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Rule ID(s): 5934
File Date: 4/14/15
Effective Date: 7/13/15

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

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

Revision Type (check all that apply):

X Amendment
___ New
___ Repeal

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

Chapter Number	**Chapter Title**
1200-13-01	TennCare Long-Term Care Programs
Rule Number	**Rule Title**
1200-13-01-.02	Definitions
1200-13-01-.05	TennCare CHOICES Program
1200-13-01-.10	Medical (Level of Care) Eligibility Criteria for TennCare Reimbursement of Care in Nursing Facilities, CHOICES HCBS and PACE

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

Paragraph (4) Advance Determination of Rule 1200-13-01-.02 Definitions is deleted in its entirety and subsequent paragraphs renumbered accordingly.

Rule 1200-13-01-.02 Definitions is amended by inserting in alphabetical order the following new Paragraph, with all paragraphs numbered appropriately so that the new Paragraph shall read as follows:

( ) 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 an Applicant 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)).

(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. Diagnosed complex acute or chronic medical conditions which require frequent, 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;

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; and

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.

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

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

(6) Safety Determination Requests

(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), a Safety Determination by TennCare regarding whether a CHOICES Applicant would qualify for enrollment into CHOICES Group 3 shall be made upon request of the Applicant, the Applicant's Representative, or the entity submitting the PAE, including the AAAD, MCO, NF, or PACE Organization if 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);

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(125)), such that a higher level of care is needed.

(b) Any of these criteria shall be sufficient to warrant review of a Safety Determination request by the Bureau; however 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, 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, 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 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 (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) 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:

   (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;

3. A person-centered plan of care developed by the MCO Care 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 is not required for a Safety Determination submitted by the AAAD.) 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 and non-CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the Applicant's needs in the community.

(f) Approval of a Safety Determination Request

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, 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 unpaid supports provided by family members and other caregivers who are willing and able to provide such care.

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)).

3. If enrolled in CHOICES Group 1 or 2 or in PACE based upon approval of a Safety Determination request, the NF, MCO, or PACE Organization, respectively, shall implement any plan of care 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 and signed by the Applicant (or authorized representative).

4. The lack of availability of suitable community housing or the need for assistance with routine medication management shall not be sufficient by itself to justify approval of a Safety Determination request.

(g) Denial of a Safety Determination Request.

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 based upon denial of a Safety Determination Request, the MCO shall implement any plan of care 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 Group 3, including covered medically necessary CHOICES HCBS and non-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 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. 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 3, 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.

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

Subparagraph (d) (PAE Effective Dates pertaining to Advance Determinations for persons not enrolled in TennCare when the PAE is submitted:) of Paragraph (3) of Rule 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for TennCare Reimbursement of Care in Nursing Facilities, CHOICES HCBS and PACE is deleted in its entirety and subsequent subparagraphs re-lettered appropriately.

Items (I) through (IX) of Subpart (iii) of Part 2. of Subparagraph (b) of Paragraph (4) of Rule 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for TennCare Reimbursement of Care in Nursing Facilities, CHOICES HCBS and PACE are deleted in their entirety and replaced with new Items (I) through (IX) which shall read as follows:

(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.

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

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration (board/commission/ other authority) on 02/24/2015 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 09/17/14

Rulemaking Hearing(s) Conducted on: (add more dates). 11/18/14

Date: 2/24/2015

Signature:

Name of Officer: Darin J. Gordon

Title of Officer: Director, Bureau of TennCare
Tennessee Department of Finance and Administration

CHERYL D. KLINE
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

Subscribed and sworn to before me on: 2/24/2015

Notary Public Signature: Cheryl D Kline

My commission expires on: AUG 23 2016

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

Herbert H. Slatery III
Herbert H. Slatery III
Attorney General and Reporter

4/10/2015
Date

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PUBLICATIONS

Filed with the Department of State on: 4/14/15

Effective on: 7/13/15

Tre Hargett
Tre Hargett
Secretary of State

Public Hearing Comments

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

Copies of responses to comments are included with filing.

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

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

Impact on Local Governments

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

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

Additional Information Required by Joint Government Operations Committee

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

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

These rules are being promulgated to point out and/or clarify what constitute a Safety Determination in CHOICES Group 3 that would allow for enrollment in a higher NF LOC (CHOICES 1 or 2 or PACE, etc.).

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

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

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

The persons, organizations, corporations or governmental entities most directly affected by these Rules are the TennCare applicants, providers, and the Bureau of TennCare, Tennessee Department of Finance and Administration.

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

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

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

The promulgation of these rules is not anticipated to have an effect on state and local government revenues and expenditures.

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

Donna Tidwell
Deputy General Counsel

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

Donna Tidwell
Deputy General Counsel

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

310 Great Circle Road
Nashville, TN 37243
(615) 507-6852
donna.tidwell@tn.gov

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

GW10114314

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

February 9, 2015

Marybeth Farringer, Executive Director
Council on Aging
95 White Bridge Road
Nashville, TN 37205

Dear Ms. Farringer:

Thank you for your work in serving older adults and caregivers. Thank you also for your comments regarding the State's proposed revisions to TennCare Rule Chapter 1200-13-01 pertaining to medical eligibility for long-term services and supports—specifically the Safety Determination process for Nursing Facility (NF) level of care (LOC).

Certainly, we agree that elder abuse is a critical issue, and one that requires collaborative approaches to help protect Tennessee's most vulnerable citizens, and to ensure the availability of temporary shelter when a person must be removed from their living situation. To that end, the request for placement by law enforcement or APS is critical information that should be provided to TennCare for consideration in the Safety Determination review. In fact, the mere involvement of law enforcement or APS is sufficient for TennCare to conduct a Safety Determination upon request of the submitting entity as reflected in the rule. However, we respectfully disagree that involvement of law enforcement, or a request for placement by law enforcement or APS should automatically result in approval of NF LOC, even for a period of up to 90 days.

NF services are, pursuant to federal law [see 42 U.S. Code § 1396r] provided to persons who require medical or nursing care, rehabilitation services, or health-related care and services (*above the level of room and board*) which can be made available to them *only* through institutional facilities. The benefit is not available simply to provide emergency shelter, even when such housing arrangement may be urgently needed for non-medically related reasons.

Pursuant to Tennessee's established NF LOC criteria, other factors (beyond functional and medical needs) affecting the person's health and safety can and should be taken into account, but cannot and should not replace the person's functional and medical need for such services. The evaluation of these needs is based on an assessment and is reviewed based on supported evidence of the person's medical or functional needs. In short, Medicaid cannot "automatically" approve and provide reimbursement for NF services for any person determined to have experienced or be at risk for abuse or neglect.

Further, neither law enforcement nor APS staff is likely skilled in assessing a person's medical eligibility for LTSS, and law enforcement in particular may be completely unaware of the array of services and supports available to an individual in any of the State's programs. Finally, the availability and willingness of other caregivers who may provide needed assistance would be a significant mitigating factor.

We believe that the changes in the Safety Determination process will help to ensure that NF services are available to persons, including in situations involving elder abuse, when NF services are the most appropriate placement for a person—because the person's functional and medical needs as well as other safety concerns require that level of care.

Again, we appreciate your comments and your continued efforts on behalf of older adults and caregivers. We have attached a tracked changes version of the rule, showing the additional changes that have been made based on public comment. We hope these responses, along with appropriate adjustments in the rule, are helpful.

Respectfully,

Julie Johnson
Deputy of Operations
Long Term Services and Supports

CC: Patti Killingsworth, Assistant Commissioner and Chief of Long Term Services and Supports
Susie Baird, Director of Policy
Aaron C. Butler, Assistant Director of Policy
Kristeena Ashby, Assistant Deputy of Operations

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

February 9, 2015

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

Dear Mr. Samples:

Thank you for the opportunity to work together for over a year to develop and refine proposed revisions to TennCare Rule Chapter 1200-13-01 pertaining to medical eligibility for long-term services and supports—specifically the Safety Determination process for Nursing Facility (NF) level of care (LOC), and for your additional comments on the proposed rule.

With respect to your concerns regarding 1200-13-01-.05(6)—*"in particular the timeframes surrounding appeals of safety determinations and appeals of denials of safety determinations,"* these rules do not impact the timeframes for appeals, including appeals based on a Safety Determination which are governed by federal and state law and regulation as well as federal court orders as elaborated below. The explicit intent of these rules is to make certain improvements in the process by which a Safety Determination is made.

Further we respectfully disagree that the additional time for gathering medical evidence needed to make a Safety Determination could ever result in up to an additional forty (40) days being added to the time allotted to adjudicate a PAE. In most cases, the extension would not exceed 10 business days. If a delay is based on the reasonable needs or request of the Applicant (as documented by the MCO/AAAD), an additional extension may be afforded, not to exceed a <u>total</u> of 30 calendar days (including up to 10 business days already granted) while additional evidence is gathered.

To be clear, any delay (and financial risk) can be avoided altogether by a Nursing Facility's submission of a complete and accurate PAE, including sufficient medical evidence to make a Safety Determination.

Moreover, we are surprised at this last-minute concern, since THCA had previously expressed its support for and agreement with this provision, which is intended to ensure that TennCare is able to obtain information needed to make a Safety Determination as part of the adjudication of the PAE, rather than forcing such determination into the appeal process, which would delay a decision based on safety.

An April 14, 2014 letter received from Gerald Coggin, Senior Vice President, National HealthCare Corporation; Criss Grant, Director of Planning and Communications, Alexian Brothers PACE; Jesse Samples, Executive Director, Tennessee Health Care Association; Kristin Ware, Attorney and Gordon Bonnyman, Attorney, Tennessee Justice Center; and Carol Westlake, Tennessee Disability Coalition, included the following:

> *"'c. Doe v. Word does not foreclose the possibility of including a comprehensive safety evaluation in the PAE. Section Two of the Doe Order states that "[w]ritten notice of the Bureau of Medicaid's decision to approve or deny coverage for nursing home care shall be mailed . . . within eight (8) working dates of the receipt of the PAE application.' If a safety determination is a mandatory component of the PAE application, then the application would not be completed or submitted until the safety determination has been made. In fact, this additional information would likely improve the Bureau's ability to make an expedited decision."*

In response to this letter, the tolling of the PAE date for purposes of completing a Safety Determination was proposed in the June 12th initial draft of this proposed rule, sent to you and other Stakeholders prior to our scheduled meeting the following day (June 13, 2014).

The group's joint comments on the initial draft of the proposed rule stated the following:

> *"As the Bureau has noted, this provision would require a change in the Doe v. Word Consent Decree. We, including the Tennessee Justice Center, do not oppose a change in the Decree to accommodate Safety Determinations. We request that the language be modified to read as follows:*
>
> > *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 occasioned by the Applicant's needs or request) while such additional evidence is gathered. "*

These comments were received on July 14, 2014 from Carol Westlake indicating she was "Authorized to sign for us all -

THCA -Jesse Samples
NHC - Gerald Coggins
TJC - Gordon Bonnyman
PACE - Criss Grant

In the State's response sent to you and to Ms. Westlake on August 15, 2014, the proposed language was accepted, with the addition of the following language *"and only for a specific additional period not to exceed a total period of more than 30 calendar days, occasioned by the Applicant's needs or request,"* to specifically address the concern you raise—that PAEs are not allowed to remain open indefinitely. If a PAE is denied because the information cannot be timely obtained, a new PAE, including Safety Determination request can be filed at any time.

With respect to end dating a PAE that is approved based on Safety, the ability to end date a PAE when the circumstances giving rise to approval of a Safety Determination request are anticipated to change poses no additional financial risk to facilities. The TennCare Rules have always given TennCare permission to end-date a PAE when a person's medical condition is anticipated to change. Clearly, TennCare cannot continue to authorize a service when such service (i.e., level of care) is no longer needed. The facilities' obligations with respect to discharge notice and planning commence when the person is able to transition to a more integrated, community setting.

While we have had previous and ongoing discussions regarding THCA's concerns regarding the financial impact when applicants request continuances during a medical eligibility appeal, the proposed language pertaining to appeals is beyond the scope of these rules, as it pertains not to the process by which a Safety Determination is made (which is the explicit intent of these rules), but rather, to requirements pertaining to appeals of medical eligibility denials, which are governed by 1200-13-01-.10(7) and the *Doe* Consent Decree. *Doe* requirements related to TennCare's timely processing of PAE appeals remain in effect and require that a final administrative order be rendered within 90 days of the appeal received date, except when the case is continued at the request of the applicant.

The purpose of these rules is to improve the efficiency and effectiveness of the medical eligibility determination process in an effort to minimize the need for appeals. Since implementing these changes on November 1, 2014, we have in fact seen the volume of PAE appeals decline markedly, as reflected in the table below:

Monthly volume of PAE appeals received:

Aug	Sept	Oct	Nov	Dec	Jan
130	133	109	71	50	71

We believe this is directly related to the fact that we are receiving more Safety Determination requests, when appropriate, and while work remains to be done with respect to ensuring the completeness of such requests (particularly from Nursing Facilities), we have been able to approve 35 Safety Determination requests in the first month, and 64 in the second month (January data is pending).

Again, we appreciate your comments, and the opportunity to work with you on these important improvements. We have attached a tracked changes version of the rule, showing the additional changes that have been made based on public comment. We hope these responses, along with appropriate adjustments in the rule, are helpful.

Respectfully,

Patti Killingsworth

Patti Killingsworth
Assistant Commissioner and Chief of Long Term Services and Supports

CC: Darin J. Gordon, Deputy Commissioner, HCFA
Julie Johnson, Deputy of Operations, Long Term Services and Supports
Susie Baird, Director of Policy
Aaron C. Butler, Assistant Director of Policy
Kristeena Ashby, Assistant Deputy of Operations

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

February 9, 2015

Ms. Katie Evans Moss
Legal Aid Society of Middle Tennessee and the Cumberlands
300 Deaderick Street
Nashville, TN 37201

Dear Ms. Evans Moss:

Thank you for your comments regarding the State's proposed revisions to TennCare Rule Chapter 1200-13-01 pertaining to medical eligibility for long-term services and supports—specifically the Safety Determination process for Nursing Facility (NF) level of care (LOC).

Certainly, we recognize the need to help protect Tennessee's most vulnerable citizens, and for the availability of temporary shelter when a person is in crisis and must be removed from their living situation. To that end, the request for placement by law enforcement or APS is critical information that should be provided to TennCare for consideration in the Safety Determination review. In fact, the mere involvement of law enforcement or APS *is* sufficient for TennCare to conduct a Safety Determination upon request of the submitting entity as reflected in the rule.

However, it would not be possible for TennCare to conduct a Safety Determination review separate and apart from the medical eligibility process of which it is explicitly a part, or absent a Safety Determination request submitted as part of a complete PAE application along with the detailed medical and functional information, as well as safety-related concerns necessary for TennCare to make such a determination.

NF services are, pursuant to federal law [see 42 U.S. Code § 1396r] provided to persons who require medical or nursing care, rehabilitation services, or health-related care and services (*above the level of room and board*) which can be made available to them *only* through institutional facilities. The benefit is not available simply to provide emergency shelter, even when such housing arrangement may be urgently needed for non-medically related reasons, including crisis.

Pursuant to Tennessee's established NF LOC criteria, other factors (beyond functional and medical needs) affecting the person's health and safety can and should be taken into account, but cannot and should not replace the person's functional and medical need for such services. The evaluation of these needs is based on an assessment and is reviewed based on supporting evidence of the person's medical and functional needs. In short, Medicaid cannot simply approve and provide reimbursement for NF services for any person determined to be in crisis.

Further, while we certainly respect the dedication and expertise of APS and law enforcement as it relates to crises, neither law enforcement nor APS staff is likely skilled in assessing a person's medical eligibility for LTSS, and law enforcement in particular may be completely unaware of the array of services and supports available to an individual in any of the State's programs. Finally, the availability and willingness of other caregivers who may provide needed assistance would be a significant mitigating factor.

We believe that the changes in the Safety Determination process will help to ensure that NF services are available to persons, including in situations involving elder abuse or crisis situations, when NF services are the most appropriate placement for a person—because the person's functional and medical needs as well as other safety concerns require that level of care.

With respect to the list in Rule 1200-13-01-.05(6)(a), while we believe the list is comprehensive, we are willing to continue to consider other specific examples for inclusion in the rule. Moreover, the rules clearly identify this list as circumstances for which a Safety Determination "shall be made" by TennCare. The list does not preclude TennCare from making Safety Determinations in other circumstances which are not enumerated.

In response to this comment, we have added that clarification to the rule at 1200-13-01-.05(6)(b), while also making clear that a referral to the AAAD or MCO (based on insufficient evidence to make a Safety Determination) shall only be made in circumstances where one or more of the criteria specified in (a) are met. The Safety Determination Form has also been revised to include a section for information regarding other safety concerns not specified in (a).

Because we anticipated (and based on experience now confirm) that the new process is likely to increase significantly the volume of Safety Determination requests and because of the strict timeline within which LOC decisions are made, we believe it is important to focus the attention of TennCare nurses, as well as AAADs and MCOs, on those circumstances where substantive concerns exist. An open-ended process where any person can assert safety concerns for any reason will be unmanageable and place the Bureau at risk of missing court-ordered timelines for NF applications.

The following language is inserted at 1200-13-01-.05(6)(b).

> "TennCare 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 TennCare determines may impact the person's ability to be safely served in CHOICES Group 3, along with sufficient medical evidence to make a Safety Determination."

With respect to examples of the documentation required at 1200-13-01-.05(6)(a)(2)-(4), the "imminence and seriousness of risk" is often inherent in the presentation of symptoms of the deficit. Thus the rule requires detailed description of how the deficit impacts the applicant's safety, noting that specific examples are helpful. For example, if a person is not oriented to event or situation, it is not a safety concern if the person laughs or cries in an improper emotional context. On the other hand, if a person whose disorientation to situation has led him or her to go outside with minimal clothing in the wintertime or to walk into the middle of a busy street, the risk of harm is much greater. It is important for reviewers to understand how the deficit evidences itself and how such situations pose a risk of harm. Additional explanation of the expectation and specific examples will be added to the training materials. Please note also that item (4) does not specifically ask for explanation regarding imminence or seriousness of risk as such risk is implicit for a person who is unable to toilet and to ambulate or transfer and for whom caregivers are not available to provide needed assistance.

With respect to the proposed 1200-13-01-.05(6)(f) (1200-13-01-.05(6)(g) as revised), to be clear, it has never been the case that individuals who are in a NF and seeking NF LOC approval through CHOICES are automatically approved for Group 3 LOC when they are not approved for Group 1 or 2. A person must first meet Group 3 (or "At Risk") LOC criteria as specified in TennCare Rule 1200-13-01-.10(4)(b)(1)(ii) and (2)(iii) *before* approval of a Group 3 PAE. Once Group 3 LOC is met, the person is still not automatically enrolled in CHOICES Group 3. All eligibility and enrollment criteria must be satisfied before a person can be enrolled into CHOICES Group 3.

Of particular import, pursuant to the terms of our approved 1115 demonstration and the TennCare Rules, a person cannot be determined eligible for and enrolled in Group 2 or 3 (and the correlating demonstration eligibility category, as applicable) *until and unless* he will actually begin *receiving* home and community based services. We do in fact find that some applicants do not want to receive HCBS, and thus, must ensure that the applicant wants HCBS and intends to begin receiving HCBS *before* enrollment can proceed. This is also a matter of financial program integrity since the State is not authorized to pay a capitation payment encompassing the provision of LTSS unless the person qualifies for and will begin receiving LTSS. We will continue working with our partners and our stakeholders to try to ensure that the process of confirming the member's desire to proceed with Group 3 enrollment is obtained in as efficient and timely a manner as possible.

With respect to the applicant's right to appeal a denied PAE when a Safety Determination has been requested, that is absolutely the intent. In response, we have added the following language to proposed 1200-13-01-.05(6)(f)(1) (1200-13-01-.05(6)(g)(1) as revised):

> "This notice shall advise the Applicant of the right to appeal the PAE denial decision, which includes the Safety Determination, as applicable, within thirty (30) calendar days."

Thank you for your careful review of improvements related to ADLs and ADL-related activities and for your specific recommendation regarding self-administration of medications. We believe that the previously proposed modifications in the rule have appropriately captured this deficit to include individuals who have physical or cognitive impairments which persistently inhibit his or her ability to self-administer medications and who would be unable to manage their medications, leaving them at serious and imminent risk of harm. We do want to ensure that we do not cast the net too broadly, resulting in inappropriate institutional placement for individuals whose needs can be safely met in more integrated community settings. The proposed changes to the criteria have been thoroughly vetted with the intent of both addressing concerns raised by stakeholders, and of clarifying criteria and documentation requirements for persons completing the PAE assessment. We will, however, continue to monitor the criteria as we move forward to determine if any additional adjustments are needed.

With respect to audits of safety determination processes, audits serve as one mechanism for providing quality assurance. TennCare has a fiduciary responsibility to continuously monitor the quality of its processes pertaining to medical eligibility determinations. All PAE types are audited for the submission of complete and accurate information, including those which include a Safety Determination request.

These quality monitoring processes are not enumerated in rule (nor is such required), as they are frequently adjusted as part of a continuous quality improvement approach.

The training materials pertaining to Safety Determinations include a single slide (out of 86 total slides) regarding the audit of Safety Determination requests. The slide does not use the term "inappropriately." The slide also identifies one of the most important purposes of these audits: to enable TennCare to provide targeted technical assistance to entities found to submit incorrect or incomplete PAEs, including Safety Determination requests. Currently, TennCare reports audit findings with high error rates to the submitting entity and uses these findings to provide targeted technical assistance. We plan to soon begin providing this information to MCOs. Our intent is to be completely transparent as audit processes are defined, especially if penalties of any kind are potentially involved, which is the reason for including this information in our training materials.

We believe it is in the best interest of applicants to identify and address persistent problems with any submitting entity in order to ensure that TennCare has complete and accurate information upon which to base a medical eligibility decision (including Safety Determination request, as applicable). We respectfully disagree that such audits "discourage facilities and MCOs from submitting PAEs and safety assessments at all," but that rather, they encourage a thorough and deliberate process that yields the best outcome for applicants. We have received requests from nursing facilities not targeted for technical assistance who want to proactively improve their performance in this area, further reinforcing that this information has value to applicants, submitters and TennCare alike.

Again, we appreciate your comments and your continued efforts on behalf of older adults and caregivers. We have attached a tracked changes version of the rule, showing the additional changes that have been made based on public comment. We hope these responses, along with appropriate adjustments in the rule, are helpful.

Respectfully,

Julie Johnson
Deputy of Operations
Long Term Services and Supports

CC: Patti Killingsworth, Assistant Commissioner and Chief of Long Term Services and Supports
Susie Baird, Director of Policy
Aaron C. Butler, Assistant Director of Policy
Kristeena Ashby, Assistant Deputy of Operations

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

February 9, 2015

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

Carol Westlake
Executive Director
Tennessee Disability Coalition
955 Woodland Street
Nashville, TN 37206

Gerald Coggin
Senior Vice President
National HealthCare Corporation
P.O. Box 1398
Murfreesboro, TN 37133

Gordon Bonnyman
Attorney
Tennessee Justice Center
301 Charlotte Avenue
Nashville, TN 37201

Criss Grant
Director of Planning and Communications
Alexian Brothers PACE
425 Cumberland Street
Chattanooga, TN 37404

Dear LTSS Stakeholder:

Thank you for the opportunity to work together for over a year to develop and refine proposed revisions to TennCare Rule Chapter 1200-13-01 pertaining to medical eligibility for long-term services and supports—specifically the Safety Determination process for Nursing Facility (NF) level of care (LOC), and for your additional comments on the proposed rule. We appreciate your suggestions and the opportunity to review and thoughtfully consider them. We have reiterated your comments and recommendations below, along with a detailed response to each item. We have further attached a tracked changes version of the rules, showing the additional changes that have been made based on public comment.

1200-13-01-.05(6) Safety Determinations that an Applicant Would Not Qualify to Enroll in CHOICES Group 3 (including Interim CHOICES Group 3).

We recommend that the list of triggering events that prompt a Safety Determination include the involvement of Adult Protective Services or law enforcement. We do *not* suggest that the mere fact that a CHOICES applicant has been the subject of an APS or law enforcement intervention is sufficient

to warrant CHOICES eligibility. We recognize that some applicants who are the subject of an APS or law enforcement intervention may be able to be safely maintained in the community with a CHOICES 3 level of services. However, APS or law enforcement become involved when there is a fear for a person's safety. Such involvement should therefore raise a red flag and prompt a Safety Determination by qualified personnel on behalf of the CHOICES program.

State's response:

Certainly, we recognize the need to help protect Tennessee's most vulnerable citizens, and for the availability of temporary shelter when a person must be removed from their living situation. To that end, the request for placement by law enforcement or APS is critical information that should be provided to TennCare for consideration in the Safety Determination review. In fact, the mere involvement of law enforcement or APS *is* sufficient for TennCare to conduct a Safety Determination upon request of the submitting entity as reflected in the rule.

However, it would not be possible for TennCare to conduct a Safety Determination review separate and apart from the medical eligibility process of which it is explicitly a part, or absent a Safety Determination request submitted as part of a complete PAE application along with the detailed medical and functional information, as well as safety-related concerns necessary for TennCare to make such a determination.

NF services are, pursuant to federal law [see 42 U.S. Code § 1396r] provided to persons who require medical or nursing care, rehabilitation services, or health-related care and services (*above the level of room and board*) which can be made available to them *only* through institutional facilities. The benefit is not available simply to provide emergency shelter, even when such housing arrangement may be urgently needed for non-medically related reasons, including crisis.

Pursuant to Tennessee's established NF LOC criteria, other factors (beyond functional and medical needs) affecting the person's health and safety can and should be taken into account, but cannot and should not replace the person's functional and medical need for such services. The evaluation of these needs is based on an assessment and is reviewed based on supporting evidence of the person's medical and functional needs. In short, Medicaid cannot simply approve and provide reimbursement for NF services for any person determined to be in crisis.

We believe that the changes in the Safety Determination process will help to ensure that NF services are available to persons, including in situations involving elder abuse or crisis situations, when NF services are the most appropriate placement for a person—because the person's functional and medical needs as well as other safety concerns require that level of care.

We also recommend that the rule include an explicit statement that the list set out in (a) is not meant to be exclusive, and that a Safety Determination may be requested whenever a requester is able to present circumstances that raise a legitimate concern for the applicant's safety. It is not possible to envision all of the circumstances where an applicant can be endangered, and the rule should not limit the Bureau's ability to effectively implement and enforce the safety requirements of the CHOICES waiver.

State's response:

With respect to the list in Rule 1200-13-01-.05(6)(a), while we believe the list is comprehensive, we are willing to continue to consider other specific examples for inclusion in the rule. Moreover, the rules clearly identify this list as circumstances for which a Safety Determination "shall be made" by TennCare. The list

does not preclude TennCare from making Safety Determinations in other circumstances which are not enumerated.

In response to this comment, we have added that clarification to the rule at 1200-13-01-.05(6)(b), while also making clear by that a referral to the AAAD or MCO (based on insufficient evidence to make a Safety Determination) shall only be made in circumstances where one or more of the criteria specified in (a) are met. The Safety Determination Form has also been revised to include a section for information regarding other safety concerns not specified in (a).

Because we anticipated (and based on experience now confirm) that the new process is likely to increase significantly the volume of Safety Determination requests and because of the strict timeline within which LOC decisions are made, we believe it is important to focus the attention of TennCare nurses, as well as AAADs and MCOs, on those circumstances where substantive concerns exist. An open-ended process where any person can assert safety concerns for any reason will be unmanageable and place the Bureau at risk of missing court-ordered timelines for NF applications.

The following language is inserted at 1200-13-01-.05(6)(b).

"TennCare 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 TennCare determines may impact the person's ability to be safely served in CHOICES Group 3, along with sufficient medical evidence to make a Safety Determination."

We recommend the inclusion of examples of the documentation required to prove that there is imminent or serious risk for subparts 2, 3 and 4. (Such guidance can be included in the rule itself or in forms developed for requesting Safety Determinations.)

State's response:

With respect to examples of the documentation required at 1200-13-01-.05(6)(a)(2)-(4), the "imminence and seriousness of risk" is often inherent in the presentation of symptoms of the deficit. Thus the rule requiress detailed description of how the deficit impacts the applicant's safety, noting that specific examples are helpful. For example, if a person is not oriented to event or situation, it is not a safety concern if the person laughs or cries in an improper emotional context. On the other hand, if a person whose disorientation to situation has led him or her to go outside with minimal clothing in the wintertime or to walk into the middle of a busy street, the risk of harm is much greater. It is important for reviewers to understand how the deficit evidences itself and how such situations pose a risk of harm. Additional explanation of the expectation and specific examples will be added to the training materials. Please note also that item (4) does not specifically ask for explanation regarding imminence or seriousness of risk as such risk is implicit for a person who is unable to toilet and to ambulate or transfer and for whom caregivers are not available to provide needed assistance.

Clause (f)(2) seems to indicate that if a Safety Determination is denied, the Applicant must then take affirmative steps to become enrolled in Group 3. We fear this results in an unintended gap in services for individual not already enrolled in an MCO and may create and undue delay in the provision of services. For this reason, we think that (f)(2) should be modified to make clear that denial of a Safety Determination request automatically enrolls that person into Group 3, if the person meets all other eligibility requirements.

State's response:

With respect to the proposed 1200-13-01-.05(6)(f) (1200-13-01-.05(6)(g) as revised), to be clear, it has never been the case that individuals who are in a NF and seeking NF LOC approval through CHOICES are automatically approved for Group 3 LOC when they are not approved for Group 1 or 2. A person must first meet Group 3 (or "At Risk") LOC criteria as specified in TennCare Rule 1200-13-01-.10(4)(b)(1)(ii) and (2)(iii) *before* approval of a Group 3 PAE. Once Group 3 LOC is met, the person is still not automatically enrolled in CHOICES Group 3. All eligibility and enrollment criteria must be satisfied before a person can be enrolled into CHOICES Group 3.

Of particular import, pursuant to the terms of our approved 1115 demonstration and the TennCare Rules, a person cannot be determined eligible for and enrolled in Group 2 or 3 (and the correlating demonstration eligibility category, as applicable) *until and unless* he will actually begin *receiving* home and community based services. We do in fact find that some applicants do not want to receive HCBS, and thus, must ensure that the applicant wants HCBS and intends to begin receiving HCBS *before* enrollment can proceed. This is also a matter of financial program integrity since the State is not authorized to pay a capitation payment encompassing the provision of LTSS unless the person qualifies for and will begin receiving LTSS. We will continue working with our partners and our stakeholders to try to ensure that the process of confirming the member's desire to proceed with Group 3 enrollment is obtained in as efficient and timely a manner as possible.

We recommend that the proposed rule amendment be revised as follows to make explicit the right to appeal when a decision on a Safety Determination is adverse to the Applicant.

Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13--01-.10(7).

State's response:

With respect to the applicant's right to appeal a denied PAE when a Safety Determination has been requested, that is absolutely the intent. In response, we have added the following language to proposed 1200-13-01-.05(6)(f)(1) (1200-13-01-.05(6)(g)(1) as revised):

"This notice shall advise the Applicant of the right to appeal the PAE denial decision, which includes the Safety Determination, as applicable, within thirty (30) calendar days."

1200-13-01-.10(4)(b)

The proposed rules include important change to the definitions of impairments of activities of daily living. We appreciate that the dementia diagnosis has been eliminated from the behavior definition, and that the orientation definition has been improved, and we support the inclusion of those changes in this rule.

We request that the Bureau continue a discussion with stakeholders of the other definitions in this rule. While we have previously raised concerns about some of the definitions, these have not been part of our ongoing discussions. We believe that the sort of careful vetting to which the Safety

Determination rule was subjected would help to identify anomalies and unintended consequences in the definitions section of the rules.

For example, the definition of eating impairments [Definition (III)] recognizes 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." By contrast, the definition of "Medication Administration" [Definition (VII)] does not recognize a qualifying impairment even if the person requires "limited assistance" in the form of the same sort of observation and verbal assistance, plus additional aid, in order to take medications. That is despite the fact that the consequence of even a single medication error due to the inability to safely self-administer medication is potentially very grave. We note this anomaly only as an example of the need to carefully examine and discuss all of the definitions, now that the Bureau, consumers and providers have the benefit of extended experience with the application of those definitions.

State's response:

Thank you for reiterating your concerns regarding changes in ADL and ADL-related criteria set forth in Rule 1200-13-0l-.10(4)(b), items I-IX of the proposed rule. As previously advised, the proposed changes to the criteria were thoroughly vetted with the intent of both addressing concerns previously raised by Stakeholders, and of clarifying criteria and documentation requirements in order to aide persons completing the PAE assessment. Submission of the needed documentation with the PAE will help to ensure timely approval of the appropriate level of care, and minimize unnecessary delays and/or appeals. We have reviewed these criteria changes with the entire PAE nursing staff and have modified any language that could have potentially been misconstrued as requiring a more restrictive application of medical eligibility criteria. The team feels very strongly that these changes will help to ensure that the appropriate level of care is approved, including situations where approval will be based on an approved Safety Determination. We therefore continue to believe it is in the best interest of Applicants to move forward with these changes, but will continue to review the impact of these changes in case additional adjustments are needed.

I hope this reinforces that the time we have invested in working together on these improvements has resulted in meaningful benefit for applicants, facilities, and the State. We reiterate our gratitude for your valuable input, and look forward to continuing to work together in that regard. We hope these responses, along with appropriate adjustments in the rule, are helpful.

Respectfully,

Patti Killingsworth
Assistant Commissioner and Chief of Long Term Services and Supports

CC: Darin J. Gordon, Deputy Commissioner, HCFA
Julie Johnson, Deputy of Operations, Long Term Services and Supports
Susie Baird, Director of Policy
Aaron C. Butler, Assistant Director of Policy
Kristeena Ashby, Assistant Deputy of Operations

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

February 9, 2015

Ms. Amelia Crotwell
Elder Law of East Tennessee

Dear Ms. Crotwell:

Thank you for your comments regarding proposed revisions to TennCare Rule Chapter 1200-13-01 pertaining to medical eligibility for long-term services and supports—specifically the Safety Determination process for Nursing Facility (NF) level of care (LOC). We appreciate your suggestions and the opportunity to review and thoughtfully consider them.

The proposed rule is not published on the SOS website as "Effective Rules." See http://www.tn.gov/sos/rules/1200/1200-13/1200-13-01.20141026.pdf. Rules are also posted on the SOS website when they are scheduled for rulemaking hearing. The hearing date for the proposed rule was November 18, 2014. The proposed rule has been going through the formal rulemaking process and as such comments received have been considered. Because Safety Determination and the processes pertaining thereto have not been previously defined in rule, the policy and process changes related to Safety Determinations were implemented November, 1, 2014, upon agreement with the Tennessee Justice Center, the Tennessee Disability Coalition, the Tennessee Health Care Association and other stakeholders that these changes were in the best interest of applicants and should be implemented as soon as possible (once system modifications and training were complete). Any additional changes determined by the Bureau to be appropriate based on comments received will be implemented by the effective date of the new rule.

With respect to the items listed in 1200-13-01-.02(b), the rule clearly indicates that the review of information is not limited to the list included. It would be burdensome if not impossible to enumerate every potential kind of information which could be submitted for consideration. All information submitted with a PAE (including a Safety Determination request, as applicable) is reviewed by TennCare.

We respectfully caution, however, that not every safety concern is appropriately addressed through NF placement. One of the objectives of the State's level of care criteria is to help ensure that the more intensive NF benefit is targeted to persons with higher acuity of need—to those whose needs cannot be safely met in more integrated community settings. We want to ensure that persons who can be safely supported in more integrated community settings are not inappropriately institutionalized, when other less restrictive safety measures could be put into place. For example,

eliminating the availability of a car, or even car keys, may be a more appropriate way to address driving concerns than placement in a NF. Likewise, there may be other less restrictive ways to address medication management concerns than placing a person who requires such assistance in a NF.

With respect to the list at 1200-13-01-.05(6)(a), please see comments above with respect to the appropriateness of NF placement. Further, while we believe the list is comprehensive, we are willing to continue to consider other specific examples for inclusion in the rule. Moreover, the rules clearly identify this list as circumstances for which a Safety Determination "shall be made" by TennCare. The list does not preclude TennCare from making Safety Determinations in other circumstances which are not enumerated.

In response to this comment, we have added that clarification to the rule at 1200-13-01-.05(6)(b), while also making clear that a referral to the AAAD or MCO (based on insufficient evidence to make a Safety Determination) shall only be made in circumstances where one or more of the criteria specified in (a) are met. The Safety Determination Form has also been revised to include a section for information regarding other safety concerns not specified in (a).

Because we anticipated (and based on experience now confirm) that the new process is likely to increase significantly the volume of Safety Determination requests and because of the strict timeline within which LOC decisions are made, we believe it is important to focus the attention of TennCare nurses, as well as AAADs and MCOs, on those circumstances where substantive concerns exist. An open-ended process where any person can assert safety concerns for any reason will be unmanageable and place the Bureau at risk of missing court-ordered timelines for NF applications.

The following language is inserted at 1200-13-01-.05(6)(b).

"TennCare 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 TennCare determines may impact the person's ability to be safely served in CHOICES Group 3, along with sufficient medical evidence to make a Safety Determination."

Regarding the standard for approval of Safety Determinations in 1200-13-01-.05(6)(e)(1) of the proposed rule (1200-13-01-.05(6)(f)(1) as revised), medical eligibility decisions, including Safety Determinations, are made by licensed and registered nurses employed by the Bureau of TennCare, based on review of a comprehensive assessment and supporting medical evidence, and utilizing their trained and experienced professional judgment. The standard for approval is clearly set forth in the proposed rule, i.e., "sufficient evidence, as required and determined by TennCare, 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 unpaid supports provided by family members and other caregivers who are willing and able to provide such care." We respectfully believe that the proposed language "as least as likely as not" is far more ambiguous and lacks the rigor necessary for a determination of medical eligibility.

With respect to the recommendation to remove paragraph 1200-13-01-.05(6)(e)(4) from the proposed rule, the safety determination process is used to determine whether a person requires the level of

care provided in a nursing facility, or whether the person can be safely served in a more integrated community setting if enrolled in CHOICES Group 3. We do not believe that unnecessary placement in an institution is an "error" to be taken lightly.

NF services are, pursuant to federal law [see 42 U.S. Code § 1396r] provided to persons who require medical or nursing care, rehabilitation services, or health-related care and services (*above the level of room and board*) which can be made available to them *only* through institutional facilities. The benefit is not available simply to provide emergency shelter, even when such housing arrangement may be urgently needed for non-medically related reasons, including crisis. The lack of availability of community housing and the need for assistance with routine medication management are not sufficient by themselves to show that a person's needs cannot be safely met if enrolled in CHOICES Group 3.

Pursuant to Tennessee's established NF LOC criteria, other factors (beyond functional and medical needs) affecting the person's health and safety can and should be taken into account, but cannot and should not replace the person's functional and medical need for such services. The evaluation of these needs is based on an assessment and is reviewed based on supporting evidence of the person's medical and functional needs. In short, Medicaid cannot simply approve and provide reimbursement for NF services for any person determined to need housing or assistance with medications.

We believe that the changes in the Safety Determination process will help to ensure that NF services are available to persons when NF services are the most appropriate placement for a person—because the person's functional and medical needs as well as other safety concerns require that level of care.

With respect to proposed rule 1200-13-01-.05(6)(f), TennCare has never provided a "blanked statement" [sic] that an application is denied. Notices regarding NF PAE denials are governed by the *Doe* Consent Decree and contain a detailed description of the reasons for denial. The same standard is applied to HCBS applications. Further, TennCare provides a line-by-line explanation next to each ADL or ADL-related item and each denied safety justification in TPAES.

Thank you for your careful review of improvements related to ADLs and ADL-related activities and for your specific recommendation regarding several of these items.

With respect to eating, the assessment of functional deficit is based on the level of support needed by the individual applicant, not how such level of assistance is provided. "General supervision" and person-specific directed observation and verbal assistance describe two different levels of assistance. This does not preclude that a particular staff person might meet the one-on-one needs of more than 1 resident; what is instructive is the level of assistance needed by the applicant. A staff person who periodically instructs everyone at the table to eat does not mean that such level of assistance is required by each resident in order to perform this activity.

With respect to self-administration of medications, examples of limited assistance are included in the rule. We believe that the previously proposed modifications in the rule have appropriately captured this deficit to include individuals who have physical or cognitive impairments which persistently inhibit his or her ability to self-administer medications and who would be unable to manage their medications, leaving them at serious and imminent risk of harm. We do want to ensure that we do not cast the net too broadly, resulting in inappropriate institutional placement for individuals whose needs can be safely met in more integrated community settings. The proposed changes to the criteria have been thoroughly vetted with the intent of both addressing concerns raised by stakeholders, and of clarifying criteria and

documentation requirements for persons completing the PAE assessment. We will, however, continue to monitor the criteria as we move forward to determine if any additional adjustments are needed.

With respect to bathing, dressing and grooming, there are several reasons that these have not historically been part of the PAE application or added with recent changes. The first is that unlike most of the other ADLs assessed, these are activities that occur once or perhaps (with respect to dressing) twice per day, and usually at fairly regular times such that is easier to either have natural supports in place, or to meet the need with a moderate level of HCBS. This is not the case with ADLs such as transfers, mobility, or toileting, or needs related to orientation, communication, and behavior that may occur throughout the day. In addition, assessment of the ADLs currently included in the PAE will likely identify any deficits in bathing and dressing. For the most part, deficiencies in bathing are related to difficulties with transfers and with mobility. And part of the assessment of a person's ability to toilet independently includes consideration of dressing-related components of that particular task. Deficits regarding these needs can, however, be presented as part of broader concerns pertaining to a member's safety in the community, when applicable.

As it relates to care coordinators' concerns that the new rules "do not *automatically enroll* someone in Group 3 when the NF PAE for group 1 or 2 is denied," it has never been the case that individuals who are in a NF and seeking NF LOC approval through CHOICES are automatically approved for Group 3 LOC when they are not approved for Group 1 or 2. A person must first meet Group 3 (or "At Risk") LOC criteria as specified in TennCare Rule 1200-13-01-.10(4)(b)(1)(ii) and (2)(iii) *before* approval of a Group 3 PAE. Once Group 3 LOC is met, the person is still not automatically enrolled in CHOICES Group 3. All eligibility and enrollment criteria must be satisfied before a person can be enrolled into CHOICES Group 3.

Of particular import, pursuant to the terms of our approved 1115 demonstration and the TennCare Rules, a person cannot be determined eligible for and enrolled in Group 2 or 3 (and the correlating demonstration eligibility category, as applicable) *until and unless* he will actually begin *receiving* home and community based services. We do in fact find that some applicants do not want to receive HCBS, and thus, must ensure that the applicant wants HCBS and intends to begin receiving HCBS *before* enrollment can proceed. This is also a matter of financial program integrity since the State is not authorized to pay a capitation payment encompassing the provision of LTSS unless the person qualifies for and will begin receiving LTSS. We will continue working with our partners and our stakeholders to try to ensure that the process of confirming the member's desire to proceed with Group 3 enrollment is obtained in as efficient and timely a manner as possible.

With respect to initiation of services in Group 3, once a person satisfies all eligibility requirements and can be enrolled into Group 3, MCOs have specific timeframes within which services must be initiated. Further nursing facilities are obligated pursuant to 42 CFR 483.12 to "provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility," a longstanding federal requirement which pre-dates the CHOICES program. Part of the challenge for MCOs is making sure they are appropriately informed of a person's placement in a hospital or Skilled Nursing Facility, since the majority of applicants are dually eligible for Medicare and admitted to a Medicare SNF following a Medicare acute stay, benefits which the MCO does not manage. Discharge planning is most effective when it begins upon admission and with collaboration among all providers and payers to help ensure a timely and safe transition.

To be clear, MCOs and NFs do not make Safety Determinations. All Safety Determinations are made by licensed and registered nurses at the Bureau of TennCare.

MCOs and NFs have been provided guidance related to Safety Determinations, both before and since the issuance of this notice of public rulemaking. In preparation for implementation of these changes to the Safety Determination process, TennCare prepared training presentations specific to Safety Determination, which are now available online. We have also conducted more than 17 in-person training sessions and 2 webinars. Webinars continue to be offered twice each month. Further, TennCare facilitated a weekly conference call from September 1 through December with each MCO to further discuss changes related to the Safety Determination process. In addition, a PAE manual and TPAES training presentation, which include the Safety Determination process, are available online. If someone was unable to attend one of the several in-person trainings or webinars, or is unable to access or under the three online training tools available to describe this process, LTSS has a dedicated call center with agents who are knowledgeable about the safety Determination process and available to answer user questions during business hours.

We agree that it is problematic when a Safety Determination that should be requested is not. It is also problematic when Safety Determination requests are made frivolously, as resources are diverted away from timely processing of appropriate requests.

With respect to audits of safety determination processes, audits serve as one mechanism for providing quality assurance. TennCare has a fiduciary responsibility to continuously monitor the quality of its processes pertaining to medical eligibility determinations. All PAE types are audited for the submission of complete and accurate information, including those which include a Safety Determination request. The training materials pertaining to Safety Determinations include a single slide (out of 86 total slides) regarding the audit of Safety Determination requests. The slide also identifies one of the most important purposes of these audits: to enable TennCare to provide targeted technical assistance to entities found to submit incorrect or incomplete PAEs, including Safety Determination requests. Currently, TennCare reports audit findings with high error rates to the submitting entity and uses these findings to provide targeted technical assistance. We plan to soon begin providing this information to MCOs. Our intent is to be completely transparent as audit processes are defined, especially if penalties of any kind are potentially involved, which is the reason for including this information in our training materials. Of note, MCO contracts do provide for the assessment of liquidated damages for failure to timely submit a Safety Determination request and for the failure to ensure that such documentation is complete and accurate. No such provision is currently in place for Nursing Facilities.

We believe it is in the best interest of applicants to identify and address persistent problems with any submitting entity in order to ensure that TennCare has complete and accurate information upon which to base a medical eligibility decision (including Safety Determination request, as applicable). We respectfully disagree that such audits "discourage facilities and MCOs from submitting PAEs and safety assessments at all," but that rather, they encourage a thorough and deliberate process that yields the best outcome for applicants. We have received requests from nursing facilities not targeted for technical assistance who want to proactively improve their performance in this area, further reinforcing that this information has value to applicants, submitters and TennCare alike.

Regarding 1200-13-01-.05(6)(b), the rule enumerates a variety of examples of other services that might be available to help meet a member's needs in the community if enrolled into Group 3. As you know, TennCare is the payer of last resort; we thus expect that MCOs are assisting members in accessing benefits available through other programs, when appropriate, and that such benefits are taken into account in the planning process. The need for a physician's order or concurrent review and authorization of such services is not justification for supplanting these benefits through the Medicaid program. Many members receiving LTSS also receive Home Health services, and while

the scope of the two benefits is different, Home Health aide services can often provide needed in-home support for seniors and adults with physical disabilities.

Again, we appreciate your comments and your continued efforts on behalf of older adults and caregivers. We have attached a tracked changes version of the rule, showing the additional changes that have been made based on public comment. We hope these responses, along with appropriate adjustments in the rule, are helpful.

Respectfully,

Julie Johnson
Deputy of Operations
Long Term Services and Supports

CC: Patti Killingsworth, Assistant Commissioner and Chief of Long Term Services and Supports
Susie Baird, Director of Policy
Aaron C. Butler, Assistant Director of Policy
Kristeena Ashby, Assistant Deputy of Operations

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

February 9, 2015

Ms. Carol Westlake
Tennessee Disability Coalition
955 Woodland Street
Nashville, TN 37206

Dear Ms. Westlake:

Thank you for the opportunity to work together for over a year to develop and refine proposed revisions to TennCare Rule Chapter 1200-13-01 pertaining to medical eligibility for long-term services and supports—specifically the Safety Determination process for Nursing Facility (NF) level of care (LOC), and for your additional comments on the proposed rule.

With respect to the list in Rule 1200-13-01-.05(6)(a), while we believe the list is comprehensive, we are willing to continue to consider other specific examples for inclusion in the rule. Moreover, the rules clearly identify this list as circumstances for which a Safety Determination "shall be made" by TennCare. The list does not preclude TennCare from making Safety Determinations in other circumstances which are not enumerated.

In response to this comment, we have added that clarification to the rule at 1200-13-01-.05(6)(b), while also making clear by that a referral to the AAAD or MCO (based on insufficient evidence to make a Safety Determination) shall only be made in circumstances where one or more of the criteria specified in (a) are met. The Safety Determination Form has also been revised to include a section for information regarding other safety concerns not specified in (a).

Because we anticipated (and based on experience now confirm) that the new process is likely to increase significantly the volume of Safety Determination requests and because of the strict timeline within which LOC decisions are made, we believe it is important to focus the attention of TennCare nurses, as well as AAADs and MCOs, on those circumstances where substantive concerns exist. An open-ended process where any person can assert safety concerns for any reason will be unmanageable and place the Bureau at risk of missing court-ordered timelines for NF applications.

The following language is inserted at 1200-13-01-.05(6)(b).

"TennCare 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 TennCare determines may impact the person's ability to be safely served in CHOICES Group 3, along with sufficient medical evidence to make a Safety Determination."

With respect to examples of the documentation required at 1200-13-01-.05(6)(a)(2)-(4), the "imminence and seriousness of risk" is often inherent in the presentation of symptoms of the deficit. Thus the rule requires detailed description of how the deficit impacts the applicant's safety, noting that specific examples are helpful. For example, if a person is not oriented to event or situation, it is not a safety concern if the person laughs or cries in an improper emotional context. On the other hand, if a person whose disorientation to situation has led him or her to go outside with minimal clothing in the wintertime or to walk into the middle of a busy street, the risk of harm is much greater. It is important for reviewers to understand how the deficit evidences itself and how such situations pose a risk of harm. Additional explanation of the expectation and specific examples will be added to the training materials. Please note also that item (4) does not specifically ask for explanation regarding imminence or seriousness of risk as such risk is implicit for a person who is unable to toilet and to ambulate or transfer and for whom caregivers are not available to provide needed assistance.

Regarding your comments on 1200-13-01-.05(6)(a)(8) and a report of APS or law enforcement involvement, certainly, we recognize the need to help protect Tennessee's most vulnerable citizens, and for the availability of temporary shelter when a person must be removed from their living situation. To that end, the request for placement by law enforcement or APS is critical information that should be provided to TennCare for consideration in the Safety Determination review. In fact, the mere involvement of law enforcement or APS *is* sufficient for TennCare to conduct a Safety Determination upon request of the submitting entity as reflected in the rule.

However, it would not be possible for TennCare to conduct a Safety Determination review separate and apart from the medical eligibility process of which it is explicitly a part, or absent a Safety Determination request submitted as part of a complete PAE application, along with the detailed medical and functional information, as well as safety-related concerns necessary for TennCare to make such a determination.

NF services are, pursuant to federal law [see 42 U.S. Code § 1396r] provided to persons who require medical or nursing care, rehabilitation services, or health-related care and services (*above the level of room and board*) which can be made available to them *only* through institutional facilities. The benefit is not available simply to provide emergency shelter, even when such housing arrangement may be urgently needed for non-medically related reasons, including crisis.

Pursuant to Tennessee's established NF LOC criteria, other factors (beyond functional and medical needs) affecting the person's health and safety can and should be taken into account, but cannot and should not replace the person's functional and medical need for such services. The evaluation of these needs is based on an assessment and is reviewed based on supporting evidence of the person's medical and functional needs. In short, Medicaid cannot simply approve and provide reimbursement for NF services for any person determined to be in crisis.

We believe that the changes in the Safety Determination process will help to ensure that NF services are available to persons, including in situations involving elder abuse or crisis situations, when NF services are the most appropriate placement for a person—because the person's functional and medical needs as well as other safety concerns require that level of care.

With respect to proposed rule 1200-13-01-.05(6)(f)(2) (1200-13-01-.05(6)(g)(2) as revised), to be clear, the plan of care described in the proposed rule at 1200-13-01-.05(6)(d)(3) (1200-13-01-.05(e)(3) as revised) is submitted to TennCare by the MCO Care Coordinator, NF, or PACE Organization (the "submitting entity") as part of a PAE that includes a Safety Determination request. The Plan of Care described at 1200-13-01-.05(6)(f)(2) (1200-13-01-.05(6)(g)(2) as revised) is developed by the MCO in response to a request from TennCare in accordance with 1200-13-01-.05(6)(c) of the proposed rule (1200-13-01-.05(6)(d) as revised) when an entity other than the MCO has submitted a PAE and has requested a Safety Determination, but the medical evidence received by TennCare from the submitting entity is insufficient to make a Safety Determination and TennCare has asked the MCO to gather additional information needed by TennCare to make a final Safety Determination. In the event that the MCO's assessment finds that it can safely meet the person's needs in Group 3, the MCO is expected to submit a plan of care demonstrating how the person's needs would be safely met and would be expected to implement that plan of care upon the person's enrollment into Group 3. The distinction made here and in proposed subparagraph (d) subpart 3 is intentional.

With respect to 1200-13-01-.05(6)(f) of the proposed rule (1200-13-01-.05(6)(g) as revised), proposed revisions to rule Chapter 1200-13-01 in this notice of rulemaking prescribe certain modifications (i.e., improvements) in the medical eligibility process for CHOICES, specifically the Safety Determination process. It does not therefore address contingencies and requirements that are elaborated in other rule sections or that apply pursuant to federal law or regulation or federal court orders.
If a PAE is denied, the applicant has appeal rights afforded at 1200-13-01-.10(7)(b). Those appeal rights include the right to appeal a denial when a Safety Determination has been requested but not approved, as reiterated at 1200-13-01-.05(6)(g)(1) of the revised rule.

> "This notice shall advise the Applicant of the right to appeal the PAE denial decision, which includes the Safety Determination, as applicable, within thirty (30) calendar days."

Other obligations of the facility pursuant to notice of discharge and facilitation of discharge as specified in federal court orders in Linton v. State of Tennessee, federal regulations at 42 CFR 483.12 and state regulation at 1200-13-01-.06 (including the interaction of those requirements with the person's right to due process and to remain in the facility pending discharge), apply if the person does not qualify for Medicaid reimbursement of NF services and is unwilling to meet payment obligations for these services. These ongoing requirements are not impacted by these rules. This includes the facility's obligation pursuant to 42 CFR 483.12 to "provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility," a longstanding federal requirement which pre-dates the CHOICES program.

For TennCare members who choose to proceed with enrollment into Group 3, the person's MCO can work with the nursing facility regarding discharge in as timely and efficient a manner as possible. As you know, the member's access to housing can sometimes present a barrier that can impact the timeliness of discharge. When the member has housing available, HCBS can be arranged quickly to facilitate discharge (unless the member elects to remain in the facility pending appeal). MCOs can and do assist members who have housing needs, but access to affordable housing can be challenging.

Thank you for reiterating your concerns regarding changes in ADL and ADL-related criteria set forth in Rule 1200-13-0l-.10(4)(b), items I-IX of the proposed rule. As previously advised, the proposed changes to the criteria were thoroughly vetted with the intent of both addressing concerns previously raised by Stakeholders, and of clarifying criteria and documentation requirements in order to aide persons completing the PAE assessment. Submission of the needed documentation with the PAE will help to

ensure timely approval of the appropriate level of care, and minimize unnecessary delays and/or appeals. We have reviewed these criteria changes with the entire PAE nursing staff and have modified any language that could have potentially been misconstrued as requiring a more restrictive application of medical eligibility criteria. The team feels very strongly that these changes will help to ensure that the appropriate level of care is approved, including situations where approval will be based on an approved Safety Determination. We therefore continue to believe it is in the best interest of Applicants to move forward with these changes, but will continue to review the impact of these changes in case additional adjustments are needed.

Again, we appreciate your comments, your continued advocacy on behalf of older adults and individuals with disabilities, and the opportunity to work with you on these important improvements. We have attached a tracked changes version of the rule, showing the additional changes that have been made based on public comment. We hope these responses, along with appropriate adjustments in the rule, are helpful.

Respectfully,

Patti Killingsworth
Assistant Commissioner and Chief of Long Term Services and Supports

CC: Julie Johnson, Deputy of Operations, Long Term Services and Supports
Susie Baird, Director of Policy
Aaron C. Butler, Assistant Director of Policy
Kristeena Ashby, Assistant Deputy of Operations

RULES
OF
TENNESSEE DEPARTMENT OF FINANCE
AND ADMINISTRATION
BUREAU OF TENNCARE

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

1200-13-01-.02 DEFINITIONS.

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

(~~5~~4) Applicant. A person applying for TennCare-reimbursed LTSS, for whom a PAE has been submitted to TennCare, and/or by or on behalf of whom a Medicaid application has been submitted to DHS. For purposes of compliance with the Linton Order, the term shall include all individuals who have affirmatively expressed an intent to be considered for current or future admission to a NF or requested that their name be entered on any "wait list." All individuals who contact a NF to casually inquire about the facility's services or admissions policies shall be informed by the facility of that individual's right to apply for admission and be considered for admission on a nondiscriminatory basis and in conformance with Rule 1200-13-01-.06.

ETC.

(125) 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 an Applicant 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)).

(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. Diagnosed complex acute or chronic medical conditions which require frequent, 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;

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; and

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.

(126) Self-Determination ID Waiver. Tennessee's Self Determination Waiver under Sectio1915(c) of the Social Security Act.

ETC.

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

~~(6) Advance Determinations that an Applicant Would Not Qualify to Enroll in CHOICES Group 3 (including Interim CHOICES Group 3).~~

~~(a) For purposes of the Need for Inpatient Nursing Care, Effective July 1, 2012, as specified in TennCare Rule 1200-13-01-.10(4)(b)(2)(i)(II) and 1200-13-01-.10(4)(b)(2)(ii)(II), Advance Determination by TennCare that a CHOICES Applicant would not qualify for enrollment into CHOICES Group 3 shall be made only if all of the following criteria are met:~~

~~1. The Applicant has a total acuity score of at least six (6) but no more than eight (8);~~

~~2. The Applicant has an individual acuity score of at least three (3) for the Orientation measure;~~

~~3. The Applicant has an individual acuity score of at least two (2) for the Behavior measure;~~

~~4. The absence of intervention and supervision for dementia-related behaviors at the frequency specified in the PAE would result in imminent and serious risk of harm to the Applicant and/or others (documentation of the specific behaviors, the frequency of such behaviors, and the imminence and seriousness of risk shall be required); and~~

~~5. There is sufficient evidence, as required and determined by TennCare, to demonstrate that the necessary intervention and supervision needed by the person cannot be safely provided within the array of services and supports that would be available if the Applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the Expenditure Cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through~~

~~*Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers.*~~

~~(b) Documentation required to support an Advance Determination for Applicants enrolled in TennCare shall include all of the following:~~

~~1. A comprehensive needs assessment performed by an MCO Care Coordinator pursuant to requirements set forth in the MCO's Contractor Risk Agreement, including:~~

~~(i) An assessment of the Member's physical, behavioral, functional, and psychosocial needs;~~

~~(ii) An assessment of the Member's home environment in order to identify any modifications that may be needed, and to identify and address any issues that may affect the Member's ability to be safely served in the community;~~

~~(iii) An assessment of the Member's Natural Supports, including care being provided by family members and/or other caregivers, and LTSS the Member is currently receiving (regardless of payer), and whether there is any anticipated change in the Member's need for such care or services or the availability of such care or services from the current caregiver or payer; and~~

~~(iv) An assessment of the physical health, behavioral health, and LTSS and other social support services and assistance (e.g., *housing or income* assistance) that are needed to ensure the Member's health, safety and welfare in the community and to prevent the need for institutional placement. Such assessment shall specify the specific tasks and functions for which assistance is needed by the Member, the frequency with which such tasks must be performed, and the amount of paid assistance necessary to perform these tasks;~~

~~2. A person-centered plan of care developed by the MCO Care Coordinator which specifies the CHOICES HCBS that would be necessary and that would be approved by the MCO safely support the person in the community, as well as non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers (or attestation that the person could not be safely supported in the community with *any* combination of services and supports, as applicable);~~

~~3. An explanation regarding why an array of covered services and supports, including CHOICES HCBS up to the Expenditure Cap of $15,000 and non-CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the person's needs in the community;~~

~~4. A detailed explanation of:~~

~~(i) The Member's living arrangements and the services and supports the Member has received for the six (6) months prior to application for CHOICES, including non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance~~

~~or other funding sources, and unpaid supports provided by family members and other caregivers; and~~

~~(ii) Any recent significant event(s) or circumstances that have impacted the Applicant's need for services and supports, including how such event(s) or circumstances would impact the person's ability to be safely supported within the array of covered services and supports that would be available if the person were enrolled in CHOICES Group 3.~~

~~(c) Documentation required to support an Advance Determination for Applicants not enrolled in TennCare at the time the PAE is submitted shall include all of the items specified in Subparagraph (b) above, except as follows:~~

~~1. A comprehensive assessment, including an assessment of the Applicant's home environment, performed by the AAAD, or the most recent MDS assessment performed by a Nursing Facility contracted with one or more TennCare MCOs may be submitted in lieu of the MCO comprehensive needs assessment specified in Part (b)1. above.~~

~~2. The person-centered plan of care as described in Part (b)2. above shall not be required.~~

(6) Safety Determination Requests

(a) For purposes of the Need for Inpatient Nursing Care, as specified in the Bureau Rule 1200-13-01-.10(4)(b)2.(i)(II) and 1200-13-01-.10(4)(b)2.(ii)(II), a Safety Determination by the Bureau regarding whether a CHOICES Applicant would qualify for enrollment into CHOICES Group 3 shall be made upon request of the Applicant, the Applicant's Representative, or the entity submitting the PAE, including the AAAD, MCO, NF, or PACE Organization if 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);

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(125)), such that a higher level of care is needed.

(b) Any of these criteria shall be sufficient to warrant review of a Safety Determination request by the Bureau; however 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, 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, 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 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 (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) 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:

(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;

3. A person-centered plan of care developed by the MCO Care 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 is not required for a Safety Determination submitted by the AAAD.) 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 and non-CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the Applicant's needs in the community.

(f) Approval of a Safety Determination Request

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, including CHOICES HCBS up to the Expenditure Cap of $15,000, non-CHOICES HCBS available through the Bureau (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.

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)).

3. If enrolled in CHOICES Group 1 or 2 or in PACE based upon approval of a Safety Determination request, the NF, MCO, or PACE Organization, respectively, shall implement any plan of care 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 and signed by the Applicant (or authorized representative).

4. The lack of availability of suitable community housing or the need for assistance with routine medication management shall not be sufficient by itself to justify approval of a Safety Determination request.

(g) Denial of a Safety Determination Request.

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 based upon denial of a Safety Determination Request, the MCO shall implement any plan of care 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 Group 3, including covered medically necessary CHOICES HCBS and non-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 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. 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 3, 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.

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

(3) Medicaid Reimbursement.

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

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

2. The Bureau has received an approvable PAE for the person within ten (10) calendar days of the PAE Request Date or the physician certification date, whichever is earlier. The PAE Approval Date shall not be more than ten (10)

days prior to date of submission of an approvable PAE. An approvable PAE is one in which any deficiencies in the submitted application are cured prior to disposition of the PAE.

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

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

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

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

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

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

2. Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for NF services.

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

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

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

3. The effective date of Medicaid eligibility;

4. The date of admission to the NF; and

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

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

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

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

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

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

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

(~~f~~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.

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

(~~h~~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 and PACE.

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

1. Medical Necessity of Care:

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

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

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

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

2. Need for Inpatient Nursing Care:

(i) Applicants requesting TennCare-reimbursed NF care.

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

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

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

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

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

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

(II) Meet one (1) or more of the ADL or related criteria specified in 1200-13-01-.10(4)(b)(2)(iii) on an ongoing basis and be determined by TennCare to not qualify for enrollment in CHOICES Group 3 (see TennCare Rule 1200-13-01-.05).

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

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

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

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

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

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

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

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

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

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

(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.