

Department of State  
Division of Publications  
312 Rosa L. Parks, 8th Floor Snodgrass/TN Tower  
Nashville, TN 37243  
Phone: 615-741-2650  
Fax: 615-741-5133  
Email: [register.information@tn.gov](mailto:register.information@tn.gov)

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## Emergency Rule Filing Form

*Emergency rules are effective from date of filing for a period of up to 180 days.*

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](mailto:George.Woods@tn.gov)

**Rule Type:**

Emergency Rule

**Revision Type (check all that apply):**

Amendments

New

Repeal

**Statement of Necessity:**

The Bureau of TennCare is making changes to certain aspects of its long term care program. These changes will enable the Bureau to more fully implement the Long-Term Care Community Choices Act of 2008 ("CHOICES"), as amended by Public Chapter 971. The changes also reflect federal approval of modifications to certain CHOICES service definitions and Amendment 14 to the TennCare II Demonstration, which permits the opening of a new Interim CHOICES 3 Group and a new CHOICES At-Risk Demonstration eligibility category.

From its inception, one of the goals of CHOICES has been the stratification of long term care levels of care and reimbursement for those levels of care which reflect the acuity of the actual medical needs of the individual members. Initial implementation provided for CHOICES 1 and CHOICES 2, nursing facility care and home and community based care, respectively. Eligibility for the third category for those members who are "at risk" of the need for nursing facility care, CHOICES 3, was not opened because a change in federal law regarding eligibility for benefits, known as the Maintenance of Effort ("MOE") requirement which was included first in the American Recovery and Reinvestment Act and subsequently in the Affordable Care Act, prevented the Bureau from making changes to CHOICES eligibility criteria, which prevented opening the CHOICES 3 category. The Bureau has worked diligently with the federal government in an effort to develop a mechanism by which the State can achieve MOE compliance while still meeting its goal of modifying level of care criteria for purposes of determining the appropriate benefit category and reimbursement level based on the needs of the individual.

On May 8, 2012, the Bureau received approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to modify the definitions of certain home and community based services provided under the CHOICES program. These modifications will blend homemaker services into the personal care and attendant care benefits. Homemaker services will no longer be available as a separate benefit as of July 1, 2012, so CMS approval of the incorporation of these services into other benefits (with slight modifications to those benefits) was required in order to continue homemaker services when necessary for the health and safety of the member.

On April 27, 2012, PC 971 was passed by the Legislature and on May 10<sup>th</sup> it was signed into law with an

effective date of July 1, 2012. PC 971 amends the Choices Act in part by reiterating the requirement that the Bureau establish level of care medical eligibility criteria and reimbursement methodology based upon acuity of need and by establishing a new requirement that the Bureau hold a public hearing prior to promulgation of any emergency rules setting forth level of care eligibility criteria for all long term care services. The required public hearing was held on May 7, 2012, at the Nashville Public Library, Bordeaux Branch.

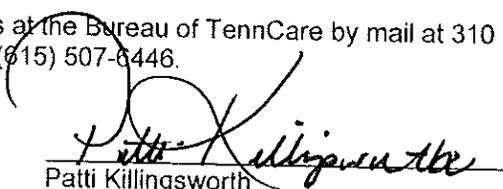
The Appropriations Act, PC 1027, was passed by the Legislature on April 30<sup>th</sup>, signed into law on May 15<sup>th</sup> and becomes effective July 1, 2012. Section 48, Item 6 of the Appropriations Act provides authorization to impose TennCare service limitations, reduce optional TennCare eligibility categories, mandate standardized reimbursement levels, and/or reduce, or limit, optional TennCare benefits as necessary to control expenditures. Section 12, Item 2 authorizes the promulgation of emergency rules in order for the TennCare program to function within the appropriations provided.

CMS approved Amendment 14 to the TennCare II Demonstration on June 15, 2012, with an effective date of July 1, 2012. This Amendment permits the Bureau to open an Interim CHOICES 3 Group and to establish a new CHOICES At-Risk eligibility category which retains the current level of care eligibility requirements in order to be determined eligible for CHOICES 3 as an "at risk" member. This retention of the current level of care eligibility requirements permits the Bureau to remain compliant with the MOE provisions of ACA while simultaneously permitting the Bureau to implement new level of care criteria based upon acuity. Approval of this amendment was required in order to implement level of care changes and to open CHOICES 3 prior to expiration of MOE provisions. It is important to note that the current level of care criteria will remain in effect for all CHOICES members who are currently enrolled as long as their status remains unchanged and they remain continuously enrolled in the program. The current level of care criteria will also be applied to determine eligibility for Interim CHOICES 3. The new level of care acuity criteria will be applied only to members enrolled in CHOICES on or after July 1, 2012.

Pursuant to T.C.A. § 4-5-208, the Bureau of TennCare is authorized to adopt an emergency rule if it is required by an enactment of the general assembly to implement rules within a prescribed period of time that precludes utilization of rulemaking procedures for the promulgation of permanent rules. Further, T.C.A. § 4-5-208 permits an agency to adopt emergency rules when the agency finds that it is required by an agency of the federal government and adoption of the rules through ordinary rulemaking procedures might jeopardize the loss of a federal program or funds.

I have made the finding that the emergency adoption of amendments to Rule Chapter 1200-13-01 is required in order to implement changes to the levels of care eligibility criteria pursuant to amendments to the Long-Term Care Community CHOICES Act of 2008 and Amendment 14 to the TennCare II Demonstration, and to implement CMS approved terminology changes to prevent the loss of needed homemaker services in a timely manner.

For a copy of these emergency rules contact: George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

  
Patti Killingsworth  
Chief Long-Term Services and Supports

**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/RuleTitle 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-.08	Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate

	Recovery for Persons Receiving LTC
1200-13-01-10	Medical (Level of Care) Eligibility Criteria for Medicaid Reimbursement of Care in Nursing Facilities Care

(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>)

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

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

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (1) and renumbering the current Paragraph (1) as (2) and subsequent paragraphs renumbered accordingly so as amended the new Paragraph (1) shall read as follows:

(1) Activities of Daily Living (ADLs).

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

1. Personal hygiene and grooming;
2. Dressing and undressing;
3. Self feeding;
4. Functional transfers (getting into and out of bed or wheelchair, getting onto or off toilet, etc.);
5. Bowel and bladder management; and
6. Ambulation (walking with or without use of an assistive device, e.g., walker, cane, or crutches; or using a wheelchair).

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (10) and renumbering the current renumbered Paragraph (10) as (11) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (10) shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by deleting renumbered Paragraph (11) and replacing it with a new Paragraph (11) so that as amended it shall read as follows:

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

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

1. ADLs such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation.
2. Continuous safety monitoring and supervision during the period of service delivery.

- (b) For members who require hands-on assistance with ADLs, attendant care may also include the following homemaker services that are essential, although secondary, to the hands-on assistance with ADLs needed by the Member in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:
  - 1. Picking up the Member's medications or shopping for the Member's groceries.
  - 2. Preparing the Member's meals and/or educating caregivers about preparation of nutritious meals for the Member.
  - 3. Household tasks such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, and doing the Member's personal laundry, ironing and mending.
- (c) Attendant Care shall not be provided for Members who do not require hands-on assistance with ADLs.
- (d) Attendant Care shall be primarily provided in the Member's place of residence, except as permitted by rule and within the scope of service (e.g., picking up medications or shopping for groceries) when accompanying the Member into the community pursuant to rule 1200-13-01-.05(8)(m), or under exceptional circumstances as authorized by an MCO in the POC to accommodate the needs of the Member.
- (e) A single Contract Provider staff person or Consumer Directed Worker may provide Attendant Care services to multiple CHOICES Members in the same home and during the same hours, as long as he can provide the services safely and appropriately to each Member. Such arrangements shall be documented in each Member's plan of care. In such instances, the total units of service provided by the staff person shall be allocated among the CHOICES Members, based on the percentage of total service units required by each Member on average. The Provider shall bill the MCO only once for each of the service units provided, and shall not bill an MCO or multiple MCOs separately to provide services to multiple Members at the same time.
- (f) Attendant Care shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services, or while a Member is receiving Adult Day Care services.
- (g) Attendant Care shall not include:
  - 1. Care or assistance including meal preparation or household tasks for other residents of the same household;
  - 2. Yard work; or
  - 3. Care of non-service related pets and animals.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (20) so that it shall read as follows:

(20) Certification.

- (a) A process by which a Physician who is licensed as a doctor of medicine or doctor of osteopathy signs and dates a PAE signifying the following:
  - 1. The person requires the requested level of institutional care or reimbursement (Level 1 NF, Level 2 NF, Enhanced Respiratory Care, or ICF/MR) or, in the case of a Section 1915(c) HCBS Waiver program, requires HCBS as an alternative to the applicable level of institutional care for which the person would qualify; and
  - 2. The requested LTC services are medically necessary for the individual.
- (b) Consistent with requirements pertaining to certification of the need for SNF care set forth at 42 CFR

424.20, certification of the need for NF care may be performed by a nurse practitioner or clinical nurse specialist, neither of whom has a direct or indirect employment relationship with the facility but who is working in collaboration with a physician.

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

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (22) and renumbering the current renumbered Paragraph (22) as (23) with subsequent paragraphs renumbered accordingly so as amended the new Paragraph (22) shall read as follows:

- (22) CHOICES At-Risk Demonstration Group. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet NF financial eligibility requirements for Medicaid reimbursed LTC, meet the NF level of care in place on June 30, 2012, but not the NF LOC in place on July 1, 2012, and who, in the absence of CHOICES HCBS available through CHOICES Group 3, are At Risk for Institutionalization as defined in these rules. Members eligible for TennCare in the CHOICES At-Risk Demonstration Group on December 31, 2013, may continue to qualify in this group after December 31, 2013, so long as they continue to meet NF financial eligibility, continue to be At Risk for Institutionalization as defined in these rules, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES Group 3.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (26) and renumbering the current renumbered Paragraph (26) as (27) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (26) shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (27) and renumbering the current renumbered Paragraph (27) as (28) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (27) shall read as follows:

- (27) CHOICES Home and Community Based Services (HCBS). Services specified in rule 1200-13-01-.05(8)(k) that are available only to eligible persons enrolled in CHOICES Group 2 or Group 3 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost neutrality cap.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (34) so that it shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (39) so that it shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (45) so that it shall read as follows:

- (45) Eligible CHOICES HCBS. For purposes of CD, CHOICES HCBS that may be consumer-directed are limited to Attendant Care, Personal Care Visits, In-Home Respite Care, or Companion Care. Eligible CHOICES HCBS do not include home health or private duty nursing services.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (49) so that it shall read as follows:

- (49) Enrollment Target.
- (a) The maximum number of individuals who can be enrolled in CHOICES Group 2 or CHOICES Group 3 at any given time, subject to the exceptions provided in this Chapter.
- (b) The Enrollment Target is not calculated on the basis of "unduplicated participants." Vacated slots in CHOICES Group 2 or CHOICES Group 3 may be refilled immediately, rather than being held until the next program year, as is required in the HCBS Waiver programs.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (50) and renumbering the current renumbered Paragraph (50) as (51) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (50) shall read as follows:

- (50) Expenditure Cap. For purposes of CHOICES Group 3, the annual limit on expenditures for CHOICES HCBS, excluding minor home modifications, that a CHOICES Group 3 Member can receive. The Expenditure Cap shall be \$15,000 (fifteen thousand dollars) per Member per calendar year.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (57) so that it shall read as follows:

- (57) Home and Community Based Services (HCBS). Services that are provided under the authority of a Section 1915(c) HCBS waiver or (in the case of CHOICES) a Section 1115 waiver pursuant to a written POC as an alternative to LTC institutional services in a NF or an ICF/MR to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require the LOC provided in the institution to which the HCBS offer an alternative, or in the case of CHOICES Group 3, are At Risk for Institutionalization. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (61) so that it shall read as follows:

- (61) Homemaker Services.
- (a) General household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, doing the Member's personal laundry, ironing or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the Member, assistance with maintenance of a safe environment, and errands such as grocery shopping and having the Member's prescriptions filled.
- (b) Provided only for the Member (and not for other household members) and only when the Member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the Member.
- (c) Effective July 1, 2012, provided only as part of Personal Care Visits and Attendant Care services for Members who also require hands-on assistance with ADLs. Homemaker Services authorized in an approved plan of care on or before June 30, 2012, shall continue to be provided for no more than ninety (90) days after July 1, 2012, pending a reassessment of the Member's needs and modifications to the Member's plan of care to comport with the new benefit structure, as well as

individual notice of action, when required. Homemaker Services shall not be continued pending resolution of any appeal filed on or after July 1, 2012, as Homemaker Services are no longer covered as a stand-alone benefit. Homemaker Services are not covered for anyone that does not also require hands-on assistance with ADLs.

- (d) Shall not be provided to Members living in a CBRA facility or receiving Short-Term NF Services.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (66) so that it shall read as follows:

(66) Immediate Eligibility.

- (a) A mechanism by which the Bureau may elect, based on a preliminary determination of an individual's eligibility for the CHOICES 217-Like Group, to enroll the individual into CHOICES Group 2 and provide immediate access to a limited package of CHOICES HCBS pending a final determination of eligibility.
- (b) To qualify an individual must:
  - 1. Be applying to receive covered CHOICES HCBS;
  - 2. Be determined by the Bureau to meet NF LOC;
  - 3. Have submitted an application for financial eligibility determination to DHS;
  - 4. Be expected to qualify in the CHOICES 217-Like Group based on review of the financial information provided by the applicant; and
  - 5. Meet all other specified criteria for enrollment into CHOICES Group 2, subject to categorical and financial eligibility determination.
- (c) Immediate Eligibility shall only be for Specified CHOICES HCBS (no other covered services) and for a maximum of forty-five (45) days.
- (d) Immediate Eligibility is not available for individuals who are already enrolled in TennCare or for persons who may qualify in the CHOICES At-Risk Demonstration Group.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (68) and renumbering the current renumbered Paragraph (68) as (69) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (68) shall read as follows:

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

- (a) The response to a specific ADL or related question in the PAE for NF LOC that is supported by the medical evidence submitted with the PAE; or
- (b) A specific skilled or rehabilitative service determined by TennCare to be needed by the applicant on a daily basis or at least five (5) days per week for rehabilitative services based on the medical evidence submitted with the PAE and for which TennCare would authorize level 2 or enhanced respiratory care reimbursement in a NF.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (75) and renumbering current renumbered paragraph (75) as (76) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (75) shall read as follows:

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

- (a) Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients or as members of the CHOICES At-Risk

Demonstration Group, and who are At Risk for Institutionalization as defined in these rules. There will be no Enrollment Target applied to Interim CHOICES Group 3.

- (b) Members enrolled in Interim CHOICES Group 3 on December 31, 2013 may continue to qualify in this group after December 31, 2013, so long as they continue to meet NF financial eligibility, continue to be At Risk for Institutionalization, can be safely served in Interim CHOICES Group 3, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES Group 3.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (79) so that it shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (89) and renumbering the current renumbered Paragraph (89) as (90) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (89) shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (107) so that it shall read as follows:

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

- (a) Visits to a Member who, due to age and/or physical disability, needs assistance that can be provided through intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance and related tasks as specified below.
- (b) Personal Care Visits may include assistance with ADLs such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation.
- (c) For members who require hands-on assistance with ADLs, Personal Care Visits may also include the following homemaker services that are essential, although secondary, to the hands-on assistance with ADLs needed by the Member in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:
  1. Picking up the Member's medications or shopping for the Member's groceries.
  2. Preparing the Member's meals and/or educating caregivers about the preparation of nutritious meals for the Member.
  3. Household tasks such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, and doing the Member's personal laundry, ironing and mending.

- (d) Personal Care Visits shall not be provided for members who do not require hands-on assistance with ADLs.
- (e) Personal Care Visits shall be primarily provided in the Member's place of residence, except as permitted within the scope of service (e.g., picking up medications or shopping for groceries), when accompanying the Member into the community pursuant to rule 1200-13-01-.05(8)(m), or under exceptional circumstances as authorized by an MCO in the POC to accommodate the needs of the Member.
- (f) A single Contract Provider staff person or Consumer Directed Worker may provide Personal Care Visits to multiple CHOICES members in the same home and during the same hours, as long as he can provide the services safely and appropriately to each member. Such arrangements shall be documented in each member's plan of care. In such instances, the total units of service provided by the staff person shall be allocated among the CHOICES members, based on the percentage of total service units required by each member on average. The Provider shall bill the MCO only once for each of the service units provided, and shall not bill an MCO or multiple MCOs separately to provide services to multiple members at the same time.
- (g) Personal Care Visits shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services, or while a Member is receiving Adult Day Care services.
- (h) Personal care visits shall not include:
  1. Companion or sitter services, including safety monitoring and supervision.
  2. Care or assistance including meal preparation or household tasks for other residents of the same household.
  3. Yard work.
  4. Care of non-service related pets and animals.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (113) so that it shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (117) so that it shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (122) and renumbering the current renumbered Paragraph (122) as (123) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (122) shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (130) so that it shall read as follows:

(130) Risk Agreement.

- (a) An agreement signed by a Member who will receive CHOICES Group 2 HCBS (or his Representative) that includes, at a minimum:
  - 1. Identified risks to the Member of residing in the community and receiving HCBS;
  - 2. The possible consequences of such risks, strategies to mitigate the identified risks; and
  - 3. The Member's decision regarding his acceptance of risk.
- (b) For Members electing to participate in CD, the Risk Agreement must include any additional risks associated with the Member's decision to act as the Employer of Record, or to have a Representative act as the Employer of Record on his behalf.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (136) so that it shall read as follows:

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

- (a) The provision of NF care for up to ninety (90) days to a CHOICES Group 2 or CHOICES Group 3 Member who was receiving HCBS upon admission and who meets NF LOC and requires temporary placement in a NF—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such Member is reasonably expected to be discharged and to resume HCBS participation within no more than ninety (90) days.
- (b) Such CHOICES Group 2 or CHOICES Group 3 Member must meet the NF LOC upon admission and in such case, while receiving Short-Term NF Care may continue enrollment in CHOICES Group 2 or CHOICES Group 3, pending discharge from the NF within no more than ninety (90) days or until such time it is determined that discharge within ninety (90) days from admission is not likely to occur, at which time the Member shall be transitioned to CHOICES Group 1, as appropriate.
- (c) The Community PNA shall continue to apply during the provision of Short-Term NF care, up to the ninetieth (90th) day, in order to allow sufficient resources for the Member to maintain his community residence for transition back to the community.
- (d) The PASRR process is required for CHOICES Group 2 and CHOICES Group 3 Members entering Short-Term NF Care.
- (e) Persons receiving Short-Term NF Care are not eligible to receive any other HCBS, except as permitted in 1200-13-01-.05 to facilitate transition to the community.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (142) so that it shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (149) and renumbering the current renumbered Paragraph (149) as (150) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (149) shall read as follows:

- (149) Tennessee Pre-Admission Evaluation System (TPAES). A component of the State's Medicaid Management Information System and the system of record for all PreAdmission Evaluation (i.e., level of care) submissions and level of care determinations, as well as enrollments into and transitions between LTC programs, including CHOICES and the State's Money Follows the Person Rebalancing Demonstration

(MFP), and which shall also be used to gather data required to comply with tracking and reporting requirements pertaining to MFP.

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

The introductory Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the word "two" and by adding the word and number "three (3)" so as amended the introductory Subparagraph (a) shall read as follows:

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

Part 1. of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 is amended by deleting the hyphen "-" between the words "Medicaid-Reimbursement" in the last sentence so as amended Part 1. shall read as follows:

1. CHOICES Group 1. Participation in CHOICES Group 1 is limited to Medicaid Enrollees of all ages who qualify for and are receiving Medicaid-reimbursed NF services. Medicaid eligibility for LTC services is determined by DHS. Medical (or LOC) eligibility is determined by the Bureau as specified in Rule 1200-13-01-.10. Persons in CHOICES Group 1 must be enrolled in TennCare Medicaid and qualify for Medicaid reimbursement of LTC services.

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

3. CHOICES Group 3.

- (i) Participation in CHOICES Group 3 is limited to TennCare Enrollees who qualify for and are receiving TennCare-reimbursed HCBS. To be eligible for CHOICES Group 3, Enrollees must meet the following criteria:
  - (I) Be in one of the defined target populations;
  - (II) Qualify in one of the specified eligibility categories;
  - (III) Be At Risk for Institutionalization as defined in Rule 1200-13-01-.02; and
  - (IV) Have needs that can be safely and appropriately met in the community and at a cost that does not exceed the Expenditure Cap for CHOICES HCBS as defined in Rule 1200-13-01-.02.
- (ii) Target Populations for CHOICES Group 3. Only persons in one of the target populations below may qualify to enroll in CHOICES Group 3:
  - (I) Persons age sixty-five (65) and older.
  - (II) Persons twenty-one (21) years of age and older who have one or more physical disabilities as defined in Rule 1200-13-01-.02.
- (iii) Eligibility Categories served in CHOICES Group 3. Participation in CHOICES Group 3 is limited to TennCare Enrollees who qualify in one of the following eligibility categories:
  - (I) SSI eligibles, who are determined eligible for SSI by the Social Security Administration. SSI eligibles are enrolled in TennCare Medicaid.
  - (II) For Interim CHOICES Group 3 only, the CHOICES At-Risk Demonstration Group, as defined in Rule 1200-13-01-.02. Financial and categorical eligibility are determined by DHS. Persons who qualify in the CHOICES At-Risk Demonstration Group will be enrolled in TennCare Standard. This eligibility category is only open for enrollment between July 1, 2012 and December 31, 2013. Members enrolled in Interim CHOICES Group 3 on December 31, 2013 may continue to qualify in this

group after December 31, 2013, so long as they continue to meet NF financial eligibility criteria and the LOC criteria in place at the time of enrollment into Interim CHOICES Group 3, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group, Interim CHOICES Group 3, and TennCare.

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

(b) Level of Care (LOC).

All Enrollees in TennCare CHOICES must meet the applicable LOC criteria, as determined by the Bureau in accordance with Rule 1200-13-01-.10. Physician certification of LOC shall be required only for NF services.

1. Persons shall meet NF LOC in order to enroll in CHOICES Group 1 or CHOICES Group 2.
2. Persons shall meet At-Risk LOC in order to enroll in CHOICES Group 3, including Interim CHOICES Group 3.
3. Members enrolled in CHOICES Group 1 on June 30, 2012, may continue to qualify in this group after June 30, 2012, so long as they continue to meet NF financial eligibility, continue to meet the NF LOC criteria in place on June 30, 2012, and remain continuously enrolled in CHOICES Group 1 and in TennCare.
4. Members enrolled in CHOICES Group 1 on June 30, 2012, who wish to begin receiving HCBS and transition to CHOICES Group 2 shall, for purposes of LOC, be permitted to do so, so long as they continue to meet the NF LOC criteria in place on June 30, 2012, and have remained continuously enrolled in CHOICES Group 1 and in TennCare since June 30, 2012.
5. Members enrolled in CHOICES Group 2 on June 30, 2012, may continue to qualify in this group after June 30, 2012, so long as they continue to meet NF financial eligibility, continue to meet the NF LOC criteria in place on June 30, 2012, and remain continuously enrolled in CHOICES Group 2 and in TennCare.
6. Members enrolled in CHOICES Group 2 on June 30, 2012, who wish to be admitted to a NF and transition to CHOICES Group 1 shall be required to meet the NF LOC criteria in place at the time of enrollment into CHOICES Group 1 unless a determination has been made by TennCare that the member's needs can no longer be safely met in the community within the member's individual cost neutrality cap, in which case, the person shall meet the NF LOC criteria in place on June 30, 2012, to qualify for enrollment into CHOICES Group 1.

Part 2. of Subparagraph (c) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by inserting the words and number "or CHOICES Group 3" following the words and number "CHOICES Group 2" wherever they appear so that as amended Part (3)(c)2. shall read as follows:

2. Persons in CHOICES Group 2 or CHOICES Group 3 are not required to complete the PASRR process unless they are admitted to a NF for the Short-term NF benefit described in Paragraph (8) of this Rule. Completion of the PASRR process is not required for Members of CHOICES Group 2 or CHOICES Group 3 who have elected the Inpatient Respite Care benefit described in Paragraph (8) of this Rule, since the service being provided is not NF services, but rather, Inpatient Respite Care, which is an HCBS.

Subparagraph (d) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the hyphen "-" between the words "Medicaid-reimbursement" and inserting the words and number "or CHOICES Group 3" following the words and number "CHOICES Group 2" so that as amended Subparagraph (3)(d) shall read as follows:

- (d) All Enrollees in TennCare CHOICES must be admitted to a NF and require Medicaid reimbursement of NF services or be receiving HCBS in CHOICES Group 2 or CHOICES Group 3.

The introductory Subparagraph (e) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the phrase "the AAAD or" after the words "determined by" and the words and commas ", as applicable," after the word "MCO" in the first sentence so as amended the introductory Subparagraph (e) shall read as follows:

- (e) All Enrollees in TennCare CHOICES Group 2 must be determined by the MCO to be able to be served safely and appropriately in the community and within their individual cost-neutrality cap, in accordance with this Rule. If a person can be served safely and appropriately in the community and within their individual cost-neutrality cap only through receipt of Companion Care services, the person may not be enrolled into CHOICES until a qualified companion has been identified, an adequate back-up plan has been developed, and the companion has completed all required paperwork and training and is ready to begin delivering Companion Care services immediately upon the person's enrollment into CHOICES. Reasons a person cannot be served safely and appropriately in the community may include, but are not limited to, the following:

Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Subparagraph (f) and re-lettering the current Subparagraph (f) as (g) so as amended Subparagraph (f) shall read as follows:

- (f) All Enrollees in TennCare CHOICES Group 3 must be determined by the MCO to be able to be served safely and appropriately in the community within the array of services and supports available in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of \$15,000 (excluding the cost of minor home modifications), non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers. Reasons a person cannot be served safely and appropriately in the community may include, but are not limited to, the following:
  - 1. The home or home environment of the applicant is unsafe to the extent that it would reasonably be expected that HCBS could not be provided without significant risk of harm or injury to the person or to individuals who provide covered services.
  - 2. The applicant or his caregiver is unwilling to abide by the POC, resulting in the inability to ensure the person's health, safety and welfare.

Part 5. of re-lettered Subparagraph (g) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the phrase "Paragraph (7)(j)" and replacing it with the phrase "Paragraph (8)(l)" so that as amended Part 5. shall read as follows:

- 5. During the period of Immediate Eligibility, individuals are eligible only for the limited package of HCBS identified in Paragraph (8)(l). They are not eligible for any other TennCare services, including other LTC services.

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

- 2. Have an approved unexpired CHOICES PAE for Level 1 reimbursement of NF services, Level 2 reimbursement of NF services, or Enhanced Respiratory Care Reimbursement for services in a NF. Eligibility for Enhanced Respiratory Care Reimbursement may be established only with a CHOICES PAE.

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

- 2. An individual must have an approved unexpired CHOICES PAE for NF LOC;
- 3. An individual must be approved by DHS for reimbursement of LTC services as an SSI recipient or in the CHOICES 217-Like Group. To be eligible in the CHOICES 217-Like Group, an individual must be approved by TennCare to enroll in CHOICES Group 2 or be approved by the Bureau for Immediate Eligibility for CHOICES Group 2, subject to categorical and financial eligibility by DHS;

4. The Bureau must have received a determination by the MCO that the individual's needs can be safely and appropriately met in the community, and at a cost that does not exceed his Individual Cost Neutrality Cap, as described in this Rule, except in instances where the person is not eligible for TennCare at the time of CHOICES application, in which case, such determination shall be made by the MCO upon enrollment into CHOICES Group 2; and

Subpart (iii) of Part 1. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "cost of" in the first and second sentences so as amended Subpart (iii) shall read as follows:

- (iii) The total cost of CHOICES HCBS, HH Services, and PDN Services he can receive while enrolled in CHOICES Group 2. The Member's Individual Cost Neutrality Cap functions as a limit on the total cost of CHOICES HCBS that, when combined with the cost of HH Services and PDN Services the Member will receive, can be provided to the Member in the home or community setting.

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

- (i) The annual cost neutrality cap shall be applied on a calendar year basis. The Bureau and the MCOs will track utilization of CHOICES HCBS, HH services, and PDN services across each calendar year.

Subpart (ii) of Part 4. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "of all" in the third sentence and after the words "cost of" in the last sentence so as amended Subpart (ii) shall read as follows:

- (ii) A Member's Individual Cost Neutrality Cap must be applied prospectively on a twelve (12) month basis. This is to ensure that a Member's POC does not establish a threshold level of supports that cannot be sustained over the course of time. This means that, for purposes of care planning, the MCO will always project the total cost of all CHOICES HCBS (including one-time costs such as Minor Home Modifications, short-term services or short-term increases in services) and HH and PDN Services forward for twelve (12) months in order to determine whether the Member's needs can continue to be safely and cost-effectively met based on the most current POC that has been developed. The cost of one-time services such as Minor Home Modifications, short-term services or short-term increases in services must be counted as part of the total cost of CHOICES HCBS for a full twelve (12) month period following the date of service delivery.

Subpart (iii) of Part 4. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "on the" so as amended Subpart (iii) shall read as follows:

- (iii) If it can be reasonably anticipated, based on the CHOICES HCBS, HH and PDN services currently received or determined to be needed in order to safely meet the person's needs in the community, that the person will exceed his cost neutrality cap, then the person does not qualify to enroll in or to remain enrolled in CHOICES Group 2.

Item (I) of Subpart (ii) of Part 5. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "reduction in" so as amended Item (I) shall read as follows:

- (I) Denial of or reductions in CHOICES HCBS based on a Member's Cost Neutrality Cap shall constitute an adverse action under the Grier Revised Consent Decree (Modified) (See Rules 1200-13-13-.01(4) and 1200-13-14-.01(4)), and shall give rise to Grier notice of action and due process rights to request a fair hearing in accordance with Rules 1200-13-13-.11 and 1200-13-14-.11.

Part 1. of Subparagraph (d) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Subpart (iv) which shall read as follows:

- (iv) Effective July 1, 2012, the Enrollment Target for CHOICES Group 2 will be twelve thousand five hundred (12,500).

Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding new Subparagraphs (e), (f), and (g) which shall read as follows:

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

- (ii) A Member's Expenditure Cap must also be applied prospectively on a twelve (12) month basis. This is to ensure that a Member's POC does not establish a threshold level of supports that cannot be sustained over the course of time. This means that, for purposes of care planning, the MCO will always project the total cost of CHOICES HCBS (excluding minor home modifications) forward for twelve (12) months in order to determine whether the Member's needs can continue to be met based on the most current POC that has been developed. The cost of one-time services such as short-term services or short-term increases in services must be counted as part of the total cost of CHOICES HCBS for a full twelve (12) month period following the date of service delivery.
  - (iii) If it can be reasonably anticipated, based on the CHOICES HCBS currently received or determined to be needed (in addition to non-CHOICES HCBS available through TennCare, e.g., home health, services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers) in order to safely meet the person's needs in the community, that the person will exceed his Expenditure Cap, then the person does not qualify to enroll in or to remain enrolled in CHOICES Group 3.
  - (iv) Any short-term NF services received by a member enrolled in CHOICES Group 3 shall not be counted against his Expenditure Cap.
- (g) Enrollment Target for CHOICES Group 3 (including Interim CHOICES Group 3).
1. The State may establish an Enrollment Target for CHOICES Group 3 which shall be at least ten (10) percent of the Enrollment Target established by the State for CHOICES Group 2.
  2. Notwithstanding any Enrollment Target established for CHOICES Group 3 as described in this subparagraph, Interim CHOICES Group 3 which is open for enrollment between July 1, 2012, and December 31, 2013, shall not be subject to an Enrollment Target.

Part 2. of Subparagraph (b) of Paragraph (5) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Part 2. which shall read as follows:

2. The Member's needs can no longer be safely met in the community at a cost that does not exceed the Member's Cost Neutrality Cap or Expenditure Cap, as appropriate and as described in this Rule.

Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Paragraph (6) and renumbering the current Paragraph (6) as (7) and all subsequent Paragraphs accordingly so as amended Paragraph (6) shall read as follows:

- (6) Advance Determinations that an Applicant Would Not Qualify to Enroll in CHOICES Group 3 (including Interim CHOICES Group 3).
- (a) For purposes of the Need for Inpatient Nursing Care, Effective July 1, 2012, as specified in TennCare Rule 1200-13-01-.10(4)(c)(2)(i)(II) and 1200-13-01-.10(4)(c)(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 such 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 Medicaid eligible members 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 long-term care services 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 long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health, safety and welfare in the community and to prevent the need for institutional placement. Such assessment shall specify the specific tasks and functions for which assistance is needed by the member, the frequency with which such tasks must be performed, and the amount of paid assistance necessary to perform these tasks;
  2. A person-centered plan of care developed by the MCO Care Coordinator which specifies the CHOICES HCBS that would be necessary and that would be approved by the MCO to safely support the person in the community, as well as non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers (or attestation that the person could not be safely supported in the community with *any* combination of services and supports, as applicable);
  3. An explanation regarding why an array of covered services and supports, including CHOICES HCBS within the \$15,000 expenditure cap for CHOICES 3 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.

Paragraph (6) renumbered as Paragraph (7) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new renumbered Paragraph (7) which shall read as follows:

(7) Transitioning Between CHOICES Groups.

(a) Transition from Group 1 to Group 2.

- 1. An MCO may request to transition a Member from Group 1 to Group 2 only when the Member chooses to transition from the NF to an HCBS setting. Members shall not be required to transition from Group 1 to Group 2.
- 2. When Members move from Group 1 to Group 2, DHS must recalculate the Member's Patient Liability based on the Community PNA.

(b) Transition from Group 2 to Group 1.

- 1. An MCO may request to transition a Member from Group 2 to Group 1 only under the following circumstances:
  - (i) Except as provided in TennCare Rule 1200-13-01-.05(3)(b)(6), the member meets the NF LOC criteria in place at the time of enrollment into CHOICES Group 1, and at least one (1) of the following is true;
    - (I) The Member chooses to transition from HCBS to NF, for example, due to a decline in the Member's health or functional status, or a change in the Member's natural caregiving supports; or
    - (II) The MCO has made a determination that the Member's needs can no longer be safely met in the community and at a cost that does not exceed the average cost of NF services for which the Member would qualify, and the Member chooses to transition to the more appropriate institutional setting in order to safely meet his needs.
  - (ii) When Members move from Group 2 to Group 1, DHS must recalculate the Member's Patient Liability based on the Institutional PNA.

- (c) At such time as a transition between CHOICES Groups 1 and 2 is made, the MCO shall issue notice of transition to the Member. Because the Member has elected the transition and remains enrolled in CHOICES, such transition between CHOICES groups shall not constitute an adverse action. Thus, the notice will not include the right to appeal or request a fair hearing regarding the Member's decision.
- (d) Transition from CHOICES Group 1 or CHOICES Group 2 to CHOICES Group 3.
  1. The State or the MCO shall, subject to eligibility and enrollment criteria set forth in TennCare Rule 1200-13-01-.05(3) and (4), initiate a transition from Group 1 or from Group 2 to Group 3 when a member who was enrolled in CHOICES Group 1 or Group 2 on or after July 1, 2012, no longer meets NF LOC, but is At Risk for Institutionalization as defined in Rule 1200-13-01-.02.
  2. When a Member transitions from CHOICES Group 1 to Group 3, DHS must recalculate the Member's Patient Liability based on the Community PNA.
- (e) Transition from CHOICES Group 3 to CHOICES Group 1 or CHOICES Group 2.
  1. The State or the MCO shall initiate a transition from Group 3 to Group 1 or Group 2, as appropriate, when the Member meets NF LOC in place at the time of the transition request and satisfies all requirements for enrollment into the requested Group.
  2. When a member transitions from Group 3 to Group 1, DHS must recalculate the Member's Patient Liability based on the Institutional PNA.

Subparagraph (c) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the word "receive" so as amended Subparagraph (c) shall read as follows:

- (c) Members of CHOICES Group 2 who are Medicaid eligible receive CHOICES HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Medicaid recipients, as specified in Rule 1200-13-13-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.

Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding new Subparagraphs (e) and (f) and the current Subparagraphs (e) and (f) are re-lettered as Subparagraphs (g) and (h) and subsequent subparagraphs are re-lettered accordingly so as amended the new Subparagraphs (e) and (f) shall read as follows:

- (e) Members of CHOICES Group 3 who are SSI Eligible receive HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Medicaid recipients, as specified in Rule 1200-13-13-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.
- (f) Members of CHOICES Group 3 who are eligible for TennCare Standard in the CHOICES At-Risk Demonstration Group receive HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Standard recipients, as specified in Rule 1200-13-14-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.

Subparagraph (h) re-lettered as (j) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new re-lettered Subparagraph (j) which shall read as follows:

- (j) All LTC services, NF services as well as HCBS, must be authorized by the MCO in order for MCO payment to be made for the services. An MCO may elect to accept the Bureau's PAE determination as its prior authorization for NF services. NF care may sometimes start before authorization is obtained, but payment will not be made until the MCO has authorized the service. HCBS must be

specified in an approved POC and authorized by the MCO prior to delivery of the service in order for MCO payment to be made for the service.

Subparagraph (i) re-lettered as (k) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" at the beginning of the first sentence and replacing "(h)" in the third sentence with "(j)" so as amended re-lettered Subparagraph (k) shall read as follows:

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

Parts 3., 6., 9., 10. and 13. of Subparagraph (i) re-lettered as Subparagraph (k) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with new Parts 3., 6., 9., 10. and 13., and Subparagraph (k) is also amended by adding a new Table for "Benefits for CHOICES 3 Members":

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction  ("Eligible HCBS")	Benefits for Immediate Eligibles  ("Specified HCBS")
3. Attendant Care	<p>Covered only for persons who require hands-on assistance with ADLs when needed for more than 4 hours per occasion or visits at intervals of less than 4 hours between visits.</p> <p>For Members who do not require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1080 hours per calendar year, per Member.</p> <p>For Members who require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1240 hours for calendar year 2012, per Member.</p> <p>For Members who require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, beginning January 1, 2013, covered with a limit of 1400 hours per calendar year, per Member.</p> <p>Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.</p>	Yes	Yes

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
6. Homemaker Services	<p>*Covered only for members who also need hands-on assistance with ADLs and as a component of Attendant Care or Personal Care Visits as defined in these rules.</p> <p>Not covered as a stand-alone benefit.</p> <p>Not covered for persons who do not require hands-on assistance with ADLs.</p> <p>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.</p>	*	*
9. Minor Home Modifications	<p>Covered with a limit of \$6,000 per project, \$10,000 per calendar year, and \$20,000 per lifetime.</p> <p>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care, except when provided as a CEA to facilitate transition from a NF to the community. See Rule 1200-13-01-.05(8)(o).</p>	No	N/A
10. Personal Care Visits	<p>Covered with a limit of 2 intermittent visits per day, per Member; visits limited to a maximum of 4 hours per visit and there shall be at least four (4) hours between intermittent visits.</p> <p>Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.</p>	Yes	Yes
13. Short-Term NF Care	<p>Covered with a limit of 90 days per stay, per Member.</p> <p>Approved PAE and PASRR required.</p> <p>Members receiving Short-Term NF Care are not eligible to receive any other HCBS except when permitted as a CEA to facilitate transition to the community. See Rule 1200-13-01-.05(8)(o).</p>	No	N/A

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction  ("Eligible HCBS")	Benefits for Immediate Eligibles  ("Specified HCBS")
1. Adult Day Care	Covered with a limit of 2080 hours per calendar year, per CHOICES Member.	No	N/A
2. Assistive Technology	Covered with a limit of \$900 per calendar year, per Member.	No	N/A
3. Attendant Care	<p>Covered only for persons who require hands-on assistance with ADLs when needed for more than 4 hours per occasion or visits at intervals of less than 4 hours between visits.</p> <p>For Members who do not require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1080 hours per calendar year, per Member.</p> <p>For Members who require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1240 hours for calendar year 2012, per Member.</p> <p>For Members who require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, beginning January 1, 2013, covered with a limit of 1400 hours per calendar year, per Member.</p> <p>Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.</p>	Yes	N/A
4. Home-Delivered Meals	<p>Covered with a limit of 1 meal per day, per Member.</p> <p>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.</p>	No	N/A
5. Homemaker Services	<p>*Covered only for members who also need hands-on assistance with ADLs and as a component of Attendant Care or Personal Care Visits as defined in these rules.</p> <p>Not covered as a stand-alone benefit.</p> <p>Not covered for persons who do not require hands-on assistance with ADLs.</p> <p>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.</p>	*	*
6. In-Home Respite Care	<p>Covered with a limit of 216 hours per calendar year, per Member.</p> <p>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.</p>	Yes	N/A

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")	Benefits for Immediate Eligibles ("Specified HCBS")
7. Inpatient Respite Care	Covered with a limit of 9 days per calendar year, per Member.  PAE and PASRR approval not required.  Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.	No	N/A
8. Minor Home Modifications	Covered with a limit of \$6,000 per project, \$10,000 per calendar year, and \$20,000 per lifetime.  Not covered when the Member is receiving CBRA facility services or Short-Term NF Care, except when provided as a CEA to facilitate transition from a NF to the community. See Rule 1200-13-01-.05(8)(o).	No	N/A
9. Personal Care Visits	Covered with a limit of 2 intermittent visits per day, per Member; visits limited to a maximum of 4 hours per visit and there shall be at least four (4) hours between intermittent visits.  Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.	Yes	N/A
10. PERS	Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.	No	N/A
11. Pest Control	Covered with a limit of 9 treatment visits per calendar year, per Member.  Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.	No	N/A
12. Short-Term NF Care	Covered with a limit of 90 days per stay, per Member.  Approved PAE and PASRR required.  Members receiving Short-Term NF Care are not eligible to receive any other HCBS except when permitted as a CEA to facilitate transition to the community. See Rule 1200-13-01-.05(8)(o).	No	N/A

Part 3. Homemaker Services of Subparagraph (j) re-lettered as Subparagraph (l) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and subsequent parts renumbered accordingly.

Introductory Subparagraph (j) re-lettered as Subparagraph (l) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the phrase "Subparagraph (j)" and replacing it with the phrase "Subparagraph (k)" so that as amended introductory Subparagraph (l) shall read as follows:

- (l) Applicants who qualify as "Immediate Eligibles" are eligible only for certain HCBS covered under CHOICES. They are not eligible for any other TennCare benefits, including other CHOICES benefits. These HCBS, called Specified HCBS, are listed below. The limits are the same as those specified in Subparagraph (k) above. When the limit is an annual limit, the services used in the Immediate Eligibility period count against the annual limit if the applicant should become eligible for TennCare.

Introductory paragraph of Subparagraph (m) re-lettered as Subparagraph (o) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "or CHOICES 3" after the number two "2" in the first sentence so as amended the introductory Subparagraph (o) shall read as follows:

- (o) Transition Allowance. For CHOICES Members moving from CHOICES 1 to CHOICES 2 or CHOICES 3, the MCO may, at its sole discretion, provide a Transition Allowance not to exceed two thousand dollars (\$2,000) per lifetime as a CEA to facilitate transition of the Member from the NF to the community. Items that may be purchased or reimbursed are limited to the following:

Introductory Subparagraph (a) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "and CHOICES Group 3" after the word and number "Group 2" so as amended introductory Subparagraph (a) shall read as follows:

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

Parts 3. and 4. of Subparagraph (a) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with new Parts 3. and 4. which shall read as follows:

3. Upon completion of the comprehensive needs assessment, CHOICES Members determined to need Eligible CHOICES HCBS may elect to receive one or more of the Eligible CHOICES HCBS through a Contract Provider, or they may participate in CD. Companion Care is available only through CD.
4. CHOICES Members who do not need Eligible CHOICES HCBS shall not be offered the opportunity to enroll in CD.

Introductory Subparagraph (b) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Introductory Subparagraph (b) which shall read as follows:

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

Subpart (ii) of Part 1. of Subparagraph (b) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subpart (ii) which shall read as follows:

- (ii) Companion Care (available only to Members electing CD and in CHOICES Group 2; not available to CHOICES Group 3 members).

Subpart (iii) Homemaker Services of Part 1. of Subparagraph (b) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and subsequent parts renumbered accordingly.

Part 1. of Subparagraph (c) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "or CHOICES Group 3" at the end of the sentence so as amended Part 1. shall read as follows:

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

Part 1. of Subparagraph (d) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Part 1. which shall read as follows:

1. A CHOICES Group 2 or CHOICES Group 3 Member assessed to need one or more Eligible CHOICES HCBS may elect to participate in CD at any time.

Subpart (i) of Part 1. of Subparagraph (f) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "or CHOICES Group 3" at the end of the sentence so as amended Subpart (i) shall read as follows:

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

Subpart (ii) of Part 1. of Subparagraph (i) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the words and comma "Homemaker Services," in the third sentence so as amended Subpart (ii) shall read as follows:

- (ii) Members may hire family members, excluding spouses, to serve as Workers. However, a family member shall not be reimbursed for a service that he would have otherwise provided without pay. A member shall not be permitted to employ any person who resides with the member to deliver Personal Care Visits, Attendant Care, or In-Home Respite Care. A Member or his Representative for CD shall not be permitted to employ either of the following to deliver Companion Care services:

Part 1. of Subparagraph (j) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "or CHOICES Group 3" after the word and number "Group 2" so as amended Part 1. shall read as follows:

1. A Competent Adult, as defined in this Chapter, with a functional disability living in his own home, enrolled in CHOICES Group 2 or CHOICES Group 3, and participating in CD, or his Representative for CD, may choose to direct and supervise a Consumer-Directed Worker in the performance of a Health Care Task as defined in this Chapter.

Part 3. of Subparagraph (j) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "delivering Eligible" so as amended Part 3. shall read as follows:

3. A Member shall not receive additional amounts of any service as a result of his decision to self-direct health care tasks. Rather, the Health Care Tasks shall be performed by the Worker in the course of delivering Eligible CHOICES HCBS already determined to be needed, as specified in the POC.

Part 7. of Subparagraph (j) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the word "eligible" in the first sentence so as amended Part 7. shall read as follows:

7. The Member or his Representative for CD will identify one or more Consumer-Directed Workers who will perform the task in the course of delivery of eligible CHOICES HCBS. If a Worker agrees to perform the Health Care Tasks, the tasks to be performed must be specified in the Service Agreement. The Member or his Representative for CD is solely responsible for identifying a Worker who is willing to perform Health Care Tasks, and for instructing the paid personal aide on the task(s) to be performed.

Subpart (iii) of Part 1. of Subparagraph (k) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the word "Eligible" in the first sentence so as amended Subpart (iii) shall read as follows:

- (iii) If a Member voluntarily withdraws or is involuntarily withdrawn from CD, any Eligible CHOICES HCBS he receives, with the exception of Companion Care, shall be provided

through Contract Providers, subject to the requirements in this Chapter. Companion Care is only available through CD.

Item (II) of Subpart (i) of Part 2. of Subparagraph (k) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Item (II) which shall read as follows"

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

Subparagraph (c) of Paragraph (11) renumbered as Paragraph (12) of Rule 1200-13-01-.05 TennCare CHOICES program is amended by deleting the words "Rule 1200-13-01-.10(6)" after the words "in accordance with" and replacing them with the words "Rule 1200-13-01-.10(7)" so that as amended Subparagraph (c) shall read as follows:

- (c) Appeals related to the PAE process (including decisions pertaining to the PASRR process) are processed by the Bureau's Division of Long-Term Care in accordance with Rule 1200-13-01-.10(7).

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

Subparagraph (b) of Paragraph (1) of Rule 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC is deleted in its entirety and replaced with a new Subparagraph (b) which shall read as follows:

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

Subparagraphs (c) and (d) of Paragraph (2) of Rule 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC are deleted in their entirety and replaced with new Subparagraphs (c) and (d) which shall read as follows:

- (c) For Members of the CHOICES 217-Like Group and the CHOICES At-Risk Demonstration Group, the State uses institutional eligibility and post-eligibility rules for determining Patient Liability in the same manner as specified under 42 C.F.R. §§ 435.217, 435.236, and 435.726 and Section 1924 of the Social Security Act (42 U.S.C.A. § 1396r-5), if the HCBS were provided under a Section 1915(c) Waiver.
- (d) For a Member of CHOICES Group 2 or CHOICES Group 3 receiving the Short-Term NF Care benefit (for up to 90 days) or an Enrollee in one of the State's Section 1915(c) Waiver programs who is temporarily placed in a medical institution, i.e., a hospital, NF or ICF/MR (for up to 90 days), the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. The purpose is to ensure that the individual can maintain a community residence for transition back to the community. After 90 days, or as soon as it appears that the inpatient stay will not be a short-term stay, whichever comes first, a CHOICES Group 2 or CHOICES Group 3 Member will be transitioned to CHOICES Group 1, or a waiver participant must be disenrolled from the waiver, and the institutional post-eligibility calculation shall apply.

Part 2. of Subparagraph (e) of Paragraph (2) of Rule 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC is deleted in its entirety and replaced with a new Part 2. which shall read as follows:

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

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

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

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

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

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

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

1. When a Medicaid Eligible is admitted to a NF for receipt of Medicaid-reimbursed NF Services.
2. When a private-paying resident of a NF attains Medicaid Eligible status.
3. When Medicare reimbursement for SNF services has ended and Medicaid Level 2 reimbursement for services is requested.
4. When a NF Eligible is changed from Medicaid Level 1 to Medicaid Level 2 reimbursement, or from Medicaid Level 1 or Level 2 reimbursement to a Chronic Ventilator or Tracheal Suctioning Enhanced Respiratory Care rate, except as specified in Rule 1200-13-01-.10(5)(f).
5. When a NF Eligible is changed from Medicaid Level 2 reimbursement or an Enhanced Respiratory Care rate to Medicaid Level 1 reimbursement, unless the individual has an approved unexpired Level 1 PAE.
6. When a NF Eligible is changed from an Enhanced Respiratory Care rate to Medicaid Level 2 reimbursement, unless the individual has an approved unexpired Level 2 PAE.
7. When a NF Eligible requires continuation of the same LOC beyond the expiration date assigned by the Bureau.
8. When a NF Eligible no longer requires the specific skilled nursing or rehabilitative services for which a Level 2 PAE was approved but requires other Level 2 care in a NF.

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

1. When a CHOICES member transfers from one Nursing Facility to another such facility.
2. When a CHOICES member discharges to the hospital (even when readmission to the NF is expected following the hospital stay).
3. When a CHOICES member elects to receive hospice services (even if Medicare will be responsible for payment of the hospice benefit).
4. When a CHOICES member discharges home, with or without HCBS. In this case, the NF is obligated to notify the MCO before the member is discharged from the facility and to coordinate with the MCO in discharge planning in order to ensure that any home and community based services needed by the member will be available upon discharge, and to avoid a lapse in CHOICES and/or TennCare eligibility.
5. Upon the death of a CHOICES member.

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

1. When a Medicaid Eligible with an approved unexpired Level 1 PreAdmission Evaluation returns to the Nursing Facility after being hospitalized.
2. When a Medicaid Eligible with an approved unexpired Level 2 PreAdmission Evaluation returns to the Nursing Facility after being hospitalized, if there has been no change in the skilled nursing or rehabilitative service for which the PreAdmission Evaluation was approved.
3. When a Medicaid Eligible changes from Level 2 to Level 1 NF reimbursement and has an approved unexpired Level 1 PreAdmission Evaluation.
4. To receive Medicaid co-payment when Medicare is the primary payer of Skilled Nursing Facility care.
5. When a Discharge/Transfer/Hospice Form is appropriate in accordance with (2)(b).
6. For authorization by an MCO of Ventilator Weaning services or short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention. Medical necessity determinations and authorization of Ventilator Weaning services and short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate during the post-weaning period will be managed by the Enrollee's MCO.
7. When a person will be receiving hospice services in the NF.

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

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

1. A PAE that is not used within 365 days of the PAE Approval Date shall expire and shall not be updated.
2. A PAE shall also expire upon the person's discharge from a NF, unless:
  - (i) The person transfers to another NF.
  - (ii) The person is discharged to the hospital and returns directly to the NF or to another NF.
  - (iii) The person is discharged home for therapeutic leave and returns to the NF within no more than ten (10) days.

- (iv) The person is discharged home and a request to transition to CHOICES Group 2 is submitted by the MCO to TennCare prior to the person's discharge from the NF.
3. For persons electing hospice:
- (i) If a person receiving NF services elects to receive hospice, is disenrolled from CHOICES Group 1, and subsequently withdraws the hospice election and wishes to re-enroll in CHOICES Group 1, the approved PAE may be used so long as:
    - (I) the person has remained in the NF;
    - (II) the person's condition has not changed;
    - (III) no more than thirty (30) days have lapsed since the person's disenrollment from CHOICES Group 1; and
    - (IV) NF LOC criteria have not changed.
  - (ii) If the person's condition has changed or if more than thirty (30) days have lapsed since the person's disenrollment from CHOICES Group 1, a new PAE shall be required.
  - (iii) If the PAE effective date was prior to July 1, 2012, a new PAE must be submitted and the person must qualify based on the new NF LOC criteria in place as of July 1, 2012.
- (f) A PAE must include a recent history and physical or current medical records that support the applicant's functional and/or skilled nursing or rehabilitative needs, as reflected in the PAE. A history and physical performed within 365 calendar days of the PAE Request Date may be used if the patient's condition has not significantly changed. Medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed, or may be used in lieu of a history and physical, so long as the records provide medical evidence sufficient to support the functional and/or skilled or rehabilitative needs reflected in the PAE.
- (g) A PAE must be certified as follows:
1. Physician certification shall be required for reimbursement of NF services and enrollment into CHOICES Group 1. Consistent with requirements pertaining to certification of the need for SNF care set forth at 42 CFR § 424.20, certification of the need for NF care may be performed by a nurse practitioner or clinical nurse specialist, neither of whom has a direct or indirect employment relationship with the facility but who is working in collaboration with a physician.
  2. Certification of the level of care assessment by a Qualified Assessor shall be required for all PAEs.
- (h) A PAE may be approved by the Bureau for a fixed period of time with an expiration date based on an assessment by the Bureau of the individual's medical condition and anticipated continuing need for inpatient nursing care. Notice of appeal rights shall be provided when a PAE is approved with an expiration date.
- (i) PASRR
1. All individuals who reside in or seek admission to a Medicaid-certified Nursing Facility must have a PASRR Level I screen for mental illness and mental retardation. The initial Level I screen must be completed prior to admission to the Nursing Facility and submitted to TennCare regardless of:
    - (i) payer source;
    - (ii) whether the PASRR screening is positive or negative (including specified exemptions); and
    - (iii) the level of nursing facility reimbursement requested.

2. If the Level I screen indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness and/or mental retardation, the individual must undergo the PASRR Level II evaluation prior to admission to the Nursing Facility.
- (j) Medicaid payment will not be available for any dates of Nursing Facility services rendered prior to the date the PASRR process is complete and the individual has been determined appropriate for nursing home placement. The PASRR process is complete when either:
1. TennCare has received a negative Level I PASRR screen form and no contradictory information is subsequently received; or
  2. For persons with a positive Level I PASRR screen (as submitted or upon review and determination by the Bureau), the Bureau has received a certified exemption or advance categorical determination signed by the physician; or a determination by DMH and/or DIDD, as applicable, that the person is appropriate for NF placement. Determination by the Bureau that a Level II PASRR evaluation must be performed may be made:
    - (i) Upon receipt of a positive PASRR screen from the NF or other submitting entity;
    - (ii) Based on TennCare review of a negative PASRR screening form or history and physical submitted by a NF or other entity; or
    - (iii) Upon review of any contradictory information submitted in the PAE application or supporting documentation at any time prior to disposition of the PAE.
- (k) A NF that has entered into a provider agreement with a TennCare MCO shall assist a resident or applicant as follows:
1. The Nursing Facility shall assist a Nursing Facility resident or an applicant for admission in applying for Medicaid eligibility and in applying for Medicaid-reimbursed Nursing Facility care. This shall include assistance in properly completing all necessary paperwork and in providing relevant Nursing Facility documentation to support the PreAdmission Evaluation. Reasonable accommodations shall be made for an individual with disabilities or, alternatively, for a designated Correspondent with disabilities when assistance is needed with the proper completion and submission of a PreAdmission Evaluation.
  2. The Nursing Facility shall request a Notice of Disposition or Change from the Department of Human Services upon learning that a resident or applicant has, or is likely to have, applied for Medicaid eligibility.
- (l) The Bureau shall process PAEs independently of determinations of Medicaid eligibility by DHS; however, Medicaid reimbursement for NF care shall not be available until the PASRR process has been completed, and both the PAE and financial eligibility have been approved.
- (3) Medicaid Reimbursement
- (a) A NF that has entered into a provider agreement with a TennCare MCO is entitled to receive Medicaid reimbursement for covered services provided to a NF Eligible if:
1. The Nursing Facility has completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.
  2. The Bureau has received an approvable PAE for the individual 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 Pre Admission Evaluation System (TPAES) a Medicaid

Only Payer Date.

4. The person has been enrolled into CHOICES Group 1.
  5. For a retroactive eligibility determination, the Bureau has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired PAE within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change, so long as the person has remained in a NF since the PAE was completed (except for short-term hospitalization). The effective date of payment for NF services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE that has been updated.
  6. If the NF participates in the Enrollee's MCO, reimbursement will be made by the MCO to the NF as a Network Provider. If the NF does not participate in the Enrollee's MCO, reimbursement will be made by the MCO to the NF as a non-participating provider, in accordance with Rule 1200-13-01-.05(10).
- (b) Any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.
1. Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no more than ten (10) days prior to the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application.
  2. Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for nursing facility services.
- (c) The earliest date of Medicaid reimbursement for care provided in a Nursing Facility shall be the date that all of the following criteria are met:
1. Completion of the PASRR process, as defined in 1200-13-01-.10(2)(i) above;
  2. The effective date of level of care eligibility as reflected by the PAE Approval Date;
  3. The effective date of Medicaid eligibility;
  4. The date of admission to the Nursing Facility; 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. Advance determination by TennCare that a person not enrolled in TennCare at the time the PAE is submitted cannot be safely supported within the array of services and supports that would be available if the person were enrolled in CHOICES 3 and approval of NF LOC shall be effective for no more than thirty (30) days, pending a comprehensive assessment and plan of care developed by the MCO Care Coordinator once the person 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 subsequently 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 made.

(e) Application of new LOC Criteria

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

1. It is the date of enrollment into CHOICES and not the date of PAE submission, approval, or the PAE effective date which determines the LOC criteria that must be applied.
2. TennCare may, at its discretion, review a PAE that had been reviewed and approved based on the NF LOC criteria in place as of June 30, 2012, to determine whether a person who will be enrolled into CHOICES on or after July 1, 2012, meets the new LOC criteria. However, all persons enrolled into CHOICES with an effective date of enrollment on or after July 1, 2012, shall meet the criteria in place at the time of enrollment, and in accordance with these rules.

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

(g) Medicaid reimbursement will only be made to a Nursing Facility on behalf of the Nursing Facility Eligible and not directly to the Nursing Facility Eligible.

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

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

(a) The Nursing Facility must have completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.

(b) The individual must be determined by DHS to be eligible for Medicaid reimbursement for NF care.

(c) An individual must meet both of the following criteria in order to be approved:

1. Medical Necessity of Care:

(i) Persons requesting Medicaid-reimbursed NF care

Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.

(ii) Persons requesting HCBS in CHOICES or PACE

HCBS must be required in order to allow the person to continue living safely in the home or community-based setting and to prevent or delay placement in a nursing facility, and such HCBS must be specified in an approved plan of care and needed on an ongoing basis.

(l) 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 nursing facility.

2. Need for Inpatient Nursing Care:

- (i) Persons requesting care in a Nursing Facility

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

- (I) Have a total score of at least nine (9) on the TennCare NF LOC Acuity Scale; or
- (II) Meet one or more of the ADL or related criteria specified in 1200-13-01-10(4)(c)(2)(iii) on an ongoing basis and be determined by TennCare to not qualify for enrollment in CHOICES Group 3 (see TennCare Rule 1200-13-01-.05).

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

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

- (I) Have a total score of at least nine (9) on the TennCare NF LOC Acuity Scale; or
- (II) Meet one (1) or more of the ADL or related criteria specified in 1200-13-01-10(4)(c)(2)(iii) on an ongoing basis and be determined by TennCare to not qualify for enrollment in CHOICES Group 3 (see TennCare Rule 1200-13-01-.05).

- (iii) Persons not eligible to receive care in a NF, but at risk of NF placement and requesting HCBS in CHOICES Group 3, including Interim CHOICES Group 3.

The individual must have a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. In the absence of ongoing CHOICES HCBS, the person 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 capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance. The individual must be unable to self-perform needed nursing care and must meet one (1) or more of the following criteria on an ongoing basis:

- (I) Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or at least four days per week).
- (II) Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or at least four days per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the

ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

- (III) Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth (daily or at least four days per week). Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.
  - (IV) Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or at least four days per week).
  - (V) Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual intervention (daily or at least four days per week).
  - (VI) Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility) daily or at least four days per week.
  - (VII) Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications (daily or at least four days per week) despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.
  - (VIII) Behavior - The individual requires persistent intervention (daily or at least four days per week) due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement).
  - (IX) Skilled Nursing or Rehabilitative Services - The individual 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.
- (d) For continued Medicaid reimbursement of care in a Nursing Facility, an individual must continue to be financially eligible for Medicaid reimbursement for Nursing Facility Care and must continue to meet NF LOC (including medical necessity of care and the need for inpatient care) in place at the time of enrollment into CHOICES Group 1.
  - (e) A Nursing Facility Eligible admitted to a Nursing Facility and to CHOICES Group 1 prior to July 1, 2012, who continues to meet the LOC criteria in place at the time of enrollment into CHOICES Group 1 shall continue to meet NF LOC for purposes of enrolling in CHOICES Group 2, subject to requirements set forth in 1200-13-01-.05(3).
  - (f) A Nursing Facility Eligible receiving HCBS in CHOICES Group 2 prior to July 1, 2012, shall be required to meet the NF LOC in place as of July 1, 2012, in order to qualify for Medicaid-reimbursed NF care unless TennCare determines that the person's needs can no longer be safely and cost-effectively met in CHOICES Group 2.
- (5) Criteria for Medicaid Level 2 and Enhanced Respiratory Care Reimbursement of Care in a Nursing Facility
    - (a) The Nursing Facility must have completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.

- (b) The individual must be determined by DHS to be eligible for Medicaid reimbursement for NF care.
- (c) An individual must meet both of the following criteria in order to be approved for Medicaid Level 2 reimbursement of care in a Nursing Facility:

1. The individual must meet NF LOC as defined in 1200-13-01-.10(4) above.
2. Need for Inpatient Skilled Nursing or Rehabilitative Services on a Daily Basis:

The individual must have a physical or mental condition, disability, or impairment that requires skilled nursing or rehabilitative services on a daily basis or skilled rehabilitative services at least five days per week when skilled rehabilitative services constitute the primary basis for the approval of the PreAdmission Evaluation. The individual must require such services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit. In addition, the individual must be mentally or physically unable to perform the needed skilled services or the individual must require skilled services which, in accordance with accepted medical practice, are not usually and customarily self-performed.

For interpretation of this rule, the following shall apply:

- (i) Administration of oral medications, ophthalmics, otics, inhalers, subcutaneous injections (e.g., fixed-dose insulin, subtherapeutic heparin, and calcitonin), topicals, suppositories, nebulizer treatments, oxygen administration, shall not, in and of itself, be considered sufficient to meet the requirement of (5)(c)2.
  - (ii) Nursing observation and assessment, in and of itself, shall not be considered sufficient to meet the requirement of (5)(c)2. Examples of nursing services for which Level 2 reimbursement might be provided include, but are not limited to, the following:
    - (I) Gastrostomy tube feeding
    - (II) Sterile dressings for Stage 3 or 4 pressure sores
    - (III) Total parenteral nutrition
    - (IV) Intravenous fluid administration
    - (V) Nasopharyngeal and tracheostomy suctioning
    - (VI) Ventilator services
  - (iii) A skilled rehabilitative service must be expected to improve the individual's condition. Restorative and maintenance nursing procedures (e.g., routine range of motion exercises; stand-by assistance during ambulation; applications of splints/braces by nurses and nurses aides) shall not be considered sufficient to fulfill the requirement of (5)(c)2. Factors to be considered in the decision as to whether a rehabilitative service meets, or continues to meet, the requirement of (5)(c)2. shall include, but not be limited to, an assessment of the type of therapy and its frequency, the remoteness of the injury or impairment, and the reasonable potential for improvement in the individual's functional capabilities or medical condition.
  - (iv) Effective July 1, 2012, level 2 NF reimbursement for sliding scale insulin may be authorized for an initial period of no more than two (2) weeks for residents with unstable blood glucose levels that require daily monitoring and administration of sliding scale insulin. Approval of such reimbursement will require a physician's order and supporting documentation including a plan of care for stabilizing the applicant's blood sugar and transitioning to fixed dosing during the approval period. Additional periods of no more than two (2) weeks per period, not to exceed a maximum total of sixty (60) days, may be authorized upon submission of a new PAE and only with a physician's order and detailed explanation regarding why previous efforts to stabilize and transition to fixed dosing were not successful.
- (d) In order to be approved for Medicaid-reimbursed care in a NF at the Chronic Ventilator rate of reimbursement, an individual must be ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula).

- (e) In order to be approved by the Bureau for Medicaid-reimbursed care in a NF at the Tracheal Suctioning rate of reimbursement, an individual must have a functioning tracheostomy and require suctioning through the tracheostomy, at a minimum, multiple times per eight (8) hour shift. The suctioning must be required to remove excess secretions and/or aspirate from the trachea, which cannot be removed by the patient's spontaneous effort. Suctioning of the nasal or oral cavity does not qualify for this higher level of reimbursement. An MCO may authorize, based on medical necessity, short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention during the post-weaning period.
- (f) Determination of medical necessity and authorization for Medicaid reimbursement of Ventilator Weaning services, or short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention shall be managed by the Enrollee's MCO.
- (6) TennCare Nursing Facility Level of Care Acuity Scale
- (a) Effective July 1, 2012, for all new enrollments into CHOICES Groups 1 and 2, level of care (LOC) eligibility for TennCare-reimbursement of NF services shall be based on an assessment of the following measures:
1. The applicant's need for assistance with the following Activities of Daily Living (ADLs):
    - (i) Transfer;
    - (ii) Mobility;
    - (iii) Eating; and
    - (iv) Toileting;
  2. The applicant's level of independence (or deficiency) in the following ADL-related functions:
    - (i) Communication (expressive and receptive);
    - (ii) Orientation (to person and place);
    - (iii) Dementia-related behaviors; and
    - (iv) Self-administration of medications; and
  3. The applicant's need for certain skilled and/or rehabilitative services.
- (b) One or more questions on the PAE for NF LOC shall be used to assess each of the ADL or related measures specified above. There are four (4) possible responses to each question.
- (c) Weighted Values
1. Interpretation of possible responses for all measures except behavior
    - (i) "Always" shall mean that the applicant is always independent with that ADL or related activity.
    - (ii) "Usually" shall mean that the person is usually independent (requiring assistance fewer than 4 days per week).
    - (iii) "Usually not" shall mean that the applicant is usually not independent (requiring assistance 4 or more days per week).
    - (iv) "Never" means that the applicant is never independent with that ADL or related activity.

2. Interpretation of possible responses for the behavior measure

- (i) "Always" shall mean that the applicant always requires intervention for dementia-related behaviors.
- (ii) "Usually" shall mean that the applicant requires intervention for dementia-related behaviors 4 or more days per week.
- (iii) "Usually not" shall mean that the applicant requires intervention for dementia-related behaviors, but fewer than 4 days per week.
- (iv) "Never" shall mean that the applicant does not have dementia-related behaviors that require intervention.

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

ADL (or related) question	Condition	Always	Usually	Usually not	Never	Maximum Individual Acuity Score	Maximum Acuity Score for the Measure(s)
Transfer	Highest value of two measures	0	1	3	4	4	4
Mobility		0	1	2	3	3	
Eating	Highest value of three questions for the toileting measure	0	1	3	4	4	3
Toileting		0	0	1	2	2	
Incontinence care		0	1	2	3	3	
Catheter/ostomy care		0	1	2	3	3	4
Orientation		0	1	3	4	4	4
Expressive communication	Highest value of two questions for the communication measure	0	0	0	1	1	1
Receptive communication		0	0	0	1	1	
Self-administration of medication	First question only; excludes SS insulin	0	0	1	2	2	2
Behavior		3	2	1	0	3	3
Maximum possible ADL (or related) Acuity Score							21

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

Skilled or rehabilitative service	Maximum Individual Acuity Score
Ventilator	5
Frequent tracheal suctioning	4
New tracheostomy or old tracheostomy requiring suctioning through the tracheostomy multiple times per day at less frequent intervals, i.e., < every 4 hours	3
Total Parenteral Nutrition (TPN)	3
Complex wound care (i.e., infected or dehisced wounds)	3
Wound care for stage 3 or 4 decubitus	2

Peritoneal dialysis	2
Tube feeding, enteral	2
Intravenous fluid administration	1
Injections, sliding scale insulin	1
Injections, other IV, IM	1
Isolation precautions	1
PCA pump	1
Occupational Therapy by OT or OT assistant	1
Physical Therapy by PT or PT assistant	1
Teaching catheter/ostomy care	0
Teaching self-injection	0
Other	0
Maximum Possible Skilled Services Acuity Score	5

#### 5. Conditions

##### (i) Maximum Acuity Score for Transfer and Mobility

- (I) Assessment of the need for assistance with transfer and the need for assistance with mobility are separate but overlapping measures of an applicant's physical independence (or dependence) with movement.
- (II) The maximum individual acuity score for transfer shall be four (4).
- (III) The maximum individual acuity score for mobility shall be three (3).
- (IV) The highest individual acuity score among the transfer and mobility measures shall be the applicant's total acuity score across both measures.
- (V) The maximum acuity score across both of the transfer and mobility measures shall be four (4).

##### (ii) Maximum Acuity Score for Toileting

- (I) Assessment of the need for assistance with toileting shall include the following:
  - I. An assessment of the applicant's need for assistance with toileting;
  - II. Whether the applicant is incontinent, and if so, the degree to which the applicant is independent in incontinence care; and
  - III. Whether the applicant requires a catheter and/or ostomy, and if so, the degree to which the applicant is independent with catheter and/or ostomy care.
- (II) The highest individual acuity score among each of the three (3) toileting questions shall be the applicant's total acuity score for the toileting measure.
- (III) The maximum acuity score for toileting shall be two (2).

##### (iii) Maximum Acuity Score for Communication

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

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

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

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

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

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

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

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

(v) Maximum Skilled Services Acuity Score

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

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

(d) Maximum Acuity Score

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

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

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

(e) Calculating an Applicant's Total Acuity Score

1. Subject to the conditions set forth in 1200-13-01-.10(6)(c)(5), an applicant's acuity score for each functional measure (i.e., eating, toileting, orientation, communication, self-administration of medication, or behavior), or in the case of transfer and mobility, the applicant's acuity score across both measures shall be added in order to determine the applicant's total ADL or related acuity score (up to a maximum of 21).

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

(7) PreAdmission Evaluation Denials and Appeal Rights

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

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

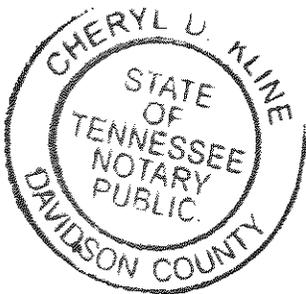
1. A written notice of denial shall be sent to the individual and, where applicable, to the designated

correspondent. A notice of denial shall also be provided to the Nursing Facility. This notice shall advise the individual of the right to appeal the denial decision within thirty (30) calendar days. The notice shall also advise the individual of the right to submit within thirty (30) calendar days either the original PreAdmission Evaluation with additional information for review or a new PreAdmission Evaluation. The notice shall be mailed to the individual's address as it appears upon the PreAdmission Evaluation. If no address appears on the PreAdmission Evaluation and supporting documentation, the notice will be mailed to the Nursing Facility for forwarding to the individual.

2. If the PAE is resubmitted with additional information for review or if a new PAE is submitted, and the Bureau continues to deny the PAE, another written notice of denial shall be sent as described in (7)(b)1.
  - (c) The individual has the right to be represented at the hearing by anyone of his/her choice. The hearing will be conducted according to the provisions of the Tennessee Uniform Administrative Procedures Act.
  - (d) Reasonable accommodations shall be made for individuals with disabilities who require assistance with an appeal.
  - (e) Any notice required pursuant to this section shall be a plain language written notice.
  - (f) When a PAE is approved for a fixed period of time with an Expiration Date determined by the Bureau, the individual shall be provided with a notice of appeal rights, including the opportunity to submit an appeal within thirty (30) calendar days of receipt of the notice of denial. Nothing in this section shall preclude the right of the individual to submit a new PAE establishing medical necessity of care when the Expiration Date has been reached.

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

I certify that this is an accurate and complete copy of an emergency rule(s), lawfully promulgated and adopted.



Date: 6/21/12

Signature: Patti Killingsworth

Name of Officer: Patti Killingsworth  
Chief, Long-Term Services and Supports, Bureau of TennCare

Title of Officer: Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: 6/21/12

Notary Public Signature: Cheryl D Kline

My commission expires on: 9/31/2012

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

RE Cooper Jr

Robert E. Cooper, Jr.  
Attorney General and Reporter

6-28-12

Date

Department of State Use Only

Filed with the Department of State on: 6/29/12

Effective for: 180 \*days

Effective through: 12/26/12

\* Emergency rule(s) may be effective for up to 180 days from the date of filing.

Tre Hargett

Tre Hargett  
Secretary of State

### **Impact on Local Governments**

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

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

**Additional Information Required by Joint Government Operations Committee**

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

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

The rules allow for changes to the Nursing Facility Level of Care requirements for entry into CHOICES, TennCare's program of long-term services and supports for individuals who are elderly or physically disabled.

- (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 T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

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

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

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

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

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

The promulgation of these rules is anticipated to decrease state FY 2013 expenditures by \$17,930,000.

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

Darin J. Gordon  
Director, Bureau of TennCare

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

Darin J. Gordon  
Director, Bureau of TennCare

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

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

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

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312 Rosa L. Parks, 8th Floor Snodgrass/TN Tower  
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Fax: 615-741-5133  
Email: [register.information@tn.gov](mailto:register.information@tn.gov)

**For Department of State Use Only**

Sequence Number: \_\_\_\_\_  
Rule ID(s): \_\_\_\_\_  
File Date (effective date): \_\_\_\_\_  
End Effective Date: \_\_\_\_\_

# Emergency Rule Filing Form

*Emergency rules are effective from date of filing for a period of up to 180 days.*

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

**Rule Type:**

Emergency Rule

**Revision Type (check all that apply):**

Amendments  
 New  
 Repeal

**Statement of Necessity:**

The Bureau of TennCare is making changes to certain aspects of its long term care program. These changes will enable the Bureau to more fully implement the Long-Term Care Community Choices Act of 2008 ("CHOICES"), as amended by Public Chapter 971. The changes also reflect federal approval of modifications to certain CHOICES service definitions and Amendment 14 to the TennCare II Demonstration, which permits the opening of a new Interim CHOICES 3 Group and a new CHOICES At-Risk Demonstration eligibility category.

From its inception, one of the goals of CHOICES has been the stratification of long term care levels of care and reimbursement for those levels of care which reflect the acuity of the actual medical needs of the individual members. Initial implementation provided for CHOICES 1 and CHOICES 2, nursing facility care and home and community based care, respectively. Eligibility for the third category for those members who are "at risk" of the need for nursing facility care, CHOICES 3, was not opened because a change in federal law regarding eligibility for benefits, known as the Maintenance of Effort ("MOE") requirement which was included first in the American Recovery and Reinvestment Act and subsequently in the Affordable Care Act, prevented the Bureau from making changes to CHOICES eligibility criteria, which prevented opening the CHOICES 3 category. The Bureau has worked diligently with the federal government in an effort to develop a mechanism by which the State can achieve MOE compliance while still meeting its goal of modifying level of care criteria for purposes of determining the appropriate benefit category and reimbursement level based on the needs of the individual.

On May 8, 2012, the Bureau received approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to modify the definitions of certain home and community based services provided under the CHOICES program. These modifications will blend homemaker services into the personal care and attendant care benefits. Homemaker services will no longer be available as a separate benefit as of July 1, 2012, so CMS approval of the incorporation of these services into other benefits (with slight modifications to those benefits) was required in order to continue homemaker services when necessary for the health and safety of the member.

On April 27, 2012, PC 971 was passed by the Legislature and on May 10<sup>th</sup> it was signed into law with an effective date of July 1, 2012. PC 971 amends the Choices Act in part by reiterating the requirement that the Bureau establish level of care medical eligibility criteria and reimbursement methodology based upon acuity of need and by establishing a new requirement that the Bureau hold a public hearing prior to promulgation of any emergency rules setting forth level of care eligibility criteria for all long term care services. The required public hearing was held on May 7, 2012, at the Nashville Public Library, Bordeaux Branch.

The Appropriations Act, PC 1027, was passed by the Legislature on April 30<sup>th</sup>, signed into law on May 15<sup>th</sup> and becomes effective July 1, 2012. Section 48, Item 6 of the Appropriations Act provides authorization to impose TennCare service limitations, reduce optional TennCare eligibility categories, mandate standardized reimbursement levels, and/or reduce, or limit, optional TennCare benefits as necessary to control expenditures. Section 12, Item 2 authorizes the promulgation of emergency rules in order for the TennCare program to function within the appropriations provided.

CMS approved Amendment 14 to the TennCare II Demonstration on June 15, 2012, with an effective date of July 1, 2012. This Amendment permits the Bureau to open an Interim CHOICES 3 Group and to establish a new CHOICES At-Risk eligibility category which retains the current level of care eligibility requirements in order to be determined eligible for CHOICES 3 as an "at risk" member. This retention of the current level of care eligibility requirements permits the Bureau to remain compliant with the MOE provisions of ACA while simultaneously permitting the Bureau to implement new level of care criteria based upon acuity. Approval of this amendment was required in order to implement level of care changes and to open CHOICES 3 prior to expiration of MOE provisions. It is important to note that the current level of care criteria will remain in effect for all CHOICES members who are currently enrolled as long as their status remains unchanged and they remain continuously enrolled in the program. The current level of care criteria will also be applied to determine eligibility for Interim CHOICES 3. The new level of care acuity criteria will be applied only to members enrolled in CHOICES on or after July 1, 2012.

Pursuant to T.C.A. § 4-5-208, the Bureau of TennCare is authorized to adopt an emergency rule if it is required by an enactment of the general assembly to implement rules within a prescribed period of time that precludes utilization of rulemaking procedures for the promulgation of permanent rules. Further, T.C.A. § 4-5-208 permits an agency to adopt emergency rules when the agency finds that it is required by an agency of the federal government and adoption of the rules through ordinary rulemaking procedures might jeopardize the loss of a federal program or funds.

I have made the finding that the emergency adoption of amendments to Rule Chapter 1200-13-01 is required in order to implement changes to the levels of care eligibility criteria pursuant to amendments to the Long-Term Care Community CHOICES Act of 2008 and Amendment 14 to the TennCare II Demonstration, and to implement CMS approved terminology changes to prevent the loss of needed homemaker services in a timely manner.

For a copy of these emergency rules contact: George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

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Patti Killingsworth  
Chief Long-Term Services and Supports

**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-.08	Personal Needs Allowance(PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC

1200-13-01-.10	Medical (Level of Care) Eligibility Criteria for Medicaid Reimbursement of Care in Nursing Facilities Care
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(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>)

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

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

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (1) and renumbering the current Paragraph (1) as (2) and subsequent paragraphs renumbered accordingly so as amended the new Paragraph (1) shall read as follows:

(1) Activities of Daily Living (ADLs).

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

1. Personal hygiene and grooming;

2. Dressing and undressing;

3. Self feeding;

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

5. Bowel and bladder management; and

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

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (10) and renumbering the current renumbered Paragraph (10) as (11) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (10) shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by deleting renumbered Paragraph (11) and replacing it with a new Paragraph (11) so that as amended it shall read as follows:

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

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

1. ADLs such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation.
  2. ~~IADLs that are essential, although secondary, to the personal care tasks needed by the Member in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:~~
    - ~~(i) Picking up medications or shopping for groceries.~~
    - ~~(ii) Meal preparation.~~
    - ~~(iii) Household tasks such as making the bed, washing soiled linens or bedclothes.~~
  3. Continuous safety monitoring and supervision during the period of service delivery.
- (b) For members who require hands-on assistance with ADLs, attendant care may also include the following homemaker services that are essential, although secondary, to the hands-on assistance with ADLs needed by the Member in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:
1. Picking up the Member's medications or shopping for the Member's groceries.
  2. Preparing the Member's meals and/or educating caregivers about preparation of nutritious meals for the Member.
  3. Household tasks such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, and doing the Member's personal laundry, ironing and mending.
- (c) Attendant Care shall not be provided for Members who do not require hands-on assistance with ADLs.
- (bd) Attendant Care shall be primarily provided in the Member's place of residence, except as permitted by rule and within the scope of service (e.g., picking up medications or shopping for groceries); when accompanying the Member into the community pursuant to rule ~~1200-13-01-05(7)(k)~~ 1200-13-01-05(8)(m), or under exceptional circumstances as authorized by an MCO in the POC to accommodate the needs of the Member.
- (e) A single Contract Provider staff person or Consumer Directed Worker may provide Attendant Care services to multiple CHOICES Members in the same home and during the same hours, as long as he can provide the services safely and appropriately to each Member. Such arrangements shall be documented in each Member's plan of care. In such instances, the total units of service provided by the staff person shall be allocated among the CHOICES Members, based on the percentage of total service units required by each Member on average. The Provider shall bill the MCO only once for each of the service units provided, and shall not bill an MCO or multiple MCOs separately to provide services to multiple Members at the same time.
- (ef) Attendant Care shall not be provided to Members living in a CBRA facility or receiving Short-Term NF services, or while a Member is receiving Adult Day Care services.
- (dg) Attendant Care ~~does~~ shall not include:
1. Care or assistance including meal preparation or household tasks for other residents of the same household;
  2. Yard work; or

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

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (20) so that it shall read as follows:

(1820) Certification.

- (a) A process by which a Physician who is licensed as a doctor of medicine or doctor of osteopathy signs and dates a PAE signifying the following:
1. The person requires the requested level of institutional care or reimbursement (Level 1 NF, Level 2 NF, Enhanced Respiratory Care, or ICF/MR) or, in the case of a Section 1915(c) HCBS Waiver program, requires HCBS as an alternative to the applicable level of institutional care for which the person would qualify; and
  2. The requested LTC services are medically necessary for the individual.
- (b) Consistent with requirements pertaining to certification of the need for SNF care set forth at 42 CFR 424.20, certification of the need for NF care may be performed by a nurse practitioner or clinical nurse specialist, neither of whom has a direct or indirect employment relationship with the facility but who is working in collaboration with a physician.
- (bc) Physician certification is not required for CHOICES HCBS.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (22) and renumbering the current renumbered Paragraph (22) as (23) with subsequent paragraphs renumbered accordingly so as amended the new Paragraph (22) shall read as follows:

(22) CHOICES At-Risk Demonstration Group. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet NF financial eligibility requirements for Medicaid reimbursed LTC, meet the NF level of care in place on June 30, 2012, but not the NF LOC in place on July 1, 2012, and who, in the absence of CHOICES HCBS available through CHOICES Group 3, are At Risk for Institutionalization as defined in these rules. Members eligible for TennCare in the CHOICES At-Risk Demonstration Group on December 31, 2013 may continue to qualify in this group after December 31, 2013, so long as they continue to meet NF financial eligibility, continue to be At Risk for Institutionalization as defined in these rules, and remain continuously enrolled in the CHOICES At- Risk Demonstration Group and in CHOICES Group 3.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (26) and renumbering the current renumbered Paragraph (26) as (27) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (26) shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (27) and renumbering the current renumbered Paragraph (27) as (28) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (27) shall read as follows:

(27) CHOICES Home and Community Based Services (HCBS). Services specified in rule 1200-13-01-.05(8)(k) that are available only to eligible persons enrolled in CHOICES Group 2 or Group 3 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost neutrality cap.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (34) so that it shall read as follows:

~~(2934)~~ Consumer Direction (CD) of Eligible CHOICES HCBS. For purposes of CHOICES, the opportunity for a Member assessed to need ~~specified types of Eligible CHOICES HCBS~~ (limited to Attendant Care, Personal Care Visits, ~~Homemaker Services~~, In-Home Respite Care, or Companion Care) to elect to direct and manage (or to have a Representative direct and manage) certain aspects of the provision of such services, primarily the hiring, firing, and day-to-day supervision of Consumer-Directed Workers delivering the needed service(s).

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (39) so that it shall read as follows:

~~(3439)~~ Cost Neutrality Cap. For purposes of CHOICES Group 2, the average cost of the level of NF reimbursement that would be paid if the Member were institutionalized. The Cost Neutrality Cap functions as a limit on the total cost of HCBS that, ~~when combined with the cost of HH Services and PDN Services the person will receive~~, can be provided to the individual in the home or community setting, including CHOICES HCBS, HH Services and PDN Services. The Cost Neutrality Cap shall be individually applied.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (45) so that it shall read as follows:

~~(4045)~~ Eligible CHOICES HCBS. For purposes of CD, ~~services-CHOICES HCBS~~ that may be consumer-directed are limited to Attendant Care, Personal Care Visits, ~~Homemaker Services~~, In-Home Respite Care, or Companion Care. Eligible CHOICES HCBS do not include home health or private duty nursing services.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (49) so that it shall read as follows:

~~(4449)~~ Enrollment Target.

- (a) The maximum number of individuals who can be enrolled in CHOICES Group 2 or CHOICES Group 3 at any given time, subject to the exceptions provided in this Chapter.
- (b) The Enrollment Target is not calculated on the basis of "unduplicated participants." Vacated slots in CHOICES Group 2 or CHOICES Group 3 may be refilled immediately, rather than being held until the next program year, as is required in the HCBS Waiver programs.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (50) and renumbering the current renumbered Paragraph (50) as (51) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (50) shall read as follows:

~~(50)~~ Expenditure Cap. For purposes of CHOICES Group 3, the annual limit on expenditures for CHOICES HCBS, excluding minor home modifications, that a CHOICES Group 3 Member can receive. The Expenditure Cap shall be \$15,000 (fifteen thousand dollars) per Member per calendar year.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (57) so that it shall read as follows:

~~(5257)~~ Home and Community Based Services (HCBS). Services not covered by Tennessee's Title XIX State Plan that are provided under the authority of a Section 1915(c) HCBS waiver or (in the case of CHOICES) a Section 1115 waiver pursuant to a written POC as an alternative to LTC institutional services in a NF or an ICF/MR to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require the LOC provided in the institution to which the HCBS offer an alternative, or in the case of CHOICES Group 3, are At Risk for Institutionalization. HCBS does not include HH or PDN services. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (61) so that it shall read as follows:

~~(5661)~~Homemaker Services.

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

~~2.~~(b) Provided only for the Member (and not for other household members) and only when the Member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the Member; and

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

~~3.~~(d). Shall not be provided to Members living in a CBRA facility or receiving Short-Term NF Services.

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

~~1. General household activities and chores such as sweeping, mopping, dusting, changing linens, making beds, washing dishes, doing personal laundry, ironing, mending, meal preparation and/or education about preparation of nutritious appetizing meals, assistance with maintenance of safe environment and errands such as grocery shopping and having prescriptions filled;~~

~~2. Provided when the enrollee is unable to perform such activities and the individual regularly responsible for these activities is unable to perform such activities for the Enrollee; and~~

~~3. Shall not be provided to Enrollees living in a CBRA facility or receiving Short Term NF services.~~

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (66) so that it shall read as follows:

~~(6466)~~ Immediate Eligibility.

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

(b) To qualify an individual must:

1. Be applying to receive covered CHOICES HCBS;

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

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

4. Be expected to qualify in the CHOICES 217-Like Group based on review of the financial information provided by the applicant; and
  5. Meet all other specified criteria for enrollment into CHOICES Group 2, subject to categorical and financial eligibility determination.
- (c) Immediate Eligibility shall only be for Specified CHOICES HCBS (no other covered services) and for a maximum of forty-five (45) days.
- (d) Immediate Eligibility is not available for individuals who are already enrolled in TennCare or for persons who may qualify in the CHOICES At-Risk Demonstration Group.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (68) and renumbering the current renumbered Paragraph (68) as (69) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (68) shall read as follows:

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

- (a) The response to a specific ADL or related question in the PAE for NF LOC that is supported by the medical evidence submitted with the PAE; or
- (b) A specific skilled or rehabilitative service determined by TennCare to be needed by the applicant on a daily basis or at least five (5) days per week for rehabilitative services based on the medical evidence submitted with the PAE and for which TennCare would authorize level 2 or enhanced respiratory care reimbursement in a NF.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (75) and renumbering current renumbered paragraph (75) as (76) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (75) shall read as follows:

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

- (a) Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients or as members of the CHOICES At-Risk Demonstration Group, and who are At Risk for Institutionalization as defined in these rules. There will be no Enrollment Target applied to Interim CHOICES Group 3.
- (b) Members enrolled in Interim CHOICES Group 3 on December 31, 2013 may continue to qualify in this group after December 31, 2013, so long as they continue to meet NF financial eligibility, continue to be At Risk for Institutionalization, can be safely served in Interim CHOICES Group 3, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES Group 3.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (79) so that it shall read as follows:

(7279) Level of Care (LOC). Medical eligibility criteria for receipt of an institutional service, HCBS offered as an alternative to the institutional service, or in the case of persons At Risk for Institutionalization, to delay or prevent institutional placement. An individual who meets the LOC criteria for NF care is an individual who has been determined by the Bureau to meet the medical eligibility criteria established for that service.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (89) and renumbering the current renumbered Paragraph (89) as (90) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (89) shall read as follows

(89) Medicaid Only Payer Date (MOPD). The date a NF certifies that Medicaid reimbursement for NF services will begin because the applicant has been admitted to the facility and all other primary sources of reimbursement (including Medicare and private pay) have been exhausted. (This does not preclude the applicant's responsibility for payment of patient liability as described in these rules.) The MOPD must be

known (and not projected) as it will result in the determination of eligibility for Medicaid reimbursement of NF services and in many cases, eligibility for Medicaid, as well as a capitation payment and payments for Medicaid services (including, but not limited to LTC) received. The PAE may be submitted without an MOPD date, in which case the MOPD shall be submitted by the facility when it is known. Enrollment into CHOICES Group 1 and eligibility for reimbursement of NF services shall be permitted only upon submission of a MOPD. The effective date of CHOICES enrollment and Medicaid reimbursement of NF services shall not be earlier than the MOPD.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (107) so that it shall read as follows:

(99107) Personal Care Visits. For purposes of CHOICES:

- (a) Visits to a Member who, due to age and/or physical disability, needs assistance that can be provided through intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance and related tasks as specified below.
- (b) Personal Care Visits may include assistance with the following: ADLs such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation
  - ~~1. ADLs such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation.~~
  - ~~2. IADLs that are essential, although secondary, to the personal care tasks needed by the Enrollee in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:
    - ~~(i) Picking up medications or shopping for groceries.~~
    - ~~(ii) Meal preparation.~~
    - ~~(iii) Household tasks such as making the bed, washing soiled linens or bedcloth~~~~
- (c) For members who require hands-on assistance with ADLs, Personal Care Visits may also include the following homemaker services that are essential, although secondary, to hands-on assistance with ADLs needed by the Member in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need, such as:
  - 1. Picking up the Member's medications or shopping for the Member's groceries.
  - 2. Preparing the Member's meals and/or educating caregivers about the preparation of nutritious meals for the Member.
  - 3. Household tasks such as sweeping, mopping, and dusting in areas of the home used by the Member, changing the Member's linens, making the Member's bed, washing the Member's dishes, and doing the Member's personal laundry, ironing and mending.
- (d) Personal Care Visits shall not be provided for members who do not require hands-on assistance with ADLs.
- (ee) Personal Care Visits shall be primarily provided in the Member's place of residence, except as permitted within the scope of service (e.g., picking up medications or shopping for groceries), when accompanying the Member into the community pursuant to rule ~~1200-13-01-.05(7)(k)~~ 1200-13-01-.05(8)(m), or under exceptional circumstances as authorized by an MCO in the POC to accommodate the needs of the Member.
- (f) A single Contract Provider staff person or Consumer Directed Worker may provide Personal Care Visits to multiple CHOICES members in the same home and during the same hours, as long as he can provide the services safely and appropriately to each member. Such arrangements shall be documented in each member's plan of care. In such instances, the total units of service provided by

the staff person shall be allocated among the CHOICES members, based on the percentage of total service units required by each member on average. The Provider shall bill the MCO only once for each of the service units provided, and shall not bill an MCO or multiple MCOs separately to provide services to multiple members at the same time.

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

(eh) Personal care visits ~~do~~ shall not include:

1. Companion or sitter services, including safety monitoring and supervision.
2. Care or assistance including meal preparation or household tasks for other residents of the same household.
3. Yard work.
4. Care of non-service related pets and animals.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (113) so that it shall read as follows:

~~(405113)~~ (113) Physically Disabled. For purposes of enrollment into CHOICES Group 2 or ~~the Statewide ED Waiver, CHOICES Group 3,~~ an adult aged twenty-one (21) or older who has one or more physical disabilities.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (117) so that it shall read as follows:

~~(409117)~~ (117) PreAdmission Evaluation (PAE). A process of assessment by the Bureau used to determine an individual's medical (or LOC) eligibility for Medicaid-reimbursed care in a NF or ICF/MR, and in the case of NF services, the appropriate level of reimbursement for such care, as well as eligibility for HCBS as an alternative to institutional care, or in the case of persons At-Risk for Institutionalization, in order to delay or prevent NF placement. For purposes of CHOICES, the PAE application shall be used for the purposes of determining LOC and for persons enrolled in CHOICES Group 2, calculating the Member's Individual Cost Neutrality Cap.

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (122) and renumbering the current renumbered Paragraph (122) as (123) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (122) shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (130) so that it shall read as follows:

~~(424130)~~ Risk Agreement.

- (a) An agreement signed by a Member who will receive CHOICES Group 2 HCBS (or his Representative) that includes, at a minimum:
1. Identified risks to the Member of residing in the community and receiving HCBS;
  2. The possible consequences of such risks, strategies to mitigate the identified risks; and
  3. The Member's decision regarding his acceptance of risk.

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

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (136) so that it shall read as follows:

~~(127)~~136 Short-Term Nursing Facility (NF) Care. For purposes of CHOICES:

- (a) The provision of NF care for up to ninety (90) days to a CHOICES Group 2 or CHOICES Group 3 Member who was receiving HCBS upon admission and who meets NF LOC and requires temporary placement in a NF—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such Member is reasonably expected to be discharged and to resume HCBS participation within no more than ninety (90) days.
- (b) Such CHOICES Group 2 or CHOICES Group 3 Member must meet the NF LOC upon admission and in such case, while receiving Short-Term NF Care may continue enrollment in CHOICES Group 2 or CHOICES Group 3, pending discharge from the NF within no more than ninety (90) days or until such time it is determined that discharge within ninety (90) days from admission is not likely to occur, at which time the Member shall be transitioned to CHOICES Group 1, as appropriate.
- (c) The Community PNA shall continue to apply during the provision of Short-Term NF care, up to the ninetieth (90th) day, in order to allow sufficient resources for the Member to maintain his community residence for transition back to the community.
- (d) The PASRR process is required for CHOICES Group 2 and CHOICES Group 3 Members entering Short-Term NF Care.
- (e) Persons receiving Short-Term NF Care are not eligible to receive any other HCBS, except as permitted in 1200-13-01-.05 to facilitate transition to the community.

Rule 1200-13-01-.02 Definitions is amended by revising renumbered Paragraph (142) so that it shall read as follows:

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

Rule 1200-13-01-.02 Definitions is amended by adding a new Paragraph (149) and renumbering the current renumbered Paragraph (149) as (150) with subsequent paragraphs being renumbered accordingly so as amended the new Paragraph (149) shall read as follows:

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

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

The introductory Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the word "two" and by adding the word and number "three (3)" so as amended the introductory Subparagraph (a) shall read as follows:

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

Part 1. of Subparagraph (a) of Paragraph (3) of Rule 1200-13-01-.05 is amended by deleting the hyphen "-"

between the words "Medicaid-Reimbursement" in the last sentence so as amended Part 1. shall read as follows:

1. CHOICES Group 1. Participation in CHOICES Group 1 is limited to Medicaid Enrollees of all ages who qualify for and are receiving Medicaid-reimbursed NF services. Medicaid eligibility for LTC services is determined by DHS. Medical (or LOC) eligibility is determined by the Bureau as specified in Rule 1200-13-01-.10. Persons in CHOICES Group 1 must be enrolled in TennCare Medicaid and qualify for ~~Medicaid-reimbursement~~ Medicaid reimbursement of LTC services.

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

3. CHOICES Group 3.

(i) Participation in CHOICES Group 3 is limited to TennCare Enrollees who qualify for and are receiving TennCare-reimbursed HCBS. To be eligible for CHOICES Group 3, Enrollees must meet the following criteria:

(I) Be in one of the defined target populations;

(II) Qualify in one of the specified eligibility categories;

(III) Be At-Risk for Institutionalization as defined in Rule 1200-13-01-.02; and

(IV) Have needs that can be safely and appropriately met in the community and at a cost that does not exceed the Expenditure Cap for CHOICES HCBS as defined in Rule 1200-13-01-.02.

(ii) Target Populations for CHOICES Group 3. Only persons in one of the target populations below may qualify to enroll in CHOICES Group 3:

(I) Persons age sixty-five (65) and older.

(II) Persons twenty-one (21) years of age and older who have one or more physical disabilities as defined in Rule 1200-13-01-.02.

(iii) Eligibility Categories served in CHOICES Group 3. Participation in CHOICES Group 3 is limited to TennCare Enrollees who qualify in one of the following eligibility categories:

(I) SSI eligibles, who are determined eligible for SSI by the Social Security Administration. SSI eligibles are enrolled in TennCare Medicaid.

(II) For Interim CHOICES Group 3 only, the CHOICES At-Risk Demonstration Group, as defined in Rule 1200-13-01-.02. Financial and categorical eligibility are determined by DHS. Persons who qualify in the CHOICES At-Risk Demonstration Group will be enrolled in TennCare Standard. This eligibility category is only open for enrollment between July 1, 2012 and December 31, 2013. Members enrolled in Interim CHOICES Group 3 on December 31, 2013 may continue to qualify in this group after December 31, 2013, so long as they continue to meet NF financial eligibility criteria and the LOC criteria in place at the time of enrollment into Interim CHOICES Group 3, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group, Interim CHOICES Group 3, and TennCare.

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

(b) Level of Care (LOC).

All Enrollees in TennCare CHOICES must meet the applicable LOC criteria ~~for NF services~~, as determined by the Bureau in accordance with Rule 1200-13-01-.10. Physician certification of LOC

shall be required only for NF services. ~~Upon implementation of CHOICES in the Grand Division, only the CHOICES PAE may be submitted to establish LOC eligibility for CHOICES LTC services. However, an unexpired non-CHOICES PAE eligibility segment may be used as permitted by the Bureau for enrollment into CHOICES, including persons on a Waiting List for HCBS.~~

1. Persons shall meet NF LOC in order to enroll in CHOICES Group 1 or CHOICES Group 2.
2. Persons shall meet At-Risk LOC in order to enroll in CHOICES Group 3, including Interim CHOICES Group 3.
3. Members enrolled in CHOICES Group 1 on June 30, 2012, may continue to qualify in this group after June 30, 2012, so long as they continue to meet NF financial eligibility, continue to meet the NF LOC criteria in place on June 30, 2012, and remain continuously enrolled in CHOICES Group 1 and in TennCare.
4. Members enrolled in CHOICES Group 1 on June 30, 2012, who wish to begin receiving HCBS and transition to CHOICES Group 2 shall, for purposes of LOC, be permitted to do so, so long as they continue to meet the NF LOC criteria in place on June 30, 2012, and have remained continuously enrolled in CHOICES Group 1 and in TennCare since June 30, 2012.
5. Members enrolled in CHOICES Group 2 on June 30, 2012, may continue to qualify in this group after June 30, 2012, so long as they continue to meet NF financial eligibility, continue to meet the NF LOC criteria in place on June 30, 2012, and remain continuously enrolled in CHOICES Group 2 and in TennCare.
6. Members enrolled in CHOICES Group 2 on June 30, 2012, who wish to be admitted to a NF and transition to CHOICES Group 1 shall be required to meet the NF LOC criteria in place at the time of enrollment into CHOICES Group 1 unless a determination has been made by TennCare that the member's needs can no longer be safely met in the community within the member's individual cost neutrality cap, in which case, the person shall meet the NF LOC criteria in place on June 30, 2012, to qualify for enrollment into CHOICES Group 1.

Part 2. of Subparagraph (c) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by inserting the words and number "or CHOICES Group 3" following the words and number "CHOICES Group 2" wherever they appear so that as amended Part (3)(c)2. shall read as follows:

2. Persons in CHOICES Group 2 or CHOICES Group 3 are not required to complete the PASRR process unless they are admitted to a NF for the Short-term NF benefit described in Paragraph (78) of this Rule. Completion of the PASRR process is not required for Members of CHOICES Group 2 or CHOICES Group 3 who have elected the Inpatient Respite Care benefit described in Paragraph (78) of this Rule, since the service being provided is not NF services, but rather, Inpatient Respite Care, which is an HCBS.

Subparagraph (d) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the hyphen "-" between the words "Medicaid-reimbursement" and inserting the words and number "or CHOICES Group 3" following the words and number "CHOICES Group 2" so that as amended Subparagraph (3)(d) shall read as follows:

- (d) All Enrollees in TennCare CHOICES must be admitted to a NF and require ~~Medicaid-reimbursement~~ Medicaid reimbursement of NF services or be receiving HCBS in CHOICES Group 2 or CHOICES Group 3.

The introductory Subparagraph (e) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the phrase "the AAAD or" after the words "determined by" and the words and commas ", as applicable," after the word "MCO" in the first sentence so as amended the introductory Subparagraph (e) shall read as follows:

- (e) All Enrollees in TennCare CHOICES Group 2 must be determined by ~~the AAAD or~~ the MCO, ~~as applicable,~~ to be able to be served safely and appropriately in the community and within their

individual cost-neutrality cap, in accordance with this Rule. If a person can be served safely and appropriately in the community and within their individual cost-neutrality cap only through receipt of Companion Care services, the person may not be enrolled into CHOICES until a qualified companion has been identified, an adequate back-up plan has been developed, and the companion has completed all required paperwork and training and is ready to begin delivering Companion Care services immediately upon the person's enrollment into CHOICES. Reasons a person cannot be served safely and appropriately in the community may include, but are not limited to, the following:

Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Subparagraph (f) and re-lettering the current Subparagraph (f) as (g) so as amended Subparagraph (f) shall read as follows:

(f) All Enrollees in TennCare CHOICES Group 3 must be determined by the MCO to be able to be served safely and appropriately in the community within the array of services and supports available in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of \$15,000 (excluding the cost of minor home modifications), non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers. Reasons a person cannot be served safely and appropriately in the community may include, but are not limited to, the following:

1. The home or home environment of the applicant is unsafe to the extent that it would reasonably be expected that HCBS could not be provided without significant risk of harm or injury to the person or to individuals who provide covered services.
2. The applicant or his caregiver is unwilling to abide by the POC, resulting in the inability to ensure the person's health, safety and welfare.

Part 5. of re-lettered Subparagraph (g) of Paragraph (3) of Rule 1200-13-01-.05 TennCare CHOICES program is amended by deleting the phrase "Paragraph (7)(j)" and replacing it with the phrase "Paragraph (8)(l)" so that as amended Part 5. shall read:

5. During the period of Immediate Eligibility, individuals are eligible only for the limited package of HCBS identified in ~~Paragraph (7)(j)~~ Paragraph (8)(l). They are not eligible for any other TennCare services, including other LTC services.

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

2. Have an approved unexpired CHOICES PAE for Level 1 reimbursement of NF services, Level 2 reimbursement of NF services, or Enhanced Respiratory Care Reimbursement for services in a NF. ~~The Bureau may also accept, at its discretion, an approved, unexpired non-CHOICES PAE for the applicable LOC (Level 1 NF or Level 2 NF) submitted prior to implementation of CHOICES in the Grand Division.~~ Eligibility for Enhanced Respiratory Care Reimbursement may be established only with a CHOICES PAE.

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

2. An individual must have an approved unexpired CHOICES PAE for NF LOC. ~~The Bureau may also accept, at its discretion, an approved, unexpired non-CHOICES PAE for Level 1 NF care or the Statewide E/D Waiver submitted prior to implementation of CHOICES in the Grand Division;~~
3. An individual must be approved by DHS for reimbursement of LTC services as an SSI recipient or in the CHOICES 217-Like Group. To qualify be eligible in the CHOICES 217-Like Group, an individual must be enrolled-approved by TennCare to enroll in CHOICES Group 2 or be approved by the Bureau for Immediate Eligibility for CHOICES Group 2, subject to categorical and financial eligibility by DHS;
4. The Bureau must have received a determination by the ~~AAAD or MCO, as applicable,~~ that the individual's needs can be safely and appropriately met in the community, and at a cost that

does not exceed his Individual Cost Neutrality Cap, as described in this Rule, except in instances where the person is not eligible for TennCare at the time of CHOICES application, in which case, such determination shall be made by the MCO upon enrollment into CHOICES Group 2; and

Subpart (iii) of Part 1. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "cost of" in the first and second sentences so as amended Subpart (iii) shall read as follows:

- (iii) The total cost of CHOICES HCBS, HH Services, and PDN Services he can receive while enrolled in CHOICES Group 2. The Member's Individual Cost Neutrality Cap functions as a limit on the total cost of CHOICES HCBS that, when combined with the cost of HH Services and PDN Services the Member will receive, can be provided to the Member in the home or community setting.

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

- (i) The annual cost neutrality cap shall be applied on a calendar year basis. The Bureau and the MCOs will track utilization of CHOICES HCBS, HH services, and PDN services across each calendar year increments.

Subpart (ii) of Part 4. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "of all" in the third sentence and after the words "cost of" in the last sentence so as amended Subpart (ii) shall read as follows:

- (ii) A Member's Individual Cost Neutrality Cap must be applied prospectively on a twelve (12) month basis. This is to ensure that a Member's POC does not establish a threshold level of supports that cannot be sustained over the course of time. This means that, for purposes of care planning, the ~~AAAD~~ or MCO will always project the total cost of all CHOICES HCBS (including one-time costs such as Minor Home Modifications, short-term services or short-term increases in services) and HH and PDN Services forward for twelve (12) months in order to determine whether the Member's needs can continue to be safely and cost-effectively met based on the most current POC that has been developed. The cost of one-time services such as Minor Home Modifications, short-term services or short-term increases in services must be counted as part of the total cost of CHOICES HCBS for a full twelve (12) month period following the date of service delivery.

Subpart (iii) of Part 4. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "on the" so as amended Subpart (iii) shall read as follows:

- (iii) If it can be reasonably anticipated, based on the CHOICES HCBS, HH and PDN services currently received or determined to be needed in order to safely meet the person's needs in the community, that the person will exceed his cost neutrality cap, then the person does not qualify to enroll in or to remain enrolled in CHOICES Group 2.

Item (I) of Subpart (ii) of Part 5. of Subparagraph (c) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "reduction in" so as amended Item (I) shall read as follows:

- (I) Denial of or reductions in CHOICES HCBS based on a Member's Cost Neutrality Cap shall constitute an adverse action under the Grier Revised Consent Decree (Modified) (See Rules 1200-13-13-.01(4) and 1200-13-14-.01(4)), and shall give rise to Grier notice of action and due process rights to request a fair hearing in accordance with Rules 1200-13-13-.11 and 1200-13-14-.11.

Part 1. of Subparagraph (d) of Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Subpart (iv) which shall read as follows:

- (iv) Effective July 1, 2012, the Enrollment Target for CHOICES Group 2 will be twelve thousand five hundred (12,500).

Paragraph (4) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding new Subparagraphs (e), (f), and (g) which shall read as follows:

(e) Enrollment into CHOICES Group 3. To qualify for enrollment into CHOICES Group 3 (including Interim CHOICES Group 3):

1. An individual must be in one of the target populations specified in this Rule;
2. An individual must have an approved unexpired PAE for At-Risk LOC;
3. An individual must be approved by DHS for reimbursement of LTC services as an SSI recipient or for Interim CHOICES Group 3 only, in the CHOICES At-Risk Demonstration Group, as defined in Rule 1200-13-01-.02. To be eligible in the CHOICES At-Risk Demonstration Group, an individual must be enrolled in Interim CHOICES Group 3, subject to categorical and financial eligibility by DHS;
4. The Bureau must have received a determination by the MCO that the individual's needs can be safely and appropriately met in the community, and at a cost that does not exceed his Expenditure Cap, as described in this Rule, except in instances where the person is not eligible for TennCare at the time of CHOICES application, in which case, such determination shall be made by the MCO upon enrollment into CHOICES Group 3; and
5. There must be capacity within the established Enrollment Target, as applicable, to enroll the individual in accordance with this Rule.

(f) Expenditure Cap for CHOICES Group 3.

1. Each Member enrolling or enrolled in CHOICES Group 3 shall be subject to an Expenditure Cap on CHOICES HCBS. The Expenditure Cap shall be used to determine:
  - (i) Whether or not an applicant qualifies to enroll in CHOICES Group 3;
  - (ii) Whether or not a member qualifies to remain enrolled in CHOICES Group 3; and
  - (iii) The total cost of CHOICES HCBS a member can receive while enrolled in CHOICES Group 3, excluding the cost of minor home modifications. The Expenditure Cap functions as a limit on the total cost of CHOICES HCBS, excluding minor home modifications, that can be provided by the MCO to the member in the home or community setting.
2. A Member is not entitled to receive services up to the amount of the expenditure cap. A Member shall receive only those services that are medically necessary (i.e., required in order to help ensure the Member's health, safety and welfare in the home or community setting and to delay or prevent the need for NF placement). Determination of the services that are needed shall be based on a comprehensive assessment, conducted by the Member's Care Coordinator, of the Member's needs and the availability of Natural Supports and other (non-TennCare reimbursed) services to meet identified needs.
3. The Expenditure Cap for CHOICES HCBS provided to CHOICES Group 3 members shall be \$15,000 (fifteen thousand dollars) annually, excluding the cost of minor home modifications.
4. Application of the Expenditure Cap.
  - (i) The annual expenditure cap shall be applied on a calendar year basis. The Bureau and the MCOs will track utilization of CHOICES HCBS excluding minor home modifications, across each calendar year.

- (ii) A Member's Expenditure Cap must also be applied prospectively on a twelve (12) month basis. This is to ensure that a Member's POC does not establish a threshold level of supports that cannot be sustained over the course of time. This means that, for purposes of care planning, the MCO will always project the total cost of CHOICES HCBS (excluding minor home modifications) forward for twelve (12) months in order to determine whether the Member's needs can continue to be met based on the most current POC that has been developed. The cost of one-time services such as short-term services or short-term increases in services must be counted as part of the total cost of CHOICES HCBS for a full twelve (12) month period following the date of service delivery.
- (iii) If it can be reasonably anticipated, based on the CHOICES HCBS currently received or determined to be needed (in addition to non-CHOICES HCBS available through TennCare, e.g., home health, services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers) in order to safely meet the person's needs in the community, that the person will exceed his Expenditure Cap, then the person does not qualify to enroll in or to remain enrolled in CHOICES Group 3.
- (iv) Any short-term NF services received by a member enrolled in CHOICES Group 3 shall not be counted against his Expenditure Cap.

(g) Enrollment Target for CHOICES Group 3 (including Interim CHOICES Group 3).

1. The State may establish an Enrollment Target for CHOICES Group 3 which shall be at least ten (10) percent of the Enrollment Target established by the State for CHOICES Group 2.
2. Notwithstanding any Enrollment Target established for CHOICES Group 3 as described in this subparagraph, Interim CHOICES Group 3 which is open for enrollment between July 1, 2012, and December 31, 2013, shall not be subject to an Enrollment Target.

Part 2. of Subparagraph (b) of Paragraph (5) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Part 2. which shall read as follows:

2. The Member's needs can no longer be safely met in the community at a cost that does not exceed the Member's Cost Neutrality Cap or Expenditure Cap, as appropriate and as described in this Rule.

Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding a new Paragraph (6) and renumbering the current Paragraph (6) as (7) and all subsequent Paragraphs accordingly so as amended Paragraph (6) shall read as follows:

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

- (a) For purposes of the Need for Inpatient Nursing Care effective July 1, 2012, as specified in TennCare Rule 1200-13-01-.10(4)(c)(2)(i)(II) and 1200-13-01-.10(4)(c)(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 such 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 Medicaid eligible members 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 long-term care services 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 long-term care services and other social support services and assistance (e.g., housing or income assistance) that are needed, as applicable, to ensure the member's health, safety and welfare in the community and to prevent the need for institutional placement. Such assessment shall specify the specific tasks and functions for which assistance is needed by the member, the frequency with which such tasks must be performed, and the amount of paid assistance necessary to perform these tasks;

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

3. An explanation regarding why an array of covered services and supports, including CHOICES HCBS within the \$15,000 expenditure cap for CHOICES 3 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.

Paragraph (6) renumbered as Paragraph (7) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new renumbered Paragraph (7) which shall read as follows:

~~(67) Transitioning into CHOICES and Transitioning Between CHOICES Groups.~~

~~(a) Transition at the time that CHOICES is implemented in a particular Grand Division of the State:~~

- 1. ~~All active participants in the existing Statewide E/D Waiver who live in that Grand Division shall be automatically transitioned into CHOICES.~~
- 2. ~~All persons receiving TennCare-reimbursed NF services in that Grand Division shall be automatically transitioned into CHOICES.~~
- 3. ~~There shall be no right to a fair hearing regarding the termination of the Section 1915(c) Waiver, and no ability to remain enrolled in the Section 1915(c) Waiver or to continue receiving FFS NF care. Once CHOICES has been implemented in a Grand Division, TennCare Members in that Grand Division may receive LTC services only through CHOICES, with the following exceptions:~~
  - (i) ~~Institutional and community services for persons with MR will continue to be offered through the ICF/MR program described in Rule 1200-13-01-.30 and the HCBS waiver programs for persons with MR described in Rules 1200-13-01-.25, .28, and .29.~~
  - (ii) ~~Elderly and disabled residents of Hamilton County may elect to participate in the PACE program, in which case they will not be enrolled with a TennCare MCO.~~
- 4. ~~Members shall remain in their currently assigned MCO. LTC services shall become part of the covered benefit package provided to the Member by his current MCO.~~

~~(b) Continuity of Care period.~~

- ~~1. Members residing in NFs and transitioning into CHOICES Group 1 and Members transitioning from the existing Section 1915(c) Waiver into CHOICES Group 2 shall receive a Continuity of Care period based on their currently authorized POC.~~
- ~~2. The Continuity of Care period shall last for a minimum of thirty (30) days and will continue for up to ninety (90) days for persons enrolled in CHOICES Group 2 or until a new POC has been implemented.~~
- ~~3. During the Continuity of Care period:~~

~~(i) CHOICES Group 1 Members.~~

- ~~(I) The Member shall continue to receive NF services from the current NF provider, regardless of whether the NF is a Contract or Non-Contract Provider, unless the Member chooses to move to another NF and such choice is documented.~~
- ~~(II) NF providers not participating in the MCO's network shall be reimbursed at the contract rate for the first thirty (30) days following implementation, and thereafter in accordance with Rule 1200-13-01-05(9)(e)3.~~

~~(ii) CHOICES Group 2 Members.~~

- ~~(I) The Member shall continue to receive the services currently specified in his Waiver POC, except for Case Management Services which shall be replaced with Coordination provided by the Member's MCO.~~
- ~~(II) The Member shall continue to receive HCBS from his current Waiver providers, regardless of whether such providers are contracted with the MCO to deliver CHOICES benefits. Non-contract HCBS providers shall be reimbursed at the MCO's full contract rate during the Continuity of Care period, even if such period is extended beyond thirty (30) days. In the case of Members receiving services in a CBRA setting, the Member shall remain in that CBRA during the Continuity of Care period, unless he chooses to move to another CBRA and such choice is documented.~~
- ~~(III) Any action to reduce or change the type, amount, frequency, or duration of Waiver services in order to implement the new POC shall require notice of action in accordance with Rules 1200-13-13-11 and 1200-13-14-11.~~

~~(c) Transitioning between CHOICES Groups.~~

~~1. Transition from Group 1 to Group 2.~~

- ~~(i) An MCO may request to transition a Member from Group 1 to Group 2 only when the Member chooses to transition from the NF to an HCBS setting. Members shall not be required to transition from Group 1 to Group 2.~~
- ~~(ii) When Members move from Group 1 to Group 2, DHS must recalculate the Member's Patient Liability based on the Community PNA.~~

~~2. Transition from Group 2 to Group 1.~~

- ~~(i) An MCO may request to transition a Member from Group 2 to Group 1 only under the following circumstances:
 
  - ~~(I) The Member chooses to transition from HCBS to NF, for example, due to a decline in the Member's health or functional status, or a change in the Member's natural caregiving supports; or~~
  - ~~(II) The MCO has made a determination that the Member's needs can no longer be safely met in the community and at a cost that does not exceed the average cost of NF services for which the Member would qualify, and the Member chooses to transition to the more appropriate institutional setting in order to safely meet his needs.~~~~
- ~~(ii) When Members move from Group 2 to Group 1, DHS must recalculate the Member's Patient Liability based on the Institutional PNA.~~

~~3. At such time as a transition between groups is made, the MCO shall issue notice of transition to the Member. Because the Member has elected the transition and remains enrolled in CHOICES, such transition between CHOICES groups shall not constitute an adverse action. Thus, the notice will not include the right to appeal or request a fair hearing regarding the Member's decision.~~

#### Transitioning Between CHOICES Groups.

##### (a) Transition from Group 1 to Group 2.

1. An MCO may request to transition a Member from Group 1 to Group 2 only when the Member chooses to transition from the NF to an HCBS setting. Members shall not be required to transition from Group 1 to Group 2.
2. When Members move from Group 1 to Group 2, DHS must recalculate the Member's Patient Liability based on the Community PNA.

##### (b) Transition from Group 2 to Group 1.

1. An MCO may request to transition a Member from Group 2 to Group 1 only under the following circumstances:
 
  - (i) Except as provided in TennCare Rule 1200-13-01-.05(3)(b)(6), the member meets the NF LOC criteria in place at the time of enrollment into CHOICES Group 1, and at least one (1) of the following is true:
 
    - (I) The Member chooses to transition from HCBS to NF, for example, due to a decline in the Member's health or functional status, or a change in the Member's natural caregiving supports; or
    - (II) The MCO has made a determination that the Member's needs can no longer be safely met in the community and at a cost that does not exceed the average cost of NF services for which the Member would qualify, and the Member chooses to transition to the more appropriate institutional setting in order to safely meet his needs.
  - (ii) When Members move from Group 2 to Group 1, DHS must recalculate the Member's Patient Liability based on the Institutional PNA.

(c) At such time as a transition between CHOICES Groups 1 and 2 is made, the MCO shall issue notice of transition to the Member. Because the Member has elected the transition and remains enrolled in CHOICES, such transition between CHOICES groups shall not constitute an adverse action. Thus,

the notice will not include the right to appeal or request a fair hearing regarding the Member's decision.

(d) Transition from CHOICES Group 1 or CHOICES Group 2 to CHOICES Group 3.

1. The State or the MCO shall, subject to eligibility and enrollment criteria set forth in TennCare Rule 1200-13-01-.05(3) and (4), initiate a transition from Group 1 or from Group 2 to Group 3 when a member who was enrolled in CHOICES Group 1 or Group 2 on or after July 1, 2012, no longer meets NF LOC, but is At Risk for Institutionalization as defined in Rule 1200-13-01-.02.
2. When a Member transitions from CHOICES Group 1 to Group 3, DHS must recalculate the Member's Patient Liability based on the Community PNA.

(e) Transition from CHOICES Group 3 to CHOICES Group 1 or CHOICES Group 2.

1. The State or the MCO shall initiate a transition from Group 3 to Group 1 or Group 2, as appropriate, when the Member meets NF LOC in place at the time of the transition request and satisfies all requirements for enrollment into the requested Group.
2. When a member transitions from Group 3 to Group 1, DHS must recalculate the Member's Patient Liability based on the Institutional PNA.

Subparagraph (c) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the word "receive" so as amended Subparagraph (c) shall read as follows:

- (c) Members of CHOICES Group 2 who are Medicaid eligible receive CHOICES HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Medicaid recipients, as specified in Rule 1200-13-13-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.

Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding new Subparagraphs (e) and (f) and the current Subparagraphs (e) and (f) are re-lettered as Subparagraphs (g) and (h) and subsequent subparagraphs are re-lettered accordingly so as amended the new Subparagraphs (e) and (f) shall read as follows:

- (e) Members of CHOICES Group 3 who are SSI Eligible receive HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Medicaid recipients, as specified in Rule 1200-13-13-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.
- (f) Members of CHOICES Group 3 who are eligible for TennCare Standard in the CHOICES At-Risk Demonstration Group receive HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Standard recipients, as specified in Rule 1200-13-14-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.

Subparagraph (h) re-lettered as (j) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new re-lettered Subparagraph (j) which shall read as follows:

- (j) All LTC services, NF services as well as HCBS, must be authorized by the MCO in order for MCO payment to be made for the services. An MCO may elect to accept the Bureau's PAE determination as its prior authorization for NF services. NF care may sometimes start before authorization is obtained, but payment will not be made until the MCO has authorized the service. ~~Except for special provisions which may be made by an MCO during the Continuity of Care period for CHOICES implementation,~~ HCBS must be specified in an approved POC and authorized by the MCO prior to delivery of the service in order for MCO payment to be made for the service.

Subparagraph (i) re-lettered as (k) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" at the beginning of the first sentence and replacing "(h)" in the third sentence with "(j)" so as amended re-lettered Subparagraph (k) shall read as follows:

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

Parts 3., 6., 9., 10. and 13. of Subparagraph (i) re-lettered as Subparagraph (k) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with new Parts 3., 6., 9., 10 and 13., and Subparagraph (k) is also amended by adding a new Table for "Benefits for CHOICES 3 Members" which shall read as follows:

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction  ("Eligible HCBS")	Benefits for Immediate Eligibles  ("Specified HCBS")
3. Attendant Care	<p><u>Covered only for persons who require hands-on assistance with ADLs when needed for more than 4 hours per occasion or visits at intervals of less than 4 hours between visits. Covered with a limit of 1080 hours per calendar year, per Member.</u></p> <p><u>For Members who do not require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1080 hours per calendar year, per Member.</u></p> <p><u>For Members who require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1240 hours for calendar year 2012, per Member.</u></p> <p><u>For Members who require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, beginning January 1, 2013, covered with a limit of 1400 hours per calendar year, per Member.</u></p> <p>Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.</p>	Yes	Yes

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction  ("Eligible HCBS")	Benefits for Immediate Eligibles  ("Specified HCBS")
6. Homemaker Services	<p><del>Covered with a limit of 3 visits per week, per Member.</del></p> <p><u>*Covered only for members who also need hands-on assistance with ADLs and as a component of Attendant Care or Personal Care Visits as defined in these rules.</u></p> <p><u>Not covered as a stand-alone benefit.</u></p> <p><u>Not covered for persons who do not require hands-on assistance with ADLs.</u></p> <p>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.</p>	<p><del>Yes</del> * -</p>	<p><del>Yes</del> * -</p>
9. Minor Home Modifications	<p>Covered with a limit of \$6,000 per project, \$10,000 per calendar year, and \$20,000 per lifetime.</p> <p>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care, except when provided as a CEA to facilitate transition from a NF to the community. See Rule <del>4200-13-01-.05(7)(m)</del> <u>1200-13-01-.05(8)(o)</u>.</p>	No	N/A
10. Personal Care Visits	<p>Covered with a limit of 2 intermittent visits per day, per Member; visits limited to a maximum of 4 hours per visit and <del>shall not run consecutively</del> <u>there shall be at least four (4) hours between intermittent visits.</u></p> <p>Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.</p>	Yes	Yes
13. Short-Term NF Care	<p>Covered with a limit of 90 days per stay, per Member.</p> <p>Approved PAE and PASRR required.</p> <p>Members receiving Short-Term NF Care are not eligible to receive any other HCBS except when permitted as a CEA to facilitate transition to the community. See Rule <del>4200-13-01-.05(7)(m)</del> <u>1200-13-01-.05(8)(o)</u>.</p>	No	N/A

<u>Service</u>	<u>Benefits for CHOICES 3 Members</u>	<u>Benefits for Consumer Direction</u>  <u>("Eligible HCBS")</u>	<u>Benefits for Immediate Eligibles</u>  <u>("Specified HCBS")</u>
<u>1. Adult Day Care</u>	<u>Covered with a limit of 2080 hours per calendar year, per CHOICES Member.</u>	<u>No</u>	<u>N/A</u>
<u>2. Assistive Technology</u>	<u>Covered with a limit of \$900 per calendar year, per Member.</u>	<u>No</u>	<u>N/A</u>
<u>3. Attendant Care</u>	<p><u>Covered only for persons who require hands-on assistance with ADLs when needed for more than 4 hours per occasion or visits at intervals of less than 4 hours between visits.</u></p> <p><u>For Members who do not require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1080 hours per calendar year, per Member.</u></p> <p><u>For Members who require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, covered with a limit of 1240 hours for calendar year 2012, per Member.</u></p> <p><u>For Members who require homemaker services as defined in Rule 1200-13-01-.02 in addition to hands on assistance with ADLs, beginning January 1, 2013, covered with a limit of 1400 hours per calendar year, per Member.</u></p> <p><u>Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.</u></p>	<u>Yes</u>	<u>N/A</u>
<u>4. Home-Delivered Meals</u>	<p><u>Covered with a limit of 1 meal per day, per Member.</u></p> <p><u>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.</u></p>	<u>No</u>	<u>N/A</u>
<u>5. Homemaker Services</u>	<p><u>*Covered only for members who also need hands-on assistance with ADLs and as a component of Attendant Care or Personal Care Visits as defined in these rules.</u></p> <p><u>Not covered as a stand-alone benefit.</u></p> <p><u>Not covered for persons who do not require hands-on assistance with ADLs.</u></p> <p><u>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.</u></p>	<u>*</u> <u>-</u>	<u>*</u> <u>-</u>
<u>6. In-Home Respite Care</u>	<p><u>Covered with a limit of 216 hours per calendar year, per Member.</u></p> <p><u>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.</u></p>	<u>Yes</u>	<u>N/A</u>

<u>Service</u>	<u>Benefits for CHOICES 3 Members</u>	<u>Benefits for Consumer Direction</u>  <u>("Eligible HCBS")</u>	<u>Benefits for Immediate Eligibles</u>  <u>("Specified HCBS")</u>
<u>7. Inpatient Respite Care</u>	<u>Covered with a limit of 9 days per calendar year, per Member.</u>  <u>PAE and PASRR approval not required.</u>  <u>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.</u>	<u>No</u>	<u>N/A</u>
<u>8. Minor Home Modifications</u>	<u>Covered with a limit of \$6,000 per project, \$10,000 per calendar year, and \$20,000 per lifetime.</u>  <u>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care, except when provided as a CEA to facilitate transition from a NF to the community. See Rule 1200-13-01-.05(8)(o).</u>	<u>No</u>	<u>N/A</u>
<u>9. Personal Care Visits</u>	<u>Covered with a limit of 2 intermittent visits per day, per Member; visits limited to a maximum of 4 hours per visit and there shall be at least four (4) hours between intermittent visits.</u>  <u>Not covered when the Member is receiving any of the following HCBS: Adult Day Care, CBRA facility services, Short-Term NF Care.</u>	<u>Yes</u>	<u>N/A</u>
<u>10. PERS</u>	<u>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.</u>	<u>No</u>	<u>N/A</u>
<u>11. Pest Control</u>	<u>Covered with a limit of 9 treatment visits per calendar year, per Member.</u>  <u>Not covered when the Member is receiving CBRA facility services or Short-Term NF Care.</u>	<u>No</u>	<u>N/A</u>
<u>12. Short-Term NF Care</u>	<u>Covered with a limit of 90 days per stay, per Member.</u>  <u>Approved PAE and PASRR required.</u>  <u>Members receiving Short-Term NF Care are not eligible to receive any other HCBS except when permitted as a CEA to facilitate transition to the community. See Rule 1200-13-01-.05(8)(0).</u>	<u>No</u>	<u>N/A</u>

Part 3. Homemaker Services of Subparagraph (j) re-lettered as Subparagraph (l) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and subsequent parts renumbered accordingly.

Introductory Subparagraph (j) re-lettered as Subparagraph (l) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the phrase "Subparagraph (i)" and replacing it with the phrase "Subparagraph (k)" so that as amended introductory Subparagraph (l) shall read as follows:

- (l) Applicants who qualify as "Immediate Eligibles" are eligible only for certain HCBS covered under CHOICES. They are not eligible for any other TennCare benefits, including other CHOICES benefits. These HCBS, called Specified HCBS, are listed below. The limits are the same as those specified in ~~Subparagraph (i)~~ Subparagraph (k) above. When the limit is an annual limit, the services used in the Immediate Eligibility period count against the annual limit if the applicant should become eligible for TennCare.

Introductory paragraph of Subparagraph (m) re-lettered as Subparagraph (o) of Paragraph (7) renumbered as Paragraph (8) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "or CHOICES 3" after the number two "2" in the first sentence so as amended the introductory Subparagraph (o) shall read as follows:

- (o) Transition Allowance. For CHOICES Members moving from CHOICES 1 to CHOICES 2 or CHOICES 3, the MCO may, at its sole discretion, provide a Transition Allowance not to exceed two thousand dollars (\$2,000) per lifetime as a CEA to facilitate transition of the Member from the NF to the community. Items that may be purchased or reimbursed are limited to the following:

Introductory Subparagraph (a) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "and CHOICES Group 3" after the word and number "Group 2" so as amended introductory Subparagraph (a) shall read as follows:

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

Parts 3. and 4. of Subparagraph (a) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program are deleted in their entirety and replaced with new Parts 3. and 4. which shall read as follows:

3. Upon completion of the comprehensive needs assessment, CHOICES Members determined to need Eligible CHOICES HCBS may elect to receive one or more of the Eligible CHOICES HCBS through a Contract Provider, or they may participate in CD. Companion Care is available only through CD.
4. CHOICES Members who do not need Eligible CHOICES HCBS shall not be offered the opportunity to enroll in CD.

Introductory Subparagraph (b) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Introductory Subparagraph (b) which shall read as follows:

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

Subpart (ii) of Part 1. of Subparagraph (b) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Subpart (ii) which shall read as follows:

- (ii) Companion Care (available only to Members electing CD and in CHOICES Group 2; not available to CHOICES Group 3 members).

Subpart (iii) Homemaker Services of Part 1. of Subparagraph (b) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and subsequent parts renumbered accordingly.

Part 1. of Subparagraph (c) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "or CHOICES Group 3" at the end of the sentence so as amended Part 1. shall read as follows:

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

Part 1. of Subparagraph (d) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Part 1. which shall read as follows:

1. A CHOICES Group 2 or CHOICES Group 3 Member assessed to need one or more eEligible CHOICES HCBS may elect to participate in CD at any time.

Subpart (i) of Part 1. of Subparagraph (f) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "or CHOICES Group 3" at the end of the sentence so as amended Subpart (i) shall read as follows:

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

Subpart (ii) of Part 1. of Subparagraph (i) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by deleting the words and comma "Homemaker Services," in the third sentence so as amended Subpart (ii) shall read as follows:

- (ii) Members may hire family members, excluding spouses, to serve as Workers. However, a family member shall not be reimbursed for a service that he would have otherwise provided without pay. A member shall not be permitted to employ any person who resides with the member to deliver Personal Care Visits, Attendant Care, ~~Homemaker Services,~~ or In-Home Respite Care. A Member or his Representative for CD shall not be permitted to employ either of the following to deliver Companion Care services:

Part 1. of Subparagraph (j) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the phrase "or CHOICES Group 3" after the word and number "Group 2" so as amended Part 1. shall read as follows:

1. A Competent Adult, as defined in this Chapter, with a functional disability living in his own home, enrolled in CHOICES Group 2 or CHOICES Group 3, and participating in CD, or his Representative for CD, may choose to direct and supervise a Consumer-Directed Worker in the performance of a Health Care Task as defined in this Chapter.

Part 3. of Subparagraph (j) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the words "delivering Eligible" so as amended Part 3. shall read as follows:

3. A Member shall not receive additional amounts of any service as a result of his decision to self-direct health care tasks. Rather, the Health Care Tasks shall be performed by the Worker in the course of delivering Eligible CHOICES HCBS already determined to be needed, as specified in the POC.

Part 7. of Subparagraph (j) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the word "eligible" in the first sentence so as amended Part 7. shall read as follows:

7. The Member or his Representative for CD will identify one or more Consumer-Directed Workers who will perform the task in the course of delivery of eligible CHOICES HCBS. If a Worker agrees to perform the Health Care Tasks, the tasks to be performed must be specified in the Service Agreement. The Member or his Representative for CD is solely responsible for identifying a Worker who is willing to perform Health Care Tasks, and for instructing the paid personal aide on the task(s) to be performed.

Subpart (iii) of Part 1. of Subparagraph (k) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is amended by adding the word "CHOICES" after the word "Eligible" in the first sentence so as amended Subpart (iii) shall read as follows:

- (iii) If a Member voluntarily withdraws or is involuntarily withdrawn from CD, any Eligible CHOICES HCBS he receives, with the exception of Companion Care, shall be provided

through Contract Providers, subject to the requirements in this Chapter. Companion Care is only available through CD.

Item (II) of Subpart (i) of Part 2. of Subparagraph (k) of Paragraph (8) renumbered as Paragraph (9) of Rule 1200-13-01-.05 TennCare CHOICES Program is deleted in its entirety and replaced with a new Item (II) which shall read as follows"

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

Subparagraph (c) of Paragraph (11) renumbered as Paragraph (12) of Rule 1200-13-01-.05 TennCare CHOICES program is amended by deleting the words "Rule 1200-13-01-.10(6)" after the words "in accordance with" and replacing them with the words "Rule 1200-13-01-.10(7)" so that as amended Subparagraph (c) shall read as follows:

- (c) Appeals related to the PAE process (including decisions pertaining to the PASRR process) are processed by the Bureau's Division of Long-Term Care in accordance with ~~Rule 1200-13-01-.10(6)~~ Rule 1200-13-01-.10(7).

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

Subparagraph (b) of Paragraph (1) of Rule 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC is deleted in its entirety and replaced with a new Subparagraph (b) which shall read as follows:

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

Subparagraphs (c) and (d) of Paragraph (2) of Rule 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC are deleted in their entirety and replaced with new Subparagraphs (c) and (d) which shall read as follows:

- (c) For Members of the CHOICES 217-Like Group and the CHOICES At-Risk Demonstration Group, the State uses institutional eligibility and post-eligibility rules for determining Patient Liability in the same manner as specified under 42 C.F.R. §§ 435.217, 435.236, and 435.726 and Section 1924 of the Social Security Act (42 U.S.C.A. § 1396r-5), if the HCBS were provided under a Section 1915(c) Waiver.
- (d) For a Member of CHOICES Group 2 or CHOICES Group 3 receiving the Short-Term NF Care benefit (for up to 90 days) or an Enrollee in one of the State's Section 1915(c) Waiver programs who is temporarily placed in a medical institution, i.e., a hospital, NF or ICF/MR (for up to ~~120 days if admitted prior to 3/1/2010, or up to 90 days, if admitted on or after 3/1/2010~~), the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. The purpose is to ensure that the individual can maintain a community residence for transition back to the community. After 90 days, ~~or 120 days, as applicable~~, or as soon as it appears that the inpatient stay will not be a short-term stay, whichever comes first, a CHOICES Group 2 or CHOICES Group 3 Member will be transitioned to CHOICES Group 1, or a waiver participant must be disenrolled from the waiver, and the institutional post-eligibility calculation shall apply.

Part 2. of Subparagraph (e) of Paragraph (2) of Rule 1200-13-01-.08 Personal Needs Allowance (PNA), Patient Liability, Third Party Insurance and Estate Recovery for Persons Receiving LTC is deleted in its entirety and replaced with a new Part 2. which shall read as follows:

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

that were reimbursed by the MCO for that month. The amount of Patient Liability collected by the MCO cannot exceed the cost of CHOICES Group 2 or CHOICES Group 3 benefits (or CEA services provided as an alternative to CHOICES Group 2 or CHOICES Group 3 benefits) reimbursed by the MCO for that month.

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

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

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

- (1) Definitions. See Rule 1200-13-01-.02.
- (2) PreAdmission Evaluations and Discharge/Transfer/Hospice Forms
  - (a) A PAE is required in the following circumstances:
    1. When a Medicaid Eligible is admitted to a NF for receipt of Medicaid-reimbursed NF Services.
    2. When a private-paying resident of a NF attains Medicaid Eligible status.
    3. When Medicare reimbursement for SNF services has ended and Medicaid Level 2 reimbursement for Level 2-NF services is requested.
    4. When a NF Eligible is changed from Medicaid Level 1 to Medicaid Level 2 reimbursement, or from Medicaid Level 1 or Level 2 reimbursement to a Chronic Ventilator or Tracheal Suctioning Enhanced Respiratory Care rate, except as specified in Rule 1200-13-01-.10(5)(f).
    5. When a NF Eligible is changed from Medicaid Level 2 reimbursement or an Enhanced Respiratory Care rate to Medicaid Level 1 reimbursement, unless the individual has an approved unexpired Level 1 PAE.
    6. When a NF Eligible is changed from an Enhanced Respiratory Care rate to Medicaid Level 2 reimbursement, unless the individual has an approved unexpired Level 2 PAE.
    7. When a NF Eligible requires continuation of the same LOC beyond the expiration date assigned by the Bureau.
    8. When a NF Eligible no longer requires the specific skilled nursing or rehabilitative services for which a Level 2 PAE was approved but requires other Level 2 care in a NF.
  - (b) ~~Transfer Forms are not required in Grand Divisions of the State where CHOICES has not been implemented. A Transfer Form is required under the FFS program (prior to implementation of the CHOICES program in the Grand Region) at the following circumstances:~~ NFs are required to complete and submit to the member's MCO a Discharge/Transfer/Hospice Form any time a member discharges from the facility or stops receiving NF services in the facility, which shall include but is not limited to the following circumstances:
    1. ~~When a Medicaid Eligible having an approved unexpired PreAdmission Evaluation transfers from Medicaid Level 1 at one Nursing Facility to Medicaid Level 1 at another facility, or CHOICES member transfers from one Nursing Facility to another such facility.~~

2. ~~When a Medicaid Eligible having an approved unexpired PreAdmission Evaluation transfers from Medicaid Level 2 at one Nursing Facility to Medicaid Level 2 at another. A Transfer Form may be used only if there is no change in the skilled nursing or rehabilitative service for which the PreAdmission Evaluation was approved. If the skilled nursing or rehabilitative service changes, a new PreAdmission Evaluation is required. CHOICES member discharges to the hospital (even when readmission to the NF is expected following the hospital stay).~~
3. ~~When a Medicaid Eligible having an approved, unexpired PAE transfers from Medicaid Level 1 in a NF to the Statewide E/D Waiver or from the Statewide E/D Waiver to Medicaid Level 1 in a NF. This requirement shall be in effect only in those Grand Divisions where the CHOICES program has not been implemented. CHOICES member elects to receive hospice services (even if Medicare will be responsible for payment of the hospice benefit).~~
4. ~~When a CHOICES member discharges home, with or without HCBS. In this case, the NF is obligated to notify the MCO before the member is discharged from the facility and to coordinate with the MCO in discharge planning in order to ensure that any home and community based services needed by the member will be available upon discharge, and to avoid a lapse in CHOICES and/or TennCare eligibility.~~
5. ~~Upon the death of a CHOICES member.~~

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

1. When a Medicaid Eligible with an approved unexpired Level 1 PreAdmission Evaluation returns to the Nursing Facility after being hospitalized.
2. When a Medicaid Eligible with an approved unexpired Level 2 PreAdmission Evaluation returns to the Nursing Facility after being hospitalized, if there has been no change in the skilled nursing or rehabilitative service for which the PreAdmission Evaluation was approved.
3. When a Medicaid Eligible changes from Level 2 to Level 1 NF reimbursement if that individual was previously receiving Medicaid-reimbursed Level 1 care and still has an approved unexpired Level 1 PreAdmission Evaluation.
4. ~~When an individual's financial status changes from Medicaid-eligible to private pay and then back to Medicaid Eligible within a 90-day time period.~~
4. To receive Medicaid co-payment when Medicare is the primary payer of Level 2 Skilled Nursing Facility care.
5. When a Discharge/Transfer/Hospice Form is appropriate in accordance with (2)(b).
6. For authorization by an MCO of Ventilator Weaning services or short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention. Medical necessity determinations and authorization of Ventilator Weaning services and short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate during the post-weaning period will be managed by the Enrollee's MCO.
7. When a person will be receiving hospice services in the NF.

(d) If a NF admits or allows continued stay of a Medicaid Eligible without an approved PAE, it does so at its own risk and in such event the NF shall give the individual a plain language

written notice, in a format approved by the Bureau, that Medicaid reimbursement will not be paid unless the PAE is approved and if it is not finally approved the individual can be held financially liable for services provided, including services delivered prior to the effective date of the PAE and enrollment in CHOICES Group 1, unless a third party is liable.

- (e) Except as specified in 1200-13-01-.10(2)(e)2., an approved PreAdmission Evaluation is valid for ninety (90) calendar days beginning with the PAE Approval Date, unless an earlier expiration date has been established by TennCare (see 1200-13-01-.10(2)(h)). A valid approved PreAdmission Evaluation that has not been used within ninety (90) calendar days of the PAE Approval Date can must be updated within 365 days of the PAE approval date if the physician certifies that the individual's current medical condition is consistent with that described in the approved PreAdmission Evaluation before it can be used. For purposes of Medicaid-reimbursed NF services, such update may be completed only upon submission of a confirmed Medicaid Only Payer Date. To update the PAE, the physician (in the case of NF services) or a Qualified Assessor (in the case of HCBS) shall certify that the applicant's medical condition on the revised PAE Request Date is consistent with that described in the initial certification and/or assessment and that Nursing Facility services, or alternative HCBS, as applicable, are medically necessary for the applicant. If the individual's medical condition has significantly improved ~~changed~~ such that the previously approved PreAdmission Evaluation does not reasonably reflect the individual's current medical condition and functional capabilities, a new PreAdmission Evaluation shall be required.

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

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

- (i) The person transfers to another NF;
- (ii) The person is discharged to the hospital and returns directly to the NF or to another NF;
- (iii) The person is discharged home for therapeutic leave and returns to the NF within no more than ten (10) days;
- (iv) The person is discharged home and a request to transition to CHOICES Group 2 is submitted by the MCO to TennCare prior to the person's discharge from the NF.

3. For persons electing hospice:

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

(I) the person has remained in the NF;

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

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

(IV) NF LOC criteria have not changed.

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

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

- (f) A PAE must include a recent history and physical or current medical records that support the applicant's functional and/or skilled nursing or rehabilitative needs, as reflected in the PAE. A history and physical performed within 365 calendar days of the PAE Request Date may be used if the patient's condition has not significantly changed. Additional Medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed, or may be used in lieu of a history and physical, so long as the records provide medical evidence sufficient to support the functional and/or skilled or rehabilitative needs reflected in the PAE.
- (g) A PAE must be certified as follows:
1. Physician certification shall be required for reimbursement of NF services and enrollment into CHOICES Group 1. Consistent with requirements pertaining to certification of the need for SNF care set forth at 42 CFR § 424.20, certification of the need for NF care may be performed by a nurse practitioner or clinical nurse specialist, neither of whom has a direct or indirect employment relationship with the facility but who is working in collaboration with a physician.
  2. Certification of the level of care assessment by a Qualified Assessor shall be required for all PAEs.
- (h) A PAE may be approved by the Bureau for a fixed period of time with an expiration date based on an assessment by the Bureau of the individual's medical condition and anticipated continuing need for inpatient nursing care. Notice of appeal rights shall be provided when a PAE is approved with an expiration date.
- (i) PASRR
1. All individuals who reside in or seek admission to a Medicaid-certified Nursing Facility must have a PASRR Level I screen for mental illness and mental retardation. The initial Level I screen must be completed prior to admission to the Nursing Facility and submitted to TennCare regardless of:
    - (i) payer source;
    - (ii) whether the PASRR screening is positive or negative (including specified exemptions); and
    - (iii) the level of nursing facility reimbursement requested.
  2. If the Level I screen indicates the need for a PASRR Level II evaluation of need for specialized services for mental illness and/or mental retardation, the individual must undergo the PASRR Level II evaluation prior to admission to the Nursing Facility.
- (j) Medicaid payment will not be available for any dates of Nursing Facility services rendered prior to the date the PASRR process is complete and the individual has been determined appropriate for nursing home placement. The PASRR process is complete when either:
1. TennCare has received a negative Level I PASRR screen form and no contradictory information is subsequently received; or
  2. For persons with a positive Level I PASRR screen (as submitted or upon review and determination by the Bureau), the Bureau has received a certified exemption or advance categorical determination signed by the physician; or a determination by DMHDDDMH and/or DHDSDIDD, as applicable, that the person is appropriate for NF placement. Determination by the Bureau that a Level II PASRR evaluation must be performed may be made:

- (i) Upon receipt of a positive PASRR screen from the NF or other submitting entity;
- (ii) Based on TennCare review of a negative PASRR screening form or history and physical submitted by a NF or other entity; or
- (iii) Upon review of any contradictory information submitted in the PAE application or supporting documentation at any time prior to disposition of the PAE.

(k) A NF that has entered into a provider agreement with ~~the Bureau of~~ a TennCare MCO shall assist a resident or applicant as follows:

- 1. The Nursing Facility shall assist a Nursing Facility resident or an applicant for admission in applying for Medicaid eligibility and in applying for Medicaid-reimbursed Nursing Facility care. This shall include assistance in properly completing all necessary paperwork and in providing relevant Nursing Facility documentation to support the PreAdmission Evaluation. Reasonable accommodations shall be made for an individual with disabilities or, alternatively, for a designated Correspondent with disabilities when assistance is needed with the proper completion and submission of a PreAdmission Evaluation.
- 2. The Nursing Facility shall request a Notice of Disposition or Change from the Department of Human Services upon learning that a resident or applicant has, or is likely to have, applied for Medicaid eligibility.

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

(3) Medicaid Reimbursement

(a) A NF that has entered into a provider agreement with ~~the Bureau or an Enrollee's~~ a TennCare MCO is entitled to receive Medicaid reimbursement for covered services provided to a NF Eligible if:

- 1. The Nursing Facility has completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.
- 2. The Bureau has received an approvable PAE for the individual 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. ~~Prior to implementation of the CHOICES Program, for the same level transfer to NF services (Level 1 to Level 1, Level 2 to Level 2, or HCBS to Level 1) of an individual having an approved unexpired PAE, the Bureau has received an approvable Transfer Form within ten (10) calendar days after admission into the same LOC at the admitting NF (i.e., the NF to which the individual is being transferred). For transfer from Level 1 NF services to the Statewide HCBS E/D Waiver, the Transfer Form must be submitted and approved prior to enrollment in HCBS. The NF has entered into the TennCare Pre Admission 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(109).
- (b) Any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.
1. Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no earlier more than ten (10) days prior to the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application.
  2. Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for nursing facility services.
- (c) The earliest date of Medicaid reimbursement for care provided in a Nursing Facility shall be the date that all of the following criteria are met:
1. Completion of the PASRR process, as defined in 1200-13-01-.10(2)(i) above;
  2. The effective date of level of care eligibility as reflected by the PAE Approval Date;
  3. The effective date of Medicaid eligibility; ~~and~~
  4. The date of admission to the Nursing Facility; 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. Advance determination by TennCare that a person not enrolled in TennCare at the time the PAE is submitted cannot be safely supported within the array of services and supports that would be available if the person were enrolled in CHOICES 3 and approval of NF LOC shall be effective for no more than thirty (30) days, pending a comprehensive assessment and plan of care developed by the MCO Care Coordinator once the person 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 subsequently 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 made.

(e) Application of new LOC Criteria

The new LOC criteria set forth in 1200-13-01-.10(4) shall be applied to all persons 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 which must be applied.
2. TennCare may, at its discretion, review a PAE that had been reviewed and approved based on the LOC NF criteria in place as of June 30, 2012, to determine whether a person who will be enrolled into CHOICES on or after July 1, 2012 meets the new LOC criteria. However, all persons 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)(d) A NF that has entered into a provider agreement with ~~the Bureau or an a TennCare MCO~~ and that admits a Medicaid Eligible without completion of the PASRR process, and without an approved PAE or, ~~where applicable, an approved Transfer Form~~ does so without the assurance of Medicaid reimbursement ~~from the Bureau or the MCO.~~

(g)(e) Medicaid reimbursement will only be made to a Nursing Facility on behalf of the Nursing Facility Eligible and not directly to the Nursing Facility Eligible.

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

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

- (a) The Nursing Facility must have completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.
- (b) The individual must be determined by DHS to be eligible for Medicaid reimbursement for NF care.
- (c) An individual must meet both of the following criteria in order to be approved:
  1. Medical Necessity of Care:
    - (i) Persons receiving requesting Medicaid-reimbursed NF care  
Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.
    - (ii) Persons receiving requesting HCBS in CHOICES or PACE

HCBS must be required in order to allow the person to continue living safely in the home or community-based setting and to prevent or delay placement in a nursing facility, 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 nursing facility.

2. Need for Inpatient Nursing Care:

(i) Persons receiving requesting care in a Nursing Facility

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

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

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

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

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

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

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

(iii) Persons not eligible to receive care in a NF, but at risk of NF placement and receiving requesting HCBS in CHOICES Group 3, including Interim CHOICES Group 3.

The individual must have a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. In the absence of ongoing CHOICES HCBS, the person 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 capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance. The individual must be unable to self-perform needed nursing care and must meet one (1) or more of the following criteria on an ongoing basis:

- (I) Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or ~~multiple times~~ at least four days per week).
- (II) Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or ~~multiple times~~ at least four days per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.
- (III) Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth (daily or at least four days per week). Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.
- (IV) Toileting - The individual 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 ~~multiple times~~ at least four days per week).
- (V) Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual 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 staff intervention (daily or at least four days per week).
- (VI) Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility) daily or at least four days per week.
- (VII) Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications (daily or at least four days per week) despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.
- (VIII) Behavior - The individual requires persistent staff intervention (daily or at least four days per week) due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement).

- (IX) Skilled Nursing or Rehabilitative Services - The individual 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.

~~The intent is that the above criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.~~

- (d) For continued Medicaid reimbursement of Medicaid-reimbursed Level 1 care in a Nursing Facility, an individual must continue to be financially eligible for Medicaid reimbursement for Nursing Facility Care and must meet both of the following continued stay criteria continue to meet NF LOC (including medical necessity of care and the need for inpatient care) in place at the time of enrollment into CHOICES Group 1.
- ~~1. Medical Necessity of Care: Care in a Nursing Facility must be expected to improve or ameliorate the individual'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.~~
  - ~~2. Need for Inpatient Care: The individual must have a physical or mental condition, disability, or impairment that continues to require the availability of daily inpatient nursing care.~~
- (e) A Nursing Facility Eligible admitted to a Nursing Facility and to CHOICES Group 1 before the effective date of this rule must meet continued stay criteria in effect at the time of admission prior to July 1, 2012, who continues to meet the LOC criteria in place at the time of enrollment into CHOICES Group 1 shall continue to meet NF LOC for purposes of enrolling in CHOICES Group 2, subject to requirements set forth in 1200-13-01-.05(3).
- (f) A Nursing Facility Eligible receiving HCBS in CHOICES Group 2 prior to July 1, 2012, shall be required to meet the NF LOC in place as of July 1, 2012, in order to qualify for Medicaid-reimbursed NF care unless TennCare determines that the person's needs can no longer be safely and cost-effectively met in CHOICES Group 2.
- (5) Criteria for Medicaid Level 2 and Enhanced Respiratory Care Reimbursement of Medicaid Level 2 Care in a Nursing Facility
- (a) The Nursing Facility must have completed the PASRR process as defined in 1200-13-01-.10(2)(i) above.
  - (b) The individual must be determined by DHS to be eligible for Medicaid reimbursement for NF care.
  - (c) An individual must meet both of the following criteria in order to be approved for Medicaid-reimbursed Medicaid Level 2 reimbursement of care in a Nursing Facility:
    - ~~1. Medical Necessity of Care: Care in a Nursing Facility must be expected to improve or ameliorate the individual'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. The individual must meet NF LOC as defined in 1200-13-01-.10(4) above.~~
    2. Need for Inpatient Skilled Nursing or Rehabilitative Services on a Daily Basis: The individual must have a physical or mental condition, disability, or impairment that requires skilled nursing or rehabilitative services on a daily basis or skilled rehabilitative services at least five days per week when skilled rehabilitative services constitute the primary basis for the approval of the PreAdmission Evaluation. The individual must require such services at a greater frequency,

duration, or intensity than, for practical purposes, would be provided through a daily home health visit. In addition, the individual must be mentally or physically unable to perform the needed skilled services or the individual must require skilled services which, in accordance with accepted medical practice, are not usually and customarily self-performed.

For interpretation of this rule, the following shall apply:

- (i) Administration of oral medications, ophthalmics, otics, inhalers, subcutaneous injections (e.g., fixed-dose insulin, subtherapeutic heparin, and calcitonin), topicals, suppositories, nebulizer treatments, oxygen administration, shall not, in and of itself, be considered sufficient to meet the requirement of (5)(c)2.
- (ii) Nursing observation and assessment, in and of itself, shall not be considered sufficient to meet the requirement of (5)(c)2. Examples of nursing services for which Level 2 reimbursement might be provided include, but are not limited to, the following:
  - (I) Gastrostomy tube feeding
  - (II) Sterile dressings for Stage 3 or 4 pressure sores
  - (III) Total parenteral nutrition
  - (IV) Intravenous fluid administration
  - (V) Nasopharyngeal and tracheostomy suctioning
  - (VI) Ventilator services
- (iii) A skilled rehabilitative service must be expected to improve the individual's condition. Restorative and maintenance nursing procedures (e.g., routine range of motion exercises; stand-by assistance during ambulation; applications of splints/braces by nurses and nurses aides) shall not be considered sufficient to fulfill the requirement of (5)(c)2. Factors to be considered in the decision as to whether a rehabilitative service meets, or continues to meet, the requirement of (5)(c)2. shall include, but not be limited to, an assessment of the type of therapy and its frequency, the remoteness of the injury or impairment, and the reasonable potential for improvement in the individual's functional capabilities or medical condition.
- (iv) Effective July 1, 2012, level 2 NF reimbursement for sliding scale insulin may be authorized for an initial period of no more than two (2) weeks for residents with unstable blood glucose levels that require daily monitoring and administration of sliding scale insulin. Approval of such reimbursement will require a physician's order and supporting documentation including a plan of care for stabilizing the applicant's blood sugar and transitioning to fixed dosing during the approval period. Additional periods of no more than two (2) weeks per period, not to exceed a maximum total of sixty (60) days, may be authorized upon submission of a new PAE and only with a physician's order and detailed explanation regarding why previous efforts to stabilize and transition to fixed dosing were not successful.
- (d) In order to be approved for Medicaid-reimbursed ~~Level-2~~ care in a NF at the Chronic Ventilator rate of reimbursement, an individual must be ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula).
- (e) In order to be approved by the Bureau for Medicaid-reimbursed ~~Level-2~~ care in a NF at the Tracheal Suctioning rate of reimbursement, an individual must have a functioning tracheostomy and require suctioning through the tracheostomy, at a minimum, multiple times per eight (8) hour shift. The suctioning must be required to remove excess secretions and/or aspirate from the trachea, which cannot be removed by the patient's

spontaneous effort. Suctioning of the nasal or oral cavity does not qualify for this higher level of reimbursement. An MCO may authorize, based on medical necessity, short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention during the post-weaning period.

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

(6) TennCare Nursing Facility Level of Care Acuity Scale

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

- 1. The applicant's need for assistance with the following Activities of Daily Living (ADLs):
  - (i) Transfer;
  - (ii) Mobility;
  - (iii) Eating; and
  - (iv) Toileting;
- 2. The applicant's level of independence (or deficiency) in the following ADL-related functions:
  - (i) Communication (expressive and receptive);
  - (ii) Orientation (to person and place);
  - (iii) Dementia-related behaviors; and
  - (iv) Self-administration of medications; and
- 3. The applicant's need for certain skilled and/or rehabilitative services.

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

(c) Weighted Values

- 1. Interpretation of possible responses for all measures except behavior
  - (i) "Always" shall mean that the applicant is always independent with that ADL or related activity.
  - (ii) "Usually" shall mean that the person is usually independent (requiring assistance fewer than 4 days per week).
  - (iii) "Usually not" shall mean that the applicant is usually not independent (requiring assistance 4 or more days per week).
  - (iv) "Never" means that the applicant is never independent with that ADL or related activity.
- 2. Interpretation of possible responses for the behavior measure
  - (i) "Always" shall mean that the applicant always requires intervention for dementia-related behaviors.
  - (ii) "Usually" shall mean that the applicant requires intervention for dementia-related behaviors 4 or more days per week.
  - (iii) "Usually not" shall mean that the applicant requires intervention for dementia-related behaviors, but fewer than 4 days per week.
  - (iv) "Never" shall mean that the applicant does not have dementia-related behaviors that require intervention.
- 3. The weighted value of each of the potential responses to a question regarding

the ADL or related functions specified above when supported by the medical evidence submitted with the PAE shall be as follows:

<u>ADL (or related) question</u>	<u>Condition</u>	<u>Always</u>	<u>Usually</u>	<u>Usually not</u>	<u>Never</u>	<u>Maximum Individual Acuity Score</u>	<u>Maximum Acuity Score for the Measure(s)</u>
<u>Transfer</u>	<u>Highest value of two measures</u>	<u>0</u>	<u>1</u>	<u>3</u>	<u>4</u>	<u>4</u>	<u>4</u>
<u>Mobility</u>		<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>3</u>	
<u>Eating</u>		<u>0</u>	<u>1</u>	<u>3</u>	<u>4</u>	<u>4</u>	<u>4</u>
<u>Toileting</u>	<u>Highest value of three questions for the toileting measure</u>	<u>0</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>2</u>	<u>3</u>
<u>Incontinence care</u>		<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>3</u>	
<u>Catheter/ostomy care</u>		<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>3</u>	
<u>Orientation</u>		<u>0</u>	<u>1</u>	<u>3</u>	<u>4</u>	<u>4</u>	<u>4</u>
<u>Expressive communication</u>	<u>Highest value of two questions for the communication measure</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>1</u>	<u>1</u>	<u>1</u>
<u>Receptive communication</u>		<u>0</u>	<u>0</u>	<u>0</u>	<u>1</u>	<u>1</u>	
<u>Self-administration of medication</u>	<u>First question only; excludes SS insulin</u>	<u>0</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>2</u>	<u>2</u>
<u>Behavior</u>		<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>	<u>3</u>	<u>3</u>
<u>Maximum possible ADL (or related) Acuity Score</u>							<u>21</u>

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

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

Teaching self-injection	0
Other	0
Maximum Possible Skilled Services Acuity Score	5

## 5. Conditions

### (i) Maximum Acuity Score for Transfer and Mobility

- (I) Assessment of the need for assistance with transfer and the need for assistance with mobility are separate but overlapping measures of an applicant's physical independence (or dependence) with movement.
- (II) The maximum individual acuity score for transfer shall be four (4).
- (III) The maximum individual acuity score for mobility shall be three (3).
- (IV) The highest individual acuity score among the transfer and mobility measures shall be the applicant's total acuity score across both measures.
- (V) The maximum acuity score across both of the transfer and mobility measures shall be four (4).

### (ii) Maximum Acuity Score for Toileting

- (I) Assessment of the need for assistance with toileting shall include the following:
  - I. An assessment of the applicant's need for assistance with toileting;
  - II. Whether the applicant is incontinent, and if so, the degree to which the applicant is independent in incontinence care; and
  - III. Whether the applicant requires a catheter and/or ostomy, and if so, the degree to which the applicant is independent with catheter and/or ostomy care.
- (II) The highest individual acuity score among each of the three (3) toileting questions shall be the applicant's total acuity score for the toileting measure.
- (III) The maximum acuity score for toileting shall be two (2).

### (iii) Maximum Acuity Score for Communication

- (I) Assessment of the applicant's level of independence (or deficiency) with communication shall include an assessment of expressive as well as receptive communication.
- (II) The highest individual acuity score across each of the two (2) communication questions shall be the applicant's total score for the communication measure.
- (III) The maximum possible acuity score for communication shall be one (1).

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

- (I) Assessment of the applicant's level of independence (or deficiency) with self-administration of medications as an ADL-related function shall not take into consideration whether the applicant requires sliding scale insulin and the applicant's level of independence in self-administering sliding scale insulin.
- (II) Sliding scale insulin shall be considered along with other skilled and/or rehabilitative services for which TennCare could authorize level 2 NF reimbursement.
- (III) The maximum individual acuity score for self-administration of medication shall be two (2).
- (IV) The maximum individual acuity score for sliding scale insulin

shall be one (1).

(v) Maximum Skilled Services Acuity Score

- (I) The highest individual acuity score across all of the skilled and/or rehabilitative services shall be the applicant's total acuity score for skilled and/or rehabilitative services.
- (II) The maximum possible acuity score for skilled and/or rehabilitative services shall be five (5).

(d) Maximum Acuity Score

1. The maximum possible acuity score for Activities of Daily Living (ADL) or related deficiencies shall be twenty-one (21).
2. The maximum possible acuity score for skilled and/or rehabilitative services shall be five (5).
3. The maximum possible total NF LOC acuity score shall be twenty-six (26).

(e) Calculating an Applicant's Total Acuity Score

1. Subject to the conditions set forth in 1200-13-01-10(6)(c)(5), an applicant's acuity score for each functional measure (i.e., eating, toileting, orientation, communication, self-administration of medication, or behavior), or in the case of transfer and mobility, the applicant's acuity score across both measures shall be added in order to determine the applicant's total ADL or related acuity score (up to a maximum of 21).
2. The applicant's total ADL or related acuity score shall then be added to the applicant's skilled services acuity score (up to a maximum of 5) in order to determine the applicant's total acuity score (up to a maximum of 26).

(67) PreAdmission Evaluation Denials and Appeal Rights

- (a) A Medicaid Eligible or the legal representative of the Medicaid Eligible has the right to appeal the denial of a PreAdmission Evaluation and to request a ~~Commissioner's~~ an Administrative Hearing by submitting a written letter of appeal to the Bureau of TennCare, Division of Long-Term Care, within thirty (30) calendar days of receipt of the notice of denial.
- (b) If the Bureau denies a PAE, the individual will be notified in the following manner:
  1. A written notice of denial shall be sent to the individual and, where applicable, to the designated correspondent. A notice of denial shall also be ~~mailed or faxed~~ provided to the Nursing Facility. This notice shall advise the individual of the right to appeal the denial decision within thirty (30) calendar days. The notice shall also advise the individual of the right to submit within thirty (30) calendar days either the original PreAdmission Evaluation with additional information for review or a new PreAdmission Evaluation. The notice shall be mailed to the individual's address as it appears upon the PreAdmission Evaluation. If no address appears on the PreAdmission Evaluation and supporting documentation, the notice will be mailed to the Nursing Facility for forwarding to the individual.
  2. If the PAE is resubmitted with additional information for review or if a new PAE is submitted, and the Bureau continues to deny the PAE, another written notice of denial shall be sent as described in ~~(6)(7)(b)1~~.
- (c) The individual has the right to be represented at the hearing by anyone of his/her choice. The hearing will be conducted according to the provisions of the Tennessee Uniform Administrative Procedures Act.
- (d) Reasonable accommodations shall be made for individuals with disabilities who require assistance with an appeal.

- (e) Any notice required pursuant to this section shall be a plain language written notice.
- (f) When a PAE is approved for a fixed period of time with an Expiration Date determined by the Bureau, the individual shall be provided with a notice of appeal rights, including the opportunity to submit an appeal within thirty (30) calendar days ~~prior to the Expiration Date being reached~~ of receipt of the notice of denial. Nothing in this section shall preclude the right of the individual to submit a new PAE establishing medical necessity of care when the Expiration Date has been reached.

Statutory Authority: T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

I certify that this is an accurate and complete copy of an emergency rule(s), lawfully promulgated and adopted.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Officer: Patti Killingsworth  
Chief, Long-Term Services and Supports, Bureau of  
TennCare

Title of Officer: Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: \_\_\_\_\_

Notary Public Signature: \_\_\_\_\_

My commission expires on: \_\_\_\_\_

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

\_\_\_\_\_  
Robert E. Cooper, Jr.  
Attorney General and Reporter

\_\_\_\_\_  
Date

**Department of State Use Only**

Filed with the Department of State on: \_\_\_\_\_

Effective for: \_\_\_\_\_ \*days

Effective through: \_\_\_\_\_

*\* Emergency rule(s) may be effective for up to 180 days from the date of filing.*

\_\_\_\_\_  
Tre Hargett  
Secretary of State

### **Impact on Local Governments**

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

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

**Additional Information Required by Joint Government Operations Committee**

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

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

The rules allow for changes to the Nursing Facility Level of Care requirements for entry into CHOICES, TennCare's program of long-term services and supports for individuals who are elderly or physically disabled.

- (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 T.C.A. §§ 4-5-208, 71-5-105 and 71-5-109.

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

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

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

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

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