RULES
OF
TENNESSEE DEPARTMENT OF FINANCE
AND ADMINISTRATION
BUREAU OF TENNCARE

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

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1200-13-01-.01 PURPOSE.

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

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

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

1. NF services.

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

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

(c) HCBS waivers for individuals with MR.

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

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

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

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

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

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

(a) Individuals receiving TennCare-reimbursed LTSS, other than those enrolled in the PACE Program, are also enrolled in a TennCare MCO for primary care, behavioral health services, and acute care services.

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

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

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

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

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

(a) AAAD – Area Agencies on Aging and Disability

(b) ACLF – Assisted Care Living Facility

(c) ADL – Activity of Daily Living

(d) CBRA – Community-Based Residential Alternative

(e) CD – Consumer Direction

(f) CEA – Cost Effective Alternative

(g) CMS – Centers for Medicare and Medicaid Services

(h) DBM – Dental Benefits Manager

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

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

(l) EVV – Electronic Visit Verification

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

(n) FEA – Fiscal Employer Agent

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

(o) FERP – Federal Estate Recovery Program

(p) FFS – Fee-for-Service

(q) HCBS – Home and Community Based Services

(r) HH – Home Health

(s) IADL – Instrumental Activity of Daily Living

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

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

(v) LOC – Level of Care

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

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

(y) MCC – Managed Care Contractor

(z) MCO – Managed Care Organization

(aa) MI – Mental Illness

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

(cc) NF – Nursing Facility

(dd) OAA – Operational Administrative Agency

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

(ff) PAE – PreAdmission Evaluation

(gg) PASRR – PreAdmission Screening and Resident Review

(hh) PBM – Pharmacy Benefits Manager

(ii) PDN – Private Duty Nursing

(jj) PERS – Personal Emergency Response System

(kk) POC – Plan of Care

(ll) PNA – Personal Needs Allowance

(mm) QIT – Qualifying Income Trust

(nn) QMRP – Qualified Mental Retardation Professional

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

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

(pp) SPOE – Single Point of Entry

(qq) SSI – Supplemental Security Income

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

(ss) TCAD – Tennessee Commission on Aging and Disability

(tt) TPAES – TennCare Pre-Admission Evaluation System

(uu) TPL – Third Party Liability

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

1200-13-01-.02 DEFINITIONS.

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

(a) Personal hygiene and grooming;

(b) Dressing and undressing;

(c) Self feeding;

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

(e) Bowel and bladder management; and

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

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

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

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

delivering care on a day-to-day basis is living in the home with the individuals for whom he is providing care.

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

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

(3) Adult Day Care.

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

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

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

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

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

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

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

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

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

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

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

(9) 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.

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

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

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

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

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

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

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

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

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

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

(e) A single Contract Provider staff person or Consumer-Directed Worker may provide Attendant Care services to multiple CHOICES Members in the same home and during the same hours, as long as he can provide the services safely and appropriately to each Member. Such arrangements shall be documented in each Member’s POC. In such instances, the total units of service provided by the staff person shall be allocated among the CHOICES Members, based on the percentage of total service units required by each Member on average. The Provider shall bill the MCO only once for

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

each of the service units provided, and shall not bill an MCO or multiple MCOs separately to provide services to multiple Members at the same time.

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

(g) Attendant Care shall not include:

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

2. Yard work; or

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

(11) Back-up Plan.

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

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

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

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

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

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

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

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

(c) Ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and LTSS needed to help the Member maintain or improve

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

his physical or behavioral health status or functional abilities and maximize independence; and

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

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

(16) Certification.

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

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

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

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

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

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

(18) CHOICES 1 and 2 Carryover Group.

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

(b) Subject to the requirements set forth in 1200-13-01-.05(3)(b)6., Members eligible for TennCare in the CHOICES 1 and 2 Carryover Group may continue to qualify in this group after June 30, 2012, so long as they continue to meet NF financial eligibility, continue to meet the NF LOC criteria in place as of June 30, 2012, and remain continuously enrolled in the CHOICES 1 and 2 Carryover Group and in CHOICES Group 1 or CHOICES Group 2.

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

(20) CHOICES At-Risk Demonstration Group.

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

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

(b) Members eligible for TennCare in the CHOICES At-Risk Demonstration Group on June 30, 2015, may continue to qualify in this group after June 30, 2015, so long as they continue to meet NF financial eligibility, continue to be At Risk for Institutionalization as defined in these rules, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES Group 3.

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

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

(23) 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.

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

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

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

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

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

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

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

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

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

2. Companion Care.

(29) Community Living Supports (CLS) (For the purposes of CHOICES). A CBRA licensed by the DIDD in accordance with Title 33 of the T.C.A. and TDMHSAS Rule 0940-5-24, 0940-5-28 or 0940-5-32 as applicable that encompasses a continuum of residential support options for up to four individuals living in a home that supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and comports fully with standards applicable to HCBS settings detailed in 42 C.F.R. § 441.301(c)(4)-(5), including those requirements applicable to provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need and set forth in the person-centered plan of care. This service is available to CHOICES Group 2 and 3 Members as appropriate.

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

(a) Selecting and moving into a home.

(b) Locating and choosing suitable housemates.

(c) Acquiring and maintaining household furnishings.

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

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

(f) Building and maintaining interpersonal relationships with family and friends.

(g) Pursuing educational goals and employment opportunities.

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

(i) Scheduling and attending appropriate medical services.

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

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

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

(m) Asserting civil and statutory rights through self-advocacy.

(30) Community Living Supports Family Model (CLS-FM) (For the purposes of CHOICES). A CBRA licensed by the DIDD in accordance with Title 33 of the T.C.A. and TDMHSAS Rule 0940-5-26 that encompasses a continuum of residential support options for up to three individuals living in the home of trained family caregivers (other than the individual's own family) in an "adult foster care" arrangement. In this type of shared living arrangement, the provider allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and a family and provide the individualized services that supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and support each resident in a manner that comports fully with standards applicable to HCBS settings detailed in 42 C.F.R. § 441.301(c)(4)-(5), including those requirements applicable to provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need and set forth in the person-centered plan of care. This service is available to CHOICES Group 2 and 3 Members as appropriate.

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

(a) Selecting and moving into a home.

(b) Locating and choosing suitable housemates.

(c) Acquiring and maintaining household furnishings.

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

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

(f) Building and maintaining interpersonal relationships with family and friends.

(g) Pursuing educational goals and employment opportunities.

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

(i) Scheduling and attending appropriate medical services.

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

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

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

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

(m) Asserting civil and statutory rights through self-advocacy.

(31) Companion Care. For purposes of CHOICES:

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

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

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

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

(e) Companion Care is only available through CD.

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

(33) 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).

(34) Consumer-Directed Worker (Worker).

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

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

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

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

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

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

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

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

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

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

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

(37) 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.

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

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

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

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

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

(43) 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.

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

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

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

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

(47) Enrollment Target.

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

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

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

(48) 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.

(49) Expiration Date.

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

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

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

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

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

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

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

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

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

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

(53) Grand Divisions. See “Grand Divisions” in Rule 1200-13-13-.01.

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

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

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

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

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

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

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

(57) Home-Delivered Meals.

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

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

(58) Home Health (HH) Services. See “Home Health Services” in Rule 1200-13-13-.01.

(59) Homemaker Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Members enrolled in Interim CHOICES Group 3 on June 30, 2015, may continue to qualify in this group after June 30, 2015, so long as they continue to meet NF financial eligibility, continue to be At Risk for Institutionalization, can be safely served in Interim CHOICES Group 3, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group and in CHOICES Group 3.

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

(73) Involuntary Transfer or Discharge. Any transfer or discharge that is opposed by the resident or a Representative of the resident of a NF or ICF/IID. For purposes of compliance with the

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

requirements of this Chapter, a discharge or transfer is involuntary when the NF initiates the action to transfer or discharge.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(87) Member. See "CHOICES Member."

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

(a) The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, which is a schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but is not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

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

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

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

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

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

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

1. It is attributable to:

(i) Cerebral palsy or epilepsy, or

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

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

3. It is likely to continue indefinitely.

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

(i) Self-care;

(ii) Understanding and use of language;

(iii) Learning;

(iv) Mobility;

(v) Self-direction; and

(vi) Capacity for independent living.

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

(a) Included are the following:

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

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

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

(iii) Grab bars and other devices.

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

(i) Widening of doorways; or

(ii) Modification of bathroom facilities.

(b) Excluded are the following:

1. Installation of stairway lifts or elevators;

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

3. Adaptations that are considered improvements to the residence;

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

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

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

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

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

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

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

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

(91) Natural Supports. For purposes of CHOICES:

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

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

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

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

(94) Notice. When used in rules and regulations pertaining to NFs, information that must be provided by the facility to “residents” or “Applicants,” and shall also include notification to the person identified in a PAE application as the resident’s or Applicant’s Designated Correspondent and any other individual who is authorized by law to act on the resident’s or

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

Applicant's behalf or who is in fact acting on the resident's or Applicant's behalf in dealing with the NF.

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

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

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

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

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

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

(101) PACE Carryover Group.

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

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

1. Continue to meet NF financial eligibility;

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

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

4. Remain continuously enrolled in PACE.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) Personal care visits shall not include:

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

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

3. Yard work.

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

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

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

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

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

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

(107) Pest Control.

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

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

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

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

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

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

(109) Physical Disabilities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(122) Representative.

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

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

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

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

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

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

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

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

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

(a) Discharge from a NF;

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

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

(125) Risk Agreement.

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

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

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

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

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

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

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

(b) Property taxes;

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

(d) Building and/or grounds maintenance costs;

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

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

(g) Furnishings used by the resident;

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

(i) Resident telephone; or

(j) Resident cable or pay television.

(127) Safety Determination.

(a) A decision made by the Bureau in accordance with the process and requirements described in Rule 1200-13-01-.05(6) regarding whether an Applicant would qualify to enroll in CHOICES Group 3 (including Interim CHOICES Group 3) or if there is sufficient evidence, as required and determined by the Bureau, to demonstrate that the

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

necessary intervention and supervision needed by the Applicant cannot be safely provided within the array of services and supports that would be available if the Applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the Expenditure Cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), cost-effective alternative services (as applicable), services available through Medicare, private insurance or other funding sources, and natural supports provided by family members and other caregivers who are willing and able to provide such care, and which may impact the Applicant's NF LOC eligibility (see Rule 1200-13-01-.10(4)(b)2.(i)(II) and 1200-13-01-.10(4)(b)2.(ii)(II)).

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

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

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

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

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

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

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

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

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

(129) Self-Direction of Health Care Tasks.

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

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

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

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

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

(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.

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

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

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

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

(136) Specialized Services for Individuals with MI.

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

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

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

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

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

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

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

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

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

(139) Supports Broker. For purposes of CD:

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

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

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

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

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

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

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

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

(145) Tracheal Suctioning Reimbursement. The rate of reimbursement provided for NF services, including enhanced respiratory care assistance, delivered by a NF that meets the

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

requirements set forth in Rule 1200-13-01-.03(5), to residents determined by the Bureau to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(5)(e) or determined by an MCO to require short-term intensive respiratory intervention during the post-weaning period.

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

(147) Transition Allowance. For purposes of CHOICES.

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

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

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

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

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

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

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

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed December 31, 1979; effective February 14, 1980. Amendment filed May 26, 1983; effective June 27, 1983. Amendment filed September 16, 1987; effective October 31, 1987. Amendment filed November 10, 1988; effective December 25, 1988. Public necessity rule filed January 30, 2006; effective through July 14, 2006. Public necessity rule filed January 30, 2006, expired on July 14, 2006. On July 15, 2006, rule reverted to status in effect on January 29, 2006. Amendment filed May 3, 2006; effective July 17, 2006. Amendment filed January 30, 2007; effective April 15, 2007. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rules filed June 29, 2012; effective through December 26, 2012. Repeal and new rule filed September 26, 2012; effective December 25, 2012. Amendment filed September 26, 2013; effective December 25, 2013. Amendments filed July 28, 2014; effective October 26, 2014. Emergency rule filed June 30, 2015; effective through*

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December 27, 2015. Amendment filed April 14, 2015; effective July 13, 2015. Emergency rule filed July 27, 2015; effective through January 23, 2016. Amendment filed September 23, 2015; effective December 22, 2015.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Level 2 NFs (Medicare SNFs and TennCare NFs receiving reimbursement for Level 2 NF care) must be certified by Medicare, showing they have met the federal certification

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

standards. Any of these NFs participating in TennCare shall be terminated as a TennCare provider if certification or licensure is canceled by CMS or the State.

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

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

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

(5) Conditions for Reimbursement of Enhanced Respiratory Care.

(a) The Level 2 NF must enter into a provider agreement with one or more TennCare MCOs for the provision and reimbursement of ventilator weaning, chronic ventilator services and/or tracheal suctioning in a Level 2 certified and licensed NF.

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

(c) NFs providing ventilator weaning or chronic ventilator services and NFs receiving short-term reimbursement at the Tracheal Suctioning Rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention, shall also meet or exceed the following minimum standards:

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

(i) Ventilator care;

(ii) Administration of medical gases;

(iii) Administration of aerosol medications; and

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

2. The NF shall ensure that an appropriate individualized POC is prepared for each resident requiring ventilator services. The POC shall be developed with input and participation from a pulmonologist or a physician with experience in ventilator care.

3. The NF shall establish admissions criteria to ensure the medical stability of ventilator-dependent residents prior to transfer from an acute care setting.

4. Arterial Blood Gas (ABG) shall be readily available in order to document the resident's acid base status and/or End Tidal Carbon Dioxide (etCO2) and

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

continuous pulse oximetry measurements should be performed in lieu of ABG studies.

5. An audible, redundant external alarm system shall be located outside of each ventilator-dependent resident's room for the purpose of alerting caregivers of resident disconnection, ventilator disconnection or ventilator failure.

6. Ventilator equipment shall be connected to electrical outlets connected to back-up generator power.

7. Ventilators shall be equipped with battery back-up systems.

8. The NF shall be equipped to employ the use of current ventilator technology consistent with meeting residents' needs for mobility and comfort.

9. A (one) back-up ventilator shall be available at all times in the facility.

(d) Except as provided in (c) above, the standards set forth in (c) are not applicable for Tracheal Suctioning Reimbursement; however, the NF must ensure the availability of necessary equipment, supplies, and appropriately trained and licensed nurses or licensed respiratory therapists to perform the specified tasks.

(e) If the resident has available resources to apply toward payment, including Patient Liability as determined by DHS, or TPL, which may include LTC insurance benefits, the payment made by the Bureau is the per diem rate established by the Bureau minus the resident's available resources.

(6) Reimbursement methodology for Level 1 Care.

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

1. Allowable cost;

2. Allowable charges;

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

4. An amount representing the reimbursable cost of the sixty-fifth (65th) percentile of NFs or beds, whichever is lower, participating in the NF Level 1 Program. In determining the sixty-fifth (65th) percentile ceiling for purposes of this part, operating costs from each provider's most recently filed and reviewed cost report

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

will be inflated from the mid-point of the provider's cost reporting period to the mid-point of the state's payment period. The inflation factor shall be as described in Part 3. above. Capital-related costs are not subject to indexing. Capital-related costs are property, depreciation, and amortization expenses included in Section F.18 and F.19 of the NF Cost Report Form. All other costs, including home office costs and management fees, are operating costs. No inflation factor will be allowed for providers not filing timely cost reports. For providers in the program less than three (3) years, the inflation factor shall be the fiftieth (50th) percentile of allowable inflation factors for providers participating in the program for at least three (3) years. Budgeted cost reports receive no inflation allowance; or

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

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

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

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

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

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

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

(7) Reimbursement Methodology for Level 2 Care.

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

1. Allowable costs;

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

2. Allowable charges;

3. An amount representing the reimbursable cost of the sixty-fifth (65th) percentile of all such NFs or beds, whichever is lower, participating in the Level 2 Medicaid NF Program. In determining the sixty-fifth (65th) percentile for purposes of this part, each provider's most recently filed and reviewed cost report shall be inflated from the mid-point of the provider's cost reporting period to the mid-point of the Bureau's payment period. The trending factor shall be computed for NFs that have submitted cost reports covering at least six (6) months of program operations. For NFs that have submitted cost reports covering at least three (3) full years of program participation, the trending factor shall be the average cost increase over the three (3) year period, limited to the seventy-fifth (75th) percentile trending factor of NFs participating for at least three (3) years. Negative averages shall be considered zero (0). For NFs that have not completed three (3) full years in the program, the one (1) year trending factor shall be the fiftieth (50th) percentile trending factor of NFs participating in the program for at least three (3) years. For NFs that have failed to file timely cost reports, the trending factor shall be zero (0);

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

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

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

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

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

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

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

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

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

(8) Reimbursement for enhanced respiratory care services in a Medicare-certified and licensed Level 2 SNF shall be made only by TennCare MCOs in accordance with this Chapter and rates established by the Bureau.

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

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

1. The resident intends to return to the NF.

2. For hospital leave days:

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

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

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

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

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

(10) Other Reimbursement Issues.

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

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

law to secure and recoup these funds from the selling entity. In addition, purchasers of NFs are responsible for obtaining an accurate accounting and transfer of funds held in trust for Medicaid residents at the time of the change of ownership or controlling interest.

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

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

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

1200-13-01-.04 REPEALED.

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

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

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

(2) Program components. The TennCare CHOICES Program is a managed LTSS program that is administered by the TennCare MCOs under contract with the Bureau. The MCOs are responsible for coordinating all covered physical, behavioral, and LTSS for their Members who qualify for and are enrolled in CHOICES. The program consists of two components:

(a) NF services, as described in this Chapter.

(b) CHOICES HCBS, as described in this Chapter.

(3) Eligibility for CHOICES.

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

1. CHOICES Group 1. Participation in CHOICES Group 1 is limited to TennCare Members of all ages who qualify for and are receiving TennCare-reimbursed NF services. Eligibility for TennCare-reimbursed LTSS is determined by DHS. Medical (or LOC) eligibility is determined by the Bureau as specified in Rule 1200-13-01-.10. Persons in CHOICES Group 1 must be enrolled in TennCare Medicaid or in the CHOICES 1 and 2 Carryover Group and qualify for TennCare reimbursement of LTSS. Persons who qualify in the CHOICES 1 and 2 Carryover Group are enrolled in TennCare Standard.

2. CHOICES Group 2.

(i) Participation in CHOICES Group 2 is limited to TennCare Members who qualify for and are receiving TennCare-reimbursed CHOICES HCBS. To be eligible for CHOICES Group 2, Applicants must meet the following criteria:

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

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

(III) Meet NF LOC; and

(IV) Have needs that can be safely and appropriately met in the community and at a cost that does not exceed their Individual Cost Neutrality Cap as defined in Rule 1200-13-01-.02.

(ii) Target Populations for CHOICES Group 2. Only persons in one of the target populations below may qualify to enroll in CHOICES Group 2:

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

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

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

(iii) Eligibility Categories Served in CHOICES Group 2. Participation in CHOICES Group 2 is limited to TennCare Members who qualify in one of the following eligibility categories:

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

(II) The CHOICES 217-Like Group, as defined in Rule 1200-13-01-.02. Financial and categorical eligibility are determined by DHS. Persons who qualify in the CHOICES 217-Like Group in accordance with Rule 1200-13-14-.02 are enrolled in TennCare Standard.

(III) The CHOICES 1 and 2 Carryover Group, as defined in Rule 1200-13-01-.02. Financial and categorical eligibility are determined by DHS. Persons who qualify in the CHOICES 1 and 2 Carryover Group are enrolled in TennCare Standard.

3. CHOICES Group 3, including Interim CHOICES Group 3.

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

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

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

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

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

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

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

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

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

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

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

(II) For Interim CHOICES Group 3 only, the CHOICES At-Risk Demonstration Group, as defined in Rule 1200-13-01-.02. Financial and categorical eligibility are determined by the State. Persons who qualify in the CHOICES At-Risk Demonstration Group will be enrolled in TennCare Standard. This eligibility category is only open for enrollment between July 1, 2012 and June 30, 2015. Members enrolled in Interim CHOICES Group 3 on June 30, 2015, may continue to qualify in this group after June 30, 2015, so long as they continue to meet NF financial eligibility criteria and the LOC criteria in place at the time of enrollment into Interim CHOICES Group 3, and remain continuously enrolled in the CHOICES At-Risk Demonstration Group, Interim CHOICES Group 3, and TennCare.

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

1. Persons shall meet NF LOC in order to enroll in CHOICES Group 1 or CHOICES Group 2.

2. Persons shall be At Risk for Institutionalization, as defined in Rule 1200-13-01-.02, in order to enroll in CHOICES Group 3, including Interim CHOICES Group 3.

3. Members enrolled in CHOICES Group 1 on June 30, 2012, may continue to qualify in this group after June 30, 2012, so long as they continue to meet NF financial eligibility, continue to meet the NF LOC criteria in place on June 30, 2012, and remain continuously enrolled in CHOICES Group 1 and in TennCare.

4. Members enrolled in CHOICES Group 1 on June 30, 2012, who wish to begin receiving HCBS and transition to CHOICES Group 2 shall, for purposes of LOC, be permitted to do so, so long as they continue to meet the NF LOC criteria in place on June 30, 2012, and have remained continuously enrolled in CHOICES Group 1 and in TennCare since June 30, 2012.

5. Members enrolled in CHOICES Group 2 on June 30, 2012, may continue to qualify in this group after June 30, 2012, so long as they continue to meet NF financial eligibility, continue to meet the NF LOC criteria in place on June 30, 2012, and remain continuously enrolled in CHOICES Group 2 and in TennCare.

6. Members enrolled in CHOICES Group 2 on June 30, 2012, who wish to be admitted to a NF and transition to CHOICES Group 1 shall be required to meet the NF LOC criteria in place at the time of enrollment into CHOICES Group 1 unless a determination has been made by TennCare that the Member's needs can no longer be safely met in the community within the Member's Individual Cost Neutrality Cap, in which case, the Member shall meet the NF LOC criteria in place on June 30, 2012, to qualify for enrollment into CHOICES Group 1.

(c) With respect to the PASRR process described in Rule 1200-13-01-.23:

1. Members in CHOICES Group 1 must have been determined through the PASRR process described in Rules 1200-13-01-.10 and 1200-13-01-.23 to be appropriate for NF placement.

2. Members in CHOICES Group 2 or CHOICES Group 3 are not required to complete the PASRR process unless they are admitted to a NF for Short-Term NF Care described in Paragraph (8) of this Rule and defined in Rule 1200-13-01-

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

.02. Completion of the PASRR process is not required for Members of CHOICES Group 2 or CHOICES Group 3 who have elected the Inpatient Respite Care benefit described in Paragraph (8) of this Rule, since the service being provided is not NF services, but rather, Inpatient Respite Care, which is a CHOICES HCBS.

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

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

1. The home or home environment of the Applicant is unsafe to the extent that it would reasonably be expected that HCBS could not be provided without significant risk of harm or injury to the Applicant or to individuals who provide covered services.

2. The Applicant refuses or fails to sign a Risk Agreement, or the Applicant's decision to receive services in the home or community poses an unacceptable level of risk.

3. The Applicant or his caregiver is unwilling to abide by the POC or Risk Agreement.

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

1. The home or home environment of the Applicant is unsafe to the extent that it would reasonably be expected that HCBS could not be provided without significant risk of harm or injury to the Applicant or to individuals who provide covered services.

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

(4) Enrollment in TennCare CHOICES. Enrollment into CHOICES shall be processed by the Bureau as follows:

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

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

1. Have completed the PASRR process as defined in Rules 1200-13-01-.10 and 1200-13-01-.23;

2. Have an approved unexpired PAE for NF LOC, including Level 1 reimbursement of NF services, Level 2 reimbursement of NF services, or Enhanced Respiratory Care Reimbursement for services in a NF. Eligibility for Enhanced Respiratory Care Reimbursement shall be established in accordance with Rule 1200-13-01-.10;

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

4. Be admitted to a NF. The Bureau must have received notification from the NF that Medicaid reimbursement is requested for the effective date of CHOICES enrollment (i.e., the individual is no longer privately paying for NF services and Medicare payment of NF services is not available). Enrollment into CHOICES Group 1 (and payment of a capitation payment for LTSS) cannot begin until the Bureau or the MCO will be responsible for payment of NF services.

(b) Enrollment into CHOICES Group 2. To qualify for enrollment into CHOICES Group 2:

1. An Applicant must be in one of the target populations specified in this Rule;

2. An Applicant must have an approved unexpired PAE for NF LOC;

3. An Applicant must be approved by DHS for TennCare reimbursement of LTSS as an SSI recipient, in the CHOICES 217-Like Group, or in the CHOICES 1 and 2 Carryover Group. To be eligible in the CHOICES 217-Like Group, an Applicant must be approved by TennCare to enroll in CHOICES Group 2;

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

5. There must be capacity within the established Enrollment Target to enroll the Applicant in accordance with this Rule which may include satisfaction of criteria for Reserve Capacity, as applicable; or the Applicant must meet specified exceptions to enroll even when the Enrollment Target has been reached.

(c) Individual Cost Neutrality Cap.

1. Each Member enrolling or enrolled in CHOICES Group 2 shall have an Individual Cost Neutrality Cap, which shall be used to determine:

(i) Whether or not he qualifies to enroll in CHOICES Group 2;

(ii) Whether or not he qualifies to remain enrolled in CHOICES Group 2; and

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

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

2. A Member is not entitled to receive services up to the amount of his Cost Neutrality Cap. A Member shall receive only those services that are medically necessary (i.e., required in order to help ensure the Member's health, safety and welfare in the home or community setting and to delay or prevent the need for NF placement). Determination of the services that are needed shall be based on a comprehensive assessment of the Member's needs and the availability of Natural Supports and other (non-TennCare reimbursed) services to meet identified needs which shall be conducted by the Member's Care Coordinator.

3. Calculating a Group 2 Member's Individual Cost Neutrality Cap.

   (i) Each Group 2 Member will have an Individual Cost Neutrality Cap that is based on the average cost of the level of NF reimbursement that would be paid if the Member were institutionalized in a NF as set forth in Items (I) through (III) below. CHOICES Group 2 does not offer an alternative to hospital level of care.

      (I) A Member who would qualify only for Level 1 NF reimbursement shall have a Cost Neutrality Cap set at the average Level 1 cost of NF care.

      (II) A Member who would qualify for Level 2 NF reimbursement shall have a Cost Neutrality Cap set at the average Level 2 cost of NF care.

      (III) A Member who would qualify for the Enhanced Respiratory Care Reimbursement for persons who are chronically ventilator dependent, or for persons who have a functioning tracheostomy that requires frequent suctioning through the tracheostomy will have a Cost Neutrality Cap that reflects the higher payment that would be made to the NF for such care. There is no Cost Neutrality Cap for Ventilator Weaning Reimbursement, as such service is available only on a short-term basis in a SNF or acute care setting.

   (ii) The PAE application shall be used to submit information to the Bureau that will be used to establish a Member's Individual Cost Neutrality Cap.

   (iii) A Member's Individual Cost Neutrality Cap shall be the average Level 1 cost of NF care unless a higher Cost Neutrality Cap is established based on information submitted in the PAE application.

4. Application of the Individual Cost Neutrality Cap.

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

   (ii) A Member's Individual Cost Neutrality Cap must also be applied prospectively on a twelve (12) month basis. This is to ensure that a Member's POC does not establish a threshold level of supports that cannot be sustained over the course of time. This means that, for purposes of care planning, the MCO will always project the total cost of all CHOICES HCBS (including one-time costs such as Minor Home Modifications, short-term services or short-term increases in services) and HH and PDN Services forward for twelve (12) months in order to determine whether the Member's

needs can continue to be safely and cost-effectively met based on the most current POC that has been developed. The cost of one-time services such as Minor Home Modifications, short-term services or short-term increases in services must be counted as part of the total cost of HCBS for a full twelve (12) month period following the date of service delivery.

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

5. As the setting of an individual's Cost Neutrality Cap does not, in and of itself, result in any increase or decrease in a Member's services, notice of action shall not be provided regarding the Bureau's Cost Neutrality Cap calculation.

(i) A Member has a right to due process regarding his Individual Cost Neutrality Cap when services are denied or reduced, when a determination is made that an Applicant cannot be enrolled into CHOICES, or a currently enrolled CHOICES Member can no longer remain enrolled in CHOICES because his needs cannot be safely and effectively met in the home and community-based setting at a cost that does not exceed his Individual Cost Neutrality Cap.

(ii) When an adverse action is taken, notice of action shall be provided, and the Applicant or Member shall have the right to a fair hearing regarding any valid factual dispute pertaining to such action, which may include, but is not limited to, whether his Cost Neutrality Cap was calculated appropriately.

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

(II) Denial of enrollment and/or involuntary disenrollment because a person's Cost Neutrality Cap will be exceeded shall constitute an eligibility/enrollment action, and shall give rise to notice of action and due process rights to request a fair hearing in accordance with this rule.

(d) Enrollment Target for CHOICES Group 2.

1. There shall be an Enrollment Target for CHOICES Group 2. The Enrollment Target functions as a cap on the total number of persons who can be enrolled into CHOICES Group 2 at any given time.

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

(ii) Once the Enrollment Target (including Reserve Capacity as defined in 1200-13-01-.02 and as described in 1200-13-01-.05(d)(2)) is reached, qualified Applicants shall not be enrolled into CHOICES Group 2 or qualify in the CHOICES 217-Like eligibility category based on receipt of HCBS

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

until such time that capacity within the Enrollment Target is available, with the following exceptions:

(I) NF-to-Community Transitions. A Member being served in CHOICES Group 1 who meets requirements to enroll in CHOICES Group 2 can enroll in CHOICES Group 2 even though the Enrollment Target has been met. This Member will be served in CHOICES Group 2 outside the Enrollment Target but shall be moved within the CHOICES Enrollment Target at such time that a slot becomes available. A request to transition a Member from CHOICES Group 1 to CHOICES Group 2 in excess of the CHOICES Group 2 Enrollment Target must specify the name of the NF where the Member currently resides, the date of admission and the planned date of transition.

(II) CEA Enrollment. An MCO with an SSI-eligible recipient who meets all other criteria for enrollment into CHOICES Group 2, but who cannot enroll in CHOICES Group 2 because the Enrollment Target for that group has been met, has the option, at its sole discretion, of offering HCBS as a CEA to the Member. Upon receipt of satisfactory documentation from the MCO of its CEA determination and assurance of provider capacity to meet the Member's needs, the Bureau will enroll the person into CHOICES Group 2, regardless of the Enrollment Target. The person will be served in CHOICES Group 2 outside the Enrollment Target, but shall be moved within the CHOICES Group 2 Enrollment Target at such time that a slot becomes available. Satisfactory documentation of the MCO's CEA determination shall include an explanation of the Member's circumstances that warrant the immediate provision of NF services unless HCBS are immediately available. Documentation of adequate provider capacity to meet the Member's needs shall include a listing of providers for each HCBS in the Member's POC which the MCO has confirmed are willing and able to initiate HCBS within ten (10) business days of the Member's enrollment into CHOICES Group 2.

(III) If enrollment into CHOICES Group 2 is denied because the Enrollment Target has been reached, notice shall be provided to the Applicant, including the right to request a fair hearing regarding any valid factual dispute pertaining to the Bureau's decision. If the person otherwise qualifies for enrollment into CHOICES Group 2, but does not meet the exceptions specified in 1200-13-01-.05(4)(d)(1)(ii), the Applicant shall be placed on a Waiting List for CHOICES Group 2.

(IV) Once the CHOICES Group 2 Enrollment Target is reached, any persons enrolled in excess of the Enrollment Target in accordance with this Rule must receive the first available slots. Only after all persons enrolled in excess of the Enrollment Target have been moved under the Enrollment Target can additional persons be enrolled into CHOICES Group 2.

2. Reserve Capacity.

(i) The Bureau shall reserve three hundred (300) slots within the CHOICES Group 2 Enrollment Target. These slots are available only when the Enrollment Target has otherwise been reached, and only to the following:

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

(I) Applicants being discharged from a NF; and

(II) Applicants being discharged from an acute care setting who are at imminent risk of being placed in a NF setting absent the provision of HCBS.

(ii) Once all other available (i.e., unreserved) slots have been filled, Applicants who meet specified criteria (including new Applicants seeking to establish eligibility in the CHOICES 217-Like Group as well as current SSI-eligible individuals seeking enrollment into CHOICES Group 2) may be enrolled into reserved slots. TennCare may require confirmation of the NF or hospital discharge and in the case of hospital discharge, written explanation of the Applicant's circumstances that warrant the immediate provision of NF services unless HCBS are immediately available.

(iii) If enrollment into a Reserve Capacity slot is denied, notice shall be provided to the Applicant, including the right to request a fair hearing regarding any valid factual dispute pertaining to the Bureau's decision. If the person otherwise qualifies for enrollment into CHOICES Group 2, but does not meet the specified criteria for Reserve Capacity, the Applicant shall be placed on a Waiting List for CHOICES Group 2.

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

1. An individual must be in one of the target populations specified in this Rule;

2. An individual must be At Risk for Institutionalization, as defined in Rule 1200-13-01-.02;

3. An individual must be approved by DHS for reimbursement of LTSS as an SSI recipient or for Interim CHOICES Group 3 only, in the CHOICES At-Risk Demonstration Group, as defined in Rule 1200-13-01-.02. To be eligible in the CHOICES At-Risk Demonstration Group, an individual must be enrolled in Interim CHOICES Group 3, subject to determination of categorical and financial eligibility by DHS;

4. The Bureau must have received a determination by the MCO that the individual's needs can be safely and appropriately met in the community, and at a cost that does not exceed his Expenditure Cap, as described in this Rule, except in instances where the person is not eligible for TennCare at the time of CHOICES application, in which case, such determination shall be made by the MCO upon enrollment into CHOICES Group 3; and

5. There must be capacity within the established Enrollment Target, as applicable, to enroll the individual in accordance with this Rule.

(f) Expenditure Cap for CHOICES Group 3.

1. Each Member enrolling or enrolled in CHOICES Group 3 shall be subject to an Expenditure Cap on CHOICES HCBS. The Expenditure Cap shall be used to determine:

(i) Whether or not an Applicant qualifies to enroll in CHOICES Group 3;

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

(ii) Whether or not a Member qualifies to remain enrolled in CHOICES Group 3; and

(iii) The total cost of CHOICES HCBS a Member can receive while enrolled in CHOICES Group 3, excluding the cost of Minor Home Modifications. The Expenditure Cap functions as a limit on the total cost of CHOICES HCBS, excluding Minor Home Modifications, that can be provided by the MCO to the Member in the home or community setting.

2. A Member is not entitled to receive services up to the amount of the Expenditure Cap. A Member shall receive only those services that are medically necessary (i.e., required in order to help ensure the Member's health, safety and welfare in the home or community setting and to delay or prevent the need for NF placement). Determination of the services that are needed shall be based on a comprehensive assessment of the Member's needs and the availability of Natural Supports and other (non-TennCare reimbursed) services to meet identified needs, which shall be conducted by the Member's Care Coordinator.

3. The Expenditure Cap for CHOICES HCBS provided to CHOICES Group 3 Members shall be $15,000 (fifteen thousand dollars) annually, excluding the cost of Minor Home Modifications.

4. Application of the Expenditure Cap.

(i) The annual Expenditure Cap shall be applied on a calendar year basis. The Bureau and the MCOs will track utilization of CHOICES HCBS excluding Minor Home Modifications, across each calendar year.

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

(iii) If it can be reasonably anticipated, based on the CHOICES HCBS currently received or determined to be needed (in addition to non-CHOICES HCBS available through TennCare, e.g., home health, services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers) in order to safely meet the person's needs in the community, that the person will exceed his Expenditure Cap, then the person does not qualify to enroll in or to remain enrolled in CHOICES Group 3.

(iv) Any Short-Term NF Care received by a Member enrolled in CHOICES Group 3 shall not be counted against his Expenditure Cap.

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

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

1. The State may establish an Enrollment Target for CHOICES Group 3 which shall be at least ten (10) percent of the Enrollment Target established by the State for CHOICES Group 2.

2. Notwithstanding any Enrollment Target established for CHOICES Group 3 as described in this subparagraph, Interim CHOICES Group 3 which is open for enrollment between July 1, 2012, and June 30, 2015, shall not be subject to an Enrollment Target.

(5) Disenrollment from CHOICES. A Member may be disenrolled from CHOICES voluntarily or involuntarily.

(a) Voluntary disenrollment from CHOICES means the Member has chosen to disenroll, and no notice of action shall be issued regarding a Member's decision to voluntarily disenroll from CHOICES. However, notice shall be provided regarding any subsequent adverse action that may occur as a result of the Member's decision, including any change in benefits, cost-sharing responsibility, or continued eligibility for TennCare when the Member's eligibility was conditioned on receipt of LTSS. Voluntary disenrollment shall proceed only upon:

1. Discharge from a NF when the Member is not transitioning to CHOICES Group 2 or CHOICES Group 3, as described in these rules;

2. Election by the Member to receive hospice services in a NF, which is not a LTSS; or

3. Receipt of a statement signed by the Member or his authorized Representative voluntarily requesting disenrollment.

(b) A Member may be involuntarily disenrolled from CHOICES only by the Bureau, although such process may be initiated by a Member's MCO. Reasons for involuntary disenrollment include but are not limited to:

1. The Member no longer meets one or more criteria for eligibility and/or enrollment as specified in this Rule.

2. The Member's needs can no longer be safely met in the community. This may include but is not limited to the following instances:

(i) The home or home environment of the Member becomes unsafe to the extent that it would reasonably be expected that HCBS could not be provided without significant risk of harm or injury to the Member or to individuals who provide covered services to the Member.

(ii) The Member or his caregiver refuses to abide by the POC or Risk Agreement.

(iii) Even though an adequate provider network is in place, there are no providers who are willing to provide necessary services to the Member.

(iv) The Member refuses or fails to sign a Risk Agreement, or the Member's decision to continue receiving services in the home or community poses an unacceptable level of risk.

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

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

4. The Member no longer needs or is no longer receiving LTSS.

5. The Member has refused to pay his Patient Liability. The MCO and/or its participating providers are unwilling to serve the Member in CHOICES because he has not paid his Patient Liability, and/or no other MCO is willing to serve the Member in CHOICES.

(6) Safety Determination Requests

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

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

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

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

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

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

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

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

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

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

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

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

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

12. The Applicant's MCO has determined, upon enrollment into Group 3 based on a PAE submitted by another entity, that the Applicant's needs cannot be safely met within the array of services and supports available if enrolled in Group 3 (see 1200-13-01-.02(125)), such that a higher level of care is needed.

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

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

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

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

(e) Documentation required to support a Safety Determination request shall include all of the following:

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

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

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

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

(iii) Detailed explanation regarding any recent significant event(s) or circumstances that have impacted the Applicant's need for services and supports, including how such event(s) or circumstances impact the Applicant's ability to be safely supported within the array of covered services and supports that would be available if the Applicant were enrolled in CHOICES Group 3;

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

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

submitted by an MCO or AAAD for a NF resident, the plan of care shall be developed in collaboration with the NF, as appropriate; and

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

(f) Approval of a Safety Determination Request

1. A Safety Determination request shall be approved if there is sufficient evidence, as required and determined by the Bureau, to demonstrate that the necessary intervention and supervision needed by the Applicant cannot be safely provided within the array of services and supports that would be available if the Applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the Expenditure Cap of $15,000, non-CHOICES HCBS available through TennCare (e.g., home health), cost-effective alternative services (as applicable), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers who are willing and able to provide such care.

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

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

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

(g) Denial of a Safety Determination Request.

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

2. If enrolled in CHOICES Group 3 based upon denial of a Safety Determination Request, the MCO shall implement any plan of care developed by the MCO and submitted as part of the Safety Determination process to demonstrate that the Applicant's needs can be safely met in Group 3, including covered medically necessary CHOICES HCBS and non-CHOICES HCBS available through TennCare and cost-effective alternative services upon which denial of the Safety

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

Determination was based, subject to changes in the Applicant's needs which shall be reflected in a revised plan of care and signed by the Applicant (or authorized representative).

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

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

2. Pursuant to Rule 1200-13-01-.10(7)(f), when a PAE for NF LOC is approved for a fixed period of time with an expiration date based on an assessment by the Bureau of the Applicant's medical condition and anticipated continuing need for inpatient nursing care, and how long it is reasonably anticipated that the Applicant's needs cannot be safely and appropriately met in the community within the array of services and supports available if enrolled in CHOICES Group 3, the Applicant shall be provided with a Notice of appeal rights, including the opportunity to submit an appeal within 30 calendar days of receipt of this notice. Nothing in this section shall preclude the right of the Applicant to submit a new PAE (including a new Safety Determination request) establishing medical necessity of care before the Expiration Date has been reached or anytime thereafter.

(7) Transitioning Between CHOICES Groups.

(a) Transition from Group 1 to Group 2.

1. An MCO may request to transition a Member from Group 1 to Group 2 only when the Member chooses to transition from the NF to an HCBS setting. Members shall not be required to transition from Group 1 to Group 2. Only an MCO may submit to TennCare a request to transition a Member from Group 1 to Group 2.

2. A Member that has already been discharged from the NF shall not be transitioned to CHOICES Group 2. Once a Member has discharged from the NF, he has voluntarily disenrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 2. A new PAE shall be required for enrollment into CHOICES Group 2.

3. When Members move from Group 1 to Group 2, DHS must recalculate the Member's Patient Liability based on the Community PNA.

(b) Transition from Group 2 to Group 1. An MCO may request to transition a Member from Group 2 to Group 1 only under the following circumstances:

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

1. Except as provided in TennCare Rule 1200-13-01-.05(3)(b)6, the Member meets the NF LOC criteria in place at the time of enrollment into CHOICES Group 1, and at least one (1) of the following is true:

   (i) The Member chooses to transition from HCBS to NF, for example, due to a decline in the Member's health or functional status, or a change in the Member's natural caregiving supports; or

   (ii) The MCO has made a determination that the Member's needs can no longer be safely met in the community and at a cost that does not exceed the average cost of NF services for which the Member would qualify, and the Member chooses to transition to the more appropriate institutional setting in order to safely meet his needs.

2. When Members move from Group 2 to Group 1, DHS must recalculate the Member's Patient Liability based on the Institutional PNA.

(c) At such time as a transition between CHOICES Groups 1 and 2 is made, the MCO shall issue notice of transition to the Member. Because the Member has elected the transition and remains enrolled in CHOICES, such transition between CHOICES groups shall not constitute an adverse action. Thus, the notice will not include the right to appeal or request a fair hearing regarding the Member's decision.

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

1. The Bureau or the MCO shall, subject to eligibility and enrollment criteria set forth in TennCare Rule 1200-13-01-.05(3) and (4), initiate a transition from Group 1 or from Group 2 to Group 3 when a Member who was enrolled in CHOICES Group 1 or Group 2 on or after July 1, 2012, no longer meets NF LOC, but is At Risk for Institutionalization as defined in Rule 1200-13-01-.02.

2. A Member that has already been discharged from the NF shall not be transitioned from CHOICES Group 1 to CHOICES Group 3. Once a Member has discharged from the NF, he has voluntarily disenrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 3. A new PAE shall be required for enrollment into CHOICES Group 3.

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

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

1. The Bureau or the MCO shall initiate a transition from Group 3 to Group 1 or Group 2, as appropriate, when the Member meets NF LOC in place at the time of the transition request and satisfies all requirements for enrollment into the requested Group.

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

(8) Benefits in the TennCare CHOICES Program.

(a) CHOICES includes NF care and CHOICES HCBS benefits, as described in this Chapter. Pursuant to federal regulations, NF services must be ordered by the treating physician. A physician's order is not required for CHOICES HCBS.

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

(b) Members of CHOICES Group 1 who are Medicaid eligible receive NF care, in addition to all of the medically necessary covered benefits available for Medicaid recipients, as specified in Rule 1200-13-13-.04. While receiving NF care, Members are not eligible for HCBS.

(c) Members of CHOICES Group 1 who are eligible for TennCare Standard in the CHOICES 1 and 2 Carryover Group receive NF care, in addition to all of the medically necessary covered benefits available for TennCare Standard recipients, as specified in Rule 1200-13-14-.04. While receiving NF care, Members are not eligible for HCBS.

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

(e) Members of CHOICES Group 2 who are eligible for TennCare Standard in the CHOICES 217-Like Group or in the CHOICES 1 and 2 Carryover Group receive CHOICES HCBS as specified in an approved POC, in addition to medically necessary covered benefits available for TennCare Standard recipients, as specified in Rule 1200-13-14-.04. While receiving HCBS, Members are not eligible for NF care, except for Short-Term NF care, as described in this Chapter.

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

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

(h) Members are not eligible to receive any other HCBS during the time that Short-Term NF services are provided. CHOICES HCBS such as Minor Home Modifications or installation of a PERS which are required to facilitate transition from the NF back to the home or community may be provided during the NF stay and billed with date of service being on or after discharge from the NF.

(i) Members receiving CBRA services, other than Companion Care, are eligible to receive only Assistive Technology services, since other types of support and assistance are within the defined scope of the 24-hour CBRA benefit and are the responsibility of the CBRA provider.

(j) Members receiving Companion Care are eligible to receive only Assistive Technology, Minor Home Modifications, and Pest Control, since all needed assistance with ADLs and IADLs are within the defined scope of the 24-hour CBRA benefit.

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

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

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

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

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

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

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

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

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

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

Service	Benefits for CHOICES 2 Members	Benefits for Consumer Direction ("Eligible HCBS")
13. Short-Term NF Care	Covered with a limit of 90 days per stay, per Member. Approved PASRR required. Members receiving Short-Term NF Care are not eligible to receive any other HBCS except when permitted to facilitate transition to the community. See Rule 1200-13-01-.05(8)(h).	No

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

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

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

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")
4. CBRA	CBRA services (e.g., ACLFs, CLS, and CLS-FM as specified below). CBRAs available to individuals in Group 3 include only Assisted Care Living Facility services, CLS, and CLS-FM that can be provided within the limitations set forth in the expenditure cap as defined in Rule 1200-13-01-.02 and further specified in Rule 1200-13-01-.05(4)(f), when the cost of such services will not exceed the cost of CHOICES HCBS that would otherwise be needed by the Member to 1) safely transition from a nursing facility to the community; or 2) continue being safely served in the community and to delay or prevent nursing facility placement.	No
5. Home-Delivered Meals	Covered with a limit of 1 meal per day, per Member. Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.	No
6. Homemaker Services	*Covered only for Members who also need hands-on assistance with ADLs and as a component of Attendant Care or Personal Care Visits as defined in these rules. Not covered as a stand-alone benefit. Not covered for persons who do not require hands-on assistance with ADLs. Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.	*

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

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")
7. In-Home Respite Care	Covered with a limit of 216 hours per calendar year, per Member. Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.	Yes
8. Inpatient Respite Care	Covered with a limit of 9 days per calendar year, per Member. PASRR approval not required. NF LOC not required. Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.	No
9. Minor Home Modifications	Covered with a limit of $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime. Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting. Not covered when the Member is receiving Short-Term NF Care, except when provided to facilitate transition from a NF to the community. See Rule 1200-13-01-.05(8)(h).	No
10. Personal Care Visits	Covered with a limit of 2 intermittent visits per day, per Member; visits limited to a maximum of 4 hours per visit and there shall be at least four (4) hours between intermittent visits. Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving any of the following HCBS: Adult Day Care, CBRA services (including Companion Care), or Short-Term NF Care.	Yes

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

Service	Benefits for CHOICES 3 Members	Benefits for Consumer Direction ("Eligible HCBS")
11. PERS	Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving CBRA services (including Companion Care) or Short-Term NF Care.	No
12. Pest Control	Covered with a limit of 9 treatment visits per calendar year, per Member. Not covered (regardless of payer), when the Member is living in an ACLF, Adult Care Home, Residential Home for the Aged or other group residential setting, or receiving Short-Term NF Care.	No
13. Short-Term NF Care	Covered with a limit of 90 days per stay, per Member. Approved PASRR required. Member must meet NF LOC. Members receiving Short-Term NF Care are not eligible to receive any other HCBS except when permitted to facilitate transition to the community. See Rule 1200-13-01-.05(8)(h).	No

(m) Transportation.

1. Emergency and non-emergency transportation for TennCare covered services other than CHOICES services is provided by the MCOs in accordance with Rules 1200-13-13-.04 and 1200-13-14-.04.

2. Transportation is not provided to HCBS covered by CHOICES, except in the circumstance where a Member requires Adult Day Care that is not available within 30 miles of the Member's residence.

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

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

and/or an increased rate of reimbursement be provided as a result of an agency/Worker decision to accompany or transport a Member outside the home.

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

(n) Freedom of Choice.

1. CHOICES Members who meet NF LOC as defined in Rule 1200-13-01-.10 shall be given freedom of choice of NF care or CHOICES HCBS, so long as the Member meets all criteria for enrollment into CHOICES Group 2, as specified in this Chapter and the Member may be enrolled into CHOICES Group 2 in accordance with requirements pertaining to the CHOICES Group 2 Enrollment Target as described in this Chapter.

2. CHOICES Members shall also be permitted to choose providers for CHOICES HCBS specified in the POC from the MCO's list of participating providers, if the participating provider selected is available and willing to initiate services timely and to deliver services in accordance with the POC. The Member is not entitled to receive services from a particular provider. A Member is not entitled to a fair hearing if he is not able to receive services from the provider of his choice.

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

1. Those items which the Member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition;

2. Rent and/or utility deposits; and

3. Essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

(p) Community Based Residential Alternatives (CBRAs).

1. Intent.

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

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

regulations, and program policies and protocols applicable to these services and/or providers of these services.

2. Requirements for CBRAs.

(i) Member Choice.

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

I. Have been selected by the Member;

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

III. The setting has been determined to be appropriate for the Member based on the Member's needs, interests, and preferences. A CLS or CLS-FM provider shall not admit a Member and CLS or CLS-FM services shall not be authorized for a CHOICES Member unless the CLS or CLS-FM provider is able to safely meet the Member's needs and ensure the Member's health, safety and well-being.

(ii) Member Rights.

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

I. To be treated with respect and dignity;

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

III. To receive services regardless of gender, race, creed, marital status, national or

IV. To be free from abuse, neglect and exploitation;

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

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

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

VIII. To have personal records maintained confidentially;

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

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

XI. To have choices and make decisions;

XII. To have privacy;

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

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

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

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

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

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

(iv) The Member shall have the right to manage personal finances as specified in the plan of care.

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

3. CLS Ombudsman.

TennCare shall arrange for all Members choosing to receive CLS or CLS-FM services, including Members identified for transition to CLS or CLS-FM, to have access to a CLS Ombudsman who will:

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

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

(iii) Provide Member advocacy for individuals receiving CLS or CLS-FM services, including assisting individuals in understanding and exercising

personal rights, assisting Members in the resolution of problems and complaints regarding CLS or CLS-FM services, and referral to APS of potential instances of abuse, neglect or financial exploitation; and

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

4. Person-centered Delivery of CLS and CLS-FM Services.

A CLS or CLS-FM provider shall be responsible for the following:

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

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

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

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

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

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

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

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

5. Requirements for Community Living Supports (CLS).

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

(I) Be contracted with the Member's MCO for the provision of CLS services, licensed by the DIDD in accordance with Title 33 of the T.C.A. and TDMHSAS Rule 0940-5-24, 0940-5-28 or 0940-5-32 as applicable, and contracted by the DIDD to provide residential services pursuant to an approved Section 1915(c) waiver;

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

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

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

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

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

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

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

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

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

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

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

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

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

transition to CLS services; the home where CLS services are provided must have an operable smoke detector and a second means of egress, and all utilities must be working and in proper order.

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) Be contracted with the Member's MCO for the provision of CLS-FM services, licensed by the DIDD in accordance with Title 33 of the T.C.A. and TDMHSAS Rule 0940-5-26, and contracted by the DIDD to provide residential services pursuant to an approved Section 1915(c) waiver;

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

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

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

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

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

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

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

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

(iv) A CLS-FM provider may deliver CLS-FM services in a home where other CHOICES Members receiving CLS-FM reside. A CLS-FM provider may also deliver CLS services in a home where CHOICES Members receiving CLS-FM reside along with individuals enrolled in a Section 1915(c) HCBS

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

waiver program operated by the DIDD, when the provider is able and willing to provide supports in a blended residence, comply with all applicable program requirements, and meet the needs and ensure the health, safety and welfare of each resident. In instances of blended homes, there shall be no more than three (3) service recipients residing in the home, regardless of the program or funding source.

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Reimbursement of CLS and CLS-FM Services

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

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

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

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

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

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

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

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

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

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

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

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

(xiii) Personal Care Visits, Attendant Care, and Home Delivered Meals shall not be authorized or reimbursed for a Member receiving CLS or CLS-FM services.

(xiv) In-home Respite shall not be authorized or reimbursed for a member receiving CLS services. In-home Respite shall only be reimbursed for a member receiving CLS-FM if CLS-FM services are not reimbursed for that day.

(xv) CLS and CLS-FM service shall not be provided or reimbursed in nursing facilities, ACLFs, hospitals or ICFs/IID.

(9) Consumer-Direction (CD).

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

1. The model of CD that will be implemented in CHOICES is an employer authority model.

2. The determination regarding the services a Member will receive shall be based on a comprehensive needs assessment performed by a Care Coordinator that identifies the Member's needs, the availability of family and other caregivers to meet those needs, and the gaps in care for which paid services may be authorized.

3. Upon completion of the comprehensive needs assessment, CHOICES Members determined to need Eligible CHOICES HCBS may elect to receive one or more of the Eligible CHOICES HCBS through a Contract Provider, or they may participate in CD. Companion Care is available only through CD.

4. CHOICES Members who do not need Eligible CHOICES HCBS shall not be offered the opportunity to enroll in CD.

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

1. CD is limited to the following HCBS:

(i) Attendant Care.

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

(iii) In-Home Respite Care.

(iv) Personal Care Visits.

2. CHOICES Members do not have budget authority. The amount of a covered benefit available to the Member shall not increase as a result of his decision to participate in CD, even if the rate of reimbursement for the service is lower in CD. The amount of each covered benefit to be provided to the Member is specified in the approved POC.

3. HH Services, PDN Services, and CHOICES HCBS other than those specified above shall not be available through CD.

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

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

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

3. Be willing and able to serve as the Employer of Record for his Consumer-Directed Workers and to fulfill all of the required responsibilities for CD, or he must have a qualified Representative who is willing and able to serve as the Employer of Record and to fulfill all of the required responsibilities for CD. Assistance shall be provided to the Member or his Representative by the FEA.

4. Any additional risks associated with a Member's decision to participate in CD must be identified and addressed in a signed Risk Agreement, as applicable, and the MCO must determine that the Member's needs can be safely and appropriately met in the community while participating in CD.

5. The Member or his Representative for CD and any Workers he employs must agree to use the services of the Bureau's contracted FEA to perform required Financial Administration and Supports Brokerage functions.

(d) Enrollment in CD.

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

2. If the Member is unable to make a decision regarding his participation in CD or to communicate his decision, only a legally appointed Representative may make such decision on his behalf. The Member, or a family member or other caregiver, must sign a CD participation form reflecting the decision the Member has made.

3. If the Member is unable to make a decision regarding CD or to communicate his decision and does not have a legally appointed Representative, the Member cannot participate in CD since there is no one with the legal authority to assume and/or delegate the Member's CD responsibilities.

4. Self-Assessment Tool. If a Member elects to participate in CD, he must complete a self-assessment tool developed by the Bureau to determine whether he requires the assistance of a Representative to perform the responsibilities of CD.

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

5. Representative. If the Member requires assistance in order to participate in CD, he must designate, or have appointed by a legally appointed Representative, a Representative to assume the CD responsibilities on his behalf.

(i) A Representative must meet all of the following criteria:

(I) Be at least eighteen (18) years of age;

(II) Have a personal relationship with the Member and understand his support needs;

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

(IV) Be physically present in the Member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each Consumer-Directed Worker.

(ii) If a Member requires a Representative but is unwilling or unable to appoint one, the MCO may submit to the Bureau, for review and approval, a request to deny the Member's participation in CD.

(iii) If a Member's Care Coordinator believes that the person selected as the Member's representative for CD does not meet the specified requirements (e.g., the Representative is not physically present in the Member's residence at a frequency necessary to adequately supervise Workers), the Care Coordinator may request that the Member select a different Representative who meets the specified requirements. If the Member does not select another Representative who meets the specified requirements, the MCO may, in order to help ensure the Member's health and safety, submit to the Bureau, for review and approval, a request to deny the Member's participation in CD.

(iv) A Member's Representative shall not receive payment for serving in this capacity and shall not serve as the Member's Worker for any Consumer-Directed Service.

(v) Representative Agreement. A Representative Agreement must be signed by the Member (or person authorized to sign on the Member's behalf) and the Representative in the presence of the Care Coordinator. By completing a Representative agreement, the Representative confirms that he agrees to serve as a Member's representative and that he accepts the responsibilities and will perform the duties associated with being a Representative.

(vi) A Member may change his Representative at any time by notifying his Care Coordinator and his Supports Broker that he intends to change Representatives. The Care Coordinator shall verify that the new Representative meets the qualifications as described above. A new Representative Agreement must be completed and signed, in the presence of a Care Coordinator, prior to the new Representative assuming his respective responsibilities.

(e) Employer of Record.

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

1. If a Member elects to participate in CD, either he or his Representative must serve as the Employer of Record.

2. The Employer of Record is responsible for the following:

(i) Recruiting, hiring and firing Workers;

(ii) Determining Workers' duties and developing job descriptions;

(iii) Scheduling Workers;

(iv) Supervising Workers;

(v) Evaluating Worker performance and addressing any identified deficiencies or concerns;

(vi) Setting wages from a range of reimbursement levels established by the Bureau;

(vii) Training Workers to provide personalized care based on the Member's needs and preferences;

(viii) Ensuring that Workers deliver only those services authorized, and reviewing and approving hours worked by Consumer-Directed Workers;

(ix) Reviewing and ensuring proper documentation for services provided; and

(x) Developing and implementing as needed a Back-up Plan to address instances when a scheduled Worker is not available or fails to show up as scheduled.

(f) Denial of Enrollment in CD.

1. Enrollment into CD may be denied by the Bureau when:

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

(ii) The Member does not need one or more of the HCBS eligible for CD, as specified in the POC.

(iii) The Member is not willing or able to serve as the Employer of Record for his Consumer-Directed Workers and to fulfill all of the required responsibilities for CD, and does not have a qualified Representative who is willing and able to serve as the Employer of Record and to fulfill all of the required responsibilities for CD.

(iv) The Member is unwilling to sign a Risk Agreement which identifies and addresses any additional risks associated with the Member's decision to participate in CD, or the risks associated with the Member's decision to participate in CD pose too great a threat to the Member's health, safety and welfare.

(v) The Member does not have an adequate Back-up Plan for CD.

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

(vi) The Member's needs cannot be safely and appropriately met in the community while participating in CD.

(vii) The Member or his Representative for CD, or the Consumer-Directed Workers he wants to employ are unwilling to use the services of the Bureau's contracted FEA to perform required Financial Administration and Supports Brokerage functions.

(viii) Other significant concerns regarding the Member's participation in CD which jeopardize the health, safety or welfare of the Member.

2. Denial of enrollment in CD gives rise to notice and due process including the right to a fair hearing, as set forth in this rule.

(g) Fiscal Employer Agent (FEA).

1. The FEA shall perform the following functions on behalf of all Members participating in CD:

(i) Financial Administration functions in the performance of payroll and related tasks; and

(ii) Supports Brokerage functions to assist the Member or his Representative with other non-payroll related tasks such as recruiting and training workers.

2. The FEA shall:

(i) Assign a Supports Broker to each CHOICES Member electing to participate in CD of HCBS.

(ii) Provide initial and ongoing training to Members and their Representatives (as applicable) on CD and other relevant issues.

(iii) Verify Worker qualifications, including conducting background checks on Workers, enrolling Workers into TennCare, assigning Medicaid provider ID numbers, and holding TennCare provider agreements.

(iv) Provide initial and ongoing training to workers on CD and other relevant issues.

(v) Assist the Member and/or Representative in developing and updating Service Agreements.

(vi) Withhold, file and pay applicable federal, state and local income taxes; employment and unemployment taxes; and worker's compensation.

(vii) Pay Workers for authorized services rendered within authorized timeframes.

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

1. Each Member participating in CD or his Representative is responsible for the development and implementation of a Back-up Plan that identifies how the Member or Representative will address situations when a scheduled Worker is not available or fails to show up as scheduled.

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

2. The Member or Representative may not elect, as part of the Back-up Plan, to go without services.

3. The Back-up Plan for CD shall include the names and telephone numbers of contacts (Workers, agency staff, organizations, supports) for alternate care, the order in which each shall be notified and the services to be provided by contacts.

4. Back-up contacts may include paid and unpaid supports; however, it is the responsibility of the Member electing CD and/or his Representative to secure paid (as well as unpaid) back-up contacts who are willing and available to serve in this capacity, and for initiating the back-up plan when needed.

5. The Member's Back-up Plan for Consumer-Directed Workers shall be integrated into the Member's Back-up Plan for services provided by Contract Providers, as applicable, and the Member's POC.

6. The Care Coordinator shall review the Back-up Plan developed by the Member and/or his Representative to determine its adequacy to address the Member's needs. If an adequate Back-up Plan cannot be provided to CD, enrollment into CD may be denied, as set forth in this Rule.

7. The Back-up Plan shall be reviewed and updated at least annually, and as frequently as necessary if there are changes in the type, amount, duration, scope of eligible CHOICES HCBS or the schedule at which such services are needed, changes in Workers (when such Workers also serve as a back-up to other Workers) and changes in the availability of paid or unpaid back-up Workers to deliver needed care.

8. A Member may use Contract Providers to serve as back-up to Consumer Directed Workers only upon prior arrangement by the Member (or Representative for CD) with the Contract Provider, inclusion in the Member's back-up plan, verification by the Supports Broker, prior approval by the MCO and subject to the Member's Individual Cost Neutrality Cap as described in Rule 1200-13-01-.05(4)(c). If the higher cost of services delivered by a Contract Provider would result in a Member's Cost Neutrality Cap being exceeded, a Member shall not be permitted to use Contract Providers to provide back-up workers. A Member's MCO shall not be required to maintain Contract Providers on "stand-by" to provide back-up for services delivered through Consumer Direction.

(i) Consumer-Directed Workers (Workers).

1. Hiring Consumer-Directed Workers.

(i) Members shall have the flexibility to hire individuals with whom they have a close personal relationship to serve as Workers, such as neighbors or friends.

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

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

(I) An Immediate Family Member as defined in Rule 1200-13-01-.02.

(II) Any person with whom the Member currently resides, or with whom the Member has resided in the last five (5) years.

(iii) Members may elect to have a Worker provide more than one service, have multiple Workers, or have both a Worker and a Contract Provider for a given service, in which case, there must be a set schedule which clearly defines when Contract Providers will be used.

2. Qualifications of Consumer-Directed Workers. Workers must meet the following requirements prior to providing services:

(i) Be at least eighteen (18) years of age or older.

(ii) Pass a background check that includes a criminal background check (including fingerprinting), or, as an alternative, a background check from a licensed private investigation company.

(iii) Verification that the person's name does not appear on the State abuse registry.

(iv) Verification that the person's name does not appear on the State and national sexual offender registries and licensure verification, as applicable.

(v) Complete all required training.

(vi) Complete all required applications to become a TennCare provider.

(vii) Sign an abbreviated Medicaid agreement.

(viii) Be assigned a Medicaid provider ID number.

(ix) Sign a Service Agreement.

(x) If the Worker will be transporting the Member as specified in the Service Agreement, a valid driver's license and proof of insurance must also be provided.

3. Disqualification from Serving as a Consumer-Directed Worker. A Member cannot waive a background check for a potential Worker. The following findings shall disqualify a person from serving as a Worker:

(i) Conviction of an offense involving physical, sexual or emotional abuse, neglect, financial exploitation or misuse of funds, misappropriation of property, theft from any person, violence against any person, or manufacture, sale, possession or distribution of any drug.

(ii) Entering of a plea of nolo contendere or when a jury verdict of guilty is rendered but adjudication of guilt is withheld with respect to a crime reasonably related to the nature of the position sought or held.

(iii) Identification on the abuse registry.

(iv) Identification on the State or national sexual offender registry.

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

(v) Failure to have a required license.

(vi) Refusal to cooperate with a background check.

4. Exception to Disqualification of a Consumer-Directed Worker. If a Worker fails the background check, an exception to disqualification may be granted at the Member's discretion if all of the following conditions are met:

(i) Offense is a misdemeanor;

(ii) Offense occurred more than five (5) years prior to the background check;

(iii) Offense is not related to physical or sexual or emotional abuse of another person;

(iv) Offense does not involve violence against another person or the manufacture, sale, or distribution of drugs; and

(v) There is only one disqualifying offense.

5. Service Agreement.

(i) A Member shall develop a Service Agreement with each Worker, which includes, at a minimum:

(I) The roles and responsibilities of the Worker and the Member;

(II) The Worker's schedule (as developed by the Member and/or Representative), including hours and days;

(III) The scope of each service (i.e., the specific tasks and functions the Worker is to perform);

(IV) The service rate; and

(V) The requested start date for services.

(ii) The Service Agreement must be in place for each Worker prior to the Worker providing services.

(iii) The Service Agreement shall also stipulate if a Worker will provide one or more Self-Directed Health Care Tasks, the specific task(s) to be performed, and the frequency of each Self-Directed Health Care Task.

6. Payments to Consumer-Directed Workers.

(i) Rates.

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

(I) Monthly Companion Care rates are only available for a full month of service delivery and will be pro-rated when a lesser number of days are actually delivered.

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

(II) The back-up per diem rate is available only when a regularly scheduled companion is ill or unexpectedly unable to deliver services, and shall not be authorized as a component of ongoing Companion Care Services.

(ii) Payments to Consumer-Directed Workers. In order to receive payment for services rendered, all Workers must:

(I) Deliver services in accordance with the schedule of services specified in the Member's POC and in the MCO's service authorization, and in accordance with Worker assignments determined by the Member or his Representative.

(II) Use the EVV system to log in and out at each visit.

(III) Provide detailed documentation of service delivery including but not limited to the specific tasks and functions performed for the Member at each visit, which shall be maintained in the Member's home.

(IV) Provide no more than forty (40) hours of services within a consecutive seven (7) day period, unless explicitly permitted by program guidelines and in accordance with service authorizations.

(iii) Termination of Consumer-Directed Workers' Employment.

(I) A Member may terminate a Worker's employment at any time.

(II) The MCO may not terminate a Worker's employment, but may request that a Member be involuntarily withdrawn from CD if it is determined that the health, safety and welfare of the Member may be in jeopardy if the Member continues to employ a Worker but the Member and/or Representative does not want to terminate the Worker.

(j) Self-Direction of Health Care Tasks.

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

2. For purposes of this rule, home does not include a NF or ACLF.

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

4. Health Care Tasks that may be self-directed for the purposes of this Subparagraph are limited to administration of oral, topical and inhaled medications.

5. The Member or Representative who chooses to self-direct a health care task is responsible for initiating self-direction by informing the health care professional who has ordered the treatment which involves the Health Care Task of the

individual or caregiver's intent to perform that task through self-direction. The provider shall not be required to prescribe self-direction of the health care task.

6. When a licensed health care provider orders treatment involving a Health Care Task to be performed through self-directed care, the responsibility to ascertain that the Member or caregiver understands the treatment and will be able to follow through on the Self-Directed Health Care Task is the same as it would be for a Member or caregiver who performs the Health Care Task for himself, and the licensed health care provider incurs no additional liability when ordering a Health Care Task which is to be performed through self-directed care.

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

8. The Member or his Representative for CD must also identify in his Back-up Plan for CD who will perform the Health Care Task if the Worker is unavailable, or stops performing the task for any reason.

9. Ongoing monitoring of the Worker performing self-directed Health Care Tasks is the responsibility of the Member or his Representative. Members are encouraged to use a home medication log as a tool to document medication administration. Medications should be kept in original containers, with labels intact and legible.

(k) Withdrawal from Participation in Consumer Direction (CD).

1. General.

(i) Voluntary Withdrawal from CD. Members participating in CD may voluntarily withdraw from participation in CD at any time. The Member's request must be in writing. Whenever possible, notice of a Member's decision to withdraw from participation in CD should be provided in advance to permit time to arrange for delivery of services through Contracted Providers.

(ii) Voluntary or involuntary withdrawal of a Member from CD of Eligible CHOICES HCBS shall not affect a Member's eligibility for LTSS or enrollment in CHOICES, provided the Member continues to meet all requirements for enrollment in CHOICES as defined in this Chapter.

(iii) If a Member voluntarily withdraws or is involuntarily withdrawn from CD, any Eligible CHOICES HCBS he receives, with the exception of Companion Care, shall be provided through Contract Providers, subject to the requirements in this Chapter. Companion Care is only available through CD.

2. Involuntary Withdrawal.

(i) A person may be involuntarily withdrawn from participation in CD of HCBS for any of the following reasons:

(I) The person is no longer enrolled in TennCare.

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

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

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

(IV) The Member is no longer willing or able to serve as the Employer of Record for his Consumer-Directed Workers and to fulfill all of the required responsibilities for CD, and does not have a qualified Representative who is willing and able to serve as the Employer of Record and to fulfill all of the required responsibilities for CD.

(V) The Member is unwilling to sign a Risk Agreement, as applicable, which identifies and addresses any additional risks associated with the Member's decision to participate in CD, or the risks associated with the Member's decision to participate in CD pose too great a threat to the Member's health, safety and welfare.

(VI) The health, safety and welfare of the Member may be in jeopardy if the Member or his Representative continues to employ a Worker but the Member or Representative does not want to terminate the Worker.

(VII) The Member does not have an adequate Back-up Plan for CD.

(VIII) The Member's needs cannot be safely and appropriately met in the community while participating in CD.

(IX) The Member or his Representative for CD, or Consumer-Directed Workers he wants to employ are unwilling to use the services of the Bureau's contracted FEA to perform required Financial Administration and Supports Brokerage functions.

(X) The Member or his Representative for CD is unwilling to abide by the requirements of the CHOICES CD program.

(XI) If a Member's Representative fails to perform in accordance with the terms of the Representative Agreement and the health, safety and welfare of the Member is at risk, and the Member wants to continue to use the Representative.

(XII) If a Member has consistently demonstrated that he is unable to manage, with sufficient supports, including appointment of a Representative, his services and the Care Coordinator or FEA has identified health, safety and/or welfare issues.

(XIII) A Care Coordinator has determined that the health, safety and welfare of the Member may be in jeopardy if the Member continues to employ a Worker but the Member or Representative does not want to terminate the Worker.

(XIV) Other significant concerns regarding the Member's participation in CD which jeopardize the health, safety or welfare of the Member.

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

(ii) The Bureau must review and approve all MCO requests for involuntary withdrawal from CD of HCBS before such action may occur. If the Bureau approves the request, written notice shall be given to the Member at least ten (10) days in advance of the withdrawal. The date of withdrawal may be delayed when necessary to allow adequate time to transition the Member to Contract Provider services as seamlessly as possible.

(iii) The Member shall have the right to appeal involuntary withdrawal from CD.

(iv) If a person is no longer enrolled in TennCare or in CHOICES, his participation in CD shall be terminated automatically.

(10) Nursing Facilities (NFs) in CHOICES.

(a) Conditions of participation. NFs participating in CHOICES must meet all of the conditions of participation and conditions for reimbursement outlined in their provider agreements with the TennCare MCOs.

(b) Level 1 reimbursement methodology for NF care: See Rule 1200-13-01-.03(6).

(c) Level 2 reimbursement methodology for NF care: See Rule 1200-13-01-.03(7).

(d) Enhanced Respiratory Care reimbursement methodology for NF care: See Rule 1200-13-01.03(8).

(e) Non-participating providers**.** NFs that wish to continue serving existing residents without entering into provider agreements with TennCare MCOs will be considered non-participating providers.

1. Non-participating NF providers must comply with Rules 1200-13-01-.03, 1200-13-01-.06, and 1200-13-01-.09.

2. Non-participating providers must sign a modified contract (called a case agreement) with the MCO to continue receiving reimbursement for existing residents, including residents who may become Medicaid eligible.

3. Non-participating NF providers will be reimbursed eighty percent (80%) of the lowest rate paid to any participating NF provider in Tennessee for the applicable level of NF services.

(f) Bed holds. See Rule 1200-13-01-.03(9).

(g) Other reimbursement issues. See Rule 1200-13-01-.03(10).

(11) HCBS Providers in CHOICES.

(a) HCBS providers delivering care under CHOICES must meet specified license requirements and shall meet conditions for reimbursement outlined in their provider agreements with the TennCare MCOs.

(b) Non-participating HCBS providers will be reimbursed by the Member's MCO at eighty percent (80%) of the lowest rate paid to any HCBS provider in the state for that service.

(12) Appeals.

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

(a) Appeals related to determinations of eligibility for TennCare Medicaid or TennCare Standard are processed by DHS, in accordance with Chapters 1200-13-13 and 1200-13-14.

(b) Appeals related to the denial, reduction, suspension, or termination of a covered service are processed by the Bureau in accordance with Rules 1200-13-13-.11 and 1200-13-14-.11.

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

(d) Appeals related to the enrollment or disenrollment of an individual in CHOICES or to denial or involuntary withdrawal from participation in CD are processed by the Division of Long-Term Services and Supports in the Bureau, in accordance with the following procedures:

1. If enrollment into CHOICES or if participation in CD is denied, notice containing an explanation of the reason for such denial shall be provided. The notice shall include the person's right to request a fair hearing within thirty (30) days from receipt of the written notice regarding valid factual disputes pertaining to the enrollment denial decision.

2. If a Member is involuntarily disenrolled from CHOICES, or if participation in CD is involuntarily withdrawn, advance notice of involuntary disenrollment or withdrawal shall be issued. The notice shall include a statement of the Member's right to request a fair hearing within thirty (30) days from receipt of the written notice regarding valid factual disputes pertaining to the decision.

3. Appeals regarding denial of enrollment into CHOICES, involuntary disenrollment from CHOICES, or denial or involuntary withdrawal from participation in CD must be filed in writing with the TennCare Division of Long-Term Services and Supports within thirty-five (35) days of issuance of the written notice if the appeal is filed with the Bureau by fax, and within forty (40) days of issuance of the written notice if the appeal is mailed to the Bureau. This allows five (5) days mail time for receipt of the written notice and when applicable, five (5) days mail time for receipt of the written appeal.

4. In the case of involuntary disenrollment from CHOICES only, if the appeal is received prior to the date of action, continuation of CHOICES benefits shall be provided, pending resolution of the disenrollment appeal.

5. In the case of involuntary withdrawal from participation in CD, if the appeal is received prior to the date of action, continuation of participation in CD shall be provided, unless such continuation would pose a serious risk to the Member's health, safety and welfare, in which case, services specified in the POC shall be made available through Contract Providers pending resolution of the appeal.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, 71-5-109, and Executive Order Nos. 11 and 23.* ***Administrative History:*** *Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendment filed April 8, 1981; effective May 26, 1981. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed November 4, 1981; effective December 21, 1981. Amendment filed January 29, 1982; effective March 15, 1982. Amendment filed May 14, 1982; effective July 1, 1982. Amendment filed May 26, 1983; effective June 27, 1983. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed November 30, 1984; effective December 30, 1984.*

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

Amendment filed September 18, 1985; effective October 18, 1985. Amendment filed February 12, 1986; effective March 14, 1986. Amendment filed February 23, 1987; effective April 9, 1987. Amendment filed March 25, 1987; effective May 9, 1987. Amendment filed July 30, 1987; effective September 13, 1987. Amendment filed September 30, 1987; effective November 14, 1987. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed October 12, 1987; effective January 27, 1988. Amendment filed August 17, 1988; effective October 1, 1988. Amendment filed July 26, 1989; effective September 10, 1989. Amendment filed February 23, 1990; effective April 9. 1990. Amendment filed May 10, 1990; effective June 24, 1990. Amendment filed June 8, 1990; effective July 23, 1990. Amendment filed August 17, 1990; effective October 1, 1990. Amendment filed September 28, 1990; effective November 12, 1990. Amendment filed November 5, 1990; effective December 20, 1990. Amendment filed November 27, 1990; effective January 11, 1991. Amendment filed January 9, 1991; effective February 23, 1991. Amendment filed February 12, 1991; effective March 29, 1991. Amendment filed February 21, 1991; effective April 7, 1991. Amendment filed February 1991; effective April 9, 1991. Amendment filed February 27, 1991; effective April 13, 1991. Amendment filed April 1, 1991; effective May 16, 1991. Amendment filed June 12, 1991; elective July 27, 1991. Amendment filed November 22, 1991; effective January 6, 1992. Amendment filed April 29, 1992; effective June 13, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed October 8, 1992; effective November 22, 1992. Amendment filed October 26, 1992; effective December 10, 1992. Amendment filed November 17, 1993; effective January 31, 1994. Amendment filed March 11, 1994; effective May 25, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed May 2, 1994; effective July 16, 1994. Amendment filed November 10, 1994; effective January 24, 1995. Amendment filed March 3, 1995; effective June 15, 1995. Amendment filed June 29, 2000; effective September 12, 2000. Amendment filed August 21, 2001; effective November 4, 2001. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rule filed September 23, 2011; effective through March 21, 2012. Amendment filed December 15, 2011; effective March 14, 2012. Emergency rules filed June 29, 2012; effective through December 26, 2012. Amendments filed September 26, 2012; effective December 25, 2012. Numbering errors were found with the rules for 1200-13-01-.05 by the Secretary of State's office. On December 20, 2012, the Attorney General's office approved the legality of the correctly renumbered rule 1200-13-01-.05 as presented by TennCare. Amendments filed September 26, 2013; effective December 25, 2013. Amendments filed July 28, 2014; effective October 26, 2014. Amendment filed April 14, 2015; effective July 13, 2015. Emergency rule filed July 27, 2015; effective through January 23, 2016.

1200-13-01-.06 SPECIAL FEDERAL REQUIREMENTS PERTAINING TO NURSING FACILITIES.

(1) Anti-discrimination.

No Medicaid-reimbursed resident of a NF shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination by any such facility.

(a) A NF may not directly or through contractual or other arrangements, on ground of race, color, or national origin:

1. Deny a Medicaid-reimbursed resident any service or benefit provided under the program.

2. Provide any service or benefit to a Medicaid-reimbursed resident which is different, or is provided in a different manner, from that provided to others under the program.

3. Subject a Medicaid-reimbursed resident to segregation or separate treatment in any matter related to the receipt of any service or benefit under the program.

(Rule 1200-13-01-.06, continued)

4. Restrict a Medicaid-reimbursed resident in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit under the program.

5. Treat a Medicaid-reimbursed resident differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which the resident must meet in order to be provided any service or benefit provided under the program.

(b) A NF, in determining the types of services, or benefits which will be provided under any such program, or the Medicaid-reimbursed resident to whom, or the situations in which, such services or benefits will be provided under the program, or the Medicaid-reimbursed resident to be afforded an opportunity to participate in the program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting those residents to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishments of the objective of the program with respect to those residents of a particular race, color, or national origin.

(c) As used in this rule, the services or benefits provided by a NF shall be deemed to include any service, or benefit provided in or through a facility participating in this program.

(d) The enumeration of specific forms of prohibited discrimination in this rule does not limit the generality of the prohibition in this rule.

(e) When a NF has previously discriminated against persons on the ground of race, color, or national origin, the facility must take affirmative action to overcome the effects of prior discrimination.

(f) Even in the absence of such prior discrimination, a facility may take affirmative action to overcome the effects of conditions which resulted in limiting participation by persons of a particular race, color, or national origin.

(2) Admissions, transfers, and discharges from NFs.

(a) All NFs shall establish written policies and procedures addressing admission, transfer and discharge, consistent with these rules. These policies and procedures shall be available for inspection by the state.

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

(c) NFs participating in the Medicaid Program shall not as a condition of admission to or continued stay at the facility request or require:

1. Transfer or discharge of a Medicaid-eligible resident because Medicaid has been or becomes the resident's source of payment for long-term care.

2. Payment of an amount from a Medicaid-eligible resident in excess of the amount of Patient Liability determined by DHS.

3. Payment in excess of the amount of Patient Liability determined by DHS from any resident who is financially eligible for medical assistance but who has not

(Rule 1200-13-01-.06, continued)

submitted a PAE for consideration or whose appeal rights for a denied PAE have not been exhausted.

4. Any person to forego his or her right to Title XIX Medical Assistance benefits for any period of time.

5. A third party (i.e. responsible party) signature, except as required of a court appointed legal guardian or conservator, or require payment of any kind by a third party on behalf of a Medicaid Eligible individual.

(d) NFs participating in the Medicaid Program must comply with the following guidelines regarding transfers, discharges and/or readmissions.

1. Transfer and Discharge Rights.

(i) A NF must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

(I) The transfer or discharge is necessary to meet the resident's welfare which cannot be met in the facility;

(II) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(III) The safety of individuals in the facility is endangered;

(IV) The health of individuals in the facility would otherwise be endangered;

(V) The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Title XIX or Title XVIII on the resident's behalf) for a stay at the facility; or

(VI) The facility ceases to operate.

(ii) In each of the cases described above, no resident shall be discharged or transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. Each NF shall establish a policy for handling residents who wish to leave the facility against medical advice. The basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in items (I) and (II) above, the documentation must be made by the resident's physician, and in the case described in item (IV) above, the documentation must be made by a physician. For purposes of item (V), in the case of a resident who becomes eligible for assistance under Title XIX after admission to the facility, only charges which may be imposed under Title XIX shall be considered to be allowable.

(iii) When a resident is transferred, a summary of treatment given at the facility, condition of resident at time of transfer and date and place to which transferred shall be entered in the record. If transfer is due to an emergency; this information will be recorded within forty-eight (48) hours; otherwise, it will precede the transfer of the resident.

(Rule 1200-13-01-.06, continued)

(iv) When a resident is transferred, a copy of the clinical summary should, with consent of the resident, be sent to the NF that will continue the care of the resident.

(v) Where an involuntary transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

(I) The traumatic effect on the resident.

(II) The proximity of the proposed NF to the present facility and to the family and friends of the resident.

(III) The availability of necessary medical and social services at the proposed NF.

(IV) Compliance by the proposed NF with all applicable federal and State regulations.

2. Pre-Transfer and Pre-Discharge Notice. Before effecting a transfer or discharge of a resident, a NF must:

(i) Notify the resident (and, if known, a family member of the resident or legal Representative) of the transfer or discharge and the reasons therefore.

(ii) Record the reasons in the resident's clinical record (including any documentation required pursuant to Part 1. above) and include in the notice the items described in Part 4. below.

(iii) Notify the Department of Health and the LTC Ombudsman.

(iv) Not transfer or discharge a resident until the above agencies have designated their intention to intervene and until any appeal process is complete, should the resident request a fair hearing.

3. Timing of Notice. The notice under Part 2. above must be made at least thirty (30) days in advance of the resident's transfer or discharge except:

(i) In a case described in Items 1200-13-01-.06(2)(d)1.(i)(III) and (IV).

(ii) In a case described in Item 1200-13-01-.06(2)(d)1.(i)(II) where the resident's health improves sufficiently to allow a more immediate transfer or discharge.

(iii) In a case described in Item 1200-13-01-.06(2)(d)1.(i)(I) where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs.

(iv) In a case where a resident has not resided in the facility for thirty (30) days.

In the case of such exceptions, notice must be given as many days before the date of transfer or discharge as is practicable.

4. Items included in notice. Each pre-transfer and pre-discharge notice under Part 2. above must include:

(i) Notice of the resident's right to appeal the transfer or discharge.

(ii) The name, mailing address, and telephone number of the LTC Ombudsman.

(iii) In the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.

(iv) In the case of mentally ill residents, the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

5. Orientation. A NF must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer discharge from the facility.

6. Notice of Bed-Hold Policy and Readmission. Before a resident of a NF is transferred for hospitalization or therapeutic leave, a NF must provide written information to the resident and a family member or legal representative concerning:

(i) The provisions of the State Plan under this Title XIX regarding the period (if any) during which the resident will be permitted under the State Plan to return and resume residence in the facility, and

(ii) The policies of the facility consistent with Part 7. below, regarding such a period.

7. Notice Upon Transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a NF must provide written notice to the resident and a family member or legal representative of the duration of any period under the State Plan allowed for the resumption of residence in the facility.

(e) NFs participating in the Medicaid Program must establish and follow a written policy under which an Enrollee, whose hospitalization or therapeutic leave exceeds the bed hold period, is readmitted to the NF immediately upon the first availability of a bed in a semi-private room if the Enrollee:

1. Requires the services provided by the NF; and

2. Is eligible for the level of NF care services.

(3) Single Wait List.

(a) Each NF participating in the TennCare must develop and consistently implement policies and procedures regarding its admissions, including the development and maintenance of a single Wait List of persons requesting admission to those facilities. This list must at a minimum contain the following information pertaining to each request for admission:

1. The name of the applicant.

2. The name of the contact person or designated representative other than the applicant (if any).

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3. The address of the applicant and the contact person or designated representative (if any).

4. The telephone number of the applicant and the contact person or designated representative (if any).

5. The name of the person or agency referring the applicant to the NF.

6. The sex and race of the applicant.

7. The date and time of the request for admission.

8. Reason(s) for refusal/non-acceptance/other-action-taken pertaining to the request for admission.

9. The name and title of the NF staff person taking the application for admission.

10. A notation stating whether the applicant is anticipated to be Medicaid eligible at time of admission or within one year of admission.

(b) The Wait List should be updated and revised at least once each quarter to remove the names of previous applicants who are no longer interested in admission to the NF. Following three (3) contacts each separated by a period of at least ten (10) days, the NF shall, consistent with the written notice required in this section move an applicant to the end of the single admission list whenever an available bed is not accepted at the time of the vacancy, but the applicant wishes to remain on the admissions list. Applicants shall be advised of these policies at the time of their inquiry, and must be notified in writing, in a format approved by the Department of Health, when their name is removed from the list or moved to the end of the list. Such contacts shall be documented in the facility log containing the Wait List. The date, time and method of each contact shall be recorded along with the name of the facility staff person making the contact, and the identity of the applicant or contact person contacted. The log of such contacts shall also summarize the communication between the facility staff person and the applicant or contact person.

(c) Each facility shall send written confirmation that an applicant's name has been entered on the Wait List, their position on the wait list, and a notification of their right of access to the wait list as provided in Subparagraph (h) of this Rule. This confirmation shall include at a minimum the date and time of entry on the wait list and shall be mailed by first class postage to the applicant and their designated representative (if any) identified pursuant to the requirements in Subparagraph (a) of this Rule.

(d) Each NF participating in TennCare shall admit applicants in the chronological order in which the referral or request for admission was received by the facility, except as permitted in Subparagraph (e) of this Rule.

(e) Documentation justifying deviation from the order of the Wait List must be maintained for inspection by the State. Inspection shall include the right to review and/or make copies of these records. Deviation may be based upon:

1. Medical need, including, but not necessarily limited to, the expedited admission of patients being discharged from hospitals and patients who previously resided in a NF at a different level of care, but who, in both cases, continue to require institutional medical services;

(Rule 1200-13-01-.06, continued)

2. The applicant's sex, if the available bed is in a room or a part of the facility that exclusively serves residents of the opposite sex;

3. Necessity to implement the provisions of a plan of affirmative action to admit racial minorities, if the plan has previously been approved by the Department of Health;

4. Emergency placements requested by the Department when evacuating another health care facility or by the Adult Protective Service of the Tennessee Department of Human Services;

5. Other reasons or policies, e.g., previous participation in a community based waiver or other alternative care program, when approved by the Medical Director of the Department of Health's Bureau of Health Licensure and Regulation, provided, however, that no such approval shall be granted if to do so would in any way impair the Department's or the facility's ability to comply with its obligations under federal and state civil rights laws, regulations or conditions of licensure or participation.

6. If a Medicaid-eligible recipient's hospitalization or therapeutic leave exceeds the period paid for under the Tennessee Medicaid program for the holding of a bed in the facility for the resident and if the resident continues to require the services provided by the NF, then the resident must be readmitted to the facility immediately upon the first availability of a bed in the facility, consistent with Part 2. above;

7. Where, with the participation and approval of the Department of Health, expedited admission is approved for residents who are being displaced from another facility or its waiting list as a result of that facility's withdrawal from the Medicaid program.

(f) Telephone requests to be placed on the Wait List shall be accepted. The information required in Subparagraph (a) of this Rule shall be documented.

(g) If an applicant, whether on his own behalf or acting through another, requests admission or to be placed on a list of applicants awaiting admission, the information on the waiting list must be recorded and preserved.

(h) Applicants or their representatives shall have the right to be informed by telephone of their position on the Wait List. Ombudsmen and appropriate State and federal personnel shall have access to the Wait List when requested, and such access shall include the right to review and/or copy the Wait List.

(i) Any referrals received from the DHS shall be handled in the following manner.

1. Applicants shall be placed on a Wait List without formal application until such facility is within sixty (60) days of admission to the facility based on experience.

2. When the applicant is within sixty (60) days of admission to the facility as estimated by the facility based on its experience, the facility shall notify the applicant and DHS in writing so that a formal application can be made prior to consideration for admittance.

3. If, after sixty (60) days from the date notification is issued, the facility has not received a completed application then the facility may remove the applicant's name from the Wait List.

(Rule 1200-13-01-.06, continued)

(4) Physician visits.

(a) NFs are responsible for assuring that physician visits are made according to the schedule set out at 42 C.F.R. § 483.40. To meet the requirement for a physician visit, the physician must, at the time of the visit,

1. See the resident;

2. Review the resident's total program of care, including treatments;

3. Verify that the resident continues to need the designated level of NF care and document it in the progress notes or orders;

4. Write, sign, and date progress notes; and

5. Sign all orders.

(b) At the option of the physician, required visits after the initial visit may alternate between visits by a physician and visits by a physician assistant or nurse practitioner working under the physician's delegation.

(c) A physician visit will be considered to be timely if it occurs not later than ten (10) days after the date of the required visit. Failure of the visit to be made timely will result in non-payment of claims, or a recoupment of all amounts paid by the Bureau or the MCO during the time that the physician visit has lapsed.

(d) NFs are responsible for assuring that the physician verify at the time of each physician's visit the Medicaid recipient's continued need for NF LOC and whether or not he is being served at the appropriate LOC.

1. Failure to obtain the verification at the time of the scheduled physician visit may result in a recoupment of all amounts paid by the Bureau or the MCO during the time that the verification/physician visit has lapsed.

2. If such a recoupment is made, the participating facility shall not:

(i) Attempt to recoup from the resident; or

(ii) Discharge the resident based on the recoupment.

3. In cases where the physician refused to make the required verification because the physician believes that the LOC is no longer appropriate, a new resident assessment must be completed by the NF.

(5) Termination of NF provider agreements.

(a) Facilities requesting voluntary termination of provider agreements shall comply with the following:

1. Facilities that choose to voluntarily terminate their provider agreements may do so by notifying the Bureau or the MCO(s) in writing of such intent. The effective date of the termination will be determined by the Bureau consistent with the terms of the TennCare Provider Agreement then in force between the Bureau or the MCO(s) and the facility.

(Rule 1200-13-01-.06, continued)

2. The facility will not be entitled to payment for any additional or newly admitted TennCare eligible residents from the date of the facility's notice of withdrawal from the TennCare Program. The facility may, however, at its election, continue to receive TennCare payment for those individuals who resided in the facility, on the date of such notice, so long as they continue to reside in and receive services from the facility and provided that such individuals are TennCare-eligible during the period for which reimbursement is sought. The facility's right to continue to receive TennCare payments for such individuals following the date of its notice of intent to withdraw from the TennCare program is contingent upon:

   (i) The facility's compliance with all requirements for TennCare participation; and

   (ii) Its agreement to continue to serve, and accept TennCare payment for, on a non-discriminatory basis, all individuals residing in the facility on the date of notification of withdrawal, who are or become TennCare eligible.

3. The notification must provide the following information:

   (i) The reason(s) for voluntary termination;

   (ii) The names and TennCare identification numbers of all TennCare-eligible residents;

   (iii) Name of the resident and name of the contact person for the resident (if any) for each resident with an application for TennCare eligibility pending;

   (iv) A copy of the letter the facility will send to each resident informing him of the voluntary termination, and a copy of the letter to be sent to all TennCare-eligible residents regarding this action;

   (v) A copy of the letter sent to all applicants on the Wait List informing them of the facility's voluntary termination;

   (vi) Whether or not the facility intends to continue to provide services to non-TennCare residents who were residents of the facility on the date withdrawal was approved, in the event they convert to TennCare eligibility; and a copy of the notice to residents explaining that decision; and,

   (vii) Other information determined by the Bureau or the MCOs as necessary to process the request for termination.

4. The termination of the provider's involvement in TennCare must be done in such a manner as to minimize the harm to current residents.

   (i) Residents who are currently TennCare-eligible shall be informed, in a notice to be provided by the facility and approved by the Bureau, that the facility has elected to withdraw from the TennCare program. If the facility has elected under Subpart (ii) of the section to continue to receive TennCare payments for residents of the facility as of the date of notice of withdrawal from the TennCare Program, the notice shall inform the resident of the right to remain in the facility as a TennCare resident as long as he wishes to do so and remain otherwise eligible under the rules of the TennCare Program. The notice shall also inform the resident that, if he wishes to transfer to another facility, under the supervision of TennCare, the NF where he now resides will assist in locating a new placement and

providing orientation and preparation for the transfer, in accordance with 42 U.S.C.A. §1396r(c)(2)(B) and implementing regulations and guidelines, if any.

(ii) All other residents of the facility shall receive a separate notice informing them of the facility's intention to withdraw from the TennCare program. The notice will be provided by the facility after having been first reviewed and approved by the Bureau. The notice shall inform such residents that, should they become eligible for TennCare coverage, they will be able to convert to TennCare from their current source of payment and remain in the facility only during a period that ends with the termination of the facility's provider agreement, a date to be determined in accordance with the terms of the provider agreement. They will not be eligible for TennCare coverage of their care in the facility thereafter. Transfer of these residents shall be considered an involuntary transfer and shall comply with federal and State regulations governing involuntary transfer or discharges.

The same notice will caution these residents that, if they require care as TennCare residents after the facility's provider agreement is terminated, they will have to transfer to another facility. The notice will also inform the residents that, when their present facility is no longer participating in the TennCare program, certain legal rights and protections that apply to all residents (regardless of source of payment) in TennCare facilities will no longer be available to those who remain in the NF. Readers of the notice will be informed that, if they wish to transfer, or to have their names placed on Wait Lists at other facilities, the facility that is withdrawing from the program will assist them by providing preparation and orientation under the supervision of the Bureau, as required by 42 U.S.C.A. § 1396r(c)(2)(B) and implementing regulations and guidelines, if any.

(iii) Applicants whose names are on the facility's Wait List will be notified by the facility on a form that has been reviewed and approved by the Bureau that the facility intends to withdraw from the TennCare Program. They will be cautioned that they will not be able to obtain TennCare coverage for any care that they receive in the facility. The notice shall also inform them that certain legal rights and protections that apply to all residents (regardless of source of payment) in TennCare participating facilities will not be available in the NF to which they have applied, once that facility has withdrawn from the TennCare program.

Applicants shall be informed in the notice that, if they wish to make application at other facilities, the withdrawing facility, under the supervision of TennCare, shall assist them in seeking placement elsewhere.

5. Following submission of a notice of withdrawal from the TennCare Program a facility cannot opt to receive continued TennCare payments for any resident unless it agrees to accept continual TennCare payment for all individuals who are residents on the date of the notice of withdrawal, and who are or become TennCare-eligible provided, however, that the Bureau or the Enrollee's MCO will pay the facility for all covered services actually provided to TennCare-eligible residents following notice of the facility's withdrawal and pending the resident's transfer or discharge. In instances where facilities elect to continue to receive such TennCare payments, their provider agreements will remain in effect until the last TennCare-eligible individual, who resided in the facility as of the date of notification of withdrawal, has been discharged or transferred from the facility in accordance with TennCare and State licensure requirements.

(Rule 1200-13-01-.06, continued)

6. Facilities which terminate their provider agreement shall not be permitted to participate in TennCare for a period of at least two (2) years from the date the provider agreement is terminated.

7. Unless the facility notifies the Bureau within thirty (30) days after giving a notice of termination, the facility may not stop the termination procedure consistent with this order without written approval from the Bureau.

(b) NFs may be involuntarily decertified by the Tennessee Department of Health's Division of Health Care Facilities because of their failure to comply with the provisions of these rules. Facilities that are involuntarily decertified shall not be permitted to participate in the Medicaid program for a minimum of five (5) years from the date of the decertification.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 12-4-301, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 1979; effective March 16, 1979. Amendment filed August 31, 1981; effective October 15, 1981. Amendment filed September 16, 1981; effective November 2, 1981. Amendment filed November 6, 1981; effective December 21, 1981. Amendment filed August 18, 1982; effective September 17, 1982. Amendment filed September 2, 1982; effective October 4, 1982. Amendment filed September 27, 1982; effective October 27, 1982. Amendment filed November 12, 1982; effective December 13, 1982. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed August 31, 1983; effective September 30, 1983. Amendment filed March 12, 1984; effective April 11, 1984. Amendment filed June 27, 1984; effective July 27, 1984. Amendments filed March 27, 1985; effective April 26, 1985. Amendment filed June 4, 1985; effective July 4, 1985. Amendment filed September 18, 1985; effective October 18, 1985. Amendment filed April 29, 1986; effective May 29, 1986. Amendment filed June 30, 1986; effective July 30, 1986. Amendment filed July 17, 1986; effective August 31, 1986. Amendment filed September 2, 1986; effective October 17, 1986. Amendment filed July 30, 1987; effective September 13, 1987. Amendment filed September 30, 1987; effective November 14, 1987. Amendment filed February 19, 1988; effective April 4, 1988. Amendment filed June 2, 1988; effective July 17, 1988. Amendment filed September 6, 1988; effective October 21, 1988. Amendment filed November 10, 1988; effective December 25, 1988. Amendment filed March 22, 1989; effective May 8, 1989. Amendment filed June 22, 1989; effective August 4, 1989. Amendment filed June 29, 1989; effective August 14, 1989. Amendment filed July 26, 1989; effective September 10, 1989. Amendment filed August 31, 1989; effective October 15, 1989. Amendment filed October 11, 1989; effective November 25, 1989. Amendment filed November 30, 1989; effective January 14, 1990. Amendment filed December 8, 1989; effective January 22, 1990. Amendments filed January 29, 1990; effective March 15, 1990. Amendment filed July 5, 1990; effective August 19, 1990. Amendment filed August 17, 1990; effective October 1, 1990. Amendment filed November 27, 1990; effective January 11, 1991. Amendment filed December 14, 1990; effective January 28, 1991. Amendment filed January 16, 1991; effective March 2, 1991. Amendment filed February 19, 1991; effective April 5, 1991. Amendment filed February 26, 1991; effective April 12, 1991. Amendment filed May 7, 1991; effective June 21, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed June 14, 1991; effective July 29, 1991. Amendment filed September 16, 1991; effective October 31, 1991. Amendment filed September 17, 1991; effective November 1, 1991. Amendment filed September 30, 1991; effective November 14, 1991. Amendment filed October 14, 1991; effective November 28, 1991. Amendment filed October 21, 1991; effective December 5, 1991. Amendment filed October 23, 1991; effective December 7, 1991. Amendment filed March 10, 1992; effective April 24, 1992. Amendment filed March 26, 1992; effective May 10, 1992. Amendment filed April 29, 1992; effective June 13, 1992. Amendment filed September 29, 1992; effective November 13, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 7, 1993; effective February 20, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed May 25, 1994; effective August 9, 1994. Amendment filed November 10, 1994; effective January 24, 1995. Amendment filed August 1, 1995; effective October 14, 1995. Amendment filed October 20, 1995; effective January 3, 1996. Amendment filed July 15, 1996; effective September 28, 1996. Amendment filed April 20, 1998; effective July 4, 1998.*

(Rule 1200-13-01-.06, continued)

Amendment filed October 14, 1998; effective December 28, 1998. Amendment filed January 3, 2000; effective March 18, 2000. Amendment filed June 22, 2000; effective September 5, 2000. Amendment filed January 9, 2002; effective March 25, 2002. Amendment filed July 24, 2003; effective October 7, 2003. Public necessity rule filed July 1, 2005; effective through December 13, 2005. Public necessity rule filed September 26, 2005; effective through March 10, 2006. Amendments filed December 20, 2005; effective March 5, 2006. Amendment filed January 16, 2006; effective April 1, 2006. Amendment filed July 17, 2007; effective September 30, 2007. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010.

1200-13-01-.07 REPEALED

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109 and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed November 17, 1977; effective December 19, 1977. Amendment filed January 31, 197; effective March 16, 1979. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed June 27, 1984; effective July 27, 1984. Amendment filed May 8, 1985; effective August 13, 1985. Amendment filed April 29, 1986, effective May 29, 1986. Amendment filed January 22, 1988; effective March 7, 1988. Amendment filed January 30, 1989; effective March 16, 1989. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed February 23, 1990; effective April 9, 1990. Amendment filed July 5, 1990; effective August 19, 1990. Amendment filed August 30, 1990; effective October 14, 1990. Amendment filed October 30, 1990; effective December 14, 1990. Amendment filed January 9, 1991; effective February 23, 1991. Amendment filed February 27, 1991; effective April 13, 1991. Amendment filed April 29, 1991; effective June 13, 1991. Amendment filed May 8, 1991; effective June 22, 1991. Amendment filed June 12, 1991; effective July 27, 1991. Amendment filed September 19, 1991; effective November 3, 1991. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 26, 1992; effective May 10, 1992. Amendment filed March 27, 1992; effective May 11, 1992. Amendment filed May 1, 1992; effective June 15, 1992. Amendment filed August 4, 1992; effective September 18, 1992. Amendment filed September 29, 1992; effective November 13, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed December 30, 1992; effective February 16, 1993. Amendment filed December 10, 1993; effective February 23, 1994. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 28, 2007; effective April 11, 2007.*

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

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

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

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

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

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

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

(Rule 1200-13-01-.08, continued)

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

(2) Patient Liability.

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

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

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

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

(e) Patient Liability shall be collected as follows:

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

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

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

(Rule 1200-13-01-.08, continued)

(3) TPL for LTSS.

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

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

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

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

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

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

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

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

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

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

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

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

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

(Rule 1200-13-01-.08, continued)

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

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

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

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

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

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

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

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

Authority: *T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.* ***Administrative History:*** *Original rule filed May 15, 1980; effective June 29, 1980. Amendment filed May 27, 1983; effective June 27, 1983. Amendment filed February 22, 1991; effective April 9, 1991. Emergency rule filed March 1, 2009; effective through August 28, 2010. Amendment filed May 27, 2010; effective August 25, 2010. Emergency rules filed June 29, 2012; effective through December 26, 2012. Repeal and new rule filed September 26, 2012; effective December 25, 2012.*

1200-13-01-.09 THIRD PARTY SIGNATURE.

(1) No facility may require a third party signature for a Medicaid recipient as a condition of application or admission to, or continued stay in, the facility. However, any person appointed by a court of competent jurisdiction to act on behalf of a recipient may be required to perform all requirements normally required of an applicant.

(2) If a facility has collected an advance payment or deposit from or on behalf of a person retroactively determined to be eligible for Medicaid, the amount collected less the amount determined by the Department of Human Services to be the patient's liability for that period of time shall be refunded within ten (10) days after receiving payment for retroactive period from the state of its agents.

(3) The facility must file for such retroactive reimbursement for the full period of retroactive eligibility on the next claim for reimbursement filed by the facility following the date of notification of eligibility.

(Rule 1200-13-01-.09, continued)

Authority: *T.C.A. §§ 14-1945 and 14-23-109.* ***Administrative History:*** *Original rule filed May 15, 1980; effective June 29, 1980. Amendment filed October 8, 1985; effective November 7, 1985.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Rule 1200-13-01-.10, continued)

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

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

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

5. Upon the death of a CHOICES Member.

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

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

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

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

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

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

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

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

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

(e) Except as specified in 1200-13-01-.10(2)(e)2., an approved PAE is valid for ninety (90) calendar days beginning with the PAE Approval Date, unless an earlier expiration date has been established by TennCare (see 1200-13-01-.10(2)(h)). A valid approved PAE that has not been used within ninety (90) calendar days of the PAE Approval Date must be updated before it can be used. For purposes of Medicaid-reimbursed NF services,

(Rule 1200-13-01-.10, continued)

such update may be completed only upon submission of a confirmed Medicaid Only Payer Date. To update the PAE, the physician (in the case of NF services) or a Qualified Assessor (in the case of HCBS) shall certify that the Applicant's medical condition on the revised PAE Request Date is consistent with that described in the initial certification and/or assessment and that NF services, or alternative HCBS, as applicable, are medically necessary for the Applicant. If the Applicant's medical condition has significantly changed such that the previously approved PAE does not reasonably reflect the Applicant's current medical condition and functional capabilities, a new PAE shall be required.

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

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

   (i) The person transfers to another NF.

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

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

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

3. For persons electing hospice:

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

      (I) the person has remained in the NF;

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

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

      (IV) NF LOC criteria have not changed.

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

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

(f) A PAE must include a recent history and physical or current medical records that support the Applicant's functional and/or skilled nursing or rehabilitative needs, as reflected in the PAE. A history and physical performed within 365 calendar days of the PAE Request Date may be used if the Applicant's condition has not significantly changed. Medical records (progress notes, office records, discharge summaries, etc.)

(Rule 1200-13-01-.10, continued)

may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed, or may be used in lieu of a history and physical, so long as the records provide medical evidence sufficient to support the functional and/or skilled or rehabilitative needs reflected in the PAE.

(g) A PAE must be certified as follows:

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

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

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

(i) PASRR.

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

(i) payer source;

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

(iii) the level of NF reimbursement requested.

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

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

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

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

(Rule 1200-13-01-.10, continued)

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

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

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

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

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

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

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

(3) Medicaid Reimbursement.

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

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

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

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

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

5. For a retroactive eligibility determination, the Bureau has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired PAE within thirty (30) calendar days of the mailing date of

(Rule 1200-13-01-.10, continued)

the Notice of Disposition or Change, so long as the person has remained in a NF since the PAE was completed (except for short-term hospitalization). The effective date of payment for NF services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE that has been updated.

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

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

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

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

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

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

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

3. The effective date of Medicaid eligibility;

4. The date of admission to the NF; and

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

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

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

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

(Rule 1200-13-01-.10, continued)

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

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

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

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

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

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

1. Medical Necessity of Care:

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

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

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

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

2. Need for Inpatient Nursing Care:

(i) Applicants requesting TennCare-reimbursed NF care.

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

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

(II) Meet one (1) or more of the ADL or related criteria specified in 1200-13-01-.10(4)(b)2.(iii) on an ongoing basis and be determined by TennCare through approval of a Safety Determination Request to not qualify for enrollment in CHOICES Group 3. An applicant who could be safely served in CHOICES Group 3 except that he does not meet Medicaid categorical and financial eligibility criteria for CHOICES Group 3 (i.e. is not an SSI recipient) shall not be eligible for CHOICES Group 1 or Group 2 as a result of a Safety Determination.

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

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

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

(II) Meet one (1) or more of the ADL or related criteria specified in 1200-13-01-.10(4)(b)2.(iii) on an ongoing basis and be determined by TennCare through approval of a Safety Determination Request to not qualify for enrollment in CHOICES Group 3. An applicant who could be safely served in CHOICES Group 3 except that he does not meet Medicaid categorical and financial eligibility criteria for CHOICES Group 3 (i.e. is not an SSI recipient) shall not be eligible for CHOICES Group 1 or Group 2 as a result of a Safety Determination.

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

(I) Transfer. The Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or at least four days per week). Approval of this deficit shall require documentation of the medical condition(s)

(Rule 1200-13-01-.10, continued)

contributing to this deficit, as well as the specific type and frequency of transfer assistance required.

(II) Mobility. The Applicant requires physical assistance from another person for mobility on an ongoing basis (daily or at least four days per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair (manual or electric) if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement. Approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of mobility assistance required.

(III) Eating. The Applicant requires physical assistance with gastrostomy tube feedings or physical assistance or constant one-on-one observation and verbal assistance (reminding, encouraging) 4 or more days per week to consume prepared food and drink (or self-administer tube feedings, as applicable) or must be fed part or all of each meal. Food preparation, tray set-up, assistance in cutting up foods, and general supervision of multiple residents shall not be considered to meet this requirement. Approval of this deficit shall require documentation which supports the need for such intervention, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task. For PAEs submitted by the AAAD (or entity other than an MCO, NF, or PACE Organization), an eating or feeding plan specifying the type, frequency and duration of supports required by the Applicant for feeding, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task shall be required.

(IV) Toileting. The Applicant requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or catheter care on an ongoing basis (daily or at least four days per week). Approval of this deficit shall require documentation of the specific type and frequency of toileting assistance required.

(V) Expressive and Receptive Communication. The Applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including through the use of assistive devices; or the Applicant is incapable of understanding and following very simple instructions and commands without continual intervention (daily or at least four days per week). Approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of communication assistance required.

(VI) Orientation. The Applicant is disoriented to person (e.g., fails to remember own name, or recognize immediate family members), place (e.g., does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make decisions that prevent risk of harm) daily or at least four days per week.

(Rule 1200-13-01-.10, continued)

Approval of this deficit shall require documentation of the specific orientation deficit(s), including the frequency of occurrence of such deficit(s), and the impact of such deficit(s) on the Applicant.

(VII) Medication Administration. The Applicant is not cognitively or physically capable (daily or at least four days per week) of self-administering prescribed medications at the prescribed schedule despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to Applicant, reassurance of the correct dose, and the use of assistive devices including a prepared medication box. An occasional lapse in adherence to a medication schedule shall not be sufficient for approval of this deficit; the Applicant must have physical or cognitive impairments which persistently inhibit his or her ability to self-administer medications. Approval of this deficit shall require evidence that such interventions have been tried or would not be successful, and that in the absence of intervention, the Applicant's health would be at serious and imminent risk of harm.

(VIII) Behavior. The Applicant requires persistent staff or caregiver intervention and supervision (daily or at least four days per week) due to an established and persistent pattern of behavioral problems which are not primarily related to a mental health condition (for which mental health treatment would be the most appropriate course of treatment) or a substance abuse disorder (for which substance abuse treatment would be the most appropriate course of treatment), and which, absent such continual intervention and supervision, place the Applicant or others at imminent and serious risk of harm. Such behaviors may include physical aggression (including assaultive or self-injurious behavior, destruction of property, resistive or combative to personal and other care, intimidating/threatening, or sexual acting out or exploitation) or inappropriate or unsafe behavior (including disrobing in public, eating non-edible substances, fire setting, unsafe cooking or smoking, wandering, elopement, or getting lost). Approval of this deficit shall require documentation of the specific behaviors and the frequency of such behaviors.

(IX) Skilled Nursing or Rehabilitative Services. The Applicant requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through daily home health visits. Approval of such skilled nursing or rehabilitative services shall require a physician's order and other documentation as specified in the PAE. Level 2 reimbursement for rehabilitative services and acuity points for such rehabilitative services shall not be approved for chronic conditions, exacerbations of chronic conditions, weakness after hospitalization, or maintenance of functional status, although the NF shall be required to ensure that appropriate services and supports are provided based on the individualized needs of each resident.

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

(Rule 1200-13-01-.10, continued)

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

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

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

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

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

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

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

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

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

(I) Gastrostomy tube feeding

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

(III) Total parenteral nutrition

(IV) Intravenous fluid administration

(V) Nasopharyngeal and tracheostomy suctioning

(Rule 1200-13-01-.10, continued)

(VI) Ventilator services

(iii) A skilled rehabilitative service must be expected to improve the Applicant's condition. Restorative and maintenance nursing procedures (e.g., routine range of motion exercises; stand-by assistance during ambulation; applications of splints/braces by nurses and nurses aides) shall not be considered sufficient to fulfill the requirement of (5)(b)2. Factors to be considered in the decision as to whether a rehabilitative service meets, or continues to meet, the requirement of (5)(b)2. shall include, but not be limited to, an assessment of the type of therapy and its frequency, the remoteness of the injury or impairment, and the reasonable potential for improvement in the Applicant's functional capabilities or medical condition.

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

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

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

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

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

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

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

(Rule 1200-13-01-.10, continued)

(i) Transfer;

(ii) Mobility;

(iii) Eating; and

(iv) Toileting.

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

(i) Communication (expressive and receptive);

(ii) Orientation (to person and place);

(iii) Dementia-related behaviors; and

(iv) Self-administration of medications.

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

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

(c) Weighted Values.

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

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

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

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

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

2. Interpretation of possible responses for the behavior measure:

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

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

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

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

(Rule 1200-13-01-.10, continued)

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

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

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

Skilled or rehabilitative service	Maximum Individual Acuity Score
Ventilator	5
Frequent tracheal suctioning	4
New tracheostomy or old tracheostomy requiring suctioning through the tracheostomy multiple times per day at less frequent intervals, i.e., < every 4 hours	3
Total Perenteral Nutrition (TPN)	3
Complex wound care (i.e., infected or dehisced wounds)	3
Wound care for stage 3 or 4 decubitus	2
Peritoneal dialysis	2
Tube feeding, enteral	2
Intravenous fluid administration	1
Injections, sliding scale insulin	1
Injections, other IV, IM	1
Isolation precautions	1

(Rule 1200-13-01-.10, continued)

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).

(Rule 1200-13-01-.10, continued)

(7) PreAdmission Evaluation Denials and Appeal Rights.

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

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

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

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

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

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

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

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

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed October 22, 1981; effective December 7, 1981. Amendment filed March 1, 1982; effective April 15, 1982. Amendment filed June 23, 1983; effective July 25, 1983. Amendment filed May 24, 1985; effective June 23, 1985. Amendment filed November 9, 1988; effective December 24, 1988. Amendment filed March 30, 1995; effective June 15, 1995. Repeal and new rule filed June 29, 2000; effective September 12, 2000. Amendment filed July 24, 2003; effective October 7, 2003. Amendment filed September 30, 2005; effective December 14, 2005. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Emergency rules filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Emergency rule filed June 29, 2012; effective through December 26, 2012. Repeal and new rule filed September 26, 2012; effective December 25, 2012. Emergency rule filed June 30, 2015; effective through December 27, 2015. Amendment filed April 14, 2015; effective July 13, 2015. Amendment filed September 23, 2015; effective December 22, 2015.*

1200-13-01-.11 REPEALED.

Authority: *T.C.A. §§ 4-5-202 and 71-5-105.* ***Administrative History:*** *Original rule filed June 7, 1982; effective July 22, 1982. Repeal and new rule filed February 23, 1987; effective April 9, 1987. Amendment filed March 22, 1989; effective Mayl6, 1989. Amendment filed June 8, 1990; effective July 23, 1990. Amendment filed March 18, 1994; effective June 1, 1994. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Repeal filed February 1, 2013; effective July 29, 2013.*

1200-13-01-.12 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 14-23-105, 14-23-109, 71-5-105, and 71-5-109.* ***Administrative History:*** *Original rule filed March 2, 1983; effective April 4, 1983. Repeal and new rule filed February 4, 1985; effective March 6, 1985. Amendment filed July 5, 1990; effective August 19, 1990. Repeal filed March 18, 1994; effective June 1, 1994.*

1200-13-01-.13 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 11.* ***Administrative History:*** *Original rule filed June 23, 1983; effective July 25, 1983. Amendment filed March 30, 1995; effective June 15, 1995. Repeal filed June 29, 2000; effective September 12, 2000.*

1200-13-01-.14 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed February 14, 1984; effective March 15, 1984. Amendment filed August 21, 1984; effective September 20, 1984. Repeal filed March 18, 1994; effective June 1, 1994.*

1200-13-01-.15 MEDICAL (LOC) ELIGIBILITY CRITERIA FOR MEDICAID REIMBURSEMENT OF CARE IN AN ICF/MR.

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

(2) ICF/MR PreAdmission Evaluations and Transfer Forms

(a) An ICF/MR PreAdmission Evaluation is required to be submitted to the Bureau of TennCare for approval when

1. A Medicaid Eligible is admitted to an ICF/MR.

2. A private-paying resident of an ICF/MR attains Medicaid Eligible status or applies for Medicaid eligibility. A new ICF/MR PreAdmission Evaluation is not required when an individual's financial status changes from Medicaid Eligible to private pay and then back to Medicaid Eligible within a 90-day time period.

(b) A Transfer Form is required to be submitted to the Bureau of TennCare for approval when an ICF/MR Eligible having an approved unexpired ICF/MR PAE transfers from one ICF/MR to another ICF/MR or from the HCBS MR Waiver Program to an ICF/MR. A Transfer Form is required to be submitted to the Division of Intellectual Disabilities Services for approval when an ICF/MR Eligible having an approved unexpired ICF/MR PAE transfers from an ICF/MR to the HCBS MR Waiver Program.

(c) An approved ICF/MR PreAdmission Evaluation is valid for ninety (90) calendar days from the ICF/MR PAE Approval Date. An approved ICF/MR PreAdmission Evaluation

(Rule 1200-13-01-.15, continued)

that has not been used within ninety (90) calendar days of the ICF/MR PAE Approval Date can be updated within 365 calendar days of the ICF/MR PAE Approval Date if the physician certifies that the individual's current medical condition is consistent with that described in the approved ICF/MR PreAdmission Evaluation. A PAE that is not used within 365 days of the PAE Approval Date is expired and cannot be updated.

(d) An ICF/MR PreAdmission Evaluation must include a recent medical history and physical signed by a physician who is licensed as a doctor of medicine or doctor of osteopathy, or by a licensed nurse practitioner or physician's assistant. A medical history and physical performed within 365 calendar days of the ICF/MR PAE Request Date may be used if the individual's condition has not significantly changed. Additional medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed.

(e) An ICF/MR PAE must include a psychological evaluation of need for care. Pursuant to 42 C.F.R. § 456.370(b), such evaluation must be performed before admission to the ICF/MR or authorization of payment, but not more than three months before admission.

(3) Medicaid Reimbursement

(a) An ICF/MR which has entered into a provider agreement with the Bureau of TennCare is entitled to receive Medicaid reimbursement for covered services provided to an ICF/MR Eligible if:

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

2. For the transfer to an ICF/MR of an individual having an approved unexpired ICF/MR PreAdmission Evaluation, the Bureau of TennCare has received an approvable Transfer Form within ten (10) calendar days after the date of the transfer. For transfer from ICF/MR services to an HCBS MR Waiver program, the transfer form must be submitted and approved prior to enrollment in the HCBS MR Waiver program.

3. For a retroactive eligibility determination, the Bureau of TennCare has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired ICF/MR PreAdmission Evaluation within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change. The effective date of payment for ICF/MR services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE which has been updated.

(b) Any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.

1. Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no earlier than the date of receipt of the information which cured the original deficiencies in the denied PAE.

(Rule 1200-13-01-.15, continued)

Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application.

2. Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for ICF/MR services.

(c) An ICF/MR that admits a Medicaid Eligible without an approved ICF/MR PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement from the Bureau of TennCare.

(4) Criteria for Medicaid-reimbursed Care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)

(a) Medicaid Eligible Status: The individual must be determined by the Tennessee Department of Human Services to be financially eligible for Medicaid-reimbursed care in an Intermediate Care Facility for the Mentally Retarded.

(b) An individual must meet all of the following criteria in order to be approved for Medicaid-reimbursed care in an Intermediate Care Facility for the Mentally Retarded:

1. Medical Necessity of Care: Care must be expected to enhance the individual's functional ability or to prevent or delay the deterioration or loss of functional ability. Care in an Intermediate Care Facility for the Mentally Retarded must be ordered and supervised by a physician.

2. Diagnosis of Mental Retardation or Related Conditions.

3. Need for Specialized Services for Mental Retardation or Related Conditions: The individual must require a program of specialized services for mental retardation or related conditions provided under the supervision of a qualified mental retardation professional (QMRP). The individual must also have a significant deficit or impairment in adaptive functioning in one of the following areas: communication, comprehension, behavior, or activities of daily living (e.g., toileting, bathing, eating, dressing/grooming, transfer, mobility).

(c) Individuals with mental retardation or related conditions who were in an Intermediate Care Facility for the Mentally Retarded or who were in community residential placements funded by the Division of Intellectual Disabilities on or prior to the effective date of this rule may be deemed by the Bureau of TennCare to meet the requirements of (4)(b)2. and (4)(b)3.

(d) For continued Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded, an individual must continue to meet the criteria specified in (4)(a) and (4)(b), unless otherwise exempted by (4)(c).

(5) Grievance process

(a) A Medicaid Eligible or the legal representative of the Medicaid Eligible has the right to appeal the denial of an ICF/MR PreAdmission Evaluation and to request a Commissioner's Administrative Hearing by submitting a written letter of appeal to the Bureau of TennCare within thirty (30) calendar days of receipt of the notice of denial.

(b) If the Bureau of TennCare denies an ICF/MR PreAdmission Evaluation, the individual will be notified in the following manner:

(Rule 1200-13-01-.15, continued)

1. A written notice of denial shall be sent to the individual and, where applicable, to the Designated Correspondent. A notice of denial shall also be sent to the ICF/MR. This notice shall advise the individual of the right to appeal the denial decision within thirty (30) calendar days. The notice shall also advise the individual of the right to submit within thirty (30) calendar days either the original ICF/MR PAE with additional information for review or a new ICF/MR PAE. The notice shall be mailed to the individual's address as it appears upon the ICF/MR PAE. If no address appears on the ICF/MR PAE and supporting documentation, the notice will be mailed to the ICF/MR for forwarding to the individual.

2. If an ICF/MR PreAdmission Evaluation is resubmitted with additional information for review and if the Bureau of TennCare continues to deny the ICF/MR PreAdmission Evaluation, another written notice of denial shall be sent as described in (5)(b)1.

(c) The individual has the right to be represented at the hearing by anyone of their choice. The hearing will be conducted according to the provisions of the Tennessee Uniform Administrative Procedures Act.

(d) Reasonable accommodations shall be made for individuals with disabilities who require assistance with appeals.

(e) Any notice required pursuant to this section shall be a plain language written notice.

Authority: *T.C.A. §§ 4-5-202, 4-5-203, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 11.* ***Administrative History:*** *Original rule filed June 22, 2000; effective September 5, 2000. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.*

1200-13-01-.16 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed September 11, 1987; effective October 31, 1987. Amendment filed March 6, 1991; effective April 20, 1991. Amendment filed September 9, 1991; effective October 24, 1991. Amendment filed November 27, 1991; effective January 11, 1992. Amendment filed October 20, 1992; effective December 4, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 26, 2007; effective date April 11, 2007. Emergency rule filed March 1, 2010; effective through August 28, 2010.*

1200-13-01-.17 REPEALED.

Authority: *T.C.A. §§ 4-5-202 and 71-5-105.* ***Administrative History:*** *Original rule filed February 12, 1986; effective March 14, 1986. Amendment filed March 1, 1988; effective April 15, 1988. Amendment filed July 28, 2004; effective October 11, 2004. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Repeal filed February 1, 2013; effective July 29, 2013.*

1200-13-01-.18 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, Executive Order No. 23, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed May 1985; effective June 23, 1985. Amendment filed November 5, 1990; effective December 20, 1990. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed September 18, 2007; effective December 2, 2007.*

1200-13-01-.19 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed September 10, 1985; effective October 10, 1985. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 26, 2007; effective April 11, 2007.*

1200-13-01-.20 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Public Chapter 358 of the Acts of 1994.* ***Administrative History:*** *Original rule filed June 2, 1988; effective July 17, 1988. Amendment filed April 19, 1990; effective June 3, 1990. Amendment filed April 30, 1992; effective June 14, 1992. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed January 26, 2007; effective April 11, 2007.*

1200-13-01-.21 REPEALED.

Authority: *T.C.A. §§ 4-5-202 and 71-5-105.* ***Administrative History:*** *Original rule filed January 29, 1990; effective March 15, 1990. Amendment filed October 24, 1991; effective December 8, 1991. Amendment filed November 27, 1991; effective January 11, 1992. Amendment filed March 10, 1992; effective April 24, 1992. Amendment filed August 4, 1992; effective September 18, 1992. Amendment filed December 4, 1992; effective January 19, 1993. Amendment filed March 18, 1994; effective June 1, 1994. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Repeal filed February 1, 2013; effective July 29, 2013.*

1200-13-01-.22 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, Executive Order No. 23, and Public Chapter 358 of the Acts of 1993.* ***Administrative History:*** *Original rule filed December 1, 1988; effective January 15, 1989. Amendment filed January 29, 1990; effective March 15, 1990. Amendment filed March 18, 1994; effective June 1, 1994. Amendment filed September 18, 2007; effective December 2, 2007.*

1200-13-01-.23 NURSING HOME PREADMISSION SCREENINGS FOR MENTAL ILLNESS AND MENTAL RETARDATION.

(1) Definitions. See Rule 1200-13-01-.02.

(2) Medicaid-certified nursing facilities may not admit individuals applying for admission unless these persons are screened to determine if they have mental illness or mental retardation regardless of method of payment or “known diagnosis.” A Medicaid-certified nursing facility is prohibited from admitting any new resident who has mental illness or mental retardation (or a related condition), unless that individual has been determined by the Tennessee Department of Mental Health and Developmental Disabilities and/or the Division of Intellectual Disabilities Services, as applicable, not to be in need of specialized services and appropriate for placement in a nursing facility. (The individual must also meet the Bureau of TennCare’s preadmission criteria for nursing facility services). The criteria to be used in making determinations will be categorized into two levels: 1) identification screens (Level I) and 2) preadmission screening/resident reviews evaluations (Level II).

(a) Criteria for Identification Screen (Level I)

1. Prior to admission of any person to a nursing facility, it must be determined if:

(i) For Mental Illness:

(Rule 1200-13-01-.23, continued)

(I) The individual has a diagnosis of MI. (See definition of MI in Rule 1200-13-01-.02.)

(II) The person has any recent (within the last two years) history of mental illness, or has been prescribed a major tranquilizer on a regular basis in the absence of justifiable neurological disorder.

(III) There is any presenting evidence of mental illness (except primary diagnosis of Alzheimer's disease or dementia) including possible disturbances in orientation or mood.

(ii) For Mental Retardation or Persons with Related Conditions:

(I) The individual has a diagnosis of MR. (See definition of MR in Rule 1200-13-01-.02.)

(II) There is any history of mental retardation or developmental disability in the identified individual's past.

(III) There is any presenting evidence (cognitive or behavior functions) that may indicate the person has mental retardation or developmental disability.

(IV) The person is referred by an agency that serves persons with mental retardation (or other developmental disabilities), and the person has been deemed to be eligible for that agency's services.

(V) The preceding criteria must also be applied to residents of a nursing facility who have not received an identification screen.

(VI) There must be a record of the identification screen results and interpretation in the nursing home resident's record.

(VII) Results of the identification screen must be used (unless there is other indisputable evidence that the individual is not mentally ill or mentally retarded) in determining whether an individual has (or is suspected to have) mental illness or mental retardation and therefore must be subjected to the PASRR process. Findings from the evaluation should be used in making determinations about whether an individual has mental illness or mental retardation.

(b) Any individual for whom there is a negative response for all of the identification evaluative criteria for mental retardation or mental illness and for whom there is no other evidence of a condition of mental illness or mental retardation may be admitted to or continue to reside in a Medicaid-certified nursing facility without being determined appropriate for nursing facility placement through the PASRR evaluation process (Level II).

(c) Any individual for whom there is a positive response for any of the identification evaluative criteria for mental retardation or mental illness may not be admitted to or continue to reside in a Medicaid-certified nursing facility without being determined appropriate for nursing facility placement through the PASRR evaluation process (Level II).

(d) Exemptions from Level II Review

(Rule 1200-13-01-.23, continued)

An individual who has a diagnosis of mental illness or mental retardation will be exempt from the PASRR process if they meet any of the following criteria:

1. Dementia - This must be a primary diagnosis based on criteria in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition; or it may be the secondary diagnosis (including Alzheimer's disease and related disorders) as long as the primary diagnosis is not a major mental illness. The primary or secondary diagnosis of dementia (including Alzheimer's disease and related disorders) must be based on a neurological examination. Dementia is not allowed as an exemption if the individual has, or is suspected of having, a diagnosis of mental retardation.

2. Convalescent Care - Any person with MI or MR as long as that person is not a danger to self and/or others, may be admitted to a Medicaid-certified NF after release from an acute care hospital for a period of recovery without being subjected to the PASRR process for evaluation of MI or MR.

3. Terminal Illness - Under 42 U.S.C.A. § 1395x(dd)(3)(A), a Medicare beneficiary is considered to be terminally ill if he has a medical prognosis that his life expectancy is six (6) months or less. This same standard is to be applied to Medicaid recipients with MI, MR, or related conditions who are found to be suffering from a terminal illness. An individual with MI or MR, as long as that person is not a danger to self and/or others, may be admitted to or reside in a Medicaid-certified NF without being subjected to the PASRR/MI or PASRR/MR evaluative process if he is certified by a physician to be "terminally ill," as that term is defined in 42 U.S.C.A. § 1395x(dd)(3)(A), and requires continuous nursing care and/or medical supervision and treatment due to his physical condition.

4. Severity of Illness - Any person with mental illness or mental retardation who is comatose, ventilator dependent, functions at the brain stem level, or has a diagnosis of: Severe Parkinson's Disease, Huntingdon's Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure, or Chronic Obstructive Pulmonary Disease, and any other diagnosis so determined by the Centers for Medicare and Medicaid Services.

(e) Processes upon expiration of exemption

1. If an individual is admitted to a nursing facility as a Medicare patient, with a "30-day hospital discharge exemption" on the PASRR screen form, and it is determined that the individual will need to extend the stay beyond 30 days, it is the responsibility of the nursing facility to notify TennCare and to ensure that a PASRR evaluation is completed no more than 40 days from the original date of admission (i.e., within 10 days of expiration of the 30-day exemption). If Medicaid reimbursement will be sought, this includes submission and disposition of the PAE which will be required in order to timely complete the PASRR evaluation.

2. If an individual enters the facility with an exemption of "120-day short term stay" on the PASRR screen form and it is determined that the individual will need to extend the stay beyond 120 days, it is the responsibility of the nursing facility to notify TennCare at least seven (7) working days prior to expiration of the 120 days in order to ensure that a PASRR evaluation is completed timely before the 120-day exemption expires. If Medicaid reimbursement will be sought, the PAE must also be submitted to TennCare with sufficient time for review and approval. In such case, it is the responsibility of the nursing facility to notify TennCare and

(Rule 1200-13-01-.23, continued)

to submit a completed PAE at least ten (10) working days prior to expiration of the 120 days in order to ensure that a PASRR evaluation is completed timely before the 120-day exemption expires.

(3) Right to Appeal - Each patient has the right to appeal any decision made. The appeal process will be handled in accordance with T.C.A. §71-5-113.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105 and 71-5-109.* ***Administrative History:*** *Original rule filed June 29, 1989; effective; August 14, 1989. Amendment filed March 30, 1995; effective June 15, 1995. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendment filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010.*

1200-13-01-.24 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109.* ***Administrative History:*** *Original rule filed October 21, 1991; effective December 5, 1991. Amendment filed March 18, 1994; effective June 1, 1994. Repeal filed May 5, 2009; effective July 19, 2009.*

1200-13-01-.25 TENNESSEE'S HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED UNDER SECTION 1915 (c) OF THE SOCIAL SECURITY ACT (STATEWIDE MR WAIVER).

(1) Definitions: The following definitions shall apply for interpretation of this rule:

(a) Adult Dental Services - accepted dental procedures which are provided to adult Enrollees (i.e., age 21 years or older) as specified in the Plan of Care. Adult Dental Services may include fillings, root canals, extractions, the provision of dentures and other dental treatments to relieve pain and infection. Preventive dental care is not covered under Adult Dental Services.

(b) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.

(c) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.

(d) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.

(e) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a Pre-Admission Evaluation signifying that the named individual requires services provided through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.

(f) Covered Services or Covered Waiver Services – The services which are available through Tennessee's Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled when medically necessary and when provided

(Rule 1200-13-01-.25, continued)

in accordance with the Waiver as approved by the Centers for Medicare and Medicaid Services.

(g) Day Services - individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities.

(h) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.

(i) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(j) Enrollee - a Medicaid Eligible who is enrolled in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(k) Environmental Accessibility Modifications – only those interior or exterior physical modifications to the Enrollee's place of residence which are required to ensure the health, welfare and safety of the Enrollee or which are necessary to enable the Enrollee to function with greater independence.

(l) Family Model Residential Support – a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(m) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities and Homes for the Aged.

(n) Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled or "Waiver" - the Home and Community Based Services waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who have mental retardation and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.

(o) ICF/MR Pre-Admission Evaluation (ICF/MR PAE) – the assessment form used by the State Medicaid Agency to document the current medical and habilitative needs of an individual with mental retardation and to document that the individual meets the Medicaid level of care eligibility criteria for care in an ICF/MR.

(p) Individual Support Plan – the individualized written Plan of Care.

(q) Individual Transportation Services –non-emergency transport of an Enrollee to and from approved activities specified in the Plan of Care.

(Rule 1200-13-01-.25, continued)

(r) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for an ICF/MR.

(s) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have the State Medicaid Agency make reimbursement for covered services.

(t) Medicaid State Plan – the plan approved by the Center for Medicare and Medicaid Services which specifies the covered benefits for the Medicaid program in Tennessee.

(u) Medical Residential Services – a type of residential service provided in a residence where all residents require direct skilled nursing services and habilitative services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting. Medical Residential Services must be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services. The enrollee who receives Medical Residential Services shall require direct skilled nursing services on a daily basis and at a level which cannot for practical purposes be provided through two or fewer daily skilled nursing visits. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(v) Nursing Services –skilled nursing services that fall within the scope of Tennessee's Nurse Practice Act and that are directly provided to the Enrollee in accordance with a plan of care. Nursing Services shall be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services.

(w) Nutrition Services - assessment of nutritional needs, nutritional counseling, and education of the Enrollee and of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat. Nutrition Services are intended to promote healthy eating practices and to enable the Enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.

(x) Occupational Therapy Services – diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(y) Operational Administrative Agency - the approved agency with which the State Medicaid Agency contracts for the administration of the day-to-day operations of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(z) Orientation and Mobility Training – assessment of the ability of an Enrollee who is legally blind to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the Enrollee and of caregivers responsible for assisting in the mobility of the Enrollee.

(Rule 1200-13-01-.25, continued)

(aa) Personal Assistance – the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(bb) Personal Emergency Response System - a stationary or portable electronic device used in the Enrollee's place of residence which enables the Enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device.

(cc) Physical Therapy Services - diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(dd) Plan of Care – an individualized written Plan of Care which describes the medical and other services (regardless of funding source) to be furnished to the Enrollee, the Waiver Service frequency, and the type of provider who will furnish each Waiver Service and which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees.

(ee) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.

(ff) Re-evaluation - the annual process approved by the State Medicaid Agency by which a licensed physician or registered nurse or a Qualified Mental Retardation Professional assesses the Enrollee's need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.

(gg) Residential Habilitation - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(hh) Respite - services provided to an Enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness or injury, or when unpaid caregivers need relief from routine caregiving responsibilities.

(ii) Safety Plan - an individualized plan by which the Operational Administrative Agency ensures the health, safety and welfare of Enrollees who do not have 24-hour direct care services.

(jj) Specialized Medical Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls or appliances which enable an Enrollee to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment, and supplies for the proper functioning of such items. Specialized Medical Equipment, Supplies, and Assistive Technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician or nurse practitioner) based on an assessment

(Rule 1200-13-01-.25, continued)

of the Enrollee's needs and capabilities and shall be furnished as specified in the Plan of Care. Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that Specialized Medical Equipment and Assistive Technology which requires custom fitting meets the needs of the Enrollee and may include training of the Enrollee by a physical therapist, occupational therapist or speech therapist to effectively utilize such customized equipment.

(kk) Speech, Language and Hearing Services – diagnostic, therapeutic and corrective services which are within the scope of state licensure which enable an Enrollee to improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function.

(ll) State Medicaid Agency – the bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program in Tennessee.

(mm) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Operational Administrative Agency to provide Waiver Services to an Enrollee.

(nn) Support Coordination - case management services that assist the Enrollee in identifying, selecting, obtaining, coordinating and using both paid services and natural supports to enhance the Enrollee's independence, integration in the community and productivity as specified in the Enrollee's Plan of Care. Support Coordination shall be person-centered and shall include, but is not limited to, ongoing assessment of the Enrollee's strengths and needs; development, evaluation and revision of the Plan of Care; assistance with the selection of service providers; provision of general education about the Waiver program, including Enrollee rights and responsibilities; and monitoring implementation of the plan of care and initiating individualized corrective actions as necessary (e.g., reporting, referring, or appealing to appropriate entities).

(oo) Support Coordinator - the person who is responsible for developing the Individual Support Plan and participating in the development of, monitoring and assuring the implementation of the Plan of Care; who provides Support Coordination services to an Enrollee; and who meets the qualifications for a Support Coordinator as specified in the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled.

(pp) Supported Living - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain or improve skills necessary to reside in a home that is under the control and responsibility of the Enrollee. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(qq) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Intellectual Disabilities Services (DIDS). DIDS shall submit a Transfer

(Rule 1200-13-01-.25, continued)

Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.

(rr) Vehicle Accessibility Modifications - interior or exterior physical modifications to a vehicle owned by the Enrollee or to a vehicle which is owned by the guardian or conservator of the Enrollee and which is routinely available for transport of the Enrollee. Such modifications must be intended to ensure the transport of the Enrollee in a safe manner.

(2) Covered Services and Limitations.

(a) Adult Dental Services.

1. Adult Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting.

2. Adult Dental Services shall exclude orthodontic services.

3. Adult Dental Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the waiver.

(b) Behavioral Respite Services.

1. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider.

2. Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence.

3. Behavioral Respite Services shall be limited to a maximum of sixty (60) days per Enrollee per year.

4. Enrollees who receive Behavioral Respite Services shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Behavioral Respite Services is being provided.

(c) Behavior Services.

1. Behavior Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Behavior Services shall be provided face to face with the Enrollee except for Enrollee-specific training of staff; behavior assessment and plan development; and presentation of Enrollee behavior information at human rights committee meetings, behavior support committee meetings, and Enrollee planning meetings.

3. Reimbursement for presentation of Enrollee behavior information at meetings shall be limited to a maximum of five (5) hours per Enrollee per year per provider.

(Rule 1200-13-01-.25, continued)

Reimbursement for behavior assessments shall be limited to a maximum of eight (8) hours per assessment with a maximum of two (2) assessments per year. Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first thirty (30) days following its approval for use shall be limited to a maximum of six (6) hours.

(d) Day Services.

1. Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the Enrollee's place of residence if there is a health, behavioral, or other medical reason or if the Enrollee has chosen retirement. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

2. With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day (i.e., between the hours of 7:30 a.m. and 6:00 p.m.), as specified in the Plan of Care.

3. Day Services shall be limited to a maximum of six (6) hours per day and five (5) days per week up to a maximum of 243 days per Enrollee per year.

4. Transportation to and from the Enrollee's place of residence to Day Services and transportation that is needed during the time that the Enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day Services reimbursement rate (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service; or

(ii) Transportation necessary for Orientation and Mobility Training.

5. Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

6. For an Enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies or unrelated vocational training expenses such as the following:

(i) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(ii) Payments that are passed through to users of supported employment programs; or

(iii) Payments for vocational training that is not directly related to an Enrollee's supported employment program.

(e) Environmental Accessibility Modifications.

1. Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning, construction of an additional room) are excluded from coverage.

(Rule 1200-13-01-.25, continued)

2. Any modification which is not of direct medical or remedial benefit to the Enrollee is excluded from coverage.

3. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an Enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.

4. Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per Enrollee per two (2) year period.

(f) Family Model Residential Support.

1. With the exception of homes that were already providing services to three (3) residents prior to January 1, 2004, a Family Model Residential Support home shall have no more than two (2) residents who receive services and supports.

2. The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

3. Transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

(ii) Transportation necessary for Behavioral Respite Services; or

(iii) Transportation necessary for Orientation and Mobility Training.

4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

5. Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to the Enrollee's parent, step-parent, spouse, child, or sibling or to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(g) Individual Transportation Services.

Individual Transportation Services shall not be used for:

1. Transportation to and from Day Services;

2. Transportation to and from supported or competitive employment;

3. Transportation of school aged children to and from school;

4. Transportation to and from medical services covered by the Medicaid State Plan; or

5. Transportation of an Enrollee receiving a residential service, except as described herein for Orientation and Mobility Training or Behavioral Respite Services.

(h) Medical Residential Services.

1. The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day when the Enrollee is not at school and shall be responsible for the cost of Day Services needed by the Enrollee.

2. Transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

(ii) Transportation necessary for Behavioral Respite Services; or

(iii) Transportation necessary for Orientation and Mobility Training.

3. Reimbursement for Medical Residential Services shall not include the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator. Reimbursement shall not be made for room and board if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the Enrollee, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's place of residence. If an Enrollee owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

5. Medical Residential Services providers must be licensed by the Department of Mental Health and Developmental Disabilities as a Mental Retardation Residential Habilitation Facility provider or a Supported Living Service provider and ensure that employed nurses are licensed to practice in the state of Tennessee.

(i) Nursing Services.

1. Nursing Services shall be provided face to face with the Enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.

2. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.

3. This service shall be provided in home and community settings, as specified in the Plan of Care, excluding inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

(Rule 1200-13-01-.25, continued)

4. An Enrollee who is receiving Medical Residential Services shall not be eligible to receive Nursing Services during the hours Medical Residential Services are being provided.

5. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

6. Nursing Services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

(j) Nutrition Services.

1. Nutrition Services must be provided face to face with the Enrollee except for Enrollee-specific training of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat and except for that portion of the assessment involving development of the POC.

2. Nutrition Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Speech, Language and Hearing Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

3. Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one (1) assessment visit per month with a maximum of three (3) assessment visits per year per Enrollee per provider Nutrition Services other than such assessments (e.g., Enrollee-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one (1) visit per day. Nutrition Services assessments shall not be billed on the same day with other Nutrition Services.

(k) Occupational Therapy Services.

1. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.

2. Occupational Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).

4. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.

5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two

(Rule 1200-13-01-.25, continued)

services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Occupational Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(l) Orientation and Mobility Training.

1. Orientation and Mobility Training shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Behavior Services; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Orientation and Mobility Training shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

3. Reimbursement for an Orientation and Mobility Training assessment with development of the Orientation and Mobility Training plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Orientation and Mobility Training assessments shall not be billed on the same day with other Orientation and Mobility Training services. Orientation and Mobility Training services other than such assessments (e.g., Enrollee training; Enrollee-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of fifty-two (52) hours of services per Enrollee per year.

4. Enrollees receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training.

(m) Personal Assistance.

1. Personal Assistance may be provided in the home or community; however, it shall not be provided in school settings and shall not be provided to replace personal assistance services required to be covered by schools or services available through the Medicaid State Plan.

2. An Enrollee who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance. Personal Assistance shall not be provided during the same time period when the Enrollee is receiving Day Services.

(Rule 1200-13-01-.25, continued)

3. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the Enrollee. The Personal Assistance provider shall not be the spouse and shall not be the Enrollee's parent if the Enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(n) Personal Emergency Response System. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

(o) Physical Therapy Services.

1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

2. Physical Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).

4. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.

5. Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Physical Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Physical Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(p) Residential Habilitation.

1. A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.

(Rule 1200-13-01-.25, continued)

2. The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

3. Transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

   (ii) Transportation necessary for Behavioral Respite Services; or

   (iii) Transportation necessary for Orientation and Mobility Training.

4. Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator.

5. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

(q) Respite.

1. Respite may be provided in the Enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider.

2. An Enrollee receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Respite as a service.

3. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence.

4. Respite shall be limited to a maximum of thirty (30) days per Enrollee per year.

5. Enrollees who receive Respite shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite is being provided.

(r) Specialized Medical Equipment and Supplies and Assistive Technology.

1. Face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that specialized medical equipment and assistive technology which requires custom fitting meets the needs of the Enrollee and training of the Enrollee by a physical therapist, occupational therapist, or speech therapist to effectively utilize such customized equipment shall be limited to a maximum of three (3) hours per Enrollee per day.

2. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food

(Rule 1200-13-01-.25, continued)

and food supplements, and diapers and other incontinence supplies are excluded.

3. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.

4. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.

5. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per Enrollee per two (2) year period.

(s) Speech, Language and Hearing Services.

1. Services must be provided by a licensed speech language pathologist or by a licensed audiologist.

2. Speech, Language and Hearing Services must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Speech, Language and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language and Hearing assessments (i.e., assess and treat orders are not accepted).

4. Speech, Language and Hearing Services assessments shall not be billed on the same day with other Speech, Language and Hearing Services

5. Speech, Language and Hearing Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Speech, Language, and Hearing Services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(t) Support Coordination. There must be at least one face-to-face contact with the Enrollee per calendar month. If the Enrollee receives a residential service, the Support Coordinator shall have at least one face-to-face contact with the Enrollee in the Enrollee's place of residence each quarter.

(u) Supported Living.

1. The Supported Living provider shall not own the Enrollee's place of residence or be a co-signer of a lease on the Enrollee's place of residence unless the

(Rule 1200-13-01-.25, continued)

Supported Living provider signs a written agreement with the Enrollee that states that the Enrollee will not be required to move if the primary reason is because the Enrollee desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to an Enrollee if such entity requires, as a condition of renting or leasing, the Enrollee to move if the Supported Living provider changes.

2. The Supported Living home shall have no more than three (3) residents including the Enrollee.

3. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must have an operable smoke detector and a second means of egress.

4. The Supported Living provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

5. Transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

   (ii) Transportation necessary for Behavioral Respite Services; or

   (iii) Transportation necessary for Orientation and Mobility Training.

6. Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's home. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

7. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

8. The Enrollee or the Enrollee's guardian or conservator shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.

9. The Enrollee shall have the right to manage personal funds as specified in the Individual Support Plan.

(v) Vehicle Accessibility Modifications.

1. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.

2. Vehicle Accessibility Modifications shall be limited to a maximum of $20,000 per Enrollee per five (5) year period.

(Rule 1200-13-01-.25, continued)

(w) Out-of-State Services. A provider of Personal Assistance, Residential Habilitation, Supported Living, Medical Residential Services, and Family Model Residential Services may provide such Covered Service outside the State of Tennessee and be reimbursed only when provided in accordance with the following:

1. Covered Services provided out of state shall be for the purpose of visiting relatives or for vacations and shall be included in the Enrollee's Plan of Care. Trips to casinos or other gambling establishments shall be excluded from coverage.

2. Covered Services provided out of state shall be limited to a maximum of fourteen (14) days per Enrollee per year.

3. The waiver service provider agency must be able to assure the health and safety of the Enrollee during the period when Covered Services will be provided out of state and must be willing to assume the additional risk and liability of provision of Covered Services out of state.

4. During the period when Covered Services are being provided out of state, the waiver service provider agency shall maintain an adequate amount of staffing to meet the needs of the Enrollee and must ensure that staff meet the applicable provider qualifications.

5. The provider agency which provides Covered Services out of state shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the Waiver. The costs of travel, lodging, food, and other expenses incurred by the Enrollee while receiving out-of-state services shall be the responsibility of the Enrollee and shall not be reimbursed through the waiver.

(x) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(3) Eligibility.

(a) To be eligible for enrollment in the Waiver, an individual must meet all of the following criteria:

1. The individual must be a resident of the State of Tennessee.

2. The individual must, but for the provision of Waiver Services, require the LOC provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in TennCare Rule 1200-13-01-.15, except that requirements pertaining to a psychological evaluation shall be in accordance with Rule 1200-13-01-.25(3)(a)5.

3. The individual's habilitative, medical, and specialized services needs must be such that they can be effectively and safely met through the Waiver, as determined by the Operational Administrative Agency based on a pre-enrollment assessment.

4. The individual must have an unexpired ICF/MR Pre-Admission Evaluation which has been approved by the State Medicaid Agency or by its designee and which lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

(Rule 1200-13-01-.25, continued)

5. The individual must have a psychological evaluation included as part of the approved Pre-Admission Evaluation which meets the following:

   (i) The psychological evaluation shall document that the individual:

      (I) Has mental retardation manifested before eighteen (18) years of age and has an IQ test score of seventy (70) or below; or

      (II) Is a child five (5) years of age or younger who has a developmental disability with a high probability of resulting in mental retardation (i.e., a condition of substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in mental retardation); and

   (ii) There is no time limit for when the psychological evaluation is conducted as long as it is completed prior to the submission of the PAE, and as long as the evaluation meets the requirements specified in 1200-13-01-.25(3)(a)5.(i) above, and the person's current medical, social, developmental and psycho-social history continues to support the evaluation.

   (iii) A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver shall be required if the person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.

6. The individual shall have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual.

   (i) An individual who does not have 24-hour-per-day direct care services shall:

      (I) Have an individualized Safety Plan that:

         I. Is based on a written assessment of the individual's functional capabilities and habilitative, medical, and specialized services needs by the Independent Support Coordinator in consultation with individuals who are knowledgeable of the individual's capability of functioning without direct care services twenty-four (24) hours per day;

         II. Addresses the individual's capability of functioning when direct care staff are not present;

         III. Addresses the ability of the individual to self-administer medications when direct care staff are not present;

         IV. Specifies whether a Personal Emergency Response System will be used by the individual to secure help in an emergency;

         V. Is updated as needed, but no less frequently than annually, by the Operational Administrative Agency to ensure the health and safety of the individual; and

VI. Is an attachment to the ICF/MR PAE or, if applicable, to the Transfer Form.

(II) Have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual as needed but no less frequently than one day each week.

7. An individual must have a place of residence with an environment that is adequate to reasonably ensure health, safety and welfare. Any licensed facility in which the individual resides must meet all applicable fire and safety codes.

(b) A Transfer Form approved by the State Medicaid Agency:

1. May be used to transfer an Enrollee having an approved unexpired ICF/MR PAE from the Waiver to an ICF/MR;

2. May be used to transfer an individual having an approved unexpired ICF/MR PAE from an ICF/MR to the Waiver;

3. May be used to transfer an individual from one MR Waiver to a different Home and Community Based Services MR Waiver Program as specified in 1200-13-01-.25(1)(qq) above; and

4. Shall include an initial plan of care that lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

(4) Intake and Enrollment.

(a) When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Operational Administrative Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver and shall offer the choice of available institutional services or Waiver program services. Notice to the individual shall contain:

1. A simple explanation of the Waiver and Covered Services;

2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and

3. A statement that participation in the Waiver is voluntary.

(b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.

(c) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in an ICF/MR.

(5) Certification and Re-evaluation.

(a) The ICF/MR Pre-Admission Evaluation shall include a signed and dated certification by the individual's physician that the individual requires Waiver Services.

(Rule 1200-13-01-.25, continued)

(b) The Operational Administrative Agency shall perform a re-evaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least every twelve (12) months thereafter. The re-evaluation shall be documented in a format approved by the State Medicaid Agency and shall be performed by a licensed physician or registered nurse or a Qualified Mental Retardation Professional.

(c) The Operational Administrative Agency shall maintain in its files for a minimum period of three (3) years a copy of the re-evaluations of need for continued stay.

(6) Disenrollment.

(a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's guardian or conservator to the Operational Administrative Agency. Prior to disenrollment the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(b) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:

1. The Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled is terminated.

2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.

3. An Enrollee moves out of the State of Tennessee; provided however, that when the Enrollee is the dependent of a military service member who is a legal resident of the state, but has left the state temporarily due to the military service member’s military assignment out of state, such dependent may re-enroll in the Waiver upon return to the State, so long as all conditions of eligibility are met.

4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.

5. The Enrollee’s medical or behavioral needs become such that the health, safety, and welfare of the Enrollee cannot be assured through the provision of Waiver Services.

6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.

7. The Enrollee or the Enrollee's guardian or conservator refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability of the Operational Administrative Agency to ensure quality care or the health and safety of the Enrollee.

8. The health, safety, and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan.

9. The Enrollee was transferred to a hospital, NF, ICF/MR, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period

(Rule 1200-13-01-.25, continued)

exceeding one hundred twenty (120) days, if such period began prior to March 1, 2010, or a period exceeding ninety (90) days if such period begins on or after March 1, 2010.

(c) The Operational Administrative Agency shall notify the State Medicaid Agency in writing prior to involuntary disenrollment of an Enrollee and shall give advance notice to the Enrollee of the intended involuntary disenrollment and of the Enrollee's right to appeal and have a fair hearing.

(d) If an Enrollee has been involuntarily disenrolled from the Waiver, the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(7) Plan of Care.

(a) All Waiver Services for the Enrollee shall be provided in accordance with an approved Plan of Care.

1. Prior to the development of the initial Individual Support Plan, Covered Services shall be provided in accordance with the physician's initial plan of care included in the approved ICF/MR Pre-Admission Evaluation.

2. Each Enrollee shall have a comprehensive individualized written Plan of Care (the Individual Support Plan) that shall be developed for the Enrollee within sixty (60) calendar days of admission into the Waiver.

3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.

(b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:

1. The Support Coordinator shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.

2. A team consisting of the Support Coordinator and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but no less frequently than every twelve (12) calendar months, and shall document such review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.

(8) Physician Services.

(a) The Operational Administrative Agency shall ensure that each Enrollee receives physician services as needed and that each Enrollee has a medical examination, documented in the Enrollee's record, in accordance with the following schedule:

Age	Minimum frequency of medical examinations
Up to age 21	In accordance with Medicaid EPSDT periodicity standards

(Rule 1200-13-01-.25, continued)

21-64	Every one (1) to three (3) years, as determined by the Enrollee's physician
Over age 65	Annually

(b) All Covered Services to be provided prior to the development of the initial Individual Support Plan shall be physician ordered and shall be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(c) When required by state law, Covered Services shall be ordered or reordered, by a licensed physician, licensed nurse practitioner, physician assistant, a licensed dentist, or other appropriate health care provider.

(9) Waiver Administration. The Operational Administrative Agency shall be responsible for the administration of the day-to-day operations of the Waiver under the oversight of the State Medicaid Agency and shall ensure that Covered Services are provided in accordance with state and federal laws, rules, regulations and policies established by the State Medicaid Agency. The Operational Administrative Agency shall be responsible for the following activities, whether provided directly or through subcontract:

(a) Marketing of the Waiver to potential Enrollees;

(b) Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;

(c) Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;

(d) Enrollment of eligible individuals into the Waiver;

(e) Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;

(f) Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;

(g) Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;

(h) Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;

(i) Ensuring that Waiver providers maintain comprehensive Enrollee records and documentation of services provided to Enrollees in accordance with state and federal laws, rules, regulations and State Medicaid Agency policies;

(j) Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;

(k) Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;

(l) Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;

(m) Assurance of a statewide provider network adequate to meet the needs of Enrollees;

(Rule 1200-13-01-.25, continued)

(n) Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;

(o) Ensuring that Waiver Services providers have a signed provider agreement which includes a requirement for compliance with the Division of Mental Retardation Services Provider Manual in the delivery of waiver services;

(p) Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;

(q) Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;

(r) Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;

(s) Compliance with the appeals process specified in TennCare rule 1200-13-13-.11 to ensure that Enrollees are afforded advance notice and the right to appeal an adverse decision and have a fair hearing;

(t) Ensuring that providers and subcontractors comply with the quality monitoring guidelines and requirements established by the State Medicaid Agency, by the Operational Administrative Agency, and by the Centers for Medicare and Medicaid Services, and with other state and federal laws, rules, and regulations affecting the provision of Waiver Services;

(u) Collection of applicable patient liability from Enrollees;

(v) Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;

(w) Recoupment of payments made to Waiver providers when there is lack of documentation to support that services were provided or there is a lack of medical necessity of services, or when inappropriate payments have been made due to erroneous or fraudulent billing; and

(x) Expenditure and revenue reporting in accordance with state and federal requirements.

(10) Reimbursement.

(a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care had been provided in an ICF/MR. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in an ICF/MR.

(b) The Operational Administrative Agency shall be reimbursed for Waiver Services at the rate per unit of service actually paid by the Operational Administrative Agency to the Waiver service provider or at the maximum rate per unit of service established by the State Medicaid Agency, whichever is less.

(c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational Administrative Agency or its designee shall complete appropriate forms

(Rule 1200-13-01-.25, continued)

showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency's fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.

(d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency's fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.

(e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.

(f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.

(g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.

(h) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.

(i) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Operational Administrative Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.

(11) Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13-13-.11.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed July 6, 2001; effective September 19, 2001. Amendment filed June 20, 2007; effective September 3, 2007. Public necessity rule filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendments filed June 26, 2015; effective September 24, 2015.*

1200-13-01-.26 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed July 28, 2004; effective October 11, 2004. Public necessity rule filed August 30, 2007; effective through February 11, 2008. Amendment filed November 30, 2007; effective February 13, 2008.*

1200-13-01-.27 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 4-5-209, 71-5-105, 71-5-109, and Executive Order No. 23.* ***Administrative History:*** *Original rule filed July 28, 2004; effective October 11, 2004. Public necessity rule filed December 28, 2007; effective through June 10, 2008. Repeal of rule filed March 27, 2008; effective June 10, 2008.*

1200-13-01-.28 HOME AND COMMUNITY BASED SERVICES WAIVER FOR PERSONS WITH MENTAL RETARDATION UNDER SECTION 1915(c) OF THE SOCIAL SECURITY ACT (ARLINGTON MR WAIVER).

(1) Definitions: The following definitions shall apply for interpretation of this rule:

(a) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.

(b) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.

(c) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.

(d) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a Pre-Admission Evaluation signifying that the named individual requires services provided through the Home and Community Based Services Waiver for Persons with Mental Retardation as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.

(e) Covered Services or Covered Waiver Services – The services which are available through Tennessee's Home and Community Based Services Waiver for Persons with Mental Retardation when medically necessary and when provided in accordance with the Waiver as approved by the Centers for Medicare and Medicaid Services.

(f) Day Services - individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities.

(g) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.

(h) Dental Services - accepted dental procedures which are provided to Enrollees age twenty-one (21) years or older, as specified in the Plan of Care. Dental Services may include preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments to relieve pain and infection.

(i) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Home and Community Based Services Waiver for Persons with Mental Retardation.

(Rule 1200-13-01-.28, continued)

(j) Enrollee - a Medicaid Eligible who is enrolled in the Home and Community Based Services Waiver for Persons with Mental Retardation.

(k) Environmental Accessibility Modifications – only those interior or exterior physical modifications to the Enrollee's place of residence which are required to ensure the health, welfare and safety of the Enrollee or which are necessary to enable the Enrollee to function with greater independence.

(l) Family Model Residential Support – a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(m) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities and Homes for the Aged.

(n) Home and Community Based Services Waiver for Persons with Mental Retardation or "Waiver" - the Home and Community Based Services waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals who have mental retardation and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.

(o) ICF/MR Pre-Admission Evaluation (ICF/MR PAE) – the assessment form used by the State Medicaid Agency to document the current medical and habilitative needs of an individual with mental retardation and to document that the individual meets the Medicaid level of care eligibility criteria for care in an ICF/MR.

(p) Individual Support Plan – the individualized written Plan of Care.

(q) Individual Transportation Services –non-emergency transport of an Enrollee to and from approved activities specified in the Plan of Care.

(r) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for an ICF/MR.

(s) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have the State Medicaid Agency make reimbursement for covered services.

(t) Medicaid State Plan – the plan approved by the Centers for Medicare and Medicaid Services which specifies the covered benefits for the Medicaid program in Tennessee.

(u) Medical Residential Services – a type of residential service provided in a residence where all residents require direct skilled nursing services and habilitative services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting. Medical Residential Services must be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document

(Rule 1200-13-01-.28, continued)

the medical necessity of the services and specify the nature and frequency of the nursing services. The enrollee who receives Medical Residential Services shall require direct skilled nursing services on a daily basis and at a level which cannot for practical purposes be provided through two or fewer daily skilled nursing visits. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(v) Nursing Services –skilled nursing services that fall within the scope of Tennessee's Nurse Practice Act and that are directly provided to the Enrollee in accordance with a plan of care. Nursing Services shall be ordered by the Enrollee's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services.

(w) Nutrition Services - assessment of nutritional needs, nutritional counseling, and education of the Enrollee and of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat. Nutrition Services are intended to promote healthy eating practices and to enable the Enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.

(x) Occupational Therapy Services – diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(y) Operational Administrative Agency - the approved agency with which the State Medicaid Agency contracts for the administration of the day-to-day operations of the Home and Community Based Services Waiver for Persons with Mental Retardation.

(z) Orientation and Mobility Training – assessment of the ability of an Enrollee who is legally blind to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the Enrollee and of caregivers responsible for assisting in the mobility of the Enrollee.

(aa) Personal Assistance – the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(bb) Personal Emergency Response System - a stationary or portable electronic device used in the Enrollee's place of residence which enables the Enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device.

(cc) Physical Therapy Services - diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(Rule 1200-13-01-.28, continued)

(dd) Plan of Care – an individualized written Plan of Care which describes the medical and other services (regardless of funding source) to be furnished to the Enrollee, the Waiver Service frequency, and the type of provider who will furnish each Waiver Service and which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees.

(ee) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.

(ff) Re-evaluation - the annual process approved by the State Medicaid Agency by which a licensed physician or registered nurse or a Qualified Mental Retardation Professional assesses the Enrollee's need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.

(gg) Residential Habilitation - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(hh) Respite - services provided to an Enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness or injury, or when unpaid caregivers need relief from routine caregiving responsibilities.

(ii) Safety Plan - an individualized plan by which the Operational Administrative Agency ensures the health, safety and welfare of Enrollees who do not have 24-hour direct care services.

(jj) Specialized Medical Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls or appliances which enable an Enrollee to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment, and supplies for the proper functioning of such items. Specialized Medical Equipment, Supplies and Assistive Technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician or nurse practitioner) based on an assessment of the Enrollee's needs and capabilities and shall be furnished as specified in the Plan of Care. Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist or speech therapist to assure that Specialized Medical Equipment and Assistive Technology which requires custom fitting meets the needs of the Enrollee and may include training of the Enrollee by a physical therapist, occupational therapist or speech therapist to effectively utilize such customized equipment.

(kk) Speech, Language and Hearing Services – diagnostic, therapeutic and corrective services which are within the scope of state licensure which enable an Enrollee to improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function.

(ll) State Medicaid Agency – the bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program in Tennessee.

(Rule 1200-13-01-.28, continued)

(mm) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Operational Administrative Agency to provide Waiver Services to an Enrollee.

(nn) Support Coordination - case management services that assist the Enrollee in identifying, selecting, obtaining, coordinating and using both paid services and natural supports to enhance the Enrollee's independence, integration in the community and productivity as specified in the Enrollee's Plan of Care. Support Coordination shall be person-centered and shall include, but is not limited to, ongoing assessment of the Enrollee's strengths and needs; development, evaluation and revision of the Plan of Care; assistance with the selection of service providers; provision of general education about the Waiver program, including Enrollee rights and responsibilities; and monitoring implementation of the plan of care and initiating individualized corrective actions as necessary (e.g., reporting, referring, or appealing to appropriate entities).

(oo) Support Coordinator - the person who is responsible for developing the Individual Support Plan and participating in the development of, monitoring and assuring the implementation of the Plan of Care; who provides Support Coordination services to an Enrollee; and who meets the qualifications for a Support Coordinator as specified in the Home and Community Based Services Waiver for Persons with Mental Retardation.

(pp) Supported Living - a type of residential service having individualized services and supports that enable an Enrollee to acquire, retain or improve skills necessary to reside in a home that is under the control and responsibility of the Enrollee. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the Enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(qq) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Intellectual Disabilities Services (DIDS). DIDS shall submit a Transfer Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.

(rr) Vehicle Accessibility Modifications - interior or exterior physical modifications to a vehicle owned by the Enrollee or to a vehicle which is owned by the guardian or conservator of the Enrollee and which is routinely available for transport of the Enrollee. Such modifications must be intended to ensure the transport of the Enrollee in a safe manner.

(ss) Vision Services - routine eye examinations and refraction; standard or special frames for eyeglasses; standard, bifocal, multifocal or special lenses for eyeglasses; contact lenses; and dispensing fees for ophthalmologists, optometrists, and opticians.

(2) Covered Services and Limitations.

(a) Behavioral Respite Services.

(Rule 1200-13-01-.28, continued)

1. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider.

2. Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence.

3. Behavioral Respite Services shall be limited to a maximum of sixty (60) days per Enrollee per year.

4. Enrollees who receive Behavioral Respite Services shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Behavioral Respite Services is being provided.

(b) Behavior Services.

1. Behavior Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Behavior Services shall be provided face to face with the Enrollee except for Enrollee-specific training of staff; behavior assessment and plan development; and presentation of Enrollee behavior information at human rights committee meetings, behavior support committee meetings, and Enrollee planning meetings.

3. Reimbursement for presentation of Enrollee behavior information at meetings shall be limited to a maximum of five (5) hours per Enrollee per year per provider. Reimbursement for behavior assessments shall be limited to a maximum of eight (8) hours per assessment with a maximum of two (2) assessments per year. Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first thirty (30) days following its approval for use shall be limited to a maximum of six (6) hours.

(c) Day Services.

1. Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the Enrollee's place of residence if there is a health, behavioral, or other medical reason or if the Enrollee has chosen retirement. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

2. With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day (i.e., between the hours of 7:30 a.m. and 6:00 p.m.), as specified in the Plan of Care.

3. Day Services shall be limited to a maximum of six (6) hours per day and five (5) days per week up to a maximum of 243 days per Enrollee per year.

4. Transportation to and from the Enrollee's place of residence to Day Services and transportation that is needed during the time that the Enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day

(Rule 1200-13-01-.28, continued)

Services reimbursement rate (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service; or

(ii) Transportation necessary for Orientation and Mobility Training.

5. Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

6. For an Enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies or unrelated vocational training expenses such as the following:

(i) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(ii) Payments that are passed through to users of supported employment programs; or

(iii) Payments for vocational training that is not directly related to an Enrollee's supported employment program.

(d) Dental Services.

1. Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting.

2. Dental Services shall exclude orthodontic services.

3. Dental Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the Waiver.

(e) Environmental Accessibility Modifications.

1. Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning, construction of an additional room) are excluded from coverage.

2. Any modification which is not of direct medical or remedial benefit to the Enrollee is excluded from coverage.

3. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an Enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.

4. Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per Enrollee per two (2) year period.

(f) Family Model Residential Support.

(Rule 1200-13-01-.28, continued)

1. With the exception of homes that were already providing services to three (3) residents prior to January 1, 2004, a Family Model Residential Support home shall have no more than two (2) residents who receive services and supports.

2. The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

3. Transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

   (ii) Transportation necessary for Behavioral Respite Services; or

   (iii) Transportation necessary for Orientation and Mobility Training.

4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

5. Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not include payment made to the Enrollee's parent, step-parent, spouse, child, or sibling or to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(g) Individual Transportation Services.

Individual Transportation Services shall not be used for:

1. Transportation to and from Day Services;

2. Transportation to and from supported or competitive employment;

3. Transportation of school aged children to and from school;

4. Transportation to and from medical services covered by the Medicaid State Plan; or

5. Transportation of an Enrollee receiving a residential service, except as described herein for Orientation and Mobility Training or Behavioral Respite Services.

(h) Medical Residential Services.

1. The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day when the Enrollee is not at school and shall be responsible for the cost of Day Services needed by the Enrollee.

2. Transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

(Rule 1200-13-01-.28, continued)

(i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

(ii) Transportation necessary for Behavioral Respite Services; or

(iii) Transportation necessary for Orientation and Mobility Training.

3. Reimbursement for Medical Residential Services shall not include the cost of maintenance of the dwelling, and reimbursement shall not include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator. Reimbursement shall not be made for room and board if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the Enrollee, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's place of residence. If an Enrollee owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

4. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

5. Medical Residential Services providers must be licensed by the Department of Mental Health and Developmental Disabilities as a Mental Retardation Residential Habilitation Facility provider or a Supported Living Service provider and ensure that employed nurses are licensed to practice in the state of Tennessee.

(i) Nursing Services.

1. Nursing Services shall be provided face to face with the Enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.

2. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.

3. This service shall be provided in home and community settings, as specified in the Plan of Care, excluding inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. An Enrollee who is receiving Medical Residential Services shall not be eligible to receive Nursing Services during the hours Medical Residential Services are being provided.

5. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

6. Nursing Services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

(j) Nutrition Services.

(Rule 1200-13-01-.28, continued)

1. Nutrition Services must be provided face to face with the Enrollee except for Enrollee-specific training of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat and except for that portion of the assessment involving development of the POC.

2. Nutrition Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Speech, Language and Hearing Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

3. Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one (1) assessment visit per month with a maximum of three (3) assessment visits per year per Enrollee per provider Nutrition Services other than such assessments (e.g., Enrollee-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one (1) visit per day. Nutrition Services assessments shall not be billed on the same day with other Nutrition Services.

(k) Occupational Therapy Services.

1. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.

2. Occupational Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).

4. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.

5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (30 assessments per year per Enrollee per provider. Occupational Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(Rule 1200-13-01-.28, continued)

(l) Orientation and Mobility Training.

1. Orientation and Mobility Training shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Behavior Services; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Orientation and Mobility Training shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

3. Reimbursement for an Orientation and Mobility Training assessment with development of the Orientation and Mobility Training plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Orientation and Mobility Training assessments shall not be billed on the same day with other Orientation and Mobility Training services. Orientation and Mobility Training services other than such assessments (e.g., Enrollee training; Enrollee-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of fifty-two (52) hours of services per Enrollee per year.

4. Enrollees receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training.

(m) Personal Assistance.

1. Personal Assistance may be provided in the home or community; however, it shall not be provided in school settings and shall not be provided to replace personal assistance services required to be covered by schools or services available through the Medicaid State Plan.

2. An Enrollee who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance. Personal Assistance shall not be provided during the same time period when the Enrollee is receiving Day Services.

3. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the Enrollee. The Personal Assistance provider shall not be the spouse and shall not be the Enrollee's parent if the Enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(n) Personal Emergency Response System. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

(o) Physical Therapy Services.

(Rule 1200-13-01-.28, continued)

1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

2. Physical Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).

4. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.

5. Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Physical Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Physical Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(p) Residential Habilitation.

1. A Residential Habilitation home shall have no more than four (4) residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.

2. The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

3. Transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

   (ii) Transportation necessary for Behavioral Respite Services; or

   (iii) Transportation necessary for Orientation and Mobility Training.

4. Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling, and reimbursement shall not

(Rule 1200-13-01-.28, continued)

include payment made to members of the Enrollee's immediate family or to the Enrollee's conservator.

5. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

(q) Respite.

1. Respite may be provided in the Enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider.

2. An Enrollee receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Respite as a service.

3. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence.

4. Respite shall be limited to a maximum of thirty (30) days per Enrollee per year.

5. Enrollees who receive Respite shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite is being provided.

(r) Specialized Medical Equipment and Supplies and Assistive Technology.

1. Face-to-face consultative assessment by a physical therapist, occupational therapist, or speech therapist to assure that specialized medical equipment and assistive technology which requires custom fitting meets the needs of the Enrollee and training of the Enrollee by a physical therapist, occupational therapist, or speech therapist to effectively utilize such customized equipment shall be limited to a maximum of three (3) hours per Enrollee per day.

2. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.

3. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.

4. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.

5. Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per Enrollee per two (2) year period.

(s) Speech, Language and Hearing Services.

1. Services must be provided by a licensed speech language pathologist or by a licensed audiologist.

(Rule 1200-13-01-.28, continued)

2. Speech, Language and Hearing Services must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Speech, Language and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language and Hearing assessments (i.e., assess and treat orders are not accepted).

4. Speech, Language and Hearing Services assessments shall not be billed on the same day with other Speech, Language and Hearing Services.

5. Speech, Language and Hearing Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Speech, Language, and Hearing Services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(t) Support Coordination. There must be at least one face-to-face contact with the Enrollee per calendar month. If the Enrollee receives a residential service, the Support Coordinator shall have at least one face-to-face contact with the Enrollee in the Enrollee's place of residence each quarter.

(u) Supported Living.

1. The Supported Living provider shall not own the Enrollee's place of residence or be a co-signer of a lease on the Enrollee's place of residence unless the Supported Living provider signs a written agreement with the Enrollee that states that the Enrollee will not be required to move if the primary reason is because the Enrollee desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to an Enrollee if such entity requires, as a condition of renting or leasing, the Enrollee to move if the Supported Living provider changes.

2. The Supported Living home shall have no more than three (3) residents including the Enrollee.

3. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must have an operable smoke detector and a second means of egress.

4. The Supported Living provider shall be responsible for providing an appropriate level of services and supports twenty-four (24) hours per day during the hours the Enrollee is not receiving Day Services or is not at school or work.

(Rule 1200-13-01-.28, continued)

5. Transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service;

   (ii) Transportation necessary for Behavioral Respite Services; or

   (iii) Transportation necessary for Orientation and Mobility Training.

6. Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the Enrollee and who provides services to the Enrollee in the Enrollee's home. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the Enrollee, other residents in the home, and (as applicable) live-in or other caregivers.

7. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

8. The Enrollee or the Enrollee's guardian or conservator shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.

9. The Enrollee shall have the right to manage personal funds as specified in the Individual Support Plan.

(v) Vehicle Accessibility Modifications.

1. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.

2. Vehicle Accessibility Modifications shall be limited to a maximum of $20,000 per Enrollee per five (5) year period.

(w) Vision Services. Vision Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the Waiver.

(x) Out-of-State Services. A provider of Personal Assistance, Residential Habilitation, Supported Living, Medical Residential Services, and Family Model Residential Services may provide such Covered Service outside the State of Tennessee and be reimbursed only when provided in accordance with the following:

1. Covered Services provided out of state shall be for the purpose of visiting relatives or for vacations and shall be included in the Enrollee's Plan of Care. Trips to casinos or other gambling establishments shall be excluded from coverage.

2. Covered Services provided out of state shall be limited to a maximum of fourteen (14) days per Enrollee per year.

3. The waiver service provider agency must be able to assure the health and safety of the Enrollee during the period when Covered Services will be provided out of

(Rule 1200-13-01-.28, continued)

state and must be willing to assume the additional risk and liability of provision of Covered Services out of state.

4. During the period when Covered Services are being provided out of state, the waiver service provider agency shall maintain an adequate amount of staffing to meet the needs of the Enrollee and must ensure that staff meet the applicable provider qualifications.

5. The provider agency which provides Covered Services out of state shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the Waiver. The costs of travel, lodging, food, and other expenses incurred by the Enrollee while receiving out-of-state services shall be the responsibility of the Enrollee and shall not be reimbursed through the waiver.

(y) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(3) Eligibility.

(a) To be eligible for enrollment in the Waiver, an individual must meet all of the following criteria:

1. The individual must be a resident of the State of Tennessee.

2. The individual must be a class member certified in *United States vs. State of Tennessee, et. al. (Arlington Developmental Center)*.

3. The individual must, but for the provision of Waiver Services, require the level of care provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in Rule 1200-13-01-.15, except that requirements pertaining to a psychological evaluation shall be in accordance with Rule 1200-13-01-.28(3)(a)6.

4. The individual's habilitative, medical, and specialized services needs must be such that they can be effectively and safely met through the Waiver, as determined by the Operational Administrative Agency based on a pre-enrollment assessment.

5. The individual must have an unexpired ICF/MR Pre-Admission Evaluation which has been approved by the State Medicaid Agency or by its designee and which lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

6. The individual must have a psychological evaluation included as part of the approved Pre-Admission Evaluation which meets the following:

(i) The psychological evaluation shall document that the individual has mental retardation manifested before eighteen (18) years of age and has an IQ test score of seventy (70) or below; and

(ii) There is no time limit for when the psychological evaluation is conducted as long as it is completed prior to the submission of the PAE, and as long as the evaluation meets the requirements specified in 1200-13-01-.28(3)(a)6.(i) above, and the person's current medical, social,

developmental and psycho-social history continues to support the evaluation.

(iii) A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver shall be required if the person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.

7. The individual shall have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual.

(i) An individual who does not have 24-hour-per-day direct care services shall:

(I) Have an individualized Safety Plan that:

I. Is based on a written assessment of the individual's functional capabilities and habilitative, medical, and specialized services needs by the Independent Support Coordinator in consultation with individuals who are knowledgeable of the individual's capability of functioning without direct care services twenty-four (24) hours per day;

II. Addresses the individual's capability of functioning when direct care staff are not present;

III. Addresses the ability of the individual to self-administer medications when direct care staff are not present;

IV. Specifies whether a Personal Emergency Response System will be used by the individual to secure help in an emergency;

V. Is updated as needed, but no less frequently than annually, by the Operational Administrative Agency to ensure the health and safety of the individual; and

VI. Is an attachment to the ICF/MR PAE or, if applicable, to the Transfer Form.

(II) Have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual as needed but no less frequently than one day each week.

8. An individual must have a place of residence with an environment that is adequate to reasonably ensure health, safety and welfare. Any licensed facility in which the individual resides must meet all applicable fire and safety codes.

(b) A Transfer Form approved by the State Medicaid Agency:

1. May be used to transfer an Enrollee having an approved unexpired ICF/MR PAE from the Waiver to an ICF/MR;

(Rule 1200-13-01-.28, continued)

2. May be used to transfer an individual having an approved unexpired ICF/MR PAE from an ICF/MR to the Waiver;

3. May be used to transfer an individual from one MR Waiver to a different Home and Community Based Services MR Waiver Program as specified in 1200-13-01-.28(1)(qq) above; and

4. Shall include an initial plan of care that lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

(4) Intake and Enrollment.

(a) When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Operational Administrative Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver and shall offer the choice of available institutional services or Waiver program services. Notice to the individual shall contain:

1. A simple explanation of the Waiver and Covered Services;

2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and

3. A statement that participation in the Waiver is voluntary.

(b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.

(c) Enrollment of new Enrollees into the Waiver may be suspended when the average per capita fiscal year expenditure under the Waiver exceeds or is reasonably anticipated to exceed 100% of the average per capita expenditure that would have been made in the fiscal year if the care was provided in an ICF/MR.

(5) Certification and Re-evaluation.

(a) The ICF/MR Pre-Admission Evaluation shall include a signed and dated certification by the individual's physician that the individual requires Waiver Services.

(b) The Operational Administrative Agency shall perform a re-evaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least every twelve (12) months thereafter. The re-evaluation shall be documented in a format approved by the State Medicaid Agency and shall be performed by a licensed physician or registered nurse or a Qualified Mental Retardation Professional.

(c) The Operational Administrative Agency shall maintain in its files for a minimum period of three (3) years a copy of the re-evaluations of need for continued stay.

(6) Disenrollment.

(a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's guardian or conservator to the Operational Administrative Agency. Prior to disenrollment the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(Rule 1200-13-01-.28, continued)

(b) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:

1. The Home and Community Based Services Waiver for Persons with Mental Retardation is terminated.

2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.

3. An Enrollee moves out of the State of Tennessee; provided however, that when the Enrollee is the dependent of a military service member who is a legal resident of the state, but has left the state temporarily due to the military service member's military assignment out of state, such dependent may re-enroll in the Waiver upon return to the State, so long as all conditions of eligibility are met.

4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.

5. The Enrollee's medical or behavioral needs become such that the health, safety, and welfare of the Enrollee cannot be assured through the provision of Waiver Services.

6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.

7. The Enrollee or the Enrollee's guardian or conservator refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability of the Operational Administrative Agency to ensure quality care or the health and safety of the Enrollee.

8. The health, safety and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan.

9. The Enrollee was transferred to a hospital, NF, ICF/MR, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding one hundred twenty (120) days, if such period began prior to March 1, 2010, or a period exceeding ninety (90) days if such period begins on or after March 1, 2010.

(c) The Operational Administrative Agency shall notify the State Medicaid Agency in writing prior to involuntary disenrollment of an Enrollee and shall give advance notice to the Enrollee of the intended involuntary disenrollment and of the Enrollee's right to appeal and have a fair hearing.

(d) If an Enrollee has been involuntarily disenrolled from the Waiver, the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(7) Plan of Care.

(a) All Waiver Services for the Enrollee shall be provided in accordance with an approved Plan of Care.

(Rule 1200-13-01-.28, continued)

1. Prior to the development of the initial Individual Support Plan, Covered Services shall be provided in accordance with the physician's initial plan of care included in the approved ICF/MR Pre-Admission Evaluation.

2. Each Enrollee shall have a comprehensive individualized written Plan of Care (the Individual Support Plan) that shall be developed for an Enrollee within sixty (60) calendar days of admission into the Waiver.

3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.

(b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:

1. The Support Coordinator shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.

2. A team consisting of the Support Coordinator and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but no less frequently than every twelve (12) calendar months, and shall document such review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.

(8) Physician Services.

(a) The Operational Administrative Agency shall ensure that each Enrollee receives physician services as needed and that each Enrollee has a medical examination, documented in the Enrollee's record, in accordance with the following schedule:

Age	Minimum frequency of medical examinations
Up to age 21	In accordance with Medicaid EPSDT periodicity standards
21-64	Every one (1) to three (3) years, as determined by the Enrollee's physician
Over age 65	Annually

(b) All Covered Services to be provided prior to the development of the initial Individual Support Plan shall be physician ordered and shall be included in the physician’s plan of care section of the Pre-Admission Evaluation application.

(c) When required by state law, Covered Services shall be ordered or reordered, by a licensed physician, licensed nurse practitioner, physician assistant, a licensed dentist, or other appropriate health care provider.

(9) Waiver Administration. The Operational Administrative Agency shall be responsible for the administration of the day-to-day operations of the Waiver under the oversight of the State Medicaid Agency and shall ensure that Covered Services are provided in accordance with state and federal laws, rules, regulations and policies established by the State Medicaid

(Rule 1200-13-01-.28, continued)

Agency. The Operational Administrative Agency shall be responsible for the following activities, whether provided directly or through subcontract:

(a) Marketing of the Waiver to potential Enrollees;

(b) Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;

(c) Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;

(d) Enrollment of eligible individuals into the Waiver;

(e) Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;

(f) Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;

(g) Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;

(h) Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;

(i) Ensuring that Waiver providers maintain comprehensive Enrollee records and documentation of services provided to Enrollees in accordance with state and federal laws, rules, regulations and State Medicaid Agency policies;

(j) Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;

(k) Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;

(l) Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;

(m) Assurance of a statewide provider network adequate to meet the needs of Enrollees;

(n) Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;

(o) Ensuring that Waiver Services providers have a signed provider agreement which includes a requirement for compliance with the Division of Mental Retardation Services Provider Manual in the delivery of waiver services;

(p) Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;

(q) Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;

(r) Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;

(Rule 1200-13-01-.28, continued)

(s) Compliance with the appeals process specified in TennCare rule 1200-13-13-.11 to ensure that Enrollees are afforded advance notice and the right to appeal an adverse decision and have a fair hearing;

(t) Ensuring that providers and subcontractors comply with the quality monitoring guidelines and requirements established by the State Medicaid Agency, by the Operational Administrative Agency, and by the Centers for Medicare and Medicaid Services, and with other state and federal laws, rules, and regulations affecting the provision of Waiver Services;

(u) Collection of applicable patient liability from Enrollees;

(v) Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;

(w) Recoupment of payments made to Waiver providers when there is lack of documentation to support that services were provided or there is a lack of medical necessity of services, or when inappropriate payments have been made due to erroneous or fraudulent billing; and

(x) Expenditure and revenue reporting in accordance with state and federal requirements.

(10) Reimbursement.

(a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care had been provided in an ICF/MR. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in an ICF/MR.

(b) The Operational Administrative Agency shall be reimbursed for Waiver Services at the rate per unit of service actually paid by the Operational Administrative Agency to the Waiver service provider or at the maximum rate per unit of service established by the State Medicaid Agency, whichever is less.

(c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational Administrative Agency or its designee shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency’s fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.

(d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency’s fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.

(e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.

(Rule 1200-13-01-.28, continued)

(f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.

(g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.

(h) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.

(i) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Operational Administrative Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.

(11) Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13-13-.11.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.* ***Administrative History:*** *Original rule filed June 20, 2007; effective September 3, 2007. Public necessity rules filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendments filed June 26, 2015; effective September 24, 2015.*

1200-13-01-.29 TENNESSEE'S SELF-DETERMINATION WAIVER UNDER SECTION 1915(c) OF THE SOCIAL SECURITY ACT (SELF-DETERMINATION MR WAIVER PROGRAM).

(1) Definitions: The following definitions shall apply for interpretation of this rule:

(a) Adult Dental Services - accepted dental procedures which are provided to adult Enrollees (i.e., age 21 years or older) as specified in the Plan of Care. Adult Dental Services may include fillings, root canals, extractions, the provision of dentures and other dental treatments to relieve pain and infection. Preventive dental care is not covered under Adult Dental Services.

(b) Behavioral Respite Services - services that provide Respite for an Enrollee who is experiencing a behavioral crisis that necessitates removal from the current residential setting in order to resolve the behavioral crisis.

(c) Behavior Services – assessment and amelioration of Enrollee behavior that presents a health or safety risk to the Enrollee or others or that significantly interferes with home or community activities; determination of the settings in which such behaviors occur and the events which precipitate the behaviors; development, monitoring, and revision of crisis prevention and behavior intervention strategies; and training of caregivers who are responsible for direct care of the Enrollee in prevention and intervention strategies.

(Rule 1200-13-01-.29, continued)

(d) Bureau of TennCare - the bureau in the Tennessee Department of Finance and Administration which is the State Medicaid Agency and is responsible for administration of the Medicaid program in Tennessee.

(e) Case Manager – an individual who assists the Enrollee or potential Enrollee in gaining access to needed Waiver and other Medicaid State Plan services as well as other needed services regardless of the funding source; develops the initial interim Plan of Care and facilitates the development of the Enrollee's Plan of Care; monitors the Enrollee's needs and the provision of services included in the Plan of Care; monitors the Enrollee's budget, and authorizes alternative emergency back-up services for the Enrollee if necessary.

(f) Certification - the process by which a physician, who is licensed as a doctor of medicine or doctor of osteopathy, signs and dates a Pre-Admission Evaluation signifying that the named individual requires services provided through the Tennessee Self-Determination Waiver Program as an alternative to care in an Intermediate Care Facility for the Mentally Retarded.

(g) Covered Services or Covered Waiver Services – The services which are available through the Tennessee Self-Determination Waiver Program when medically necessary and when provided in accordance with the Waiver as approved by the Centers for Medicare and Medicaid Services.

(h) Day Services - individualized services and supports that enable an Enrollee to acquire, retain, or improve skills necessary to reside in a community-based setting; to participate in community activities and utilize community resources; to acquire and maintain employment; and to participate in retirement activities.

(i) Denial - as used in regard to Waiver Services, the term shall mean the termination, suspension, or reduction in amount, scope, and duration of a Waiver Service or a refusal or failure to provide such service.

(j) Disenrollment - the voluntary or involuntary termination of enrollment of an individual receiving services through the Tennessee Self-Determination Waiver Program.

(k) Emergency Assistance – a supplementary increase in the amount of approved Covered Waiver Services for the purpose of preventing the permanent out of home placement of the Enrollee which is provided in one of the following emergency situations:

1. Permanent or temporary involuntary loss of the Enrollee's present residence;

2. Loss of the Enrollee's present caregiver for any reason, including death of a caregiver or changes in the caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the Enrollee; or

3. Significant changes in the behavioral, medical or physical condition of the Enrollee that necessitate substantially expanded services.

(l) Enrollee - a Medicaid Eligible who is enrolled in the Tennessee Self-Determination Waiver Program.

(m) Environmental Accessibility Modifications – only those interior or exterior physical modifications to the Enrollee's place of residence which are required to ensure the health, welfare and safety of the Enrollee or which are necessary to enable the Enrollee to function with greater independence.

(Rule 1200-13-01-.29, continued)

(n) Financial Administration Entity – an entity which meets the State Medicaid Agency requirements to provide Financial Administration services and which has been approved by the OAA to provide Financial Administration services.

(o) Financial Administration – a service which facilitates the employment of Waiver Service providers by the Enrollee and the management of the Enrollee's self-directed budget and is provided to assure that Enrollee-managed funds specified in the Plan of Care are managed and distributed as intended. Financial Administration includes filing claims for Enrollee-managed services and reimbursing individual Covered Waiver Service providers; deducting all required federal, state and local taxes, including unemployment fees, prior to issuing reimbursement or paychecks; making Workers Compensation premium payments for Waiver Service providers employed by the Enrollee; verifying that goods and services for which reimbursement is requested have been authorized in the Plan of Care; ensuring that requests for payment are properly documented and have been approved by the Enrollee or the Enrollee's guardian or conservator; and assisting the Enrollee in meeting applicable employer-of-record requirements. It also includes maintaining a separate account for each Enrollee's self-determination budget; preparation of required monthly reports detailing disbursements of self-determination budget funds, the status of the expenditure of self-determination budget funds in comparison to the budget, and expenditures for standard method services made by the state on the Enrollee's behalf; and notification of the Operational Administrative Agency when expenditure patterns potentially will result in the premature exhaustion of the Enrollee's self-determination budget. It includes, in addition, verification that self-managed Waiver Service providers meet the State Medicaid Agency provider qualification requirements.

(p) Home (of an Enrollee) - the residence or dwelling in which the Enrollee resides, excluding hospitals, nursing facilities, Intermediate Care Facilities for the Mentally Retarded, Assisted Living Facilities and Homes for the Aged

(q) ICF/MR Pre-Admission Evaluation (ICF/MR PAE) – the assessment form used by the State Medicaid Agency to document the current medical and habilitative needs of an individual with mental retardation and to document that the individual meets the Medicaid level of care eligibility criteria for care in an ICF/MR.

(r) Individual Support Plan – the individualized written Plan of Care.

(s) Individual Transportation Services –non-emergency transport of an Enrollee to and from approved activities specified in the Pan of Care.

(t) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a licensed facility approved for Medicaid vendor reimbursement that provides specialized services for individuals with mental retardation or related conditions and that complies with current federal standards and certification requirements for an ICF/MR.

(u) Medicaid Eligible - an individual who has been determined by the Tennessee Department of Human Services to be financially eligible to have the State Medicaid Agency make reimbursement for covered services.

(v) Medicaid State Plan - the plan approved by the Centers for Medicare and Medicaid Services which specifies the covered benefits for the Medicaid program in Tennessee.

(w) Nursing Services –skilled nursing services that fall within the scope of Tennessee's Nurse Practice Act and that are directly provided to the Enrollee in accordance with a plan of care. Nursing Services shall be ordered by the Enrollee's physician, physician

(Rule 1200-13-01-.29, continued)

assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services.

(x) Nutrition Services - assessment of nutritional needs, nutritional counseling, and education of the Enrollee and of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat. Nutrition Services are intended to promote healthy eating practices and to enable the Enrollee and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.

(y) Occupational Therapy Services – diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Occupational Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(z) Operational Administrative Agency - the approved agency with which the State Medicaid Agency contracts for the administration of the day-to-day operations of the Tennessee Self-Determination Waiver Program.

(aa) Orientation and Mobility Services for Impaired Vision assessment of the ability of an Enrollee who is legally blind to move independently, safely, and purposefully in the home and community environment; orientation and mobility counseling; and training and education of the Enrollee and of caregivers responsible for assisting in the mobility of the Enrollee.

(bb) Personal Assistance – the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the enrollee, budget management, attending appointments, and interpersonal and social skills building to enable the Enrollee to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

(cc) Personal Emergency Response System - a stationary or portable electronic device used in the Enrollee's place of residence which enables the Enrollee to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device.

(dd) Physical Therapy Services - diagnostic, therapeutic, and corrective services which are within the scope of state licensure. Physical Therapy Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

(ee) Plan of Care – an individualized written Plan of Care which describes the medical and other services (regardless of funding source) to be furnished to the Enrollee, the Waiver Service frequency, and the type of provider who will furnish each Waiver Service and which serves as the fundamental tool by which the State ensures the health and welfare of Enrollees.

(ff) Qualified Mental Retardation Professional (QMRP) - an individual who meets current federal standards, as published in the Code of Federal Regulations, for a qualified mental retardation professional.

(gg) Re-evaluation - the annual process approved by the State Medicaid Agency by which a licensed physician or registered nurse or a Qualified Mental Retardation Professional

(Rule 1200-13-01-.29, continued)

assesses the Enrollee's need for continued Waiver Services and certifies in writing that the Enrollee continues to require Waiver Services.

(hh) Respite - services provided to an Enrollee when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness or injury, or when unpaid caregivers need relief from routine caregiving responsibilities.

(ii) Safety Plan - an individualized plan by which the Operational Administrative Agency ensures the health, safety and welfare of Enrollees who do not have 24-hour direct care services.

(jj) Self-Directed or Self-Determined or Self-Managed – the direct management of one or more Covered Services specified in subparagraph (2)(b) with the assistance of a Financial Administration Entity which pays the Enrollee's service providers, handles taxes and other payroll or benefits related to the employment of the service providers, and provides other financial administration services as specified in subparagraph (1)(o).

(kk) Self-Direction or Self-Determination or Self-Management – the process whereby an Enrollee or the Enrollee's guardian or conservator directly manages one or more Covered Services specified in subparagraph (2)(b) with the assistance of a Financial Administration Entity which pays the Enrollee's service providers, handles taxes and other payroll or benefits related to the employment of the service providers, and provides other financial administration services as specified in subparagraph (1)(o).

(ll) Specialized Medical Equipment and Supplies and Assistive Technology - assistive devices, adaptive aids, controls or appliances which enable an Enrollee to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment, and supplies for the proper functioning of such items. Specialized Medical Equipment, Supplies and Assistive Technology shall be recommended by a qualified health care professional (e.g., occupational therapist, physical therapist, speech language pathologist, physician or nurse practitioner) based on an assessment of the Enrollee's needs and capabilities and shall be furnished as specified in the Plan of Care. Specialized Medical Equipment and Supplies and Assistive Technology may also include a face-to-face consultative assessment by a physical therapist, occupational therapist or speech therapist to assure that Specialized Medical Equipment and Assistive Technology which requires custom fitting meets the needs of the Enrollee and may include training of the Enrollee by a physical therapist, occupational therapist or speech therapist to effectively utilize such customized equipment.

(mm) Speech, Language and Hearing Services – diagnostic, therapeutic and corrective services which are within the scope of state licensure which enable an Enrollee to improve or maintain current functional abilities and to prevent or minimize deterioration of chronic conditions leading to a further loss of function.

(nn) State Medicaid Agency – the Bureau in the Tennessee Department of Finance and Administration which is responsible for administration of the Title XIX Medicaid program in Tennessee.

(oo) Subcontractor - an individual, organized partnership, professional corporation, or other legal association or entity which enters into a written contract with the Operational Administrative Agency to provide Waiver Services to an Enrollee.

(pp) Supports Broker – the person or entity that provides Supports Brokerage services to an Enrollee.

(Rule 1200-13-01-.29, continued)

(qq) Supports Brokerage – an activity designed to enable an Enrollee to manage self-directed services and provide assistance to the Enrollee to locate, access and coordinate needed services. It includes provision of training to the Enrollee in Enrollee-managed services; assistance in the recruitment of individual providers of Enrollee-managed services and negotiation of payment rates; assistance in the scheduling, training and supervision of individual providers; assistance in managing and monitoring the Enrollee's budget; and assistance in monitoring and evaluating the performance of individual providers. It may also include assistance in locating and securing services and supports and other community resources that promote community integration, community membership and independence.

(rr) Tennessee Self-Determination Waiver Program or "Waiver" - the Home and Community Based Services waiver program approved for Tennessee by the Centers for Medicare and Medicaid Services to provide services to a specified number of Medicaid-eligible individuals on the Waiting List who have mental retardation and who meet the criteria for Medicaid reimbursement of care in an Intermediate Care Facility for the Mentally Retarded.

(ss) Transfer Form - the form approved by the State Medicaid Agency and used to document the transfer of an Enrollee having an approved unexpired ICF/MR Pre-Admission Evaluation from the Waiver to an ICF/MR, from an ICF/MR to the Waiver or from one MR Waiver program to another MR Waiver program. For purposes of transfer to an MR Waiver program, whether from an ICF/MR or from another MR Waiver program, such Transfer Form shall be processed by TennCare only if submitted by the Division of Intellectual Disabilities Services (DIDS). DIDS shall submit a Transfer Form only after verifying that the person otherwise meets all applicable admission criteria for the applicable MR Waiver program, as the Transfer Form accomplishes only the transfer of the level of care eligibility.

(tt) Vehicle Accessibility Modifications - interior or exterior physical modifications to a vehicle owned by the Enrollee or to a vehicle which is owned by the guardian or conservator of the Enrollee and which is routinely available for transport of the Enrollee. Such modifications must be intended to ensure the transport of the Enrollee in a safe manner.

(uu) Waiting List – A document prepared and updated by the Operational Administrative Agency which lists persons who are seeking home and community-based mental retardation services in Tennessee.

(2) Self-Direction of Covered Services.

(a) Self-Directed Services.

1. The Covered Services specified in subparagraph (2)(b) may be Self-Directed or Self-Managed by the Enrollee or the Enrollee's guardian or conservator in accordance with State Medicaid Agency guidelines.

2. The Enrollee or the Enrollee's guardian or conservator shall have the right to decide whether to Self-Direct the Covered Services specified in subparagraph (2)(b) or to receive them through the provider-directed service delivery method. When the Enrollee or the Enrollee's guardian or conservator does not choose to Self-Direct a Covered Service, such service shall be furnished through the provider-directed service delivery method.

(Rule 1200-13-01-.29, continued)

3. When the Enrollee or the Enrollee's guardian or conservator elects to Self-Direct one or more of the Covered Services specified in Subparagraph (2)(b), a Financial Administration Entity must provide Financial Administration services.

(b) The following Covered Services may be Self-Directed:

1. Day Services which are not facility-based.

2. Individual Transportation Services.

3. Personal Assistance.

4. Respite Services when provided by an approved respite provider who serves only one (1) Enrollee.

(c) The following Covered Services shall not be Self-Directed:

1. Adult Dental Services.

2. Behavioral Respite Services.

3. Behavior Services.

4. Day Services which are facility-based.

5. Emergency Assistance.

6. Nursing Services.

7. Nutrition Services.

8. Occupational Therapy Services.

9. Orientation and Mobility Training.

10. Personal Emergency Response Systems.

11. Physical Therapy Services.

12. Respite Services when provided by an approved respite provider who serves more than one (1) Enrollee.

13. Specialized Medical Equipment and Supplies and Assistive Technology.

14. Speech, Language and Hearing Services.

(d) Termination of Self-Direction of Covered Services.

1. Self-Direction of Covered Services by the Enrollee may be voluntarily terminated by the Enrollee or the Enrollee's guardian or conservator at any time.

2. Self-Direction of Covered Services by the Enrollee may be involuntarily terminated for any of the following reasons:

(i) The Enrollee or the Enrollee's guardian or conservator does not carry out the responsibilities required for the Self-Direction of Covered Services; or

(ii) Continued use of Self-Direction as the method of service management would result in the inability of the Operational Administrative Agency to ensure the health and safety of the Enrollee.

3. Termination of Self-Direction of Covered Services shall not affect the Enrollee's receipt of Covered Services. Covered Services shall continue to be provided through the provider-directed method of service delivery.

(e) Changing the Amount of Self-Directed Services by the Enrollee.

1. The Enrollee shall have the flexibility to change the amount of those Self-Directed Covered Services specified in subparagraph (2)(b) that have been approved in the Individual Support Plan if:

(i) The change is consistent with the needs, goals, and objectives identified in the Individual Support Plan;

(ii) The change does not affect the total amount of the Enrollee's self-determination budget; and

(iii) The Enrollee notifies the Financial Administration Entity, the Supports Broker (if applicable) and the Case Manager.

2. The Case Manager and the Financial Administration Entity shall maintain documentation of such changes by the Enrollee in the amount of the Self-Directed Covered Services for audit purposes.

(3) Covered Services and Limitations.

(a) Adult Dental Services.

1. Adult Dental Services shall not include hospital outpatient or inpatient facility services or related anesthesiology, radiology, pathology, or other medical services in such setting.

2. Adult Dental Services shall exclude orthodontic services.

3. Adult Dental Services shall be limited to adults age twenty-one (21) years or older who are enrolled in the waiver.

(b) Behavioral Respite Services.

1. Behavioral Respite Services may be provided in a Medicaid-certified ICF/MR, in a licensed respite care facility, or in a home operated by a licensed residential provider.

2. Reimbursement shall not be made for the cost of room and board except when provided as part of Behavioral Respite Services furnished in a facility approved by the State that is not a private residence.

3. Enrollees who receive Behavioral Respite Services shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Behavioral Respite Services is being provided.

(c) Behavior Services.

(Rule 1200-13-01-.29, continued)

1. Behavior Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

2. Behavior Services shall be provided face to face with the Enrollee except Enrollee-specific training of staff; behavior assessment and plan development; and presentation of Enrollee behavior information at human rights committee meetings, behavior support committee meetings, and Enrollee planning meetings.

3. Reimbursement for presentation of Enrollee behavior information at meetings shall be limited to a maximum of five (5) hours per Enrollee per year per provider. Reimbursement for behavior assessments shall be limited to a maximum of eight (8) hours per assessment with a maximum of two (2) assessments per year. Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first thirty (30) days following its approval for use shall be limited to a maximum of six (6) hours.

(d) Day Services.

1. Day Services may be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites. Services may also be provided in the Enrollee's place of residence if there is a health, behavioral, or other medical reason or if the Enrollee has chosen retirement. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

2. Day Services provided in a provider's day habilitation facility shall be provided during the provider agency's normal business hours.

3. Transportation to and from the Enrollee's place of residence to Day Services and transportation that is needed during the time that the Enrollee is receiving Day Services shall be a component of Day Services and shall be included in the Day Services reimbursement rate (i.e., it shall not be billed as a separate Waiver service) with the following exceptions:

   (i) Transportation to and from medical services covered through the Medicaid State Plan, which shall not be billed as a Waiver service; or

   (ii) Transportation necessary for Orientation and Mobility Training.

4. Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

5. For an Enrollee receiving employment supports, reimbursement shall not be made for incentive payments, subsidies or unrelated vocational training expenses such as the following:

   (i) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

   (ii) Payments that are passed through to users of supported employment programs; or

(iii) Payments for vocational training that is not directly related to an Enrollee's supported employment program.

(e) Environmental Accessibility Modifications.

1. Environmental Accessibility Modifications which are considered improvements to the home (e.g., roof or flooring repair, installing carpet, installation of central air conditioning, construction of an additional room) are excluded from coverage.

2. Any modification which is not of direct medical or remedial benefit to the Enrollee is excluded from coverage.

3. Modification of an existing room which increases the total square footage of the home is also excluded unless the modification is necessary to improve the accessibility of an Enrollee having limited mobility, in which case the modification shall be limited to the minimal amount of square footage necessary to accomplish the increased accessibility.

(f) Individual Transportation Services.

Individual Transportation Services shall not be used for:

1. Transportation to and from Day Services;

2. Transportation to and from supported or competitive employment;

3. Transportation of school aged children to and from school; or

4. Transportation to and from medical services covered by the Medicaid State Plan.

(g) Reserved

(h) Nursing Services.

1. Nursing Services shall be provided face to face with the Enrollee by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse.

2. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition.

3. This service shall be provided in home and community settings, as specified in the Plan of Care, excluding inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

5. Nursing Services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

(Rule 1200-13-01-.29, continued)

(i) Nutrition Services.

1. Nutrition Services must be provided face to face with the Enrollee except for Enrollee-specific training of caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat and except for that portion of the assessment involving development of the POC.

2. Nutrition Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Speech, Language and Hearing Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently.

3. Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one (1) assessment visit per month with a maximum of three (3) assessment visits per year per Enrollee per provider Nutrition Services other than such assessments (e.g., Enrollee-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one (1) visit per day. Nutrition Services assessments shall not be billed on the same day with other Nutrition Services.

(j) Occupational Therapy Services.

1. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.

2. Occupational Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).

4. Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services.

5. Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Occupational Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Occupational Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Occupational Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring

progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(k) Orientation and Mobility Services for Impaired Vision.

1. Orientation and Mobility Services for Impaired Vision shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Behavior Services; or Speech, Language and Hearing Services, unless there is documentation in the Enrollee's record of medical justification for the two (2) services to be provided concurrently.

2. Orientation and Mobility Services for Impaired Vision shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

3. Reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with development of the Orientation and Mobility Services for Impaired Vision plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Orientation and Mobility Services for Impaired Vision assessments shall not be billed on the same day with other Orientation and Mobility services. Orientation and Mobility Services for Impaired Vision other than such assessments (e.g., Enrollee training; Enrollee-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of fifty-two (52) hours of services per Enrollee per year.

(l) Personal Assistance.

1. Personal Assistance may be provided in the home or community; however, it shall not be provided in school settings and shall not be provided to replace personal assistance services required to be covered by schools or services available through the Medicaid State Plan.

2. Personal Assistance shall not be provided during the same time period when the Enrollee is receiving Day Services.

3. This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's).

4. Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the Enrollee. The Personal Assistance provider shall not be the spouse and shall not be the Enrollee's parent if the Enrollee is a minor. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

(m) Personal Emergency Response System. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

(n) Physical Therapy Services.

1. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

(Rule 1200-13-01-.29, continued)

2. Physical Therapy must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).

4. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services.

5. Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language and Hearing Services; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Physical Therapy shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Physical Therapy services are not intended to replace services available through the Medicaid State Plan or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

7. Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Physical Therapy services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(o) Respite.

1. Respite may be provided in the Enrollee's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/MR, in a home operated by a licensed residential provider, or in the home of an approved respite provider.

2. The cost of room and board shall be excluded from Respite reimbursement if Respite is provided in a private residence.

3. Enrollees who receive Respite shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite is being provided.

(p) Specialized Medical Equipment and Supplies and Assistive Technology.

1. Items not of direct medical or remedial benefit to the Enrollee shall be excluded. Items that would be covered by the Medicaid State Plan shall be excluded from coverage. Swimming pools, hot tubs, health club memberships, and recreational equipment are excluded. Prescription and over-the-counter medications, food and food supplements, and diapers and other incontinence supplies are excluded.

2. When medically necessary and not covered by warranty, repair of equipment may be covered when it is substantially less expensive to repair the equipment rather than to replace it.

(Rule 1200-13-01-.29, continued)

3. The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.

(q) Speech, Language and Hearing Services.

1. Services must be provided by a licensed speech language pathologist or by a licensed audiologist.

2. Speech, Language and Hearing Services must be provided face to face with the Enrollee except for that portion of the assessment involving development of the POC.

3. Speech, Language and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language and Hearing assessments (i.e., assess and treat orders are not accepted).

4. Speech, Language and Hearing Services assessments shall not be billed on the same day with other Speech, Language and Hearing Services.

5. Speech, Language and Hearing Services shall not be billed when provided during the same time period as Physical Therapy; Occupational Therapy; Nutrition Services; Orientation and Mobility Training; or Behavior Services, unless there is documentation in the Enrollee's record of medical justification for the two services to be provided concurrently. Speech, Language and Hearing Services shall not be billed with Day Services if the Day Services are reimbursed on a per hour basis.

6. Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one (1) assessment with plan development per month with a maximum of three (3) assessments per year per Enrollee per provider. Speech, Language, and Hearing Services other than such assessments (e.g., Enrollee-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of one and one-half (1.5) hours per Enrollee per day.

(r) Vehicle Accessibility Modifications. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.

(s) Out-of-State Services. A provider of Personal Assistance may provide Personal Assistance outside the State of Tennessee and be reimbursed only when provided in accordance with the following:

1. Personal Assistance provided out of state shall be for the purpose of visiting relatives or for vacations and shall be included in the Enrollee's Plan of Care. Trips to casinos or other gambling establishments shall be excluded from coverage.

2. Personal Assistance provided out of state shall be limited to a maximum of fourteen (14) days per Enrollee per year.

3. The Personal Assistance provider must be able to assure the health and safety of the Enrollee during the period when Personal Assistance will be provided out of state and must be willing to assume the additional risk and liability of provision of Personal Assistance out of state.

4. During the period when Personal Assistance is being provided out of state, staffing by qualified Personal Assistance staff shall be maintained in accordance with the Individual Support Plan to meet the needs of the Enrollee.

5. The Personal Assistance provider or provider agency which provides Personal Assistance out of state shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by Personal Assistance staff during the provision of out-of-state Personal Assistance shall not be reimbursed through the Waiver. The costs of travel, lodging, food, and other expenses incurred by the Enrollee while receiving out-of-state Personal Assistance shall be the responsibility of the Enrollee and shall not be reimbursed through the waiver.

(t) Emergency Assistance.

1. Emergency Assistance shall be provided only in one of the following emergency situations:

(i) Permanent or temporary involuntary loss of the Enrollee's present residence;

(ii) Loss of the Enrollee's present caregiver for any reason, including death of a caregiver or changes in the caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the Enrollee; or

(iii) Significant changes in the behavioral, medical or physical condition of the Enrollee that necessitate substantially expanded services.

2. Emergency Assistance shall be available only to Enrollees whose needs cannot be accommodated within the $30,000 budget limitation on Covered Waiver Services.

3. The amount of Emergency Assistance shall be limited to $6,000 per Enrollee per year. Prior authorization by the Enrollee's Case Manager shall be required and shall be renewed every thirty (30) calendar days.

4. Emergency Assistance shall only be used to provide a supplementary increase in the amount of other Covered Waiver Services.

(u) The cost of all Covered Services, including any Emergency Assistance, shall not exceed $36,000 per year per Enrollee.

(v) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(4) Eligibility.

(a) To be eligible for enrollment in the Waiver, an individual must meet all of the following criteria:

1. The individual must be a resident of the State of Tennessee.

(Rule 1200-13-01-.29, continued)

2. The individual shall have an established non-institutional place of residence and shall not require staff-supported residential services provided through a Home and Community Based Services Waiver (e.g., Residential Habilitation and Supported Living as defined in TennCare rule 1200-13-01-.25).

3. The individual must, but for the provision of Waiver Services, require the level of care provided in an ICF/MR, and must meet the ICF/MR eligibility criteria specified in TennCare Rule 1200-13-01-.15, except that requirements pertaining to a psychological evaluation shall be in accordance with Rule 1200-13-01-.29(4)(a)6.

4. The individual's habilitative, medical, and specialized services needs must be such that they can be effectively and safely met through the Waiver, as determined by the Operational Administrative Agency based on a pre-enrollment assessment.

5. The individual must have an unexpired ICF/MR Pre-Admission Evaluation which has been approved by the State Medicaid Agency or by its designee and which lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

6. The individual must have a psychological evaluation included as part of the approved Pre-Admission Evaluation which meets the following:

   (i) The psychological evaluation shall document that the individual:

      (I) Has mental retardation manifested before eighteen (18) years of age and has an IQ test score of seventy (70) or below; or

      (II) Is a child five (5) years of age or younger who has a developmental disability with a high probability of resulting in mental retardation (i.e., a condition of substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in mental retardation); and

   (ii) There is no time limit for when the psychological evaluation is conducted as long as it is completed prior to the submission of the PAE, and as long as the evaluation meets the requirements specified in 1200-13-01-.29(4)(a)6.(i) above, and the person's current medical, social, developmental and psycho-social history continues to support the evaluation.

   (iii) A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver shall be required if the person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.

7. The individual shall have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual.

   (i) An individual who does not have 24-hour-per-day direct care services shall:

      (I) Have an individualized Safety Plan that:

I. Is based on a written assessment of the individual's functional capabilities and habilitative, medical, and specialized services needs by the Case Manager in consultation with individuals who are knowledgeable of the individual's capability of functioning without direct care services twenty-four (24) hours per day;

II. Addresses the individual's capability of functioning when direct care staff are not present;

III. Addresses the ability of the individual to self-administer medications when direct care staff are not present;

IV. Specifies whether a Personal Emergency Response System will be used by the individual to secure help in an emergency;

V. Is updated as needed, but no less frequently than annually, by the Operational Administrative Agency to ensure the health and safety of the individual; and

VI. Is an attachment to the ICF/MR PAE or, if applicable, to the Transfer Form.

(II) Have one or more designated adults who shall be present in the individual's home to observe, evaluate, and provide an adequate level of direct care services to ensure the health and safety of the individual as needed but no less frequently than one day each week.

8. The individual shall have a place of residence with an environment that is adequate to reasonably ensure health, safety and welfare.

(b) A Transfer Form approved by the State Medicaid Agency:

1. May be used to transfer an Enrollee having an approved unexpired ICF/MR PAE from the Waiver to an ICF/MR;

2. May be used to transfer an individual having an approved unexpired ICF/MR PAE from an ICF/MR to the Waiver;

3. May be used to transfer an individual from one MR Waiver to a different Home and Community Based Services MR Waiver Program as specified in 1200-13-01-.29(1)(ss) above; and

4. Shall include an initial plan of care that lists the Enrollee's specific Waiver Services with the amount, scope, and duration of the services.

(5) Intake and Enrollment.

(a) When an individual is determined to be likely to require the level of care provided by an ICF/MR, the Operational Administrative Agency shall inform the individual or the individual's legal representative of any feasible alternatives available under the Waiver and shall offer the choice of available institutional services or Waiver program services. Notice to the individual shall contain:

1. A simple explanation of the Waiver and Covered Services;

2. Notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment; and

3. A statement that participation in the Waiver is voluntary.

(b) Enrollment in the Waiver shall be voluntary, but shall be restricted to the maximum number of individuals specified in the Waiver, as approved by the Centers for Medicare and Medicaid Services for the State of Tennessee.

(6) Certification and Re-evaluation.

(a) The ICF/MR Pre-Admission Evaluation shall include a signed and dated certification by the individual's physician that the individual requires Waiver Services.

(b) The Operational Administrative Agency shall perform a re-evaluation of the Enrollee's need for continued stay in the Waiver within twelve (12) calendar months of the date of enrollment and at least every twelve (12) months thereafter. The re-evaluation shall be documented in a format approved by the State Medicaid Agency and shall be performed by a licensed physician or registered nurse or a Qualified Mental Retardation Professional.

(c) The Operational Administrative Agency shall maintain in its files for a minimum period of three (3) years a copy of the re-evaluations of need for continued stay.

(7) Disenrollment.

(a) Voluntary disenrollment of an Enrollee from the Waiver may occur at any time upon written notice from the Enrollee or the Enrollee's guardian or conservator to the Operational Administrative Agency. Prior to disenrollment the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(b) An Enrollee may be involuntarily disenrolled from the Waiver for any of the following reasons:

1. The Tennessee Self-Determination Waiver Program is terminated.

2. An Enrollee becomes ineligible for Medicaid or is found to be erroneously enrolled in the Waiver.

3. An Enrollee moves out of the State of Tennessee; provided however, that when the Enrollee is the dependent of a military service member who is a legal resident of the state, but has left the state temporarily due to the military service member’s military assignment out of state, such dependent may re-enroll in the Waiver upon return to the State, so long as all conditions of eligibility are met.

4. The condition of the Enrollee improves such that the Enrollee no longer requires the level of care provided by the Waiver.

5. The Enrollee’s medical or behavioral needs become such that the health, safety and welfare of the Enrollee cannot be assured through the provision of Waiver Services.

6. The home or home environment of the Enrollee becomes unsafe to the extent that it would reasonably be expected that Waiver Services could not be provided

(Rule 1200-13-01-.29, continued)

without significant risk of harm or injury to the Enrollee or to individuals who provide covered services to the Enrollee.

7. The Enrollee or the Enrollee's guardian or conservator refuses to abide by the Plan of Care or related Waiver policies, resulting in the inability of the Operational Administrative Agency to ensure quality care or the health and safety of the Enrollee.

8. The health, safety and welfare of the Enrollee cannot be assured due to the lack of an approved Safety Plan.

9. The Enrollee was transferred to a hospital, NF, ICF/MR, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding one hundred twenty (120) days, if such period began prior to March 1, 2010, or a period exceeding ninety (90) days if such period begins on or after March 1, 2010.

10. The cost for all Covered Waiver services, including Emergency Assistance services, has reached the Waiver limit of $36,000 per year per Enrollee and the State cannot assure the health and safety of the Enrollee.

(c) The Operational Administrative Agency shall notify the State Medicaid Agency in writing prior to involuntary disenrollment of an Enrollee and shall give advance notice to the Enrollee of the intended involuntary disenrollment and of the Enrollee’s right to appeal and have a fair hearing.

(d) If an Enrollee has been involuntarily disenrolled from the Waiver, the Operational Administrative Agency shall provide reasonable assistance to the Enrollee in locating appropriate alternative placement.

(8) Plan of Care.

(a) All Waiver Services for the Enrollee shall be provided in accordance with an approved Plan of Care.

1. Prior to the development of the initial Individual Support Plan, Covered Services shall be provided in accordance with the physician's initial plan of care included in the approved ICF/MR Pre-Admission Evaluation.

2. Each Enrollee shall have an individualized written Plan of Care (the Individual Support Plan) that shall be developed for an Enrollee within sixty (60) calendar days of admission into the Waiver.

3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.

(b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:

1. The Case Manager shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.

2. A team consisting of the Case Manager and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but

(Rule 1200-13-01-.29, continued)

no less frequently than every twelve (12) calendar months, and shall document such review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.

(9) Physician Services.

(a) The Operational Administrative Agency shall ensure that each Enrollee receives physician services as needed and that each Enrollee has a medical examination, documented in the Enrollee's record, in accordance with the following schedule:

Age	Minimum frequency of medical examinations
Up to age 21	In accordance with Medicaid EPSDT periodicity standards
21-64	Every one (1) to three (3) years, as determined by the Enrollee's physician
Over age 65	Annually

(b) All Covered Services to be provided prior to the development of the initial Individual Support Plan shall be physician ordered and shall be included in the physician's plan of care section of the Pre-Admission Evaluation application.

(c) When required by state law, Covered Services shall be ordered or reordered, by a licensed physician, licensed nurse practitioner, physician assistant, a licensed dentist, or other appropriate health care provider.

(10) Waiver Administration. The Operational Administrative Agency shall be responsible for the administration of the day-to-day operations of the Waiver under the oversight of the State Medicaid Agency and shall ensure that Covered Services are provided in accordance with state and federal laws, rules, regulations and policies established by the State Medicaid Agency. The Operational Administrative Agency shall be responsible for the following activities, whether provided directly or through subcontract:

(a) Marketing of the Waiver to potential Enrollees;

(b) Intake and pre-enrollment assessment of the applicant's habilitative, medical and specialized services needs; and appropriateness for enrollment in the Waiver;

(c) Assisting the applicant with the submission of a properly completed ICF/MR Pre-Admission Evaluation;

(d) Enrollment of eligible individuals into the Waiver;

(e) Provision of a plain language explanation of appeal rights to each Enrollee upon enrollment in the Waiver;

(f) Review and approval of Plans of Care (Individual Support Plans) to ensure that Waiver Services have been authorized prior to payment;

(g) Ensuring that annual level of care re-evaluations have been performed to document the need for continuation of Waiver Services for the Enrollee;

(Rule 1200-13-01-.29, continued)

(h) Notification of the State Medicaid Agency in writing prior to involuntary disenrollment of any Enrollee;

(i) Ensuring that Waiver providers maintain comprehensive Enrollee records and documentation of services provided to Enrollees in accordance with state and federal laws, rules, regulations and State Medicaid Agency policies;

(j) Obtaining approval from the State Medicaid Agency prior to distributing policies and procedures to Waiver providers or Waiver information to Enrollees;

(k) Compliance with reporting and record-keeping requirements established by the State Medicaid Agency;

(l) Maintaining in its files the original ICF/MR Pre-Admission Evaluation and, where applicable, the original Transfer Form;

(m) Assurance of a statewide provider network adequate to meet the needs of Enrollees;

(n) Ensuring that Waiver Services providers and subcontractors meet the Waiver provider qualifications approved by the Centers for Medicare and Medicaid Services;

(o) Ensuring that Waiver Services providers have a signed provider agreement which includes a requirement for compliance with the Division of Mental Retardation Services Provider Manual in the delivery of waiver services;

(p) Assurance of the health and safety of Enrollees through the implementation of a comprehensive quality monitoring program;

(q) Reporting instances of abuse, neglect, mistreatment or exploitation to appropriate state agencies;

(r) Assurance that Covered Services are provided in accordance with the approved Waiver definitions and in accordance with the State Medicaid Agency guidelines;

(s) Compliance with the appeals process specified in TennCare rule 1200-13-13-.11 to ensure that Enrollees are afforded advance notice and the right to appeal an adverse decision and have a fair hearing;

(t) Ensuring that providers and subcontractors comply with the quality monitoring guidelines and requirements established by the State Medicaid Agency, by the Operational Administrative Agency, and by the Centers for Medicare and Medicaid Services, and with other state and federal laws, rules, and regulations affecting the provision of Waiver Services;

(u) Oversight and monitoring of the Financial Administration entity;

(v) Collection of applicable patient liability from Enrollees;

(w) Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;

(x) Recoupment of payments made to Waiver providers when there is lack of documentation to support that services were provided or there is a lack of medical necessity of services, or when inappropriate payments have been made due to erroneous or fraudulent billing; and

(Rule 1200-13-01-.29, continued)

(y) Expenditure and revenue reporting in accordance with state and federal requirements.

(11) Reimbursement.

(a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care had been provided in an ICF/MR. The total Medicaid expenditure for Waiver Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in an ICF/MR. Reimbursement for the cost of all Covered Services, including any Emergency Assistance, shall not exceed $36,000 per year per Enrollee.

(b) The Operational Administrative Agency shall be reimbursed for Waiver Services at the rate per unit of service actually paid by the Operational Administrative Agency to the Waiver service provider or at the maximum rate per unit of service established by the State Medicaid Agency, whichever is less.

(c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational Administrative Agency or its designee shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency’s fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.

(d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency’s fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.

(e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.

(f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.

(g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.

(h) The Operational Administrative Agency shall be responsible for ensuring that the Financial Administration entity fulfills its financial, ministerial, and clerical responsibilities associated with the provision of Financial Administration services to an Enrollee who Self-Directs one or more Covered Services. Examples of such responsibilities include the hiring and employment of service providers by the Enrollee or the Enrollee’s guardian or conservator; management of Enrollee accounts; disbursement of funds to Waiver service providers while withholding appropriate deductions; reviewing documentation of Covered Services to assure Enrollee approval prior to payment; ensuring that Waiver service providers possess the necessary qualifications established by the State Medicaid Agency.

(Rule 1200-13-01-.29, continued)

(i) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.

(j) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement. An Operational Administrative Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.

(12) Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13-13-.11.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.* ***Administrative History:*** *Original rule filed June 20, 2007; effective September 3, 2007. Public necessity rules filed July 1, 2009; effective through December 13, 2009. Amendments filed September 11, 2009; effective December 10, 2009. Emergency rule filed March 1, 2010; effective through August 28, 2010. Amendments filed May 27, 2010; effective August 25, 2010. Amendments filed June 26, 2015; effective September 24, 2015.*

1200-13-01-.30 TENNCARE ICF/MR SERVICES.

(1) Definitions. See Rule 1200-13-01-.02.

(2) Eligibility for Medicaid-reimbursed care in an ICF/MR.

(a) The individual must be determined by DHS to be financially and categorically eligible for Medicaid-reimbursed LTC services.

(b) The individual must have a valid, unexpired ICF/MR PAE that has been approved by the Bureau in accordance with Rule 1200-13-01-.15.

(3) Conditions of participation for ICFs/MR.

(a) The ICF/MR must enter into a provider agreement with the Bureau.

(b) The ICF/MR must be certified by the State, showing it has met the standards set out in 42 C.F.R., Part 442, Subpart C and 42 C.F.R., Part 483.

(c) ICFs/MR participating in the State of Tennessee's TennCare Program shall be terminated as TennCare providers if certification or licensure is canceled by the State.

(d) If the resident has resources to apply toward payment, the payment made by the State will be his current maximum payment per day, charges or per diem cost (whichever is less), minus the available patient resources.

(e) Payments for residents requiring ICF/MR services will not exceed per diem costs or charges, whichever is less.

(f) If an ICF/MR (upon submission of a cost report and audit of its cost), has collected on a per diem basis during the period covered by the cost report and audit, more than cost reimbursement allowed for the ICF/MR patient, the facility shall be required to reimburse the State (through the Bureau and/or the ICF/MR's Third Party), for that portion of the reimbursement collected in excess of the cost reimbursement allowed.

(Rule 1200-13-01-.30, continued)

(g) Regardless of the reimbursement rate established for an ICF/MR, no ICF/MR may charge TennCare Enrollees an amount greater than the amount per day charge to private paying patients for equivalent accommodations and services.

(h) Personal laundry services in an ICF/MR shall be considered a covered service and included in the per diem rate. TennCare Enrollees may not be charged for personal laundry services.

(4) Conditions that ICFs/MR must meet to receive Medicaid reimbursement.

(a) An ICF/MR that has entered into a provider agreement with the Bureau of TennCare is entitled to receive Medicaid reimbursement for covered services provided to an ICF/MR Eligible if

1. The Bureau has received an approvable ICF/MR PAE for the individual within ten (10) calendar days of the ICF/MR PAE Request Date or the physician certification date, whichever is earlier. The PAE Approval Date shall not be more than ten (10) days prior to date of submission of an approvable PAE. An approvable PAE is one in which any deficiencies in the submitted application are cured prior to disposition of the PAE.

2. For the transfer to an ICF/MR of an individual having an approved unexpired ICF/MR PAE, the Bureau has received an approvable Transfer Form within ten (10) calendar days after the date of the transfer. For transfer from ICF/MR services to an HCBS MR Waiver program, the transfer form must be submitted and approved prior to enrollment in the HCBS MR Waiver Program.

3. For a retroactive eligibility determination, the Bureau has received a Notice of Disposition or Change and has received an approvable request to update an approved, unexpired ICF/MR PAE within thirty (30) calendar days of the mailing date of the Notice of Disposition or Change. The effective date of payment for ICF/MR services shall not be earlier than the PAE Approval Date of the original approved, unexpired PAE which has been updated.

(b) Any deficiencies in a submitted PAE application must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.

1. Deficiencies cured after the PAE is denied but within thirty (30) days of the original PAE submission date will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted). If approved, the effective date of PAE approval can be no earlier than the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application.

2. Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for ICF/MR services.

(c) An ICF/MR that admits a Medicaid Eligible without an approved ICF/MR PreAdmission Evaluation or, where applicable, an approved Transfer Form does so without the assurance of reimbursement from the Bureau.

(Rule 1200-13-01-.30, continued)

(5) Reimbursement methodology for ICFs/MR.

(a) Private for-profit and private not-for-profit ICFs/MR shall be reimbursed at the lower of Medicaid cost or charges. An annual inflation factor will be applied to operating costs. The trending factor shall be computed for facilities that have submitted cost reports covering at least six (6) months of program operations. For facilities that have submitted cost reports covering at least three (3) full years of program participation, the trending factor shall be the average cost increase over the three-year (3-year) period, limited to the seventy-fifth (75th) percentile trending factor of facilities participating for at least three (3) years. Negative averages shall be considered zero (0). For facilities that have not completed three (3) full years in the program, the one-year (1-year) trending factor shall be the fiftieth (50th) percentile trending factor of facilities participating in the program for at least three (3) years. For facilities that have failed to file timely cost reports, the trending factor shall be zero (0). Capital-related costs are not subject to indexing. Capital-related costs are property, depreciation, and amortization expenses included in Section F.18 and F.19 of the Nursing Facility Cost Report Form. All other costs, including home office costs and management fees, are operating costs. Once a per-diem rate is determined from a clean cost report, the rate will not be changed until the next rate determination except for audit adjustments, correction of errors, or termination of a budgeted rate. Reimbursement is not to exceed the amount budgeted by the State for private ICF/MR reimbursement. The Comptroller's Office shall be authorized to adjust per diem rates up or down as necessary during the year.

(b) Public ICFs/MR that are owned by government shall be reimbursed at one hundred percent (100%) of allowable Medicaid costs with no cost-containment incentive. Reimbursement shall be based on Medicare principles of retrospective cost reimbursement with year-end cost report settlements. Interim per-diem rates for the fiscal year beginning July 1, 1995 and ending June 30, 1996 shall be established from budgeted cost and patient day information submitted by the government ICF/MR facilities. Thereafter, interim rates shall be based on the providers' cost reports. There will be a tentative year-end cost settlement within thirty (30) days of submission of the cost reports and a final settlement within twelve (12) months of submission of the cost reports.

(c) Costs for supplies and other items, including any facility staff required to deliver the service, which are billed to Medicare Part B on behalf of all patients must be included as a reduction to reimbursable expenses in Section G of the NF cost report.

(6) Bed holds.

An ICF/MR will be reimbursed in accordance with this Paragraph for the recipient's bed in that facility during the recipient's temporary absence from that facility in accordance with the following:

(a) For days not to exceed fifteen (15) days per occasion while the recipient is hospitalized and the following conditions are met:

1. The resident intends to return to the ICF/MR.

2. The hospital provides a discharge plan for the resident.

3. At least eighty-five percent (85%) of all other beds in the ICF/MR certified at the recipient's designated level of care (i.e., intensive training, high personal care or medical), when computed separately, are occupied at the time of hospital admission. An occupied bed is one that is actually being used by a patient.

(Rule 1200-13-01-.30, continued)

Beds being held for other patients while they are hospitalized or otherwise absent from the facility are not considered to be occupied beds, for purposes of this calculation. Computations of occupancy percentages will be rounded to the nearest percentage point.

4. Each period of hospitalization must be physician ordered and so documented in the patient's medical record in the ICF/MR.

(b) For days not to exceed sixty (60) days per state fiscal year and limited to fourteen (14) days per occasion while the recipient, pursuant to a physician's order, is absent from the facility on a therapeutic home visit or other therapeutic absence.

(7) Other reimbursement issues.

(a) No change of ownership or controlling interest of an existing Medicaid provider, including ICFs/MR, can occur until monies as may be owed to the Bureau or its contractors are provided for. The purchaser shall notify the Bureau of the purchase at the time of ownership change and is financially liable for the outstanding liabilities to the Bureau or its contractors for one (1) year from the date of purchase or for one (1) year following the Bureau's receipt of the provider's Medicare final notice of program reimbursement, whichever is later. The purchaser shall be entitled to use any means available to it by law to secure and recoup these funds from the selling entity. In addition, purchasers of ICFs/MR are responsible for obtaining an accurate accounting and transfer of funds held in trust for Medicaid residents at the time of the change of ownership or controlling interest.

(b) If the Bureau or an MCO has not reimbursed a business for TennCare services provided under the TennCare Program at the time the business is sold, when such an amount is determined, the Bureau or the MCO shall be required to reimburse the person owning the business provided such sale included the sale of such assets.

(c) When a provider was originally paid within a retrospective payment system that is subject to regular adjustments and the provider disputes the proposed adjustment action, the provider must file with the State not later than thirty (30) days after receipt of the notice informing the provider of the proposed adjustment action, a request for hearing. The provider's right to a hearing shall be deemed waived if a hearing is not requested within thirty (30) days after receipt of the notice.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 71-5-105 and 71-5-109.* ***Administrative History:*** *Emergency rule filed March 1, 2010; effective through August 28, 2010. Original rule filed May 27, 2010; effective August 25, 2010. Emergency rule filed December 20, 2011; effective through June 17, 2012. Amendment filed March 14, 2012; effective June 12, 2012.*