

Rulemaking Hearing Rules
of
Tennessee Department of Finance and Administration

Bureau of TennCare

Chapter 1200-13-01
General Rules

New Rule

Rule Chapter 1200-13-01 General Rules is amended by adding rule 1200-13-01-.29 Tennessee Self-Determination Waiver Program which shall read as follows:

1200-13-01-.29 Tennessee Self-Determination 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.
 - (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.
- (n) Financial Administration Entity – an entity which meets the State Medicaid Agency provider qualification requirements for a Financial Administration provider and which has been approved by the Operational Administrative Agency to provide Financial Administration as a Covered Service.
- (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 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 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.
- (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 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.
- (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 or from an ICF/MR to the Waiver.
 - (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.
 - 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 be selected to provide Financial Administration services.
 - (b) The following Covered Services may be Self-Directed:
 - 1. Day Services which are not facility-based.
 - 2. Environmental Accessibility Modifications.
 - 3. Individual Transportation Services.
 - 4. Personal Assistance.
 - 5. Respite Services when provided by an approved respite provider who serves only one (1) Enrollee.
 - 6. Supports Brokerage.
 - 7. Vehicle Accessibility Modifications.
 - (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. Financial Administration Services.
7. Nursing Services.
8. Nutrition Services.
9. Occupational Therapy Services.
10. Orientation and Mobility Training.
11. Personal Emergency Response Systems.
12. Physical Therapy Services.
13. Respite Services when provided by an approved respite provider who serves more than one (1) Enrollee.
14. Specialized Medical Equipment and Supplies and Assistive Technology.
15. 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.

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 that enrollee-specific training of staff may be provided when the Enrollee is not present.

(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) Financial Administration.
 - 1. Financial Administration shall be a Covered Service only for Enrollees who Self-Direct Covered Services.
 - 2. The use of Financial Administration shall be mandatory whenever the Enrollee is the employer of record of one or more providers of Covered Services.
 - 3. The Financial Administration Entity shall not be a provider of another waiver service, excluding Supports Brokerage, to the Enrollee.

- (g) Individual Transportation Services.
 - 1. An Enrollee receiving Orientation and Mobility Training shall be eligible to receive Individual Transportation Services to the extent necessary for participation in Orientation and Mobility Training. Enrollees who receive Respite, Behavioral Respite Services, or Personal Assistance shall be eligible to receive Individual Transportation Services only to the extent necessary during the time period when Respite, Behavioral Respite Services, or Personal Assistance is being provided.
 - 2. Individual Transportation Services shall not be used for:
 - (i) Transportation to and from Day Services;
 - (ii) Transportation to and from supported or competitive employment;
 - (iii) Transportation of school aged children to and from school; or
 - (iv) Transportation to and from medical services covered by the Medicaid State Plan.

- (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.

- (i) Nutrition Services.

1. Nutrition Services must be provided face to face with the Enrollee or, for purposes of education, with the caregivers responsible for food purchase, food preparation, or assisting the Enrollee to eat.
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.

(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.
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.

(k) 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. 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.

(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.
 2. Physical Therapy must be provided face to face with the Enrollee.
 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.
- (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.
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.
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.

(r) Supports Brokerage. Supports Brokerage shall not be provided by:

1. A family member who is a provider of another Covered Service to the Enrollee;
or
2. Any other Waiver Service provider who is a provider of another service, excluding Financial Administration, to the Enrollee.

- (s) Vehicle Accessibility Modifications. Replacement of tires or brakes, oil changes, and other vehicle maintenance procedures shall be excluded from coverage.
- (t) 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.
- (u) 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.
- (v) The cost of all Covered Services, including any Emergency Assistance, shall not exceed \$36,000 per year per Enrollee.
- (w) All Covered Services to be provided prior to the development of the initial Individual Support Plan must be included in the physician's plan of care section of the Pre-Admission Evaluation application.
- (4) Eligibility.
- (a) To be eligible for enrollment in the Waiver, an individual must meet all of the following criteria:
1. The individual must be a resident of the State of Tennessee.
 2. The individual must be on the Waiting List; be classified in one of the Crisis, Urgent, or Active Waiting List categories listed below; and, for eligibility purposes shall be prioritized, with the highest priority being individuals in the Crisis category, the second highest priority being individuals in the Urgent category, and the third highest priority being individuals in the Active category, up to the maximum number of persons approved to be served in the Waiver program each year:
 - (i) Crisis: The individual needs services immediately for one of the following reasons:
 - (I) Homelessness:
 - I. The individual is currently homeless; or
 - II. The individual will be homeless within ninety (90) days.
 - (II) Death, incapacitation, or loss of the primary caregiver and lack of an alternate primary caregiver:
 - I. The primary caregiver died;
 - II. The primary caregiver became mentally or physically incapacitated (permanently or expected to last more than thirty (30) days);
 - III. The primary caregiver serves as the primary caregiver for one or more other individuals with serious mental, physical, or developmental disabilities and is unable to provide an acceptable level of care for the enrollee; or
 - IV. The primary caregiver must be employed to provide the sole or primary income for the support of the family.

- (III) Serious and imminent danger of harm to self or to others by the individual:
 - I. The individual's current pattern of behavior poses a serious and imminent danger of self-harm which cannot be reasonably and adequately managed by the caregiver; or
 - II. The individual's current pattern of behavior poses a serious and imminent danger of harm to others which cannot be reasonably and adequately managed by the primary caregiver.
 - (IV) The individual has multiple urgent needs that are likely to result in a Crisis situation if not addressed immediately, and the individual meets two or more of the Urgent category criteria in subpart (ii) of this part.
 - (ii) Urgent: The individual meets one or more of the following criteria:
 - (I) Aging or failing health of caregiver and no alternate available to provide supports;
 - (II) Living situation presents a significant risk of abuse or neglect;
 - (III) Increasing behavioral risk to self or others;
 - (IV) Stability of the current living situation is severely threatened due to extensive support needs or family catastrophe; or
 - (V) Discharge from other service system (e.g., Tennessee Department of Children's Services, a mental health institute, a state forensics unit) is imminent.
 - (iii) Active: The individual or the individual's family or guardian or conservator is requesting access to services but the individual does not have intensive needs which meet the Urgent or Crisis criteria in subparts (i) or (ii) of this part.
3. 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).
 4. 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.
 5. 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.

6. 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.
7. The individual must have a psychological evaluation included as part of the approved Pre-Admission Evaluation and 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 have an IQ test score of seventy (70) or below; or
 - (II) Is a child four (4) 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) The psychological evaluation:
 - (I) Shall have been made no more than three (3) calendar months before the date of admission into the Waiver; or
 - (II) If performed more than three (3) calendar months but no more than twelve (12) calendar months before the date of admission, shall have been signed and updated within three (3) calendar months preceding the date of admission into the Waiver. The update must be done by the person who performed the examination or by the supervising clinical psychologist who signed the initial evaluation.
8. 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.

9. 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. Shall not be used to transfer an individual from one Waiver to a different Home and Community Based Services Waiver Program; and
- 4. Shall list 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.
 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, nursing facility, Intermediate Care Facility for the Mentally Retarded, Assisted Living Facility, and/or Home for the Aged and has resided there for a continuous period exceeding 120 days.

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 ninety (90) calendar days of admission into the Waiver.
 3. A Safety Plan for Enrollees who do not have 24-hour direct care services shall be maintained with the Plan of Care.
 - (b) To ensure that Waiver Services and other services are being appropriately provided to meet the Enrollee's needs, the Plan of Care shall be reviewed on an ongoing basis and shall be updated and signed in accordance with the following:
 1. The Case Manager shall review the Plan of Care when needed, but no less frequently than once each calendar month, and shall document such review by a dated signature.
 2. A team consisting of the Case Manager and other appropriate participants in the development of the Plan of Care shall review the Plan of Care when needed, but no less frequently than every twelve (12) calendar months, and shall document such review by dated signatures. Such annual review shall include, but not be limited to, reviewing outcomes and determining if progress is being made in accordance with the Plan of Care; reviewing the appropriateness of supports and services being provided and determining further needs of the Enrollee.
- (9) Physician Services.
- (a) The Operational Administrative Agency shall ensure that each Enrollee receives physician services as needed and that each Enrollee has a medical examination, documented in the Enrollee's record, in accordance with the following schedule:

<u>Age</u>	<u>Minimum frequency of medical examinations</u>
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;
- (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 1200-13-013-.11 to ensure that Enrollees are afforded advance notice and the right to appeal an adverse decision and have a fair hearing;
 - (t) Ensuring that providers and subcontractors comply with the quality monitoring guidelines and requirements established by the State Medicaid Agency, by the Operational Administrative Agency, and by the Centers for Medicare and Medicaid Services, and with other state and federal laws, rules, and regulations affecting the provision of Waiver Services;
 - (u) Oversight and monitoring of the Financial Administration entity;
 - (v) Collection of applicable patient liability from Enrollees;
 - (w) Reimbursement of Waiver providers in accordance with policies established by the State Medicaid Agency;
 - (x) Recoupment of payments made to Waiver providers when there is lack of documentation to support that services were provided or there is a lack of medical necessity of services, or when inappropriate payments have been made due to erroneous or fraudulent billing; and
 - (y) Expenditure and revenue reporting in accordance with state and federal requirements.
- (11) Reimbursement.
- (a) The average per capita fiscal year expenditure under the Waiver shall not exceed 100% of the average per capita expenditure that would have been made in the fiscal year if care had been provided in an ICF/MR. The total Medicaid expenditure for Waiver

Services and other Medicaid services provided to Enrollees shall not exceed 100% of the amount that would have been incurred in the fiscal year if care was provided in an ICF/MR. Reimbursement for the cost of all Covered Services, including any Emergency Assistance, shall not exceed \$36,000 per year per Enrollee.

- (b) The Operational Administrative Agency shall be reimbursed for Waiver Services at the rate per unit of service actually paid by the Operational Administrative Agency to the Waiver service provider or at the maximum rate per unit of service established by the State Medicaid Agency, whichever is less.
- (c) In accordance with 42 CFR § 435.726, the Operational Administrative Agency shall make a diligent effort to collect patient liability if it applies to the Enrollee. The Operational Administrative Agency or its designee shall complete appropriate forms showing the individual's amount of monthly income and shall submit them to the Tennessee Department of Human Services. The Tennessee Department of Human Services shall issue the appropriate forms to the Operational Administrative Agency and to the State Medicaid Agency's fiscal agent that processes and pays vendor claims, specifying the amount of patient liability to be applied toward the cost of care for the Enrollee.
- (d) The Operational Administrative Agency shall submit bills for services to the State Medicaid Agency's fiscal agent using a claim form approved by the State Medicaid Agency. On claim forms, the Operational Administrative Agency shall use a provider number assigned by the State Medicaid Agency.
- (e) Reimbursement shall not be made to the Operational Administrative Agency for therapeutic leave or hospital leave for Enrollees in the Waiver.
- (f) Medicaid benefits other than those specified in the Waiver's scope of Covered Services shall be reimbursed by the State Medicaid Agency as otherwise provided for by federal and state rules and regulations.
- (g) The Operational Administrative Agency shall be responsible for obtaining the physician's initial certification and subsequent Enrollee re-evaluations. Failure to perform re-evaluations in a timely manner and in the format approved by the State Medicaid Agency shall require a corrective action plan and shall result in partial or full recoupment of all amounts paid by the State Medicaid Agency during the time period when a re-evaluation had lapsed.
- (h) The Operational Administrative Agency shall be responsible for ensuring that the Financial Administration entity fulfills its financial, ministerial, and clerical responsibilities associated with the provision of Financial Administration services to an Enrollee who Self-Directs one or more Covered Services. Examples of such responsibilities include the hiring and employment of service providers by the Enrollee or the Enrollee's guardian or conservator; management of Enrollee accounts; disbursement of funds to Waiver service providers while withholding appropriate deductions; reviewing documentation of Covered Services to assure Enrollee approval prior to payment; ensuring that Waiver service providers possess the necessary qualifications established by the State Medicaid Agency.
- (i) The State Medicaid Agency shall be responsible for defining and establishing the billing units to be used by the Operational Administrative Agency in billing for Waiver Services.
- (j) An Operational Administrative Agency that enrolls an individual without an approved ICF/MR Pre-Admission Evaluation or, where applicable, an approved Transfer Form does

so without the assurance of reimbursement. An Operational Administrative Agency that enrolls an individual who has not been determined by the Tennessee Department of Human Services to be financially eligible to have Medicaid make reimbursement for covered services does so without the assurance of reimbursement.

- (12) Appeals. An Enrollee shall have the right to appeal an adverse action in accordance with TennCare rule 1200-13-013-.11.

Statutory Authority: T.C.A. 4-5-202, 71-5-105, 71-5-109, Executive Order No. 23.

The rulemaking hearing rules set out herein were properly filed in the Department of State on the 20th day of June, 2007, and will become effective on the 3rd day of September, 2007. (FS 06-20-07, DBID 2562)