with other funds. Excluded settlement and/or disaster payments include:

(i) Agent Orange Settlement Payments. Payments and interest are excluded as unearned income but counted when determining patient liability for institutionalized individuals;

(ii) Disaster Relief Assistance received under the Disaster Relief Act of 1974;

(iii) Distribution of perpetual judgment funds to Indian tribes under the following:

(I) Indian Judgment Funds Distribution (P.L. 93-134)

(II) Black Feet and Gros Ventre Tribes (P.L. 92-254)

(III) Grand River Band of Ottawah Indiana in Indian Claims Commission Docket No. 40-K;

(IV) Tribes of groups under P.L. 93-134;

(V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 94-433); and

(VI) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under P.L. 94-114.

(iv) Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments (and interest from payments) made as a result of the class action lawsuit to hemophilia patients infected with HIV through blood plasma products;

(v) Filipino Veterans Compensation Fund Payments. Lump sum payments (and interest from payments) made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;

(vi) Japanese-American and Aleutian Restitution Payments (and interest from payments);

(vii) Payments made to individuals because of their status as victims of Nazi persecutions (and interest from payments);

(Rule 1200-13-20-.06, continued)

(viii) Payments to children born of Vietnam veterans diagnosed with spina bifida (and interest from payments);

(ix) Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (interest is not excluded);

(x) Revenues from the Alaska Native Fund paid under Section 21(a) of the Alaska Native Claims Settlement Act;

(xi) Criminal Victims Compensation Funds paid to crime victims (excluded for nine (9) months); and

(xii) Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

35. SSI/SSA Retroactive Payments – Excluded for nine (9) months after the payment is received and countable after the nine (9) month exclusion period.

36. Stocks, Bonds and Mutual Funds – Countable if asset is held for personal use. Stocks, bonds or mutual funds held for purposes listed below are subject to different treatment:

(i) Burial;

(ii) Business or Self-Employment;

(iii) Educational Income;

(iv) Proceeds from the Sale of a Home;

(v) Prorated as Income; or

(vi) Settlement or Disaster Payment, if Excluded by Policy.

37. Tools of the trade – Excluded when essential for the production of earned income.

38. Trusts – Countable or excluded, when the applicant or household member is either the trust's trustee or beneficiary, based on the nature of the trust, the date the trust was created, the source of funds used to create the trust, plus other factors as specified in 42 U.S.C. § 1396p(d).

39. Vehicles – Exclude up to $4,600.00 of the equity value of one (1) vehicle in the applicant's household. The equity value of any other vehicle is countable, unless the vehicle can be excluded based on its use. The equity value of recreational vehicles (boats, snowmobiles, jet skis, ATVs and aircraft) is a countable resource.

(d) Disregards and Expenses Allowed. For purposes of determining the income of individuals described in this paragraph, the following expenses will be disregarded from their income:

1. Child Support Disregard – Disregard $50.00 per month per household if a child living in the home receives child support payments (current only) and the family receives TANF benefits.

(Rule 1200-13-20-.06, continued)

2. Earned Income Disregard – Disregard $90.00 per month from each household member's total earned income.

3. Payments made on Behalf of Dependents within the Home – Disregard up to $175.00 per month of day care expenses per dependent age two (2) or older. Disregard up to $200.00 per month of day care expenses per dependent under age two (2).

4. Student Income – Disregard the earnings of a child who is a full-time student or part-time student and not employed full time.

(e) Household composition for TennCare Medicaid Medically Needy categories is based on the principle of FRR.

1. The following individuals must be included in the applicant's household for TennCare Medicaid Medically Needy Child, if living with the applicant:

(i) The applicant;

(ii) The applicant's spouse;

(iii) The applicant's children under age twenty-one (21);

(iv) For applicants who are under age twenty-one (21), the applicant's natural or adoptive parents; and

(v) The applicant's siblings who are under age twenty-one (21) (including unborn children).

2. The TennCare Medicaid Medically Needy child applicant's parent(s) are not included if the applicant is an emancipated minor.

3. A step parent living in the home with a child applicant for TennCare Medicaid Medically Needy is not included in the child's household.

4. The following individuals must be included in the TennCare Medicaid Medically Needy Qualified Pregnant Woman applicant's household, if living with the applicant:

(i) The pregnant woman applicant;

(ii) The applicant's unborn child(ren);

(iii) The applicant's spouse; and

(iv) The applicant's children under age twenty-one (21).

5. Parents of a pregnant woman applying for TennCare Medicaid Medically Needy Qualified Pregnant Woman coverage are not included in the applicant's household.

(f) Spend down.

1. Applicants must produce proof of relevant medical expenses in order to "spend down" monthly income to the TennCare Medically Needy Income Standard

(Rule 1200-13-20-.06, continued)

(MNIS) to be eligible in a Medically Needy category. If income is below the MNIS, spend down will not be necessary. Applicants may reduce available monthly income with countable expense, as listed below, in order to qualify for eligibility in the Medically Needy categories. The income limits for the Medically Needy category are published in the State Plan.

2. Countable Expenses. The following Rules apply to the expenses that may be used to meet spend down:

   (i) Countable expenses incurred during the month of application, whether paid or unpaid.

   (ii) Countable expenses paid during the month of application, regardless of when such expenses were incurred.

   (iii) Countable expenses incurred during the three (3) calendar months prior to the month of application, whether paid or unpaid.

      (I) Expenses paid during the three calendar months prior to the month of application will not be counted unless such expenses were also incurred during those three calendar months.

      (II) Any expenses incurred before the three (3) calendar months prior to the month of application will not be counted unless payment is made on those expenses during the month of application, in which case only the amount paid during the month of application is counted.

      (III) When a Medically Needy enrollee has been eligible for twelve (12) months, he will be expected to meet spend down again as described in this section, except verified expenses that are documented in the enrollee's Medicaid record can be carried over to the next year as long as the individual remains continuously eligible, the expenses remain unpaid, and the bills are not written off by the provider. Only the portions of expenses that were not previously used to meet spend down can be carried over to the next eligibility determination. If an enrollee loses eligibility at any point, the carryover of unpaid medical expenses ends and the enrollee must meet spend down as if he were a new applicant.

   (iv) All medical expenses are considered incurred the date the service is provided with the following exception: medical expenses related to maternity care (e.g., global fee) are considered incurred the month the physician presents a bill once services have begun (i.e., initial examination by the physician at a minimum).

   (v) If spend down is not met by the medical bills incurred as of the date of application submission or as of the date of submission of a renewal application during redetermination, the daily countable medical expenses incurred during the application month will be added until spend down liability is reached.

3. Incurred or paid expenses for the following individuals may be considered countable expenses for purposes of determining Medically Needy financial eligibility:

   (i) The applicant;

(Rule 1200-13-20-.06, continued)

(ii) Members of the applicant's household;

(iii) The applicants FRRs or anyone for whom the applicant is financially responsible; and

(iv) Individuals not living in the applicant's home or eligible for inclusion if the applicant's household member or an applicant's FRR is legally obligated to pay the applicant's medical expenses.

4. Countable expenses are those for which the individual is still liable and that are:

(i) For medical or remedial care, including costs for over the counter medications and costs incurred for medical insurance premiums, co-payments and deductibles. Health insurance premiums may be deducted as a spend down expense only when payment is due, even if paid in another month;

(ii) Verifiable and for which the individual provides substantiation;

(iii) Incurred by eligible individuals and are the legal responsibility of a household member and not subject to payment in full or part by a third party;

(iv) Recognized under State law but not covered under the State's TennCare Medicaid plan or waiver (continuously eligible individuals); or

(v) Covered under TennCare Medicaid but incurred during the spend down period (new applicants).

5. The following list includes but is not limited to the types of medical expenses that are considered Countable Medical Expenses for the Medically Needy categories:

(i) Acupuncture services.

(ii) Bed hold at a Long Term Care Facility (Medicaid rate).

(iii) Dental expenses.

(iv) Doctor's fees – includes fees from services rendered by practitioners and others providing medical services, physicians, surgeons, dentists, optometrists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, and Christian Science providers.

(v) Drugs prescribed by a physician (prior to TennCare eligibility) – includes charges for medicines and drugs prescribed by a doctor incurred prior to establishing TennCare Medicaid eligibility and which remained unpaid or paid in the month under consideration (i.e., Spend Down month).

(vi) Guide dogs – Guide dogs for the blind or deaf and the costs of their maintenance.

(vii) Hospital charges.

(viii) Medical care charges included in tuition costs – Charges for medical care included in the tuition fee of a college or private school which is paid on a

monthly basis, provided that a breakdown of the charges is included in the bill or is furnished separately by the institution.

(ix) Nursing home costs.

(x) Nursing services – Nursing services include nursing care in an individual's home, if for the purpose of treatment or alleviation of a physical, mental, or emotional disorder and ordered by a provider acting within the provider's scope of practice. The care needed must be medical, e.g., administering medication or therapy. Cost of services solely domestic in nature, such as the preparation of meals and the performance of housework, is not deductible.

(xi) Organ transplant expenses.

(xii) Prosthetic devises – Artificial teeth, limbs, hearing aids and component parts, eyeglasses and crutches.

(xiii) Psychiatric care – Psychiatric care primarily for alleviating a mental illness or defect; the cost of maintaining a mentally ill individual at a specially equipped medical center where the individual receives continual medical care.

(xiv) Special education for handicapped – Special school for mentally or physically handicapped individuals if for the alleviation of handicap. The costs of meals and lodging, if supplied by the institution, and/or ordinary education furnished incidental to the special services are medical expenses.

(xv) Substance abuse treatment – Treatment at a therapeutic center for drug addicts or alcoholics, including meals and lodging furnished as a necessary incident to the treatment.

(xvi) Transportation for medical/remedial purposes – Transportation essential to medical care, e.g., bus, taxi, train, or plane fares, and forty-seven cents ($0.47) for each mile that the individual's car is used for medical purposes, in addition to parking fees and tolls.

(xvii) Over the counter (non-prescription) medicine – $10.00 per month is deducted for these expenses without verification, using only the applicant's statement. All of these expenses must be verified if the amount is more than $10.00 per month.

6. The following are types of medical expenses that are not considered Countable Medical Expenses for the Medically Needy categories:

(i) Expenses that have been written off as uncollectible or have been forgiven by the provider.

(ii) Expenses that are covered by the State's TennCare Medicaid plan and are incurred during a period of eligibility:

(I) Costs incurred during a period of TennCare eligibility due to co-pays or services not covered such as dental, hearing and eye care for adults are allowable as a medical expense.

(Rule 1200-13-20-.06, continued)

(II) Bills incurred during TennCare eligibility which are subject to TennCare reimbursement are not considered outstanding for subsequent spend down periods even if not paid by TennCare.

(3) ABD Financial Determinations.

(a) Coverage groups whose financial eligibility is determined based on SSI financial methodology are:

1. Members of SSI-Related Groups.

2. MSP Applicants.

3. Individuals applying for coverage of LTSS, under the Institutional Eligibility category.

(b) Income Determinations. Income countable for purposes of individuals described in this paragraph is defined at 20 C.F.R. §§ 416.1100, et seq., and as set forth below. Unless otherwise specified below, these individuals are subject to the following income requirements:

1. ABLE Accounts. Contributions and ABLE account earnings are excluded, except that contributions are not deducted from countable income of the individual making the contribution. Distributions from an ABLE account are not income of the designated beneficiary in any month regardless of whether the distribution is for non-housing QDEs, housing QDEs or non-qualified expenses. Distribution from an ABLE account is the conversion of a resource from one form to another.

2. Adoption Subsidies – Countable to the child if intended for general living expenses. Excluded if for reimbursement of child care while the adult responsible for the child is at work or seeking employment, or for medical expenses.

3. Alimony – Countable.

4. Annuity Payments – If the underlying annuity is an excluded resource, the periodic payments are countable unearned income. If the underlying annuity is a countable resource, payments are excluded.

5. Assistance Payment from another State – Countable.

6. Bonuses – Countable.

7. Care and Contribution in Exchange for a Transferred Asset – Countable.

8. Canceled Debts – Excluded.

9. Capital Gains – Countable.

10. Cash Support – Countable, unless excluded as irregular or infrequent income.

11. Child Support Arrearage – Countable to the child(ren) the payments are intended to support. Exclude one-third (1/3) of the child support arrearage payment to or for an eligible child. The one-third (1/3) exclusion does not apply to ineligible children.

12. Child Support Payments – Countable to the child(ren) the payments are intended

(Rule 1200-13-20-.06, continued)

to support. Exclude one-third (1/3) of the child support payment to or for an eligible child. The one-third (1/3) exclusion does not apply to ineligible children.

13. Commissions – Countable.

14. CSIMA – Countable as unearned income only when the institutionalized individual is not in the community spouse's household. If the applicant is a deemed member of the institutionalized individual's household, the CSIMA is excluded.

15. Contractual Payments – Excluded.

16. Death Benefits – Countable income to an individual if the total amount exceeds the expense of the deceased person's last illness and burial paid by the individual to whom the death benefit is issued.

17. DIMA – Countable as unearned income only when the institutionalized individual is not in the dependent's household. If the applicant is a deemed member of the institutionalized individual's household, the DIMA is excluded.

18. Differential Payments – Countable.

19. Domestic Volunteer Service Act Payments – Excluded if received through the following programs: Title II Retired and Senior Volunteer Program, and Foster Grandparent Program; Title III Service Corps of Retired Executives, Senior Companion Program, and Active Corps of Executives.

20. Earned Income Tax Credits – Excluded.

21. Earned In-Kind Food or Shelter – Countable.

22. Earned In-Kind Not Food or Shelter – Excluded.

23. Earned In-Kind Wages – Countable.

24. Education Income that is Not Work Study – Excluded.

25. Farmer/Fishing Income – Countable.

26. Gambling Prizes and Awards – Countable.

27. General Assistance Payments – Countable.

28. Gifts – Countable.

29. Income Not Pursued – Countable.

30. Income Produced from Resources – Income generated by a resource that is excluded is countable unearned income. Income generated by a resource that is countable is excluded as income.

31. Inheritance Cash – Countable.

32. Interest Bearing Resources – Interest earned on a countable resource is excluded as unearned income. Interest earned on an excluded resource is countable as income.

(Rule 1200-13-20-.06, continued)

33. Irregular or Infrequent Income – Exclude up to $60.00 per calendar quarter of unearned income when it is received infrequently or irregularly. Exclude up to $30.00 per calendar quarter of earned income when it is received infrequently or irregularly.

34. Jury Duty Pay – Countable unless the income is turned over to an applicant's employer.

35. Long Term Care Insurance Payments – Countable if the payment is not assigned to the nursing home or lead HCBS agency.

36. Military Allotments – The Family Subsistence Supplemental Allowance (FSSA) and the Military Basic Allowance for Housing (BAH) are counted as unearned income.

37. Older Americans Act Payments – Countable.

38. Payments from FEMA – FEMA payments issued as a result of a presidentially declared emergency or major disaster are excluded. Payments made by comparable disaster assistance programs by States, local governments and disaster assistance organizations are also excluded. FEMA payments which are made to a household to pay for rent, food and utility assistance when there is no major disaster or emergency declaration are countable.

39. Pensions – Countable.

40. PASS Payments – Funds received by a protective payee (conservator, authorized representative or representative payee) and used for the care and maintenance of a third party beneficiary (adult or child) who may or may not be a member of the protective payee's household are excluded as income to the protective payee. Any part of the payment that is retained by the protective payee for his or her own use is countable income to the protective payee. Even if the protective payee retains a fee for his or her services, the entire payment issued on behalf of the beneficiary is countable income to the beneficiary.

41. Rental or Lease Income – Countable as earned income when the individual is in the business of renting or leasing property, i.e., self-employment. Countable as unearned income when the individual is not in the business of renting or leasing property. Count the amount of income remaining after expenses related to maintaining the property are applied.

42. Royalties and Honoraria – Countable.

43. Self-Employment – Net earnings are countable.

44. Settlements or Disaster Payments – The following settlements and disaster payments are excluded as unearned income:

    (i) Agent Orange Settlement Payments. Payments and interest are excluded as unearned income but counted when determining patient liability for institutionalized individuals;

    (ii) Disaster Relief Assistance received under the Disaster Relief Act of 1974;

(Rule 1200-13-20-.06, continued)

(iii) Distribution of perpetual judgment funds to Indian tribes under the following:

(I) Indian Judgment Funds Distribution (P.L. 93-134)

(II) Black Feet and Gros Ventre Tribes (P.L. 92-254)

(III) Grand River Band of Ottawah Indiana in Indian Claims Commission Docket No. 40-K;

(IV) Tribes of groups under P.L. 93-134;

(V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 94-433); and

(VI) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under P.L. 94-114.

(iv) Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments (and interest from payments) made as a result of the class action lawsuit to hemophilia patients infected with HIV through blood plasma products;

(v) Filipino Veterans Compensation Fund Payments. Lump sum payments (and interest from payments) made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;

(vi) Japanese-American and Aleutian Restitution Payments (and interest from payments);

(vii) Payments made to individuals because of their status as victims of Nazi persecutions (and interest from payments);

(viii) Payments to children born of Vietnam veterans diagnosed with spina bifida (and interest from payments);

(ix) Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (interest is not excluded);

(x) Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act; and

(xi) Criminal Victims Compensation Funds paid to crime victims.

45. Severance – Countable.

46. Sheltered Workshop Payments – Excluded.

47. Sick/Disability Payments – Countable.

48. Social Security Payments – Countable.

49. Social Service Payments – Excluded.

50. SSI – Excluded.

(Rule 1200-13-20-.06, continued)

51. Temporary Disability Insurance – Income is countable as unearned income to the extent it is not a reimbursement for specific costs and is paid directly to the household.

52. Tips – Any amount over $20.00 per month is countable.

53. Trusts – Dividends, interest, rents and other income generated by a trust fund, unless otherwise excluded, that can be paid to the beneficiary or to a third party on the beneficiary's behalf are countable income to the beneficiary for the period the fund is intended to cover, beginning the month the funds become available, regardless of whether the income is actually paid out to the beneficiary. When funds are withdrawn irregularly, the payments are countable in the month received.

    (i) Monies withdrawn from the principal of an accessible (countable) trust fund are excluded as income to the beneficiary, because an accessible trust fund is a countable resource. Money cannot be considered income and a resource in the same month.

    (ii) Monies disbursed from the principal of an inaccessible trust fund are counted as income because an inaccessible trust fund is an excluded resource.

    (iii) Monies received by the trustee of a trust and used for the care and maintenance of a third party beneficiary (adult or child) are excluded as income for the trustee.

54. Unearned In-Kind Income or In-Kind Support and Maintenance – Unearned In-Kind income in the form of food and/or shelter may be countable or excluded and is subject to certain rules that determine the countable or excluded value.

55. Unearned In-Kind Income, Not Food or Shelter – Excluded.

56. Unemployment Compensation – Countable.

57. U.S. Department of Veterans Affairs Payments:

    (i) Additional Child Allotment – Excluded.

    (ii) Compensation – Countable.

    (iii) Death Benefit – Countable as unearned income to an individual if the total amount exceeds the expense of the deceased person's last illness and burial paid by the individual to whom the death benefit is issued.

    (iv) Dependency and Indemnity Compensation – Countable.

    (v) Pension – Veteran's benefits other than Aid and Attendance (A&A) are countable income. Homebound allowances are countable income. Any part of a veteran's pension that is attributable to A&A is excluded as income, but is treated as third party liability available to help meet the veteran's medical expenses. A&A will be contributed to the cost of care in the nursing home.

(Rule 1200-13-20-.06, continued)

(vi) If an institutionalized veteran receives the $90.00 reduced, improved pension, exclude the $90.00 from countable income and the cost of care calculation.

58. VISTA Payments – Excluded.

59. Wages – Countable.

60. Worker's Compensation – Countable as unearned income to the extent it is not an expense attributable to obtaining the compensation.

61. WIA Payments – Excluded.

62. Work Study Payments – Excluded.

(c) Resource Determinations. Resources countable for purposes of individuals described in this paragraph are defined at 20 C.F.R. §§ 416.1201, et seq. Unless otherwise specified below, individuals described in this paragraph are subject to the following resource requirements:

1. ABLE Accounts. ABLE account balances under $100,000.00 are not a countable resource of the designated beneficiary. Distributions from an ABLE account are countable as a resource when:

(i) Distributions are retained past the month of receipt for a housing-related QDE or are used for or intended to be used for non-qualified disability expenses; or

(ii) Distributions are retained past the month of receipt and were previously excluded because intended for a QDE, but used for a non-qualified expense. Count the amount of funds used as a resource the first of the month in which funds were spent; or

(iii) Distributions are retained past the month of receipt, have not been spent, and the intent to use the funds for a QDE has changed. Count the retained funds as a resource the first of the following month.

(iv) Qualified disability expenses (QDE) are expenses related to the blindness or disability of the designated beneficiary and for the benefit of the designated beneficiary. In general, a QDE includes, but is not limited to: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, funeral and burial expenses, and basic living expenses.

2. Annuities are countable resources for individuals when accessible according to 20 C.F.R. § 416.1201. An annuity is a countable resource when it is revocable, assignable, or it can be sold.

(i) If the annuity is an excluded resource, payments being received from the annuity may be countable unearned income. If the annuity is a countable resource, any payments being received from the annuity are excluded.

(ii) The countable resource value of an annuity is its FMV. If the applicant is able to provide the FMV of the annuity, verified by two (2) credible sources

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in the legitimate business of selling and purchasing annuities, accept the verified value.

(iii) If the applicant does not provide two credible statements of FMV, multiply the total annual payment by the period remaining to determine the countable value. If the period of the annuity is based on an annuitant's lifetime, the annual payments are multiplied by the annuitant's life expectancy, according to SSA's Period Life Table. If the annuity is a "period certain" annuity, annual payments are multiplied by the annuitant's life expectancy or the period certain, whichever is less. The calculated value of an annuity may be rebutted by providing two (2) credible statements of FMV amounts.

(iv) Individuals applying for or receiving LTSS must meet additional requirements regarding asset transfers and exclusion of annuities at Rule .06(3)(h).

3. Business or Self-Employment – Excluded as essential for the production of earned income. Resources may include:

(i) Tools/equipment;

(ii) Stock or raw materials;

(iii) Personal property essential for income production;

(iv) Real property;

(v) Office equipment;

(vi) Business loans for the purchase of capital assets;

(vii) Inventory;

(viii) Machinery and equipment;

(ix) Business/commercial checking accounts; and

(x) Life insurance.

4. Burial Funds.

(i) Burial funds which are not commingled are excluded resources when:

(I) The funds are used to purchase a life insurance policy which is then irrevocably assigned to a funeral provider. Either the ownership of the policy or proceeds may be assigned to the funeral provider. The purpose of the assignment is to fund a burial contract.

(II) The funds are invested in an irrevocable pre-paid or pre-need burial contract established by a funeral provider and the contract meets the following conditions:

I. Both the individual and the funeral home representative have signed the document;

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II. An itemized list of the services provided under the contract is provided;

III. The total dollar amount of the agreement is specified;

IV. The individual was neither a minor nor legally declared incompetent when the agreement was signed; and

V. The agreement specifies in writing that the money is not refundable under any circumstances.

(III) The funds are invested in a burial trust established by the individual, and the total funds in the trust, including interest payments, do not exceed $6,000.00 per individual. Transport costs which cause the trust value to exceed $6,000.00 are excluded.

(ii) Burial funds are countable resources when:

(I) The funds are used to purchase a life insurance policy and a revocable assignment of the policy or proceeds is made to a funeral provider.

(II) The funds are invested in a revocable pre-paid or pre-need burial contract established by a funeral provider.

(III) Countable burial funds are eligible to be excluded as part of the individual's burial reserve.

(iii) Burial Reserve – An individual is allowed to set aside $1,500.00 in resources to cover expenses connected to his or her burial, cremation or other funeral arrangements. Funds allowed to be excluded as part of the burial reserve include revocable, countable burial funds. These funds must not be commingled with other resources, and must be set aside for burial expenses. The $1,500.00 maximum amount of the burial reserve is first reduced by:

(I) Life insurance, if the total value of all life insurance owned by the individual is $1,500.00 or less; and

(II) Funds in an irrevocable burial agreement or contract.

5. Burial Plots – Exclude the value of one burial space for each family member, e.g. spouse, child, parent, sibling, whether living in the home or not. Burial plots and spaces include a gravesite, crypt, mausoleum, niche or other repository for bodily remains, vaults, headstones, markers, plaques, containers and arrangement for opening and closing the gravesite.

6. Cash – Countable.

7. Certificates of Deposit (CD) – Countable if held in a personal account. The value of a CD is the net amount that could be received after penalties for early withdrawal, if applicable. Taxes are not deducted in determining net value.

8. Checking Accounts – Personal checking accounts are countable. Some checking accounts that may be excluded include those designated for burial needs, educational income, Individual Development Accounts, PASS, prorated as

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income, proceeds from the sale of a home, disaster or settlement funds if excluded by policy, and retroactive SSA payments.

9. CCRC Deposit or Fee – The value of an entrance fee paid to a CCRC is a countable resource when it meets the following conditions:

   (i) The entrance fee can be used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient;

   (ii) The entrance fee or its remaining portion is refundable when the individual dies or terminates the contract and leaves the CCRC; and

   (iii) The entrance fee does not confer any ownership interest in the community.

10. Contracts for Deed or Mortgage – The value of a contract for deed or mortgage may be a countable asset dependent on the circumstances of the loan, including the individual's role as lender or borrower and the accessibility of the asset.

   (i) When the individual is the lender for a contract for deed, the lender may sell or transfer the instrument to have immediate access to the unpaid principal. The value of the resource equity value is a countable asset. Any subsequent payments to the principal made by the debtor after approval are considered a resource because the unpaid loan principal is a resource. The value of the contract may be excluded from the countable resources if the individual can demonstrate that the contract cannot be sold without his realizing a net loss.

   (ii) If the individual is the borrower the property agreement is not a resource. However, the property purchased may be a countable resource following the month of transaction.

11. Educational Income.

   (i) Educational income received under Title IV, Bureau of Indian Affairs, or Department of Veterans Affairs programs is excluded as a resource.

   (ii) Grants other than Title IV or Bureau of Indian Affairs grants, scholarships, fellowships and gifts intended to pay for tuition, fees or educational expenses are excluded for nine (9) months beginning the month after the funds are received. The individual must be enrolled in school and attending classes to be considered a student.

12. Farm, Business, Other Equipment – The equity value of non-self-employment income-producing real property, other than the homestead, is a countable resource. Exclude up to $6,000.00 in equity and count only the amount that exceeds the limit, if the net income totals at least six percent (6%) of the equity value. If the property is used for self-employment, it is excluded as Business or Self-Employment.

13. Rental property is countable if the individual who owns the property is not in the business of renting property. Someone who is in the business of renting property is someone who materially participates in the operation and decision making of the rental business for at least (20) hours per week.

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14. Homestead Exclusion - The entire value of the home, whether on land or water, all adjoining land not separated by property owned by others and any related outbuildings are excluded in determining resource eligibility as long as:

    (i) The home is the principal place of residence for the individual and/or his spouse and/or dependent relatives; and

    (ii) If the individual resides in a long-term care facility, his intent to return to the home is established.

    (iii) For an institutionalized individual, the home is excluded if the above are true and the individual's equity interest does not exceed $552,000.00, with one exception: the home equity limit does not apply to an institutionalized individual if the spouse of the individual, the individual's child under age twenty-one (21), or a blind or permanently and totally disabled child is residing in the home. An institutionalized individual whose home exceeds the $552,000.00 limit and who does not have a spouse, a child under age twenty-one (21) or a disabled or blind child living in the home, is not eligible for payment of long term services and supports, unless it is determined undue hardship exists.

    (iv) An individual must have lived in the home for it to be considered his home or principal place of residence.

    (v) The value of the home and surrounding land will not be counted as a resource during the individual's absence from an unoccupied home when he intends to return to the property. An absence from the home can be necessary to accomplish a specific purpose such as hospitalization, confinement in a nursing home or receipt of services, such as nursing or personal care services not available to the individual in his home.

    (vi) An intent to return home is nullified by any efforts to sell or dispose of the property during the exemption period. The exemption based on the intent to return ends the first day of the month after the month efforts are made to sell or dispose of the homestead property.

    (vii) Rental of a homestead which has been excluded because of intent to return does not nullify the exclusion. The homestead retains the exclusion as long as there is a clear, non-contradictory intent to return, and no efforts are made to sell or dispose of the property. The rent will be counted as unearned income in the month received.

    (viii) The exemption based on residence of the enrollee's dependent relative ends the first day of the month after the relative last lived in the homestead, if the relative does not intend to return. Real property located outside of Tennessee can be excluded from countable resources as homestead property, if there is substantiation of the individual's intent to return to the home or the property is the principal residence of the individual's spouse or dependent relatives.

15. Individual Development Account – Funds, including accrued interest, in the account are excluded as a resource as long as the individual complies with the IDA eligibility rules and continues to maintain or make contributions into the account.

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16. Income-Producing Resource - Exclude up to $6,000.00 of an individual's equity in an income-producing resource if it produces a net annual income to the individual of at least six percent (6%) of the property's equity value. If the individual's equity value is greater than $6,000.00, the amount that exceeds $6,000.00 is countable towards the resource limit.

    (i) If an income-producing resource does not produce a net annual income of at least six percent (6%) of the resource's equity value, the entire equity value of the resource is countable.

    (ii) If the individual owns more than one piece of income-producing resource and each produces income, each is reviewed to determine whether the six percent (6%) test is met. Then the amounts of the individual's equity in all of those properties producing six percent (6%) are totaled to determine if the total equity of all properties is $6,000.00 or less. If the total equity value in the properties that meet the six percent (6%) rule is over the $6,000.00 equity limit, the amount exceeding $6,000.00 is counted as a resource.

17. Insurance – Exclude Sick and Disability Insurance and Burial Insurance.

18. Items of Unusual Value, Household Goods, and Personal Effects – In general, an item may be considered an item of unusual value if the item is not excluded as a household good or personal effect, and the equity value of the item is greater than $500.00. An item of unusual value that generates income for the individual is countable. The countable value is determined by applying the Rate of Return test (see Income-Producing Resource above). A personal item of unusual value is excluded. Household Goods and Personal Effects are also excluded.

19. Life Estates – Property in which an individual holds a life estate is subject to the same exclusion rules as property the individual owns by title, subject to the following exceptions:

    (i) A life estate will be excluded as the home when the property meets the homestead exemption.

    (ii) If the property is used in the passive production of income, then the life estate is subject to the Rate of Return test (see, Income-Producing Resource above).

    (iii) A life estate will be excluded when ownership is necessary for the production of earned income.

    (iv) The terms of the life estate contract prevent the holder from selling his or her interest in the property.

    (v) If the life estate is not excluded based on the criteria (i)-(iv) above, the entire value of the life estate is a countable asset. The life estate value is determined by multiplying the Fair Market Value (FMV) of the property by the percentage listed in the SSA's Life Estate and Remainder Interest Tables for the age of the individual on whose lifetime the life estate is based. If more than one person owns the life estate, the value is based on the owner with the longest life expectancy.

    (vi) When an individual purchases, or, in some other way receives, as compensation in a transaction, a life estate in another individual's home, the purchase of the life estate is considered an asset transfer subject to

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penalty, unless the individual then lives in the home for a period of at least one year after receiving the life estate.

(vii) If the individual does live in the home for a period of one year after receiving or purchasing the life estate, then the amount of the transfer is the entire amount used to purchase the life estate.

(viii) If an individual purchases a life estate in another individual's home and then does live there for one year after the purchase, the life estate is an excluded resource while being used as the individual's (or the individual's spouse's) home. However, if payment for a life estate exceeds the FMV of the life estate the difference between the amount paid and the FMV should be treated as an asset transfer. In addition, if an individual makes a gift or transfer of a life estate interest, the value of the life estate should be treated as a transfer of assets.

20. Life Insurance – Countable or excluded based on the type of life insurance owned by the individual and its intended use. Exclude all life insurance if the total face value of all policies does not exceed $1,500.00 per owner.

21. Livestock – The value of livestock necessary for business or self-employment, as a tool of the trade, or raised for home/personal consumption is an excluded resource. Income received is countable as self-employment income. The equity value of livestock that are pets is countable. Livestock that is used as non-business income-producing property is countable, and subject to treatment as an Income-Producing Resource as described in this subparagraph.

22. Oil and Mineral Rights – May be included with land ownership or owned separately. If surface rights of the same property are excluded (for example, as a home) so are oil and mineral rights. Oil and mineral rights are countable when owned for personal use, or when the surface rights of the same property are countable (non-homestead, real property).

(i) If oil or mineral rights are producing income under a lease agreement, the owner may be constrained from selling or otherwise disposing of those rights. If the land is already excluded, the oil and mineral rights are excluded.

(ii) If oil or mineral rights are producing income to the individual, and he or she is not actively engaged in the production of income, the equity value of the rights is subject to the Rate or Return test. See Income-Producing Resource above.

23. Patient Trust Account – The balance of the account at the time of application and redetermination is a countable resource.

24. Personal – Countable unless excluded based on the terms of the asset. A personal resource is typically for the use of the individual and his family.

25. Personal Consumption – Exclude up to $6,000.00 of the equity value of non-business property currently in use to produce goods or services essential to daily activities. Any portion of the property's equity value in excess of $6,000.00 is a countable resource.

26. PASS – Any income an SSI recipient places in an approved PASS account is excluded as a resource. The PASS account itself is also excluded. This exclusion

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expires when the PASS contract expires or ends, or when the individual is no longer an SSI recipient.

27. Prepayment of Rent – Countable unless the individual cannot receive the money back under any circumstances (i.e., the lease agreement includes a no refund policy, or the landlord provides a statement that the funds will not be returned to the renter). Prepayment of an applicant's mortgage is not considered a resource.

28. Prepayment of Nursing Home Care – Prepayment for care deposited by an applicant upon his admission to a TennCare Medicaid-participating long-term care facility is a countable resource for the individual who is subsequently approved for TennCare Medicaid benefits if the deposit was paid from the individual's own funds.

29. Proceeds from the Sale of a Home – Excluded to the extent that the funds are intended to be used to purchase another home subject to the homestead exclusion, and the funds are used for such a purpose within three (3) months of the date of receipt of the proceeds.

30. Promissory Notes and other Loans – A promissory note or other loan given by the household is considered personal property and is countable, unless the note/loan balance is inaccessible or the promissory note is held for reasons other than personal use. The lender holds legal interest and has the legal ability to make available his or her share in the note or loan. The equity value of the note/loan is countable.

    (i) If a household makes a loan that is considered inaccessible, or is shown to have a significantly lower market value than the unpaid balance of the loan, the loan will be considered to be an uncompensated transfer of assets. The uncompensated asset transfer will be considered to be the outstanding balance due on the loan as of the date of the lender's application for long term services and supports (nursing facility or HCBS services).

    (ii) In addition, the Deficit Reduction Act of 2005 (DRA) provides that funds used to purchase a promissory note, loan or mortgage must meet the following criteria, or the purchase will be treated as a transfer of assets for less than FMV:

        (I) The repayment term must be actuarially sound (as determined by SSA standards);

        (II) Payments must be made in equal amounts during the term of the loan with no deferral payment and no balloon payments; and

        (III) The promissory note, loan or mortgage must prohibit the cancellation of the balance upon the death of the lender.

    (iii) If the above criteria are not met, the purchase of the promissory note or loan must be treated as a transfer of assets. The amount used to calculate a penalty will be the outstanding balance of the loan due as of the date of application for TennCare Medicaid.

    (iv) Promissory notes that are made for purposes other than personal use are treated according to their use. Promissory notes may be made for the following purposes:

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(I) Burial;

(II) Business or Self-Employment; and

(III) Proceeds from the Sale of a Home.

31. Property that represents government authority to engage in an income-producing activity – Excluded if the property is used in trade, business or non-business income-producing activity. Exclude property that is currently not in use due to circumstances beyond the individual's control and there is a reasonable expectation that the use will resume.

32. Prorated as Income – Excluded.

33. Real Property – The equity value in all real property the individual owns individually or jointly is a countable asset with the following exceptions:

(i) Property excluded as homestead;

(ii) The inaccessible equity value of real property;

(iii) Equity value of income-producing property (subject to the Rate of Return test);

(iv) Real property necessary for the production of earned income (see Business or Self-Employment); and

(v) Property excluded under a Conditional Assistance agreement between the individual and the State.

34. Retirement Accounts and Pension Plans – If retirement benefits are being received out of such accounts, the principal is not considered a resource. If payments are not being received and the account is accessible, then the equity value is countable. The equity value is the cash surrender value minus any early withdrawal penalty.

(i) Funds held in a 401(k) retirement account are countable when the individual or his or her spouse is no longer job-attached because the funds are accessible after employment terminates. If the individual is still job-attached, the value of the 401(k) is excluded. A 401(k) retirement account owned by a deemed spouse or a deemed parent is excluded as a resource.

(ii) Funds held in an IRA are considered accessible to the individual or community spouse. Count the equity value of an accessible IRA when determining eligibility. IRA funds owned by a community spouse are also considered countable and accessible when determining a CSRMA. IRA funds owned by a deemed spouse (for non-institutional categories) or deemed parent are excluded from the resource determination.

(iii) Keogh plans are considered accessible and counted as resources to the individual or community spouse even if the household is not actually accessing the funds. Keogh funds are countable resources in determining the CSRMA. Keogh plans owned by a deemed spouse (non-institutional) or deemed parent are excluded as resources.

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35. Savings Accounts – Countable if it is characterized by personal use. If the current month's income has been deposited into the account it must be excluded when determining the current value of the account. A savings account may be excluded if it is used for one of the following purposes:

    (i) Burial funds;

    (ii) Business or Self-Employment;

    (iii) Educational Income;

    (iv) Individual Development Account;

    (v) PASS;

    (vi) Proceeds from the Sale of a Home (subject to time limits);

    (vii) Prorated as income;

    (viii) Settlement or Disaster Payment, if excluded by policy; and

    (ix) SSI/SSA Retroactive Payment (subject to time limits).

36. Settlement or Disaster Payment – Payments or benefits provided under certain Federal statutes are excluded, if payments are not commingled with other funds. Excluded settlement and/or disaster payments include:

    (i) Agent Orange Settlement Payments;

    (ii) Disaster Relief Assistance received under the Disaster Relief Act of 1974;

    (iii) Distribution of perpetual judgment funds to Indian tribes under the following:

        (I) Indian Judgment Funds Distribution (P.L. 93-134);

        (II) Black Feet and Gros Ventre Tribes (P.L. 92-254);

        (III) Grand River Band of Ottawa Indians in Indian Claims Commission Docket No. 40-K;

        (IV) Tribes of groups under PL 93-134;

        (V) Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (PL 94-433); and

        (VI) Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under PL 94-114.

    (iv) Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments made to hemophilia patients infected with HIV through blood plasma products as a result of the class action lawsuit;

    (v) Filipino Veterans Compensation Fund Payments. Lump sum payments made to certain veterans and spouses of veterans who served in the

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military of the Government of the Commonwealth of the Philippines during WWII;

(vi) Japanese-American and Aleutian Restitution Payments;

(vii) Payments made to individuals because of their status as victims of Nazi persecutions;

(viii) Payments to children born of Vietnam veterans diagnosed with spina bifida;

(ix) Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (State and local payments are only excluded for nine (9) months);

(x) Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act

(xi) Criminal Victims Compensation Funds paid to crime victims (excluded for nine (9) months); and

(xii) Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

37. SSI/SSA Retroactive Payment – Excluded for nine (9) months after the payment is received and counted after that nine (9) month exclusion period.

38. Stocks/Bonds/Mutual Funds – Countable. Although personal mutual funds are countable, those held for purposes listed below are subject to different treatment:

(i) Burial;

(ii) Business or Self-Employment;

(iii) Educational Income;

(iv) Proceeds from the Sale of a Home;

(v) Prorated as Income; or

(vi) Settlement or Disaster Payment, if excluded by policy.

39. Tools of the Trade – Excluded.

40. Trusts – Countable or excluded based on the nature of the trust, the date the trust was created, the source of funds used to create the trust, plus other factors as specified in 42 U.S.C. § 1396p(d).

41. Vehicles – One car, truck, motorcycle, camper, motor home, aircraft, snowmobile, watercraft, boat, or all-terrain vehicle is excluded regardless of its value if it is used for transportation of the individual or a member of his or her household. If an applicant owns more than one vehicle, the equity value of that second vehicle is countable when it is owned by the applicant or a deemed filing unit member, and it cannot be excluded under another provision. Boats, motorcycles, snowmobiles, jet skis, ATVs, and aircraft are generally considered

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recreational vehicles. The equity value of these recreational vehicles is a countable resource unless it can be excluded under other provisions.

(d) Conditional Assistance. Real and personal property, which is not exempt under another resource provision, is exempt as a resource if the individual enters into a Conditional Assistance agreement with the State. The individual must make a bona fide effort to sell the property at its current market value, and repay the State for medical expenses covered by HCFA during the period of conditional assistance.

1. The exclusion period for real property is not to exceed nine (9) months. The exclusion period for personal property is not to exceed three (3) months, however a three (3) month extension may be granted if the individual is able to show a good cause for failure to dispose of the property. Property that remains unsold at the end of the exclusion period will be considered inaccessible so long as the individual continues the bona fide effort to sell.

2. Repayment of medical expenses covered by HCFA during the period of conditional assistance may not exceed the total net proceeds of the sale. Any proceeds remaining after the repayment of medical expenses is paid are considered a resource.

(e) Disregards and Expenses Allowed. Unless otherwise specified in Subparagraph (f) below, individuals described in Subparagraph (a) are subject to the following expense requirements.

1. Court Ordered Child Support Payments – Exclude amount actually paid up to the full court-ordered obligation. A child support disregard will not be allowed for the same individual for whom a CSIMA or DIMA is allowed in an Institutionalized Medicaid budget.

2. Legally Obligated Alimony Payments – Alimony is an expense to the payer of the alimony and is allowed when alimony is paid during the month of application. The payments must be in cash, including checks and money orders, to be considered alimony. The following payments are not alimony: child support, noncash property settlements, and payments to keep up the payer's property. Alimony expenses do not include voluntary payments.

3. General Income Disregard – A $20.00 monthly General Income Disregard is allowed per household, and is applied to unearned income. If any of the $20.00 disregard is not offset by unearned income, the remainder is applied to the spouse's unearned income and then to the applicant or enrollee's earned income.

4. Child Support Disregard – If the applicant receives child support payments (current only), exclude up to $50.00 per month of child support payments received if the family also receives TANF benefits.

5. Earned Income Disregard – The first $65.00 of the earned income of each aged, blind or disabled individual is disregarded.

6. Blind and Disability Related Work Expenses:

(i) The gross countable earned income of each blind or disabled individual (not living in a medical institution) may be reduced by the amount of expenses attributable to earning the income. The allowable Blind Work Expenses (BWE) and allowable Disability Related Work Expenses

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(DRWE) are not the same. BWE and DRWE apply only to earned income. In order to deduct either BWE or DRWE, the individual must be:

(I) Blind, blind and disabled, or disabled; and under age sixty-five (65), or

(II) Age sixty-five (65) and older; and received SSI payments due to blindness or disability the month before attaining age sixty-five (65).

(ii) These expenses do not apply to the Institutionalized Medicaid categories. Work expenses must not be payable or reimbursable by a third party, such as Medicaid, Medicare or other insurance.

7. One-Half Disregard – If an individual's gross earned income, less any of the following disregards: General Income Disregard ($20.00) remainder, Earned Income Disregard ($65.00), Disabled Work Expense and Impairment-Related Work Expenses (IRWE), is greater than $0, disregard one-half (1/2) of the remainder.

8. Student Earned Income Exclusion (SEIE) – Applies to the earnings of an individual who is under age twenty-two (22) and regularly attending school. The exclusion may apply to an eligible or ineligible individual, child, spouse, or parent(s). The SEIE monthly amount is determined by the SSA. The SEIE does not apply to children attending elementary school.

(f) Household Composition Rules – Household composition for the ABD categories is governed by the FRR principle. Financial responsibility is limited to spouse to spouse and parent to child. Household composition not only determines which income standard to use, but also how FRR income is "deemed" or available, and the amount of income "deemed" or available to an individual. See 20 C.F.R. §§ 1160, et seq.

1. The following individuals must be included in the applicant's household, if living in the same household:

(i) The applicant's spouse;

(ii) The applicant's children under eighteen (18) years of age or under twenty-two (22) years of age if a student;

(iii) The applicant's parents, for children under eighteen (18) years of age or under twenty-two (22) years of age if a student; and

(iv) The applicant's siblings that are under eighteen (18) years of age or under twenty-two (22) years of age if a student.

2. Step-children are included in the household when they live in the home and their natural parent is the spouse of the applicant and living in the home. Step-parents are included when they live in the home with the applicant and natural or adopted parent, and are married to the natural or adopted parent. Step-siblings are included when their natural or adopted parent lives in the home and is considered the applicant's step-parent.

3. Financial eligibility is determined based on a household size of one or two. Included household members are the applicant and if applicable, his spouse. If there are additional household members, they will be considered in deeming budgets, if appropriate.

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4. Parent-to-child deeming applies when a blind or disabled child is living with his parent(s), and a portion of the parent's income and resources may be deemed available to the child and counted as unearned income to the child in determining his TennCare Medicaid eligibility. The parent receives income disregards and allocations in order to meet his own needs and the needs of other children that live in the household. Child and parental allocations are deducted from the parent's income before any income is deemed to the applicant/enrollee. Parental deeming applies to the following TennCare Medicaid categories:

   (i) Medicare Savings Program (QMB, SLMB, QI1 and QDWI);

   (ii) Pickle Passalong Aged and Blind/Disabled; and

   (iii) Institutional Eligibility.

5. The countable income and resources of an applicant/enrollee's TennCare Medicaid-ineligible spouse living in the home may be deemed available to the applicant/enrollee. Spousal deeming only applies when the spouses share a living arrangement, i.e., live in the community or home together. Spousal deeming applies to the following TennCare Medicaid Categories:

   (i) Medicare Savings Program (QMB, SLMB, QI, and QDWI); and

   (ii) Pickle Passalong Aged and Blind/Disabled.

6. The countable income and resources of a LTSS applicant/enrollee's TennCare Medicaid-ineligible spouse living in the home is made available to the applicant/enrollee under the Spousal Impoverishment rules.

(g) Qualifying Income Trusts (QIT) for Institutional Applicants.

1. Individuals who are receiving or will receive nursing facility services or home and community based services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program and whose income exceeds the Medicaid Income Cap (MIC) may establish a qualified income trust. Funds placed in a QIT that meets the standards set forth below are not treated as available resources or income for purposes of determining the individual's TennCare eligibility.

2. A QIT is a trust consisting only of the individual's pension income, SSI, and other monthly income that is created for the purpose of establishing income eligibility for TennCare coverage when an individual is or soon will be confined to a nursing facility, HCBS or ICF/IID waiver program offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program.

3. An individual is eligible to establish a QIT if his income is above the level at which he would be financially eligible for nursing facility, HCBS offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program, or ICF/IID care under Medicaid.

4. The amount of income that an applicant/recipient places in a QIT cannot be limited nor can it be counted when testing income against the MIC. However, it is used in determining patient liability during post-eligibility treatment of income. If the applicant/recipient's income that is not placed in a QIT is over the MIC, the individual is not financially eligible for the Institutional category.

(Rule 1200-13-20-.06, continued)

5. A valid QIT must meet the following criteria:

(i) The trust must be irrevocable and cannot be modified or amended in whole or in part by the Grantor at any time. However, the Trustee or a court of competent jurisdiction shall have the right and jurisdiction to modify any provision of the trust to the extent necessary to maintain the eligibility of the Grantor for medical assistance.

(ii) Each month the trustee shall distribute the entire amount of income transferred into the Trust except for an amount not to exceed $20.00 for expenses of the Trust.

(iii) The sole beneficiaries of the Trust are the individual for whose benefit the Trust is established and the State of Tennessee. The Trust terminates upon the death of the individual, or when the Trust is no longer required to establish TennCare Medicaid eligibility in the State of Tennessee, or if nursing facility care or HCBS is no longer medically necessary for the individual, or if the individual is no longer receiving such services.

(iv) The Trust must provide that upon the death of the individual or termination of the Trust, whichever occurs sooner, the State of Tennessee shall receive all amounts remaining in the Trust up to the total amount of medical assistance paid by the State on behalf of the individual.

(v) Amounts remaining in the Trust that are owed to the State must be paid to HCFA within three (3) months after the death of the individual or termination of the Trust, whichever is sooner, along with an accounting of the payments from the Trust. HCFA may grant an extension if a written request is submitted within two (2) months of the termination of the Trust.

(vi) This Part applies to an income trust established on or after July 1, 2005, and under the hardship provision in Section 1613 (e) of the Social Security Act (42 U.S.C. § 1382b(e)). Hardship may be considered to exist when the institutionalized individual or his spouse would have resources in excess of the resource limit, is otherwise eligible, and for whom TennCare Medicaid ineligibility would result in loss of essential nursing care which is not available.

(vii) Allowable payments from the Trust include:

(I) Personal Needs Allowance (PNA) – The amount the individual is allowed to retain for his personal needs under TennCare Medicaid policies. As of January 1, 2005, this amount is $50.00 for confinement in a nursing facility or ICF/IID and three hundred percent (300%) of the SSI/FBR for HCBS enrollees and Self-Determination Waiver; and two hundred percent (200%) of the SSI/FBR for the Arlington and Statewide Waivers.

(II) A deduction of up to $20.00 for expenses necessary for managing the trust (i.e. bank charges).

(III) CSIMA or DIMA, if applicable.

(Rule 1200-13-20-.06, continued)

(IV) Health Insurance Premiums – Allowed when the individual has health insurance other than TennCare Medicaid (for example, Medicare premium or a Medicare supplement policy).

(V) Item D deductions – Payment for types of medical or remedial care recognized under State law, but not covered as medical assistance under TennCare Medicaid.

(viii) Any countable income not placed in the QIT and any Trust income remaining after allowable deductions are made shall be paid monthly to the nursing facility, HCBS provider, or MCO by the individual or from the Trust in an amount not to exceed the Medicaid reimbursement rate. Any excess income not distributed from the Trust shall accumulate in the Trust monthly.

(ix) No other deductions or expenses may be paid from the Trust. Expenses which cannot be paid from the Trust except as specifically provided herein include, but are not limited to, trustee fees, attorney fees and costs (including attorney fees and costs incurred in establishing the trust), accountant fees, court fees and costs, fees for guardians ad litem, funeral expenses, past due medical bills and other debts.

(h) Annuities.

1. Disclosure. Disclosure of annuities is required for all applicants pursuant to 42 U.S.C. § 1396p(e). If an individual or his or her spouse refuses to disclose information related to an annuity, the individual will be denied Medicaid eligibility based on the individual's failure to cooperate.

2. Annuities and Transfer of Assets. An annuity will not be treated as a transfer of assets if the annuity meets the requirements of 42 U.S.C. 1396p(c)(1)(G).

3. Requirement to name the State as the Remainder Beneficiary. The purchase of an annuity is subject to the transfer of assets provision unless it meets the requirements of 42 U.S.C. § 1396(c)(1)(F).

(i) Annuities purchased or converted by the individual or his spouse on or after February 8, 2006, must be changed prior to TennCare Medicaid approval or redetermination to name the State of Tennessee as the remainder beneficiary of the annuity, in the following order, if applicable:

(I) Community Spouse.

(II) A minor, blind or disabled child.

(III) State of Tennessee.

(ii) As a remainder beneficiary, the State may receive up to the total amount of medical assistance paid on behalf of the individual, including both long term services and supports and home and community based services. The State must notify the issuer of the State's right as the preferred remainder beneficiary and the issuer must notify the State if there are any changes in the amount of income or principal being withdrawn.

(iii) An annuity may be amended to meet these criteria, so that the annuity purchase will not be treated as a transfer of assets for less than FMV.

(Rule 1200-13-20-.06, continued)

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111, and 71-5-117.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016.*

1200-13-20-.07 FAMILY AND CHILD ELIGIBILITY GROUPS.

(1) Caretaker Relatives.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Individual must be a parent or caretaker relative of a minor child and must agree to cooperate with State Child Support Enforcement to establish paternity and medical support, if applicable. Failure to cooperate or show good cause for not cooperating once eligible shall result in termination.

(d) Household size is based upon the MAGI household composition Rule .06.

(e) Income Limitation: Household income cannot exceed the monthly income levels as outlined in the State Plan. Note: The FFM uses these numbers to establish an equivalent FPL.

(f) Resource Limitation: None.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(h) Individuals in this category may also be eligible for Extended Medicaid as described in 42 C.F.R. § 435.115 and Transitional Medicaid as described in 42 C.F.R. § 435.112.

(2) TennCare Pregnant Women.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Individual must be pregnant. Self-attestation of pregnancy is accepted unless the State has information that is not reasonably compatible with such attestation.

(d) Household size is based upon the MAGI household composition Rule .06.

(e) Income Limitation: Household income cannot exceed one hundred ninety-five percent (195%) of the FPL. See Rule .06.

(f) Resource Limitation: None.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(h) Other:

(Rule 1200-13-20-.07, continued)

1. Eligibility is continuous through the last day of the month of the sixty (60)-day postpartum period as defined at 42 C.F.R. § 435.4, regardless of income changes.

2. An individual in this category is eligible for all medically necessary covered services, other than LTSS, because TennCare considers all medically necessary covered services to be pregnancy-related. A pregnant woman could be eligible for LTSS if she is determined to meet the criteria for an Institutional Eligibility category.

3. Individuals in this category may also be eligible for Extended Medicaid as described in 42 C.F.R. § 435.115 and Transitional Medicaid as described in 42 C.F.R. § 435.112.

(3) Presumptive Eligibility for Pregnant Women.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04. Self-attestation of citizenship, residency and Social Security Number (SSN) are accepted at application for presumptive eligibility.

(c) Special Eligibility Requirements: Individual must be pregnant at the time of application. Self-attestation of pregnancy is accepted unless the State has information that is not reasonably compatible with such attestation.

(d) Household size is based upon the MAGI household composition Rule .06.

(e) Income Limitation: Household income cannot exceed one hundred ninety-five percent (195%) of the FPL. See Rule .06.

(f) Resource Limitation: None.

(g) Effective Date of Eligibility: The date of determination by the Tennessee Department of Health or other qualified entity. The presumptive eligibility period ends either the last day of the month following the month a presumptive eligibility determination was made, or if a full Medicaid application is submitted before the end of the month following the presumptive application, eligibility continues until a determination is made on a complete Medicaid application, or as otherwise agreed to by the Single State Agency and CMS. Only one presumptive period of eligibility is allowed for each pregnancy.

(4) Infants and Children under Age 19.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Individual must be younger than nineteen (19) years of age.

(d) Household size is based upon the MAGI household composition Rule .06.

(e) Income Limitations:

1. Infants younger than age one (1): Household income cannot exceed one hundred ninety-five percent (195%) of the FPL.

(Rule 1200-13-20-.07, continued)

2. Children from age one (1) to age five (5): Household income cannot exceed one hundred forty-two percent (142%) of the FPL.

3. Children from age six (6) to age nineteen (19): Household income cannot exceed one hundred thirty-three percent (133%) of the FPL. See Rule .06.

(f) Resource Limitations: None.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(h) Individuals in this category may also be eligible for Extended Medicaid as described in 42 C.F.R. § 435.115 and Transitional Medicaid as described in 42 C.F.R. § 435.112.

(5) Deemed Newborns.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04, except Deemed Newborns are not subject to citizenship rules. Newborns without an SSN must be enumerated by age one (1) to remain eligible for another category, or before they can be approved in another category, whichever occurs first.

(c) Special Eligibility Requirements: Newborns must be twelve (12) months or younger. A baby born to a mother eligible for and receiving TennCare Medicaid shall be eligible for TennCare Medicaid for one (1) year from the date of birth, as long as the newborn remains a resident of Tennessee during that time.

(d) Income Limitations: None.

(e) Resource Limitations: None.

(f) Effective Date of Eligibility: The child's date of birth, if mother was eligible for and receiving TennCare Medicaid at the time of birth.

(6) Newborn Presumptive.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04. Self-attestation of residency is accepted at application for presumptive eligibility. SSN is not required for newborns to age one (1).

(c) Special Eligibility Requirements: Newborns must be twelve (12) months or younger.

(d) Household size is based upon the MAGI household composition Rule .06.

(e) Income Limitations: Household income cannot exceed one hundred ninety-five percent (195%) of the FPL.

(f) Resource Limitations: None.

(g) Effective Date of Eligibility: The date of determination by the qualified entity. The presumptive eligibility period extends from the date of application through the end of the following month, or if a full Medicaid application is submitted before the end of the month following the presumptive application, eligibility continues until a determination is

(Rule 1200-13-20-.07, continued)

made on a complete Medicaid application or as otherwise agreed to by the Single State Agency and CMS.

(7) Former Foster Care Children up to Age 26.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: The individual must be under age twenty-six (26), have been in foster care provided by the State of Tennessee, and must have been receiving Medicaid in the foster care category at the time he aged out of custody in order to qualify for this category.

(d) Income Limitations: None.

(e) Resource Limitations: None.

(f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(8) Standard Child Uninsured.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Must be a Medicaid “Rollover” enrollee as defined in Rule .02, or currently enrolled in TennCare Standard, and does not have insurance or access to health insurance.

(d) Household size is based upon the MAGI household composition Rule .06.

(e) Income Limitations: Household income must be at or below two hundred eleven percent (211%) of the FPL. See Rule .04.

(f) Resource Limitations: None.

(g) Effective Date of Eligibility: The day following the TennCare Medicaid coverage end date.

(h) Other: Includes uninsured children under age nineteen (19) who have been continuously enrolled in TennCare Standard since December 31, 2001, who have family incomes at or below two hundred percent (200%) of the FPL, and who have not purchased insurance even if they have access to it. This is a “grandfathered” eligibility category. If an individual loses eligibility in this category, he or she will not be able to re-enroll in it.

(9) Standard Child Medically Eligible.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Must be an uninsured child under age nineteen (19) who is losing eligibility for Medicaid or being renewed as TennCare Standard, who

(Rule 1200-13-20-.07, continued)

does not have access to health insurance, and who has been determined to have a qualifying medical condition according to these rules.

(d) Special Application Procedures:

1. Must be a Medicaid "Rollover" enrollee as defined in Rule .02, or currently enrolled in TennCare Standard.

2. Applicants have three (3) options for proving medical eligibility:

(i) Option 1: Physician's attestation on the Medically Eligible (ME) Packet of specific qualifying conditions.

(ii) Option 2: A completed ME packet and medical records to support a qualifying medical condition with a signed release for medical records in the event additional medical records are needed.

(iii) Option 3: An existing Medically Eligible determination in Interchange.

3. If a Medicaid enrollee under age nineteen (19) whose Medicaid eligibility is ending is determined to otherwise meet technical eligibility requirements for TennCare Standard, but is not eligible as uninsured because his income is above two hundred eleven percent (211%) of poverty, he will be sent a ME packet.

4. TennCare will send the enrollee a ME packet with an explanation regarding how to apply for TennCare Standard as a medically eligible individual. The enrollee will have sixty (60) days from the date of the notice letter (inclusive of mail time) to submit his medical eligibility packet. If the individual is determined to qualify as medically eligible, coverage will be provided throughout the eligibility determination period and will continue with no break.

5. The required ME application information must be returned to the address specified within sixty (60) days from the date of the letter included in the packet. A ME form and documentation received after that time will not be processed as it exceeds the timely filing requirement. Packets which are not completed by the sixtieth (60th) day will be denied with a notice of appeal rights.

(e) Household size is based upon the MAGI household composition Rule .06.

(f) Income Limitations: Household income must exceed two hundred eleven percent (211%) of the FPL. See Rule .06.

(g) Resource Limitations: None.

(h) Effective Date of Eligibility: The day following the TennCare Medicaid coverage end date.

(10) CoverKids - CHIP Children under age 19.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Includes children under age 19 who do not have Health Insurance, as defined in Rule .02.

(Rule 1200-13-20-.07, continued)

(d) Household size is based upon the MAGI household composition Rule .06.

(e) Income Limitations: Must be over the applicable Medicaid limit and under two hundred fifty percent (250%) of the FPL. See Rule .06.

(f) Resource Limitations: None.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(11) CoverKids Pregnant Women/Unborn Children.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04. The pregnant woman's unborn child is presumed to be a U.S. citizen, regardless of the citizenship or immigration status of the mother. The mother is not required to provide proof of citizenship or immigration status.

(c) Special Eligibility Requirements: Includes pregnant women who do not have Health Insurance, as defined in Rule .02, or do not have maternity benefits or have exhausted maternity benefits.

(d) Household size is based upon the MAGI household composition Rule .06.

(e) Income Limitations: Must be ineligible for Medicaid and below two hundred fifty percent (250%) of the FPL. See Rule .06.

(f) Resource Limitations: None.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(h) Other: Eligibility for the pregnant woman is continuous through the 60 days postpartum period as defined at 42 C.F.R. § 435.4. Eligibility for the newborn child continues twelve (12) months from the mother's effective date of eligibility.

(12) IE Foster Care, Foster Care, and Adoption Assistance.

(a) Definition: Children in State foster care or in a subsidized adoptive home.

(b) Eligibility for these categories is determined by the Tennessee Department of Children's Services.

(13) Transitional Medicaid.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements for Transitional Medicaid: Eligible individuals must have been eligible for and receiving benefits for at least three (3) of the six (6) months immediately preceding the month of ineligibility. Eligible individuals receive twelve (12) months of Medicaid.

(Rule 1200-13-20-.07, continued)

(d) Special Eligibility Requirements for children: Transitional Medicaid benefits are provided to children who lose Child MAGI eligibility when the following conditions are met:

1. The child's parent or caretaker relative was previously eligible in a MAGI category with income under the Caretaker Relative income standard for three (3) of the previous six (6) months but lost eligibility due to an increase in earnings; and

2. The child was eligible and enrolled in a Child MAGI category for three (3) of the six (6) months immediately preceding the month the parent or caretaker relative lost eligibility.

(e) Special Eligibility Requirements for Pregnant women: Transitional Medicaid benefits are provided to pregnant women who lose Pregnancy MAGI eligibility when all of the following conditions are met:

1. The individual was eligible and enrolled in the Pregnancy MAGI category for three (3) of the six (6) months immediately preceding the month eligibility was lost;

2. The woman's loss of eligibility is due to an increase in earnings; and

3. The woman's household income was at or below the Caretaker Relative income standard for three (3) of the six (6) months immediately preceding the month eligibility was lost.

(f) Special Eligibility Requirements for Caretaker Relatives: Transitional Medicaid benefits are provided to parents and caretaker relatives who lose Caretaker Relative MAGI eligibility when all of the following conditions are met:

1. The individual was eligible and enrolled in the Caretaker Relative MAGI category for three (3) of the six (6) months immediately preceding the month eligibility was lost;

2. Loss of eligibility was due to an increase in earnings; and

3. The parent or caretaker relative must continue to have a dependent child in the home in order to receive Transitional Medicaid.

(g) Household size is based upon the MAGI household composition Rule .06.

(h) Income Limitations: See Rule .06.

(14) Extended Medicaid.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Eligible individuals must have been eligible for and receiving benefits for at least three (3) out of six (6) months immediately preceding the month of ineligibility. Eligible individuals receive twelve (12) months of Medicaid.

(d) Special Eligibility Requirements for children: Extended Medicaid benefits are provided to children who lose Child MAGI eligibility when the following conditions are met:

(Rule 1200-13-20-.07, continued)

1. The child's parent or caretaker relative was previously eligible in a MAGI category with income under the Caretaker Relative income standard for three (3) of the previous six (6) months but lost eligibility due to an increase in spousal support; and

2. The child was eligible and enrolled in a Child MAGI category for three (3) of the six (6) months immediately preceding the month the parent or caretaker relative lost eligibility.

(e) Special Eligibility Requirements for Pregnant Women: Extended Medicaid benefits are provided to pregnant women who lose Pregnancy MAGI eligibility when the following conditions are met:

1. The individual was eligible and enrolled in the Pregnancy MAGI category for three (3) of the six (6) months immediately preceding the month eligibility was lost;

2. The woman's loss of eligibility is due to an increase in spousal support; and

3. The woman's household income was at or below the Caretaker Relative income standard for three (3) of the six (6) months immediately preceding the month eligibility was lost.

(f) Special Eligibility Requirements for Caretaker Relatives: Extended Medicaid benefits are provided to parents and caretaker relatives who lose Caretaker Relative MAGI eligibility when the following conditions are met:

1. The individual was eligible and enrolled in the Caretaker Relative MAGI category for three (3) of the six (6) months immediately preceding the month eligibility was lost;

2. Loss of eligibility was due to an increase in spousal support; and

3. The parent or caretaker relative must continue to have a dependent child in the home in order to receive Transitional Medicaid.

(g) Household size is based upon the MAGI household composition Rule .06.

(h) Income Limitations: See Rule .06.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111, and 71-5-117.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016.*

1200-13-20-.08 AGED, BLIND OR DISABLED CATEGORIES.

(1) Supplementary Security Income (SSI) Cash recipient.

(a) Aged, blind or disabled individuals who are determined eligible for SSI payments by the SSA are eligible for TennCare Medicaid. Once SSI payments in Tennessee stop, the individual becomes an inactive SSI enrollee who must be reviewed for eligibility in all other categories.

(b) Effective date of eligibility: Date of eligibility as determined by the SSA.

(Rule 1200-13-20-.08, continued)

(2) Disabled Adult Child.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: Disabled adult children who lose SSI eligibility after July 1, 1987 because of the receipt of or an increase in benefits for DAC payments under Title II of the Social Security Act will remain eligible for Medicaid if the initial entitlement under Title II above and/or cost of living increases, whichever caused the ineligibility for SSI, were disregarded.

(d) Income Limitations: SSI Federal Benefit Rate.

(e) Resource Limitations: $2,000.00 for an individual, $3,000.00 for a couple.

(f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(3) Pickle Passalong.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: TennCare Medicaid benefits are available to individuals who would be eligible for SSI payments if increases in their Social Security benefits due to cost of living adjustments were disregarded. Individuals who meet all other non-financial and financial eligibility requirements remain eligible for TennCare Medicaid if they:

1. Were eligible for and received both Social Security and SSI benefits in the same month since April 1977. The SSI recipient who receives Social Security retroactive benefits is considered for TennCare Medicaid purposes to have received SSI and Social Security benefits in the same month, if Social Security eligibility overlaps a month the individual also received SSI benefits;

2. Lost eligibility for SSI since April 1977;

3. Currently receive Social Security benefits authorized under Title II of the Social Security Act; and

4. Have countable income equal to or less than the current SSI Federal Benefit Rate after all applicable cost of living adjustments have been deducted.

(d) Income Limitations: SSI Federal Benefit Rate.

(e) Resource Limitations: $2,000.00 for an individual, $3,000.00 for a couple.

(f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to 1200-13-20-.05, or the date all eligibility requirements are met, whichever is later.

(4) Widow/Widower.

(a) Definition: See Rule .02.

(Rule 1200-13-20-.08, continued)

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements. A disabled widow/widower is eligible for TennCare Medicaid for any month in which he is entitled to a Social Security Widow/Widower benefit, but is not eligible for SSI, if he:

1. Was eligible for SSI based on his own disability;

2. Was entitled to the Social Security Widow/Widower benefit any time after the age of fifty (50);

3. Lost SSI eligibility in the first month that the Social Security Widow/Widower benefit was paid;

4. Has been continuously entitled to the Social Security Widow/Widower benefit from the month that the SSI was authorized;

5. Would be eligible for SSI if the Widow/Widower entitlement and all subsequent COLAs were disregarded;

6. Is not entitled to Medicare Part A; and

7. Is at least age fifty (50) and up to age sixty-five (65).

(d) Income Limitations: SSI Federal Benefit Rate.

(e) Resource Limitations: $2,000.00 for an individual, $3,000.00 for a couple.

(f) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(5) Institutional Eligibility.

(a) Definition: See Rule .02.

(b) Technical Requirements: See Rule .04.

(c) Special Eligibility Requirements: To gain eligibility in this category, applicants must either be determined to meet the medical (level of care) eligibility criteria for CHOICES or ECF CHOICES, according to Rule Chapter 1200-13-01, to receive payments for long term services and supports through the CHOICES or ECF CHOICES benefits package or be continuously confined in an institution for thirty (30) consecutive days. Receipt of hospice services in a nursing facility for any length of time meets the 30-day continuous confinement requirement.

(d) Household size is based upon the Aged, Blind, and Disabled household composition Rule .06.

(e) Income Limitations: Income shall not exceed three hundred percent (300%) of the SSI Federal Benefit Rate for an individual.

(f) Resource Limitations: Resources shall not exceed $2,000.00 for an individual.

(g) Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(Rule 1200-13-20-.08, continued)

(h) Special Asset Rules:

1. Asset Disregards for Qualified Long-Term Care Insurance Policies.

(i) Individuals who purchase a qualified long term care insurance policy may have certain assets disregarded in the determination of eligibility for TennCare. TennCare shall disregard an individual's assets up to the amount of payments made by the individual's qualifying long-term care insurance policy for services covered under the policy at the time of TennCare application.

(ii) The amount of the individual's assets properly disregarded under these provisions shall continue to be disregarded through the lifetime of the individual.

(iii) Assets which were disregarded for purposes of Medicaid eligibility determination during the individual's lifetime are also protected from estate recovery. When the amount of assets disregarded during the individual's lifetime was less than total benefits paid by the qualified long term care insurance policy, additional assets may be protected in the estate recovery process up to the amount of payments made by the individual's qualifying long term care policy for services covered under the policy. If no assets were disregarded during the individual's lifetime, the personal representative may designate assets to protect from estate recovery up to the lesser of the two options specified above, even if a qualified long term care policy's benefits were not completely exhausted.

2. Entrance Fees: Any contractual provision requiring the resident to deposit entrance fees must take into account the required allocation of resources or income to the community spouse before determining the resident's cost of care. In addition, the entrance fee paid to the Continuing Care Retirement Community (CCRC) or life care community is treated as a resource to an individual for purposes of determining Medicaid eligibility. The following three (3) conditions must be met in order for the entrance fee to be considered an available resource:

(i) Any portion of the entrance fee is refunded or used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient;

(ii) The entrance fee, or any portion thereof, is refundable under the terms of the contract when the individual dies or terminates the contract and leaves the CCRC or life care community, whether or not any amount is actually refunded; and

(iii) The entrance fee does not confer an ownership interest in the community.

3. Funds used to purchase a loan, mortgage or promissory note after February 8, 2006 must be treated as a transfer of assets unless it has a repayment term that is actuarially sound, provides for payments to be made in equal amounts during the term of the loan with no deferral or balloon payment, and prohibits cancellation of the balance upon the death of the lender. If an individual purchases a home from a nursing home applicant and the purchase agreement does not meet the criteria of this part, the value of the home will be the outstanding balance due as of the date of the application for Medicaid.

(Rule 1200-13-20-.08, continued)

4. A life estate interest purchased by a nursing home applicant in another individual's home shall be treated as a transfer of assets unless the nursing home applicant resides in the home for a period of at least one (1) year after the date of the purchase.

(i) Transfer of Assets – A transfer of assets is transferring ownership of a resource for less than fair market value (FMV). An applicant for Institutional Eligibility shall not transfer assets for less than FMV during the sixty (60) months prior to the date of application. If an individual is found to have transferred an asset for less than FMV, he will be ineligible for payments for Long-Term Services and Supports.

1. An individual shall not receive a period of ineligibility to the extent that the transfer meets the requirements of 42 U.S.C. § 1396p(c)(2).

2. The transfers indicated below, if occurring on or after February 8, 2006, may be considered a transfer of assets for less than FMV with respect to an individual applying for Medicaid based on institutionalization:

(i) If the transfer of assets occurs within sixty (60) months of application for institutional care.

(ii) If the institutionalized individual, his spouse, or any person, court or administrative body with authority to act on behalf of, or at the direction or request of, the individual or his spouse, establishes a trust or similar device, which includes the individual's assets and cannot be used by or for the individual's benefit, if it occurred within sixty (60) months of application for institutional care.

(iii) If an asset is held jointly by the institutionalized individual with another person and the individual or other owner reduces or eliminates the institutionalized individual's ownership or control of the asset, if it occurred within sixty (60) months of application for institutional care.

(j) Penalty for transfer of assets.

1. The institutionalized individual may be subject to penalty if the transfer was completed by the individual; the individual's spouse; a person (including a court) or administrative body with legal authority to act in place of, or on behalf of, or at the direction or request of the institutionalized individual or his spouse.

2. Assets include all income and resources, including the home, unless transferred as indicated in subparagraph (i) above, of the institutionalized individual and his spouse, (including income and/or resources the individual is entitled to, but does not receive because of any action by the individual or his spouse or a person (including a court) or administrative body with legal authority to represent the individual, his spouse, or who acts at the direction or request of the individual and his spouse).

3. Penalty period: The period of ineligibility for payments for long-term services and supports in the CHOICES Program imposed for transfers of assets within sixty (60) months prior to application for long term care nursing services.

(i) The penalty period is determined by dividing the uncompensated value of the transferred asset by the average daily nursing home private pay rate. In determining the penalty for a transfer a State may not round down or disregard any fractional period of ineligibility. There is no limit on the

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maximum months of ineligibility. The penalty continues until expired unless hardship is considered to exist.

(ii) The penalty period for individuals receiving nursing home care begins the month the individual becomes eligible for LTSS through the CHOICES Program or the month of the transfer, whichever is later. The penalty period for HCBS begins the date of application or the date of the transfer for individuals already receiving HCBS. The penalty period runs consecutively even if the individual leaves the nursing home for a period of time and later returns. If a penalty period is imposed for new applicants, Medicaid requires a notice of penalty. If a penalty period is imposed on an individual who is already receiving Medicaid, a ten (10) day adverse action notice is required.

(iii) Applicants for, or enrollees in, nursing home coverage can still remain eligible in an Institutional Eligibility category while payments for LTSS are withheld. Applicants for, or enrollees in, HCBS cannot be eligible for an Institutional Eligibility category while subject to the period of ineligibility.

(iv) Penalty periods for more than one transferred asset will run consecutively, not concurrently. Any uncompensated value from multiple transfers is added to the initial uncompensated value if penalty periods overlap to determine the consecutive penalty period.

(k) Undue hardship.

1. Undue Hardship shall exist only when:

(i) An application of a transfer of assets provision would deprive the individual of medical care, such that the individual's health or life would be endangered, or of food, clothing, shelter, or other necessities of life;

(ii) The institutionalized individual has no available resources (other than the uncompensated value) in excess of the resource limitations, and

(iii) The necessary care is not available from any other source.

2. The individual, the individual's responsible party, or the facility in which an institutionalized individual resides may file an undue hardship claim on behalf of the applicant/recipient. TennCare will determine whether hardship exists and notify the applicant/recipient within thirty (30) days of filing.

3. If undue hardship is determined not to exist, the denial of undue hardship may be appealed within forty (40) days.

(l) Patient Liability – Individuals determined eligible for Institutional Eligibility are required to contribute to the cost of their care as a resident in a nursing facility or as a Home and Community Based Services (HCBS) recipient.

1. Patient liability is determined by allowing the following deductions from the individual's gross income:

(i) A Personal Needs Allowance (PNA) for clothing and other personal needs while receiving Institutional Eligibility. Apply the appropriate PNA based on the type of long term services and supports the individual receives, as follows:

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(I) Nursing Facility. $50.00 PNA from the gross income of an individual in a nursing facility.

(II) HCBS, PACE and Self-Determination ID Waivers. PNA is three hundred percent (300%) of the SSI FBR.

(III) Statewide ID and Comprehensive Aggregate Cap ID Waivers. PNA is two hundred percent (200%) of the SSI FBR.

(ii) An allowance equivalent to the monthly fee for maintenance of a QIT, if applicable.

(iii) A CSIMA for institutionalized individuals with a spouse residing in the community.

(iv) A DIMA for institutionalized individuals with a dependent residing in the community.

(v) Health insurance premiums, coinsurance and deductibles.

(vi) Expenses for medical services as defined at 42 C.F.R. §§ 435.725(c)(4) and 726(c)(4).

2. Community Spouse Income Maintenance Allowance (CSIMA) – When determining an institutionalized individual's patient liability, an allowance is deducted from his income for the needs of the community spouse. The CSIMA is allowed unless specifically refused by the institutionalized spouse. Funds must actually be transferred to the community spouse in order to be deducted.

(i) CSIMA is allowed under the following conditions:

(I) CSIMA is not allowed if both spouses are receiving Institutional Eligibility, unless one spouse is receiving HCBS.

(II) If the community spouse applies for TennCare Medicaid, the CSIMA will be counted as unearned income at the time of application.

(III) A community spouse receiving need-based assistance does not have to accept the total or any of the income allocation if it will result in the termination or decrease of those benefits.

(IV) If a couple is married but living separately, and considers themselves to be separated, the CSIMA may be allowed if both individuals agree to the allocation and the community spouse is not institutionalized.

(V) If the community spouse lives out of State, the CSIMA is allowed if the community spouse can be located and the couple is still married.

(ii) CSIMA Terms and Standards:

(I) Standard Maintenance Amount (SMA): The minimum monthly amount of income, as determined by CMS, that the Community Spouse must receive to meet basic needs. This is subject to annual change by CMS and released with SSI and Spousal Impoverishment Standards.

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(II) Maximum Maintenance Needs Allowance (Maximum MNA): The maximum monthly amount of income, as determined by CMS, that the Community Spouse can receive as a CSIMA. This is subject to annual change by CMS and released with SSI and Spousal Impoverishment Standards.

(III) Standard Utility Amount (SUA): The SUA is used when the community spouse is responsible for heating and/or cooling costs. If the SUA is used, then it is considered to cover all utilities, including garbage, water, lighting, etc. The SUA is subject to annual change by the Tennessee Department of Human Services.

(IV) Standard Housing Allowance (SHA): The SHA is used to determine whether the community spouse requires an Excess Shelter Allowance. This is subject to annual change by CMS and released with SSI and Spousal Impoverishment Standards.

(iii) CSIMA Calculation: The CSIMA is calculated using three steps:

(I) Determine Excess Shelter Allowance (ESA).

I. An ESA is allowed when the total shelter costs for rent, mortgage, taxes and insurance, maintenance charges and utility costs exceed the SHA. The SHA is thirty percent (30%) of the Standard Maintenance Amount.

II. The SUA is used when the community spouse is responsible for heating or cooling costs. If the SUA is used then it is considered to cover all utilities (no additional allowance for garbage, telephone, etc.). When there is no or reduced cost to the community spouse because the cost of a particular utility is paid by a third party (in cash or in-kind), reduce the amount of the SUA by the third party payment.

III. To determine the ESA, add rent, mortgages, taxes, insurance, etc., to the SUA, then subtract the SHA.

(II) Determine Community Spouse Net Income. Defined as income over which the Community Spouse has control and which is actually available to him. Child support payments and other types of court-ordered payments made by the Community Spouse are not considered income available to the Community Spouse.

(III) Calculate CSIMA: The CSIMA is calculated by adding the SMA and the ESA, and then subtracting the Community Spouse's net income.

3. Dependent Income Maintenance Allowance (DIMA): When determining patient liability, an allowance is deducted from the individual's income for the needs of his dependents.

(i) Dependent relatives include all individuals who can be or are being claimed as tax dependents.

(ii) A DIMA is not allowed for any dependent receiving HCBS or who is institutionalized.

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(iii) Pursuant to the Medicare Catastrophic Coverage Act, a dependent does not have the option of declining all or a portion of the income allocation for any reason, even if needs-based benefits may be decreased or lost because of the allocation.

(iv) The total of both the CSIMA and DIMA combined cannot exceed the Maximum MNA.

(v) The Maximum MNA for each additional dependent family member is equal to one-third of the difference between the SMA and the dependent's gross income.

(vi) DIMA Calculation: The dependent allocation(s) equals the SMA for the community spouse minus the dependent's own gross countable income divided by 3.

4. Item D Expenses: Expenses for medical or remedial care not subject to third party payment as defined at 42 C.F.R. §§ 435.725(c)(4), .726(c)(4) and .832, and outlined in the State Plan are allowable deductions. Criteria for Deduction of an Item D Expense:

(i) The expense must not be subject to payment by a third party not expecting reimbursement, e.g., medical or health insurance, the individual's spouse or family or medical trust fund, Medicare, etc.

(ii) The expense may be unpaid or paid by the individual during the month(s) of eligibility determination or paid by a member of the individual's family and reimbursement is expected by the family member.

(iii) The expense must not have been allowed previously as an allowed necessary item.

(iv) If payment for the item is outstanding, it must be considered collectible by the party who provided the medical service and one for which the individual is legally liable.

(v) Medical expenses incurred during TennCare Medicaid ineligibility do not impact whether the bill is an allowable medical expense.

(vi) Deductions will be allowed in compliance with 42 C.F.R. §§ 435.725(c)(4), .726(c)(4), and .832, and the State Plan.

(m) Resource Assessment and CSRMA.

1. Resource Assessment: When determining eligibility for a married institutionalized applicant, a calculated amount of the couple's assets is allocated to the community spouse in order to be used for her own needs. The resource assessment is a snapshot of all countable assets owned by the couple at the time the individual enters the nursing facility but conducted when the individual applies or when an assessment is requested prior to application, or is a snapshot at the time of application resulting in enrollment in an HCBS waiver. All of the countable resources owned individually or jointly by both spouses are counted; resources excluded under the ABD resource rules are not counted in the resource assessment.

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(i) Only one resource assessment will be completed for a married couple.

(ii) Under no circumstances can a resource assessment be completed prior to the date of admission to a long term care facility or enrollment in an HCBS waiver.

(iii) An assessment remains in effect until a HCFA application is filed, regardless of any interruptions in long-term care. If a resource assessment is completed and the individual applies for TennCare Medicaid, but is found ineligible, the original resource assessment is still valid if the individual applies again in the future.

2. Community Spouse Resource Maintenance Allowance: The CSRMA is based on the spouses' combined countable resources documented in the Resource Assessment. The amount of the CSMRA is the greater of:

(i) One-half (1/2) of the total countable resources, but not less than the Minimum Resource Standard or greater than the Maximum Resource Standard (released in the SSI and Spousal Impoverishment Standards and subject to change annually);

(ii) The court-ordered amount; or

(iii) The amount determined by a HCFA Eligibility Appeals Administrative Judge due to a hardship situation (extreme financial duress).

3. When an application is filed by or on behalf of the spouse seeking LTSS, the CSRMA amount determined in the resource assessment is the amount allocated to the community spouse. This amount is deducted from the combined resources of both spouses as of the first day of the first month for which assistance is requested. None of the community spouse's share of the resources is considered available to the individual seeking eligibility when determining her TennCare Medicaid eligibility.

4. Refusal of CSRMA. – A community spouse who receives needs-based assistance may accept or decline all, some or none of the CSRMA if the allocation would cause the loss of or decrease in those program benefits. If the community spouse accepts only a portion of the CSRMA, the unclaimed portion of the CSRMA is counted as part of the institutionalized spouse's resources.

5. Resource Transfer as a Result of Assessment.

(i) CSRMA "Grace Period" – Following a resource assessment and initial approval of eligibility, resources must be transferred within twelve (12) months of the approval. Both spouses must agree to the transfer in order to use the institutionalized spouse's share in determining his or her eligibility. The transfer may require conveyance of resources from the institutionalized individual to the community spouse, or vice versa.

(ii) Transfer Refusal – When the community spouse refuses to transfer resources to the institutionalized individual, the institutionalized spouse may still be eligible if on appeal the State finds that undue hardship circumstances exist.

(I) If the community spouse has available assets over the CSRMA she is legally obligated to provide support.

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(II) Hardship cannot be determined to exist unless assets have been reallocated as the result of an appeal decision or a court order.

(iii) CSRMA Appeals.

(I) When the Individual and/or Spouse Has Appeal Rights - Appeal rights are considered only after a HCFA application has been filed and either spouse alleges that the assessment or eligibility determination decision is not correct. An assessment completed exclusive of a filed application cannot be appealed, 42 U.S.C. § 1396r-5(e)(2)(A). Revisions to the spousal allowance of resources can be made by an HCFA Eligibility Appeals Administrative Judge or by court order.

(II) CSRMA Revisions – The amount of the CSRMA may only be revised by an HCFA Eligibility Appeals Administrative Judge or by court order, and only if additional verification/documentation is provided. The CSRMA may only be revised when:

I. The initial assessment was alleged to be incorrect and the HCFA Eligibility Appeals Administrative Judge confirms the allegations.

II. The community spouse's income, including the CSIMA, is inadequate to meet the basic standard maintenance amount.

(III) Allocation of Additional Resources to the Community Spouse.

I. When Additional Resources May be Allocated to Community Spouse: An HCFA Eligibility Appeals Administrative Judge may determine a larger CSRMA if necessary to offset a CSIMA that is below the required SMA. In the event that the institutionalized spouse does not have enough income to provide the community spouse with the SMA, and the couple has additional resources above the community spouse's protected amount (CSRMA), some or all of the institutionalized individual's resources can be allocated to the community spouse.

II. The Deficit Reduction Act (DRA) of 2005 requires all States to allocate the maximum amount of available income of the institutionalized spouse to the community spouse before granting an increase in the CSRMA. This is referred to as the "income-first" method.

III. Procedure: HCFA uses the Single Fixed Annuity model to address appeals when there is insufficient income to provide the community spouse with the minimum required CSIMA and the couple has additional resources. A single fixed annuity can turn a portion of an individual's savings into income payments made for the rest of the individual's life. The procedure for establishing a Single Fixed Annuity is listed below.

A. Additional resources may be allocated to the community spouse through the HCFA eligibility appeals process to

make up any shortfall between the amount of income allocated from the institutional spouse to the community spouse and the SMA, if determined appropriate.

B. The amount of additional resources that are necessary to cover the income shortfall shall be determined in reference to the purchase of a Single Premium Annuity as follows:

(A) By calculating the shortfall between the amount of income allocated and the SMA, and then determining the amount of additional resources that must be invested in a single premium annuity in order to generate the income necessary to cover the shortfall.

(B) The amount of resources needed to cover the shortfall shall be determined in reference to an annuity calculator as adopted by the HCFA.

(C) The additional resource allocation to the community spouse does not require the actual purchase of a Single Premium Annuity that is used for purposes of calculating the amount of the additional resource allocation.

(D) The amount of the community spouse's protected resources shall be excluded from this calculation.

(E) If a single premium annuity is actually purchased pursuant to these rules, the annuity must comply with all other relevant requirements of State and federal law.

(F) The amount of additional resources that are necessary to cover the shortfall in the SMA shall not be determined in reference to any investment which contemplates the return of the entire principal at maturity.

(iv) Transfer of Assets for Less than Fair Market Value.

(I) A transfer of assets for less than FMV is not considered to have occurred when resources are transferred from the institutionalized individual to the community spouse or vice versa according to a completed resource assessment.

(II) Should the spouse who received the allocation according to the resource assessment then transfer the resource to someone else for less than FMV, the transfer will be treated as a transfer of assets by the institutionalized individual.

(III) Transfer of assets for less than FMV is considered part of the application process whether or not a resource assessment has been requested previously or is requested at application. Transfer of

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assets is not considered if a resource assessment only (no TennCare Medicaid application filed concurrently) is requested.

(6) Medicare Savings Programs.

(a) QMB.

1. Definition: See Rule .02.

2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for QMB is eligible for TennCare Buy-in of his Medicare premiums, and payment of Medicare coinsurance and deductibles.

3. Technical Requirements: See Rule .04.

4. Household size is based upon the ABD household composition Rule .06.

5. Income Limitations: Below one hundred percent (100%) of the FPL.

6. Resource Limitations: Limits for an individual and couple as determined by SSA.

7. Effective Date: First day of the month following the month in which the application is approved.

(b) SLMB.

1. Definition: See Rule .02.

2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for SLMB is eligible for TennCare Buy-in of his Medicare Part B premiums.

3. Technical Requirements: See Rule .04.

4. Household size is based upon the ABD household composition Rule .06.

5. Income Limitations: Over one hundred percent (100%) but less than one hundred twenty percent (120%) of the FPL.

6. Resource Limitations: Limits for an individual and couple as determined by SSA.

7. Effective Date: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(c) QI1.

1. Definition: See Rule .02.

2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for QI1 is eligible for TennCare Buy-in of his Medicare Part B premiums, pursuant to State allocation of federal funds. The individual may not be receiving TennCare Medicaid.

3. Technical Requirements: See Rule .04.

4. Household size is based upon the ABD household composition Rule .06.

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5. Income Limitations: Over one hundred twenty percent (120%) but less than one hundred thirty-five percent (135%) of FPL.

6. Resource Limitations: Limits for an individual and couple as determined by the SSA.

7. Effective Date: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(d) QDWI.

1. Definition: See Rule .02.

2. Eligibility for this program is not eligibility for Medicaid coverage. An individual eligible for QDWI is eligible for TennCare Buy-in of his Medicare Part A premiums, but not for Part B premiums.

3. Technical Requirements: See Rule .04.

4. Special Eligibility Requirements: An individual must be under age sixty-five (65), have a disabling impairment as determined by the SSA, and be eligible to enroll in Medicare Part A but no longer entitled to free Medicare Part A due to substantial gainful activity.

5. Household size is based upon the ABD household composition Rule .06.

6. Income Limitations: Two hundred percent (200%) of FPL.

7. Resource Limitations: Resources not exceeding twice the maximum for SSI.

8. Effective Date: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(7) Other.

(a) Medically Needy Children and Pregnant Women.

1. Definition: See Rule .02.

2. Technical Requirements: See Rule .04.

3. Special Eligibility Requirements: Applicants for the Medically Needy Pregnant Woman category must be pregnant at the time of application. Applicants for the Child Medically Needy category must be under age twenty-one (21).

4. Household size is based upon the AFDC-Related household composition information set out in Rule .06.

5. Income Limitations: Household income must be less than or equal to the MNIS, based on household size. When household income exceeds the MNIS, based on household size, the individual must meet a spend-down obligation as outlined in the State Plan. See Rule .06.

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6. Resource Limitations: Medically Needy applicants are permitted to retain resources not to exceed $2,000.00 for an individual, $3,000.00 for two individuals and an additional $100.00 is added per additional individual. See Rule .06.

7. Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

8. Other: Pregnant women enrolled in the Medically Needy program shall receive continuous coverage through two (2) months postpartum, regardless of income changes.

(b) Breast and Cervical Cancer Category of Eligibility.

1. Definition: See Rule .02.

2. Technical Requirements: See Rule .04.

3. Special Eligibility Requirements:

(i) Individuals must be younger than age sixty-five (65) and must lack health insurance that will cover treatment for breast and/or cervical cancer. Once third party coverage of cancer has been exhausted, the applicant will be considered to no longer have health insurance.

(ii) Individuals must first be screened and approved by the Department of Health's BCSP.

(iii) Individuals must be actively undergoing treatment for breast or cervical cancer. A Treatment Plan Form signed by the applicant's physician must be submitted to TennCare. Individuals who are determined to require only routine monitoring services for a precancerous breast or cervical condition are not considered to need treatment for purposes of this section. Surveillance after treatment of cancer (breast or cervical) will not qualify as treatment for purposes of this section.

4. Income Limitations: Income cannot exceed two hundred fifty percent (250%) of the FPL, as determined by the Department of Health through its BCSP.

5. Resource Limitations: None.

6. Effective Date of Eligibility: Eligibility begins on the Application File Date, according to Rule .05, or the date all eligibility requirements are met, whichever is later.

(c) Presumptive Breast or Cervical Cancer.

1. Definition: See Rule .02.

2. Technical Requirements: See Rule .04.

3. Special Eligibility Requirements:

(i) Individual must be determined to be presumptively eligible by the Department of Health.

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(ii) Individual must be younger than age sixty-five (65) and must lack access to health insurance that will cover treatment for breast and/or cervical cancer.

(iii) The presumptive eligibility period will last either until the end of the month following the month of application or determination of a full Medicaid application, as defined in 42 U.S.C. § 1396r-1b.

4. Income Limitations: Income cannot exceed two hundred fifty percent (250%) of the FPL, as determined by the Department of Health through its BCSP program.

5. Resource Limitations: None.

6. Effective Date of Eligibility: The date eligibility is determined by the Tennessee Department of Health.

(d) Payment for Emergency Medical Services.

1. Definition: See Rule .02.

2. Technical Requirements: See Rule .04. Individuals must meet eligibility requirements for a Medicaid category except for citizenship and enumeration.

3. Special Eligibility Requirements: Individuals who meet all eligibility criteria except citizenship and immigration status for the following TennCare categories of eligibility:

(i) Caretaker Relative;

(ii) Infants and Children Under Age 19;

(iii) Pregnant Woman; or

(iv) Child or Qualified Pregnant Woman Medically Needy.

4. Individuals in one of the above categories may qualify for payment for emergency medical services in which the individual has a medical condition, including labor and delivery, manifested by acute symptoms of sufficient severity which, if not attended to immediately, could reasonably be expected to result in:

(i) Placing the patient's health in serious jeopardy;

(ii) Severe impairment to bodily functions: or

(iii) Serious dysfunction of any bodily organ or part.

5. Household size is based upon the appropriate TennCare category for which the enrollee is seeking coverage.

6. Income Limitations: Must meet financial criteria of one of the respective TennCare categories (Caretaker Relative, Infants and Children Under Age 19, TennCare Pregnant Woman, or Child or Qualified Pregnant Woman Medically Needy).

7. Resource Limitations: If an individual would be otherwise eligible for a Medically Needy category except for citizenship or immigration status, then the individual's

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resource limits are identical to those found in Rule .06, AFDC-Related Financial Determinations. If an individual would be otherwise eligible for a MAGI category except for citizenship or immigration status, then the individual's resources are not considered.

8. Effective Date of Eligibility: Eligibility will not begin prior to the date of admission, nor will coverage begin prior to the date of application, and will be limited to the length of time required to stabilize the emergent episode, as defined at 42 C.F.R. § 440.255. Only the services involved in the emergency itself will be reimbursed and coverage is only provided for the single episode of care.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-106, 71-5-110, 71-5-111, and 71-5-117.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016.*

1200-13-20-.09 REDETERMINATION AND TERMINATION.

(1) Redetermination of eligibility for CoverKids, TennCare Medicaid's Core Medicaid Population, and TennCare Standard.

(a) Redetermination or renewal is the process of verifying whether an enrollee continues to meet the eligibility requirements of a particular HCFA program.

1. A TennCare Medicaid, TennCare Standard or CoverKids enrollee must have eligibility redetermined once every twelve (12) months, and no more frequently than once every twelve (12) months, absent a waiver from CMS.

2. Redetermination dates are set twelve (12) months from the date the individual is determined eligible for TennCare Medicaid, TennCare Standard or CoverKids, or as otherwise agreed between the Single State Agency and CMS.

(b) Enrollees eligible for TennCare Medicaid as a result of being eligible for SSI benefits shall follow the Redetermination requirements of the SSA. Once SSI benefits are terminated, these enrollees will be reviewed by the State for eligibility in all other categories prior to termination.

(c) An enrollee's TennCare Medicaid, TennCare Standard or CoverKids eligibility shall be redetermined as required by the appropriate category of medical assistance as described in this Rule, unless otherwise agreed to by the Single State Agency and CMS. Prior to the termination of TennCare Medicaid, TennCare Standard or CoverKids eligibility, eligibility will be redetermined according to the following process:

1. HCFA will redetermine eligibility prior to the expiration of the enrollee's current eligibility period.

2. HCFA will issue a renewal packet to redetermine eligibility. TennCare Medicaid, TennCare Standard or CoverKids enrollees will be given forty (40) days, inclusive of mail time, from the date the notice is mailed to return the completed renewal packet to HCFA. The mail date will be the date on the notice. The enrollee may provide information by mail, fax or in-person, or as otherwise agreed to by the Single State Agency and CMS.

3. HCFA will provide assistance with submitting a renewal form according to Rule .05(4).

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4. HCFA will use the individual's responses in the renewal packet to complete redetermination. HCFA will request additional verification, as needed, to complete redetermination. The request for additional information or verification will provide the enrollee with twenty (20) days, inclusive of mail time, to submit the requested information.

5. If HCFA is able to renew eligibility in a TennCare Medicaid, TennCare Standard or CoverKids category based on information provided in the renewal packet, in addition to information known to HCFA and requested verifications, the agency will notify the enrollee and enroll him in the new appropriate category.

6. Enrollees who respond to the renewal form within the forty (40) day period shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while HCFA reviews their eligibility for open Medicaid categories and CoverKids. If HCFA determines that the enrollee is eligible for a TennCare Medicaid, TennCare Standard or CoverKids category, the agency will notify the individual as follows:

   (i) If HCFA determines that the enrollee is eligible for an open TennCare Medicaid category, the agency will notify the enrollee and he will be enrolled in the appropriate category. The previous category will be closed with no further notice to the enrollee.

   (ii) If HCFA determines that the enrollee is eligible for a TennCare Standard category, the agency will notify the enrollee and he will be enrolled in the appropriate category. Notification of enrollment into TennCare Standard will include notification of the denial of TennCare Medicaid eligibility.

   (iii) If HCFA determines that the enrollee is eligible for CoverKids, the agency will notify the enrollee and he will be enrolled into the CoverKids program. Notification of enrollment into CoverKids will include the denial of TennCare Medicaid eligibility.

7. If an enrollee provides some but not all of the necessary information to HCFA to determine his eligibility for open Medicaid categories or CoverKids during the forty (40) day period following the mailing of the renewal packet, HCFA will request additional information or verification. The request for additional information or verification will provide the enrollee with twenty (20) days, inclusive of mail time, to submit the requested information.

8. Enrollees who do not respond to the renewal packet within forty (40) days, or enrollees who do not respond to a request for additional information or verification within twenty (20) days from the request for additional information or verification, will be sent a notice of termination informing the enrollee that coverage will be terminated twenty (20) days from the date of the termination notice.

9. If HCFA makes a determination that the enrollee is not eligible for any open Medicaid categories, TennCare Standard or CoverKids, the enrollee will be sent a notice of termination informing the enrollee that coverage will be terminated twenty (20) days from the date of the termination notice.

10. Enrollees who respond to the additional information or verification request after the requisite time period specified in those notices but before the date of

(Rule 1200-13-20-.09, continued)

termination shall retain their eligibility for TennCare Medicaid, TennCare Standard or CoverKids while HCFA reviews their eligibility.

11. Individuals may provide the renewal packet, or additional information and verifications specified in the request for additional information and verification notice, up to ninety (90) days after termination of eligibility. Renewal packets or additional information and verification received during the ninety (90) day reconsideration period will be processed without requiring a new application. Individuals terminated for failure to respond and subsequently determined eligible during the ninety (90) day reconsideration period will have eligibility reinstated as of the date of termination.

12. Renewal packets returned after ninety (90) days will not be considered and the individual must file a new application in accordance with Rule .05.

(d) An individual who has been determined eligible for TennCare Medicaid under the rules for BCC shall annually recertify eligibility in terms of continuation of active treatment, address, and access to health insurance. If the individual is found to no longer be eligible through this review, the individual will be reviewed using the redetermination process set forth in this paragraph.

(2) Termination of TennCare Medicaid, TennCare Standard and CoverKids eligibility.

(a) HCFA will send termination notices to all enrollees being terminated pursuant to State and federal law who are not determined to be eligible for open Medicaid or TennCare Standard categories, or CoverKids.

(b) Termination notices will be sent twenty (20) days in advance of the date the coverage will be terminated. Termination notices will be sent two (2) days in advance of the date coverage will be prospectively terminated when an enrollee requests termination. Termination notices will be sent to the HCFA address of record.

(c) Termination notices will provide enrollees forty (40) days from the date of the notice to appeal the termination and will inform enrollees how they may request a hearing. Appeals will be processed by HCFA in compliance with Chapter 1200-13-19.

(d) HCFA will reconsider eligibility after termination in compliance with 42 C.F.R. § 435.916(a)(3)(iii).

(e) Enrollees with a physical health problem, mental health problem, learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with limited English proficiency will have the opportunity to request translation assistance for their appeal.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, and 71-5-117.* ***Administrative History:*** *Emergency rule filed June 16, 2016; effective through December 13, 2016. New rules filed September 14, 2016; effective December 13, 2016. Amendment filed February 12, 2018; effective May 13, 2018.*

RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE

CHAPTER 1200-13-21
COVERKIDS

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1200-13-21-.01 SCOPE AND AUTHORITY.

(1) The CoverKids program was created by the CoverKids Act of 2006, T.C.A. §§ 71-3-1101, et seq., and placed under the authority of the Tennessee Department of Finance and Administration ("Department").

(2) The Department is authorized to establish, administer and monitor the program, including contracting for the provision of services and adopting rules for governing the program.

(3) The Commissioner of the Tennessee Department of Finance and Administration placed the CoverKids Program into the Division of Health Care Finance & Administration under the oversight of the Deputy Commissioner/Director of TennCare on March 31, 2011, for the purposes of coordination of resources and to achieve greater effectiveness and efficiencies. The Division was renamed the Division of TennCare effective August 7, 2017.

(4) The purpose of the CoverKids program is to provide health care coverage for uninsured children who are not eligible for TennCare coverage.

(5) The CoverKids program is a federal program, the "State Child Health Plan Under Title XXI of the Social Security Act State Children's Health Insurance Program" and is distinct and separate from the Title XIX TennCare program.

Authority: *T.C.A. §§ 4-5-202, 71-3-1103 through 1108, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.* ***Administrative History:*** *Original rules filed November 28, 2018; effective February 26, 2018.*

1200-13-21-.02 DEFINITIONS.

(1) Covered services. Benefits listed in this Chapter and authorized by the Plan Administrator or Dental Benefits Manager.

(2) CoverKids. The program created by T.C.A. §§ 71-3-1101, et seq., its authorized employees and agents, as the context of this Chapter requires.

(3) CoverKids network. A group of health care providers that have entered into contracts with the Plan Administrator or Dental Benefits Manager to furnish covered services to CoverKids enrollees. These contracts may take the form of general contracts or single case agreements.

(4) CoverKids provider. An appropriately licensed institution, facility, agency, person, corporation, partnership or association, that delivers health care services and that participates in the Plan Administrator's or Dental Benefits Manager's network.

(Rule 1200-13-21-.02, continued)

(5) Days. Calendar days, not business days.

(6) Dental Benefits Manager (DBM). The entity responsible for the administrative services associated with providing covered dental services, preventive, routine and orthodontic, to CoverKids enrollees.

(7) Emergency services. Includes emergency medical, emergency mental health and substance abuse emergency treatment services, furnished by a provider qualified to furnish the services, needed to evaluate, treat, or stabilize an emergency medical condition manifested by the sudden and unexpected onset of acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

(8) Medically necessary. A medical item or service which meets all the following criteria:

(a) Recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within his scope of licensure who is treating the enrollee;

(b) Required in order to diagnose or treat an enrollee's medical condition;

(c) Safe and effective;

(d) The least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee; and

(e) Not experimental or investigational.

(9) Non-CoverKids provider. A health care provider of non-emergency services that does not participate in the Plan Administrator's or Dental Benefits Manager's network.

(10) Parent. A natural or adoptive father or mother of a minor child; or, a guardian as defined by T.C.A. § 34-1-101, subject to court orders entered or recognized by the courts of the state of Tennessee.

(11) Plan Administrator or PA. The entity or entities responsible for the administrative services associated with providing health care, pharmaceutical or other related services to CoverKids enrollees. This may be a private contractor, government agency, or Departmental entity.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.* ***Administrative History:*** *Original rules filed November 28, 2018; effective February 26, 2018.*

1200-13-21-.03 ELIGIBILITY. Financial and Technical Eligibility Requirements. See Chapter 1200-13-20.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.* ***Administrative History:*** *Original rules filed November 28, 2018; effective February 26, 2018.*

1200-13-21-.04 BENEFITS.

(1) The following benefits are covered by the CoverKids program for children under age 19 as medically necessary, subject to the limitations stated:

(a) Ambulance services, air and ground.

(b) Care coordination services.

(c) Case management services.

(d) Chiropractic care. Maintenance visits not covered when no additional progress is apparent or expected to occur.

(e) Clinic services and other ambulatory health care services.

(f) Dental benefits:

1. Dental services. Limited to a $1,000 annual benefit maximum per enrollee.

2. Orthodontic services. Limited to a $1,250 lifetime benefit maximum per enrollee. Covered only after a 12-month waiting period.

(g) Disposable medical supplies.

(h) Durable medical equipment and other medically-related or remedial devices:

1. Limited to the most basic equipment that will provide the needed care.

2. Hearing aids are limited to one per ear per calendar year up to age 5, and limited to one per ear every two years thereafter.

(i) Emergency care.

(j) Home health services. Prior approval required. Limited to 125 visits per enrollee per calendar year.

(k) Hospice care.

(l) Inpatient hospital services, including rehabilitation hospital services.

(m) Inpatient mental health and substance abuse services.

(n) Laboratory and radiological services.

(o) Outpatient mental health and substance abuse services.

(p) Outpatient services.

(q) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders. Limited to 52 visits per calendar year per type of therapy.

(r) Physician services.

(s) Prenatal care and prepregnancy family services and supplies.

(Rule 1200-13-21-.04, continued)

(t) Prescription drugs.

(u) Routine health assessments and immunizations.

(v) Skilled Nursing Facility services. Limited to 100 days per calendar year following an approved hospitalization.

(w) Surgical services.

(x) Vision benefits:

1. Annual vision exam including refractive exam and glaucoma screening.

2. Prescription eyeglass lenses. Limited to one pair per calendar year. $85 maximum benefit per pair.

3. Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. $100 maximum benefit per pair.

4. Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. $150 maximum benefit per pair.

(2) Mothers of eligible unborn children who are over age 19 receive all benefits listed in Paragraph (1), subject to the same limitations and as medically necessary, except chiropractic services, routine dental services, and vision services are not covered for these enrollees.

(3) All services covered by CoverKids must be medically necessary.

(4) The following services and items are excluded from coverage by the CoverKids program:

(a) Comfort or convenience items not related to an enrollee's illness.

(b) Dietary guidance services.

(c) Homemaker or housekeeping services.

(d) Maintenance visits when no additional progress is apparent or expected to occur.

(e) Meals.

(f) Medical social services.

(g) Non-treatment services.

(h) Private duty nursing services.

(i) Routine transportation.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.* ***Administrative History:*** *Original rules filed November 28, 2018; effective February 26, 2018.*

1200-13-21-.05 COST SHARING.

(1) There are no premiums or deductibles required for participation in CoverKids.

(2) Copays.

(a) The following services are exempt from copays:

1. Ambulance services.

2. Emergency services.

3. Lab and X-ray services.

4. Maternity services. There are no copays for prenatal visits or for hospital admissions for the birth of a child.

5. Routine health assessments and immunizations given under American Academy of Pediatrics guidelines.

(b) The following copays are required, based on the enrollee's household income:

Service	Copay When Household Income is Less than 200% FPL	Copay When Household Income is Between 200% FPL and 250% FPL
MEDICAL BENEFITS		
Chiropractic care	$5 per visit	$15 per visit
Emergency room	$10 copay per use for non-emergency	$50 copay per use for non-emergency
Hospital admissions and other inpatient services	$5 per admission (waived if readmitted within 48 hours for same episode)	$100 per admission (waived if readmitted within 48 hours for same episode)
Inpatient mental health and substance abuse treatment	$5 per admission (waived if readmitted within 48 hours for same episode)	$100 per admission (waived if readmitted within 48 hours for same episode)
Outpatient mental health and substance abuse treatment	$5 per session	$15 per session
Physical, speech, and occupational therapy	$5 per visit	$15 per visit
Physician office visit	$5 per visit (primary care); $5 per visit (specialist)	$15 per visit (primary care); $20 per visit (specialist)
Prescription drugs	$1 generic; $3 preferred brand; $5 non-preferred brand	$5 generic; $20 preferred brand; $40 non-preferred brand
Vision services	$5 for lenses; $5 for frames (when lenses and frames are ordered at the same time, only one copay is charged)	$15 for lenses; $15 for frames (when lenses and frames are ordered at the same time, only one copay is charged)
DENTAL BENEFITS		
Dental services	$5 per visit No copay for routine preventive oral exam, X-rays, and fluoride application	$15 per visit No copay for routine preventive oral exam, X-rays, and fluoride application

(Rule 1200-13-21-.05, continued)

Orthodontic services	$5 per visit	$15 per visit

(3) An enrollee's annual cost sharing obligations shall not exceed 5 percent of his household's annual income.

(4) Eligible children who do not pay a required copay remain enrolled in the program. An individual provider may at his discretion refuse service for non-payment of a copay unless a medical emergency exists. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay their copays.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.* ***Administrative History:*** *Original rules filed November 28, 2018; effective February 26, 2018.*

1200-13-21-.06 DISENROLLMENT.

(1) Grounds for Disenrollment from CoverKids. Children enrolled in CoverKids at or below 250% of the FPL are financially eligible for 12 months, except in the following situations which will result in disenrollment from CoverKids coverage prior to the end of the 12 month period:

(a) An enrollee, through an authorized family member, requests disenrollment.

(b) Admission of a CoverKids enrollee into a correctional facility or an institution for mental disease.

(c) A CoverKids enrollee moves from the state.

(d) Death of a CoverKids enrollee.

(e) A CoverKids enrollee is enrolled in TennCare.

(f) A CoverKids enrollee meets a TennCare Medicaid spend-down.

(g) A CoverKids enrollee turns age 19.

(h) A woman 19 or older who was enrolled because of pregnancy is no longer eligible after the last day of the month in which the sixtieth postpartum day occurs.

(i) A CoverKids enrollee is discovered not to have been eligible for CoverKids at the time of enrollment. This includes, but is not limited to, enrollees whose enrollment was obtained by fraud or misrepresentation by an enrollee, parent, guardian, or representative.

(2) Procedures. Disenrollment shall be conducted as set out in Chapter 1200-13-19.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.* ***Administrative History:*** *Original rules filed November 28, 2018; effective February 26, 2018.*

1200-13-21-.07 REVIEW OF COVERKIDS DECISIONS.

(1) Eligibility and Enrollment Matters. Administrative review of matters related to eligibility and enrollment shall be conducted as set out in Chapter 1200-13-19.

(2) Health Services Matters. A parent or authorized representative of a CoverKids enrollee may request review of a CoverKids action to delay, deny, reduce, suspend, or terminate health

(Rule 1200-13-21-.07, continued)

services, or a failure to approve, furnish, or provide payment for health services in a timely manner, according to the following provisions:

(a) Notice. Any decision denying or delaying a requested health service, reducing, suspending or terminating an existing health service, or failure to approve, furnish or provide payment for health services in a timely manner shall be in writing and must contain the reason for the determination, an explanation of review rights and procedures, the standard and expedited time frames for review, the manner of requesting a review, and the circumstances under which existing health services may continue pending review unless there is question that the existing health services are harmful.

(b) Plan Administrator (PA) or Dental Benefits Manager (DBM) Review. A parent or authorized representative may commence the review process by submitting a written request to the PA or DBM within 30 days of issuance of written notice of the action or, if no notice is provided, from the time the enrollee becomes aware of the action, not to exceed six (6) months from when the action occurred. The PA or DBM will review this request and issue a written decision within 30 days of receipt of this request. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.

(c) State Informal Review. After the PA's or DBM's internal review is completed, the parent or authorized representative of an enrollee who disagrees with the decision may request further review by telephone or by submitting a letter or form to the Division of TennCare, CoverKids Appeals, which must be received within 8 days of the PA's or DBM's decision. The Appeals Coordinator will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator will request review by the state's independent medical consultant and a written decision will be issued within 20 days of receipt of the request for further review.

(d) State Review Committee. If the informal review does not grant the relief requested by the parent or authorized representative, the request will be scheduled for review by the CoverKids Review Committee. The Committee will be composed of five members, including Division of TennCare staff and at least one independent licensed medical professional. The members of the Committee will not have been directly involved in the matter under review. The parent or authorized representative will be given the opportunity to review the file, be represented by a representative of the parent's or authorized representative's choice, and provide supplemental information. The Committee may allow the parent or authorized representative to appear in person if it finds that scheduling the appearance will not cause delay in the review process. The Review Committee is not required to provide an in-person hearing or a contested case under the Uniform Administrative Procedures Act. The parent or authorized representative will receive written notification of the final decision stating the reasons for the decision. The decision of the CoverKids Review Committee is the final administrative recourse available to the member.

(e) Time for Reviews. Review of all non-expedited health or dental services appeals will be completed within 90 days of receipt of the initial request for review by the PA or DBM. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours at each of the PA or DBM and State levels) for situations in which a benefit determination or a preauthorization denial has been made prior

(Rule 1200-13-21-.07, continued)

to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.

(3) Scope of Review. CoverKids will not provide a review process for a change in enrollment, eligibility, or coverage under the health benefits package required by a change in the State plan or Federal and State law requiring an automatic change that affects all or a group of applicants or enrollees without regard to their individual circumstances.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.* ***Administrative History:*** *Original rules filed November 28, 2018; effective February 26, 2018.*

1200-13-21-.08 PROVIDERS.

(1) Payment in full.

(a) All CoverKids providers, as defined in this rule, must accept as payment in full for provision of covered services to a CoverKids enrollee, the amount paid by the PA or DBM, plus any copayment required by the CoverKids program to be paid by the individual.

(b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the PA or DBM must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the PA or DBM plus any copayment required by the CoverKids program to be paid by the individual.

(c) CoverKids will not pay for non-emergency services furnished by non-CoverKids providers unless these services are authorized by the PA or DBM. Any non-CoverKids provider who furnishes CoverKids Program covered non-emergency services to a CoverKids enrollee without authorization from the PA or DBM does so at his own risk. He may not bill the patient for such services except as provided in Paragraph (3).

(2) Non-CoverKids Providers.

(a) When the PA or DBM authorizes a service to be rendered by a non-CoverKids provider, payment to the provider shall be no less than 80% of the lowest rate paid by the PA or DBM to equivalent participating CoverKids network providers for the same service, consistent with the methodology contained in Rule 1200-13-13-.08(2)(a).

(b) Covered medically necessary outpatient emergency services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 74% of the 2006 Medicare rates for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(b). Emergency care to enrollees shall not require preauthorization.

(c) Covered medically necessary inpatient hospital admissions required as the result of emergency outpatient services, when provided to CoverKids enrollees by non-CoverKids network hospitals, shall be reimbursed at 57% of the 2008 Medicare DRG rates (excluding Medical Education and Disproportionate Share components) determined according to 42 CFR § 412 for the services, consistent with the methodology contained in Rule 1200-13-13-.08(2)(c). Such an inpatient stay will continue until no longer medically necessary or until the patient can be safely transported to a network hospital, whichever comes first.

(Rule 1200-13-21-.08, continued)

(3) Providers may seek payment from a CoverKids enrollee only under the following circumstances. These circumstances include situations where the enrollee may choose to seek a specific covered service from a non-CoverKids provider.

(a) If the services are not covered by the CoverKids program and, prior to providing the services, the provider informed the enrollee that the services were not covered.

(b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:

1. The provider has information in her own records to support the fact that the enrollee has reached his benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by CoverKids. This information may include:

(i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to the benefit limit is still in effect;

(ii) That the provider had personally provided services to the enrollee in excess of his benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit period is still in effect; or

(iii) The enrollee's PA or DBM has provided confirmation to the provider that the enrollee has reached his benefit limit for the applicable service.

2. The provider submits a claim for service to the PA or DBM and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. After informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee for services within that same exhausted benefit category without having to submit claims for those subsequent services for repeated PA or DBM denial. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by CoverKids, the provider may bill the enrollee for that service.

3. The provider had previously taken the steps in parts 1. or 2. above and determined that the enrollee had reached his benefit limit for the particular service being requested, if the time period applicable to the benefit limit is still in effect, and informs the enrollee, prior to providing the service, that the service is not covered and will not be paid for by CoverKids.

(c) If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the enrollee that the services are not covered, the enrollee may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.

(4) Providers may not seek payment from a CoverKids enrollee under the following conditions:

(a) The provider knew or should have known about the patient's CoverKids enrollment prior to providing services.

(Rule 1200-13-21-.08, continued)

(b) The claim submitted to the PA or DBM for payment was denied due to provider billing error or a CoverKids claim processing error.

(c) The provider accepted CoverKids assignment on a claim and it is determined that another payer paid an amount equal to or greater than the CoverKids allowable amount.

(d) The provider failed to comply with CoverKids policies and procedures or provided a service which lacks medical necessity or justification.

(e) The provider failed to submit or resubmit claims for payment within the time periods required by the PA or DBM or CoverKids.

(f) The provider failed to inform the enrollee prior to providing a service not covered by CoverKids that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement if the provider has complied with paragraph (3) above.

(g) The enrollee failed to keep a scheduled appointment(s).

(5) Pharmacy providers may not waive pharmacy copayments for CoverKids enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.* ***Administrative History:*** *Original rules filed November 28, 2018; effective February 26, 2018.*