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# Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204. For questions and copies of the notice, contact the person listed below.

<b>Agency/Board/Commission:</b>	Tennessee Department of Finance and Administration
<b>Division:</b>	Division of TennCare
<b>Contact Person:</b>	George Woods
<b>Address:</b>	Division of TennCare 310 Great Circle Road Nashville, TN 37243
<b>Phone:</b>	(615) 507-6446
<b>Email:</b>	<a href="mailto:george.woods@tn.gov">george.woods@tn.gov</a>

Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

<b>ADA Contact:</b>	Talley A. Olson, Director TennCare Office of Civil Rights Compliance
<b>Address:</b>	Division of TennCare 310 Great Circle Road Nashville, TN 37243
<b>Phone:</b>	(855) 857-1673 TTY dial 711 and ask for 855-857-1673
<b>Email:</b>	<a href="mailto:hcfa.fairtreatment@tn.gov">hcfa.fairtreatment@tn.gov</a>

**Hearing Location(s)** (for additional locations, copy and paste table)

Address 1:	Division of TennCare 310 Great Circle Road, Conference Room 1 East A		
City:	Nashville, TN		
Zip:	37243		
Hearing Date:	January 11, 2021		
Hearing Time:	5:00 pm	<input checked="" type="checkbox"/> _X_ CST/CDT	<input type="checkbox"/> __EST/EDT

**Additional Hearing Information:**

Members of the public may submit written comments for consideration at the hearing until 5:00 p.m. Central Time on January 11, 2021. Written comments should be sent via email to [george.woods@tn.gov](mailto:george.woods@tn.gov).

If attending in-person, please bring identification so that you may be checked into the building.

COVID Building Entry Protocols:

As part of the Tennessee Pledge, TennCare observes and is compliant with the following building entry protocols:

- At this time, all persons working or meeting in the TennCare building are required to wear a face mask.
- We recommend meeting attendees bring their own mask, however, if an attendee does not have one, a mask will be provided to any attendee upon entry.
- Additional personal protection equipment (PPE) such as a face shield are permitted but are not a replacement

for a face mask.

- Upon entry, persons are required to complete a health screening by answering the following questions:
  1. Have you been in close contact with a confirmed case of COVID-19 in the past 14 days? (Note: This does not apply to medical personnel, first responders, or other individuals who encounter COVID-19 as part of their professional or caregiving duties while wearing appropriate PPE.)
  2. Are you experiencing a cough, shortness of breath or sore throat?
  3. Have you had a fever in the last 48 hours?
  4. Have you had new loss of taste or smell?
  5. Have you had vomiting or diarrhea in the last 24 hours?
- Persons working or meeting in the TennCare building are also required to submit to a temperature screening; persons with temperatures 100.4 degrees or higher will not be permitted to enter the building. However, an opportunity will be provided to submit comments in writing instead of in-person.

**\*\*\*NOTICE\*\*\***

Currently, Governor Lee's Emergency Order pertaining to COVID-19 that allows State Boards to hold their meetings electronically is set to expire December 27, 2020. If it does expire on that date, then this hearing will be an in-person hearing at the location and time denoted just above. If the Emergency Order is extended beyond the scheduled date of this hearing, then this hearing will be held electronically via WebEx.

In the event of an electronic hearing, members of the public may join the WebEx at the following link:

<https://tngov.webex.com/tngov/onstage/g.php?MTID=ea1e97ba5f50619e309c0a4653afebcd3>

The link above should take users directly to the rulemaking hearing. If prompted for a meeting number or password, use:

Event number: 178 828 1866

Event password: tenncare

It is recommended that interested persons join the WebEx several minutes early to ensure adequate time to install any mandatory plugins in order to attend the electronic rulemaking hearing.

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

- Amendments  
 New  
 Repeal

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

Chapter Number	Chapter Title
1200-13-01	TennCare Long-Term Care Programs
Rule Number	Rule Title
1200-13-01-.01	Purpose
1200-13-01-.02	Definitions
1200-13-01-.05	TennCare Choices Program
1200-13-01-.10	Medical (Level of Care) Eligibility Criteria for TennCare Reimbursement of Care in Nursing Facilities, Choices HCBS and PACE
1200-13-01-.11	Medical (Level of Care) Eligibility Criteria for TennCare Reimbursement of Care for Children in the Katie Beckett Program
1200-13-01-.31	TennCare Employment and Community First CHOICES (ECF CHOICES) Program
1200-13-01-.32	TennCare Katie Beckett Program

Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to

<https://sos.tn.gov/products/division-publications/rulemaking-guidelines>.

Chapter 1200-13-01TennCare Long-Term Care Programs Table of Contents is amended by adding a new rule number and title “1200-13-01-.32 TennCare Katie Beckett Program” at the end of the Table.

Paragraph (4) Acronyms of Rule 1200-13-01-.01 Purpose is amended by inserting in alphabetical order the following new subparagraph, with all subparagraphs lettered appropriately so that the new subparagraph shall read as follows

(#) EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-112, 71-5-164 and TennCare II Section 1115(a) Medicaid Demonstration Waiver Extension.

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

(#) Assistance with Premium Payments. For purposes of the Katie Beckett Program only and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B as follows:

(a) Reimbursement to assist with the cost of the eligible child’s portion only of third party liability insurance (TPL) coverage, such as employer-sponsored or other private health insurance:

1. Limited to the amount determined to be the child’s portion of TPL coverage premiums, when other family members are also covered by the same premium, calculated by dividing the total premium amount by the total number of family members covered under the policy.
2. Paid only upon proof of payment of the child’s premium for the applicable period.

(b) For a child enrolled in Medicaid Diversion Group Part B, the amount that may be reimbursed shall be limited to the amount specified in the child’s approved ISP.

(c) May be offered to a child in Katie Beckett Group Part A only if a hardship exception to the requirement to obtain/maintain TPL, as set out in Rule 1200-13-20-.08(8), is requested and would otherwise be approved. In such cases, the Assistance with Premium Payments shall be limited to the amount by which the child’s portion of the family’s monthly TPL premium exceeds the Katie Beckett Group Part A premium and shall not count against the \$15,000 per calendar year expenditure cap for Katie Beckett Group Part A wraparound HCBS.

(#) Automated Health Care and Related Expenses Reimbursement. For purposes of the Katie Beckett Program only and limited to children enrolled in Medicaid Diversion Group Part B:

(a) Payment or reimbursement, using the vendor contracted by DIDD, of the child’s qualified medical and related expenses as follows:

1. Private insurance deductibles and co-payments for physician and nursing services, therapies, and prescription drugs;
2. Medical equipment and supplies;
3. Dental, vision, and hearing services;
4. Medical mileage; and
5. Other medical expenses as determined by the Internal Revenue Service to be eligible as an itemized medical and dental expenses deduction on Schedule A (Form 1040 or 1040-SR) or qualified for payment or reimbursement under a Healthcare Reimbursement Account, Health Savings Account or Flexible Spending Account, except that health insurance premiums shall be covered only as part of the Health Insurance Premium Assistance benefit).

- (b) The child's parent or legal guardian shall specify the annual amount to be available for payment or reimbursement through the Automated Health Care and Related Expenses Reimbursement benefit each year, in accordance with processes established by DIDD, subject to the \$10,000 per child per year limit on total benefits available through Medicaid Diversion Group Part B and approval of the ISP by DIDD. Once established, this amount shall not be changed for the year. Payments or reimbursement for Automated Health Care and Related Expenses Reimbursement shall be limited to the amount specified in the child's approved ISP.
  - (c) To be covered and eligible for reimbursement, the child's parent or legal guardian shall submit documentation to the vendor contracted by DIDD as requested, sufficient to confirm the expense's eligibility for payment or reimbursement. The child's parent or legal guardian shall comply with all applicable requirements of DIDD's contracted vendor in order to receive this benefit.
  - (d) A period of ninety (90) days shall be provided at the end of each year for submission of final expenditures incurred during the annual period.
  - (e) Any funds remaining in the child's Automated Health Care and Related Expenses Reimbursement benefit at the end of the year shall be forfeited to the Katie Beckett program and shall not be permitted to "roll over" to the next year.
- (#) Comparable Cost of Institutional Care. For purposes of Katie Beckett Group Part A and the Continued Eligibility Group Part C, the requirement that in order to qualify for enrollment in Katie Beckett Group Part A or in the Continued Eligibility Group Part C, the estimated amount that would be expended by the Medicaid program for the child's care outside an institution cannot be greater than the estimated amount that would otherwise be expended by the Medicaid program for the child's care within an appropriate institution, as further defined in Rule .32(4)(d).
  - (#) Consumer Direction of Eligible Katie Beckett HCBS. The opportunity for the parent or legal guardian of a child enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B assessed to need specified types of Katie Beckett HCBS set forth in TennCare rules as available for consumer direction to elect to direct and manage (or in limited circumstances to have a representative direct and manage) certain aspects of the provision of services – primarily, the hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed service(s) and the delivery of each eligible Katie Beckett HCBS within the authorized budget for that service. Eligible Katie Beckett HCBS do not include home health or private duty nursing.
  - (#) Continued Eligibility Group Part C. A TennCare demonstration population category that provides continuity of Medicaid coverage, state plan benefits (including EPSDT), and providers for children who have been enrolled in Medicaid but are no longer eligible in any category, and who are described in Section 1902(e)(3) and meet all of the eligibility criteria for enrollment into Katie Beckett Group Part A, as determined by TennCare, but for whom there is not an available slot in Katie Beckett Group Part A. Children in the Continued Eligibility Group Part C are not eligible to receive Katie Beckett Group Part A wraparound HCBS.
  - (#) Decision Making Supports. For purposes of ECF CHOICES and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B only:
    - (a) This service offers up to \$500 in one-time consultation, education and assistance to family caregivers in understanding legal, financial, and other decision making supports and options for a person supported who cannot make some or all of their own decisions. These services shall be provided in a manner that seeks to provide support in the least-restrictive manner, preserving the rights and freedoms of the individual to the maximum extent possible and appropriate.
    - (b) This service begins with education and consultation from a qualified professional to help ensure understanding of the array of options available, including less restrictive options that can be used to preserve the person's rights and freedoms to the maximum extent possible and appropriate, while addressing decision making needs.
    - (c) Reimbursable services may then include: (1) assistance with completing necessary paperwork and

processes to establish an alternative to conservatorship, such as supported decision making, limited (and revocable) power of attorney, health care proxy, or trust; or limited or full or conservatorship that is specifically tailored to the individual's capacities and needs, if it is determined to be the least restrictive alternative; (2) evaluating the appropriateness of a decision-making instrument currently in place and assistance with costs associated with terminating or revoking a conservatorship when less restrictive options would be appropriate; and (3) training associated with decision-making support.

- (d) Decision Making Supports shall be limited to \$500 per lifetime.
- (#) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). A covered benefit for children enrolled in TennCare Medicaid. See Rule Chapter 1200-13-13 for additional information.
- (#) Eligible Katie Beckett HCBS. Respite, Supportive Home Care, Community Transportation and any other Katie Beckett HCBS specified in TennCare rules as eligible for consumer direction, which a Katie Beckett member is determined to need and which the member's parent or legal guardian elects to direct and manage (or in limited circumstances to have a representative direct and manage) certain aspects of the provision of such services – primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s) and the delivery of each eligible Katie Beckett HCBS within the authorized budget for that service. Eligible Katie Beckett HCBS do not include home health or private duty nursing services.
- (#) Individualized Therapeutic Support Reimbursement. For purposes of the Katie Beckett Program only and limited to children enrolled in Medicaid Diversion Group Part B:
  - (a) Reimbursement, using DIDD's contracted vendor, of therapeutic supports determined by DIDD to be medically necessary for the child, but not eligible for automated reimbursement as part of the Automated Health Care and Related Expenses Reimbursement benefit.
  - (b) Limited to the amount specified in the child's DIDD-approved ISP and subject to the \$10,000 per child per year limit on total benefits available through Medicaid Diversion Group Part B.
  - (c) Each type and amount of therapeutic support shall be requested and approved by DIDD as part of the child's ISP in advance of such support being purchased,
  - (d) In order to be covered and eligible for reimbursement, the child's parent or legal guardian shall submit acceptable documentation to DIDD, confirming that the approved therapeutic support has been received and paid, and is eligible for reimbursement. The child's parent or legal guardian shall comply with all applicable DIDD requirements in order to receive this benefit.
  - (e) A period of ninety (90) days shall be provided at the end of each year for submission of final expenditures incurred.
  - (f) Any funds remaining in the child's Individualized Therapeutic Support Reimbursement benefit at the end of the year shall be forfeited to the Katie Beckett program and shall not be permitted to "roll over" to the next year.
- (#) Katie Beckett Home and Community Based Services (HCBS). Specified services that are available only to eligible children enrolled in Katie Beckett Group Part A or specified services that are available only to eligible children enrolled in Medicaid Diversion Group Part B. Katie Beckett Part A and Part B HCBS are sometimes called wraparound services or wraparound HCBS because they "wrap around" a child's primary health insurance and/or Medicaid EPSDT benefits, as applicable, offering specifically defined additional benefits not typically covered by TennCare in order to help child in the home and community-based setting. Only certain Katie Beckett Group Part A or Medicaid Diversion Group Part B HCBS are eligible for Consumer Direction (see Eligible Katie Beckett HCBS). Katie Beckett Group Part A and Medicaid Diversion Group Part B 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 children, although such services shall be counted for purposes of determining whether a child meets the comparable cost of institutional care requirement as defined in this rule in order to qualify for enrollment in Katie Beckett Group Part A or the Continued Eligibility Group Part C.

- (#) Katie Beckett Group Part A. The component of Tennessee’s Katie Beckett Program that serves a limited number of children with the most significant disabilities or complex medical needs who meet institutional level of care, as established by TennCare, and who qualify for Medicaid only by waiving the deeming of parents’ income and/or assets to the child. Children enrolled by TennCare into Katie Beckett Group Part A are eligible to receive all covered, medically necessary Medicaid benefits, including benefits provided under the EPSDT program as well as case management and specified wraparound HCBS not otherwise covered by the Medicaid program, including respite. Initial and ongoing enrollment in Katie Beckett Group Part A will consist of children who are under age 18 who (1) have medical needs that are likely to last at least twelve months or result in death; and result in severe functional limitations based on medical eligibility criteria developed by TennCare specifically for children; (2) qualify for care in a medical institution; (3) qualify for supplemental security income (SSI) due the child’s disability, except for the parent’s income and/or assets; (4) have received certification from a licensed physician that in-home care will meet the child’s needs; (5) the cost of providing the child’s care at home, including traditional Medicaid benefits and wraparound HCBS, cannot exceed the estimated Medicaid cost of institutional care; and (6) is not Medicaid-eligible or receiving long-term services and supports in another Medicaid program. Upon turning age eighteen (18), individuals enrolled in Katie Beckett Group Part A may remain enrolled in Katie Beckett Group Part A for up to twelve (12) months following the enrollee’s eighteenth (18th) birthday if an application for SSI is pending or in appeal status.
  
- (#) Katie Beckett Program. A TennCare demonstration program authorized by T.C.A. § 71-5-164 that offers services and supports as defined in these rules to children under age 18 with disabilities and/or complex medical needs who are not Medicaid eligible because of their parents’ income or assets. There are three (3) distinct groups described and defined in this rule:
  - (a) Katie Beckett Group Part A
  - (b) Medicaid Diversion Group Part B
  - (c) Continued Eligibility Group Part C
  
- (#) Katie Beckett Group Part A Member. A member who has been enrolled by TennCare into Katie Beckett Group Part A of the Katie Beckett Program.
  
- (#) Legal Guardian. For purposes of the Katie Beckett Program, the individual with physical custody of the child and the legal authority to make decisions concerning the child’s protection, education, care, medical treatment, etc., including the child’s PCSP for Katie Beckett Group Part A and DIDD-approved ISP for Medicaid Diversion Group Part B. Generally, the child’s parent is the legal guardian except when guardianship has been otherwise established through court proceedings.
  
- (#) Medicaid Diversion Group Part B. The component of Tennessee’s Katie Beckett Program which offers only a capped package of wraparound services and supports including premium assistance on a sliding fee scale to a broader group of children with disabilities, including those “at risk” of institutionalization. Medicaid Diversion Group Part B is an innovative, new approach that will help divert children from becoming Medicaid eligible by helping their families purchase private insurance and providing wraparound services and supports to meet the child’s needs. Medicaid Diversion Group Part B will consist of children who are under age 18 who (1) have medical needs that are likely to last at least twelve months or result in death and result in severe functional limitations based on medical eligibility criteria developed specifically for children; (2) qualify for care in a medical institution or be “at-risk” of institutional placement; (3) are not Medicaid eligible or receiving other long-term services and supports in another TennCare Medicaid program; and (4) the child is not eligible for Katie Beckett Group Part A or is not enrolled in Katie Beckett Group Part A due to program target enrollment.
  
- (#) Nurse Care Manager. For purposes of the Katie Beckett Group Part A, a person who is employed by an MCO to perform responsibilities related to continuous engagement and management of:
  - (a) Assessing a child’s strengths, physical and behavioral health and long-term services and supports needs, goals and challenges;

- (b) Identifying the services and supports (including unpaid supports voluntarily provided by family members and other caregivers, and paid services provided by private insurance, the MCO, and other payor sources) that will be provided to the child to meet the child's physical and behavioral health and long-term services and supports needs, and support the child in achieving his or her individualized goals;
  - (c) Working closely with providers in implementing the plan of care. Long-term services and supports identified through nurse care management and provided by the MCO shall build upon and not supplant a member's existing support system, including but not limited to informal supports provided by family and other caregivers, service that may be available at no cost to the member through other entities, and services that are reimbursable through other public or private funding sources, such as Medicare or private insurance;
  - (d) Developing and maintaining for each member, through a person and family centered planning process, an individualized, plan of care. The child should be involved in helping define his or her individualized goals and develop the plan of care the maximum extent possible and appropriate. This planning process, and the resulting person and family centered plan of care shall: 1) ensure the delivery of services in a manner that reflects the family's strengths, needs, preferences and choices; 2) assists the child in achieving personally defined outcomes in the most integrated community setting, which shall include planning and preparation for the child's transition to employment and community living with as much independence as possible upon becoming an adult; and 3) help to engage, strengthen, support and build the capacity and confidence of the family in order to ensure the child's safety, well-being and permanency;
  - (e) Ensuring timely access to and provision, coordination and monitoring of covered physical and behavioral health services and wraparound HCBS; and
  - (f) Collaboration between providers and payors of the member's physical and behavioral health services and wraparound HCBS, including physicians, other physical and behavioral health care providers, HCBS providers, TennCare, DIDD, the local education authority, Vocational Rehabilitation, and the MCO to facilitate seamless access to care and maximize health and quality of life outcomes, and to plan and prepare for the child's transition to employment and community living with as much independence as possible upon becoming an adult.
- (#) Substantial Functional Limitation. For purposes of Medical (Level of Care) Eligibility for the Katie Beckett Program only, a child's inability to perform specified functions at the level expected by the child's age or to perform activities of daily living (ADLs) as defined in this Rule without extensive, hands-on assistance significantly beyond the age at which similar aged peers typically require such assistance. This assistance must be needed by the child to complete the task or function at all, rather than to complete the task better, more quickly, or to make the task easier.
- (a) In order for a limitation to be considered a substantial functional limitation, it must meet all of the following:
    1. Be the direct result of the child's disability; and
    2. Be exhibited most of the time; and
    3. Result in the child needing extensive, direct, hands-on adult intervention and assistance beyond the level of intervention similar aged peers typically require in order to avoid institutionalization.
  - (b) In addition, the assistance the child requires to perform the function must meet all of the following:
    1. Be required consistently; and

2. Be required for at least the next 12 months; and
  3. Be required to complete the function across all settings, including home, school and community.
- (c) Subject to (d) below, a child has a substantial functional limitation in an activity of daily living category (e.g., Bathing, Grooming, etc.) if the child exhibits at least one of the specific substantial functional limitations listed under the category for the child's particular age group. Not all activity of daily living categories apply to every age group due to developmental milestone variations of typically developing children.
- (d) For purposes of Medical (Level of Care) Eligibility for Katie Beckett (including Tier 1 and Tier 2 Institutional LOC and At-Risk LOC), Bathing, Grooming, Dressing, Toileting, and Eating shall be combined into a single ADL category called "Self-Care." If a child exhibits deficits in multiple of these self-care activities of daily living, this shall still be counted as one substantial functional limitation (in self-care).
- (#) Vehicle Modification. For purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B.
- (a) A structural change or alteration to a vehicle that is the child's primary means of transportation in order to accommodate the unique needs of the child, enable the child's full integration into the community, and ensure the child's health, welfare, and safety.
  - (b) All modifications shall be based on an assessment and recommendation by a licensed occupational therapist, physician, or other qualified professional and included in the Person-Centered Support Plan.
  - (c) Vehicle Modifications shall not impede routine local and state safety and emission inspections, as required by law.
  - (d) Vehicle Modifications shall be limited to no more than \$10,000 per child per year; and \$20,000 per child per lifetime.
  - (e) The Vehicle Modifications benefit may be combined with other sources of funding such as community grants. Vehicle Modifications in excess of the Katie Beckett benefit limit (which are not covered by TennCare) may be privately paid.
  - (f) The parent or legal guardian may utilize pre-approved vendors/dealerships for direct billing if they follow the approval and payment process established by the MCO.
  - (g) Excluded are the following: purchase or lease of a vehicle; upkeep and maintenance of a vehicle; assistance with vehicle registration and licensing; and modifications that are of general utility without direct medical or remedial benefit to the child.

Paragraph (1) Activities of Daily Living (ADLs) of Rule 1200-13-01-.02 Definitions is deleted in its entirety and replaced with a new paragraph which shall read as follows:

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

3. Self-feeding;
  4. Functional transfers (getting into and out of bed or wheelchair, getting onto or off toilet, etc.);
  5. Bowel and bladder management; and
  6. Ambulation (walking with or without use of an assistive device, e.g., walker, cane or crutches; or using a wheelchair).
- (b) For purposes of Katie Beckett Medical (Level of Care) eligibility as described in 1200-13-01-.11, ADLs shall include only the following:
1. Bathing: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene (does not include hair care). For older children (over 12 years of age), this also includes the ability to get in and out of the bathtub, turn faucets on and off, regulate water temperature, wash and dry fully.
  2. Grooming: The ability to brush teeth, and wash hands and face. Due to variations in hair care by culture, length of hair, etc., hair care is not to be considered.
  3. Dressing: The ability to dress as necessary. This does not include the fine motor coordination for buttons and zippers.
  4. Eating: The ability to eat and drink by finger feeding or the use of routine or adaptive utensils. The ability to swallow sufficiently to obtain adequate oral intake. This does not include cooking food or preparing it for consumption such as cutting food into bite size pieces or pureeing it.
  5. Toileting: The ability to use a toilet or urinal, transferring on/off a toilet, changing menstrual pads, and pulling pants up/down
  6. Mobility: The ability to move between locations in the individual's living environment. For children, this includes home and school. Mobility includes walking, crawling, or wheeling oneself around at home or at school. For purposes of medical (level of care) eligibility for children, mobility does not include transporting oneself between buildings or moving long distances outdoors.

The introductory paragraph to Subparagraph (b) Assistive Technology of Paragraph (10) of Rule 1200-13-01-.02 Definitions is amended by adding the phrase “and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B” so as amended the introductory paragraph shall read as follows:

- (b) For purposes of ECF CHOICES and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B:

Subpart (xiv) of Part 1 of Subparagraph (b) of Paragraph (10) Assistive Technology of Rule 1200-13-01-.02 Definitions is amended by adding the words “or legal guardian” after the words “The individual” in the last sentence so as amended the subpart shall read as follows:

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

Part 3 of Subparagraph (b) of Paragraph (10) Assistive Technology of Rule 1200-13-01-.02 Definitions is amended by adding the word “Neither” at the beginning of the part and by adding the phrase “nor the Katie Beckett Program” after the words “ECF CHOICES” and by deleting the word “not” after the word “will” and before the word “cover” in the first sentence so as amended the part shall read as follows:

3. Neither ECF CHOICES nor the Katie Beckett Program will cover Assistive Technology or Adaptive Equipment and services which are otherwise available to the individual under Section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. §§ 1401, et seq.). If this service is authorized, documentation is maintained that the service is not available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. §§ 1401, et seq.).

Paragraph (11) At Risk for Institutionalization of Rule 1200-13-01-.02 Definitions is amended by adding a new Subparagraph (c) which shall read as follows:

- (c) For purposes of the Katie Beckett Program, Medicaid Diversion Group Part B only.

The minimum medical eligibility (level of care) requirement to enroll in Kate Beckett, Medicaid Diversion Group Part B, whereby a child does not meet the institutional level of care criteria specified in 1200-13-01-.11(3)(a) but does meet the criteria specified in 1200-13-01-.11(3)(b) and in the absence of the provision of a moderate level of home and community based services and supports, the child's condition and/or ability to continue living in the community will likely deteriorate, resulting in the child qualifying for more expensive institutional placement and for Medicaid.

Paragraph (13) Back-up Plan of Rule 1200-13-01-.02 Definitions is deleted in its entirety and replaced with a new Paragraph (13) which shall read as follows:

- (13) Back-up Plan. A written plan that is a required component of the plan of care for all CHOICES members receiving companion care or the plan of care or person-centered support plan, as appropriate, for CHOICES or ECF CHOICES members receiving non-residential CHOICES or ECF CHOICES HCBS, all Katie Beckett Group Part A and Medicaid Diversion Group Part B members receiving Katie Beckett HCBS, and all members (including, but not limited to CHOICES, ECF CHOICES, and Katie Beckett Group Part A members) receiving home health (HH) or private duty nursing (PDN) services in their own homes and which specifies family members, and other unpaid persons as well as paid consumer-directed workers and/or contract providers who are available, have agreed to serve as back-up, and who will be contacted to deliver needed care or support in situations when regularly scheduled CHOICES, ECF CHOICES, or Katie Beckett HCBS providers or workers, or home health or private duty nurses or aides are unavailable or do not arrive as scheduled. A CHOICES or ECF CHOICES member or his/her representative may not elect, as part of the back-up plan, to go without services, nor may a Katie Beckett Group Part A or Medicaid Diversion Group Part B member or person receiving HH and/or PDN go without needed services. Inpatient admission shall not be considered an adequate back-up plan. The back-up plan shall include the names and telephone numbers of persons and agencies to contact and the services to be provided by each of the listed contacts. The member and his/her representative or for children in Katie Beckett Group Part A or Medicaid Diversion Group Part B, the child's parent or legal guardian shall have primary responsibility for the development and implementation of the back-up plan for consumer directed services. The FEA will assist as needed with the development and verification of the initial back-up plan for consumer direction. The CHOICES care coordinator ECF support coordinator, Nurse Care Manager or DIDD case manager, shall be responsible for assistance as needed with implementing the back-up plan and for updating and verifying the back-up plan on an ongoing basis.

Paragraph (14) Bed Hold of Rule 1200-13-01-.02 Definitions is amended by deleting the phrase "NF's receiving Level 1 reimbursement for NF care and" after the words "by which" so as amended the paragraph shall read as follows:

- (14) Bed Hold. The policy by which ICFs/IID are reimbursed for holding a resident's bed while he is away from the facility, in accordance with this Chapter.

Paragraph (16) Bureau of TennCare (Bureau) of Rule 1200-13-01-.02 Definitions is amended by replacing the word "Bureau" with "Division" and "(Bureau)" with "(TennCare)" in the first sentence and by replacing the words "the Bureau" with the word "TennCare" in the second sentence so as amended the paragraph shall read as follows:

- (16) Division of TennCare (TennCare). 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, TennCare shall represent the State of Tennessee.

Paragraph (19) Caregiver of Rule 1200-13-01-.02 Definitions is amended by adding a comma “,” and deleting the word “or” after the words “of CHOICES” and by adding the phrase and comma “or Katie Beckett Group Part A,” after “CHOICES,” and by adding a new subparagraph (d) so as amended the renumbered paragraph and subparagraph shall read as follows:

- (19) Caregiver. For purposes of CHOICES, ECF CHOICES, or Katie Beckett Group Part A, a person who:

- (d) For purposes of Katie Beckett Group Part A, the caregiver is generally the child’s parent or legal guardian except when someone other than the child’s parent or legal guardian is routinely involved in providing unpaid support and assistance to the child.

Paragraph (21) Certification of Rule 1200-13-01-.02 Definitions is amended by adding a new Subparagraph (d) which shall read as follows:

- (d) For purposes of Katie Beckett Group Part A and the Continued Eligibility Group Part C,
1. The child’s treating physician must certify that the PAE accurately reflects the child’s physical, behavioral, and functional needs and that home-based services including HCBS, are medically necessary and that the child’s needs can be safely met at home,
  2. Physician certification shall not be required for enrollment in Medicaid Diversion Group Part B.

Paragraph (33) Community Integration Support Services of Rule 1200-13-01-.02 Definitions is amended by adding a new Subparagraph (b) and Subparagraph (a) is reformatted accordingly so as amended the renumbered paragraph shall read as follows:

- (33) Community Integration Support Services.

- (a) For purposes of ECF CHOICES:

1. Services which coordinate and provide supports for valued and active participation in integrated daytime and nighttime activities that build on the person’s interests, preferences, gifts, and strengths while reflecting the person’s goals with regard to community involvement and membership. This service involves participation in one or more integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers. Community Integration Support Services are designed to promote maximum participation in integrated community life while facilitating meaningful relationships, friendships and social networks with persons without disabilities who share similar interests and goals for community involvement and participation.
2. Community Integration Support Services shall support and enhance, rather than supplant, an individual’s involvement in public education, post-secondary education/training and individualized integrated employment or self-employment (or services designed to lead to these types of employment).
3. Community Integration Support Services enable the person to increase or maintain his/her capacity for independent participation in community life and to develop age-appropriate social roles valued by the community by learning, practicing and applying skills necessary for full inclusion in the person’s community, including skills in arranging and using public transportation for individuals aged 16 or older.
4. Community Integration Support Services provide assistance for active and positive participation in a broad range of integrated community settings that allow the person to engage with people who do not have disabilities who are not paid or unpaid caregivers. The service is expected to result in the person developing and sustaining a range of valued, age-appropriate social roles and relationships; building natural supports; increasing independence; and experiencing

meaningful community integration and inclusion. Activities are expected to increase the individual's opportunity to build connections within his/her local community and include (but are not limited to) the following:

- (i) Supports to participate in age-appropriate community activities, groups, associations or clubs to develop social networks with community organizations and clubs;
  - (ii) Supports to participate in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness (e.g. yoga class, walking group, etc.);
  - (iii) Supports to participate in adult education and postsecondary education classes;
  - (iv) Supports to participate in formal/informal associations or community/neighborhood groups;
  - (v) Supports to participate in volunteer opportunities;
  - (vi) Supports to participate in opportunities focused on training and education for self-determination and self-advocacy;
  - (vii) Supports for learning to navigate the local community, including learning to use public transportation and/or private transportation available in the local area; and
  - (viii) Supports to maintain relationships with members of the broader community (e.g., neighbors, co-workers and other community members who do not have disabilities and who are not paid or unpaid caregivers) through natural opportunities and invitations that may occur.
5. This service includes a combination of training and supports as needed by the individual. The Community Integration Support Services provider shall be responsible for any personal assistance needs during the hours that Community Integration Support Services are provided; however, the personal assistance services may not comprise the entirety of the Community Integration Support Service. All providers of personal care under Community Integration Support Services meet the Personal Assistance provider qualifications.
6. This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve his or her personally identified goals for community integration, involvement, exploration and for developing and sustaining a network of positive natural supports. All settings where Community Integration Support Services are provided must be non-disability specific and meet all federal standards for HCBS settings. This service is provided separate and apart from the person's place of residence. This service does not take place in licensed facilities, sheltered workshops or any type of facility owned, leased or operated by a provider of this service.
7. This service is available only:
- (i) For children not yet old enough to work and/or not yet eligible for employment services who are enrolled in Essential Family Supports; or
  - (ii) As "wrap-around" supports to employment or employment services (Supported Employment Individual or Small Group services and/or Integrated Employment Path Services) for individuals not receiving Community Living Supports or Community Living Supports-Family Model; or
  - (iii) For individuals who are of legal working age (16+) not receiving Community Living Supports or Community Living Supports-Family Model who, after an Employment Informed Choice Process as defined by TennCare, have decided not to pursue employment; or

- (iv) For individuals of retirement age not receiving Community Living Supports or Community Living Supports-Family Model who have made a choice not to pursue further employment opportunities.
8. For individuals receiving Community Integration Support Services who are of legal working age (16+), and not participating in employment or employment services, the option to pursue employment should be discussed at least semi-annually, unless the person is age 65 or older and has declined further interest in employment.
  9. For individuals receiving Community Living Supports or Community Living Supports-Family Model, all services necessary to support community integration and participation are part of the scope of benefits provided under the CLS or CLS-FM benefit and shall not be authorized, provided or reimbursed as a separate service.
  10. For individuals of appropriate age (18+), fading of the service and less dependence on paid support for ongoing participation in community activities and relationships is expected. Fading strategies, similar to those used in Supported Employment Job Coaching, should be utilized. Milestones for the reduction/fading of paid supports and the enhancement of natural supports must be established and monitored for this service.
  11. Payment for registration, materials and supplies for participation in classes, conferences and similar types of activities, or club/association dues can be covered, but cannot exceed \$500 per year for children under age 21 or \$1,000 per year for adults age 21 or older. These costs are not included in the rates paid to the providers of Community Integration Support Services and must be prior approved before being incurred.
  12. Transportation to and from the service is not included in the rate paid for the service; but transportation during the service (when no-cost forms of transportation are not available or not being accessed) is included in the rate paid for the service.
  13. Community Integration Support Services shall be limited as follows:
    - (i) For persons not working in Individualized Integrated Employment, Individualized Integrated Self-Employment, or Small Group Employment in the community or receiving at least one employment service, no more than 20 hours per week of Community Integration Support Services and Independent Living Skills Training combined after completing an Employment Informed Choice process.
    - (ii) For persons who are working in Individualized Integrated Employment, Individualized Integrated Self-Employment, or Small Group Employment in the community (not a sheltered workshop) or receiving at least one employment service, no more than 30 hours per week of Community Integration Support Services, Independent Living Skills Training, and Individual or Small Group Employment Supports combined.
    - (iii) For persons who are working in Individualized Integrated Employment or Individualized Integrated Self-Employment (not in a small group or in a sheltered workshop), no more than 40 hours per week of Community Integration Support Services, Independent Living Skills Training, Job Coaching, Co-Worker Supports, and the hours worked without paid supports combined.
    - (iv) For persons who are working in Individualized Integrated Employment or Individualized Integrated Self-Employment (not in a small group or in a sheltered workshop) at least 30 hours per week, no more than 50 hours per week of Community Integration Support Services, Independent Living Skills Training, Job Coaching, Co-Worker Supports, and the hours worked without paid supports combined.
- (b) For purposes of the Katie Beckett Program and applicable only to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B:

1. Services which coordinate and provide supports for valued and active participation in integrated daytime and nighttime activities that build on the person's interests, preferences, gifts, and strengths while reflecting the person's goals with regard to community involvement and membership. This service involves participation in one or more integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers. Community Integration Support Services are designed to promote maximum participation in integrated community life while facilitating meaningful relationships, friendships and social networks with persons without disabilities who share similar interests and goals for community involvement and participation.
2. Community Integration Support Services shall support and enhance, rather than supplant, an individual's involvement in public education, post-secondary education/training and individualized integrated employment or self-employment (or services designed to lead to these types of employment).
3. Community Integration Support Services enable the person to increase or maintain his/her capacity for independent participation in community life and to develop age-appropriate social roles valued by the community by learning, practicing and applying skills necessary for full inclusion in the person's community, including skills in arranging and using public transportation for individuals aged 16 or older.
4. Community Integration Support Services provide assistance for active and positive participation in a broad range of integrated community settings that allow the person to engage with people who do not have disabilities who are not paid or unpaid caregivers. The service is expected to result in the person developing and sustaining a range of valued, age-appropriate social roles and relationships; building natural supports; increasing independence; and experiencing meaningful community integration and inclusion. Activities are expected to increase the individual's opportunity to build connections within his/her local community and include (but are not limited to) the following:
  - (i) Supports to participate in age-appropriate community activities, groups, associations or clubs to develop social networks with community organizations and clubs;
  - (ii) Supports to participate in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness (e.g. yoga class, walking group, etc.);
  - (iv) Supports to participate in formal/informal associations or community/neighborhood groups;
  - (v) Supports to participate in volunteer opportunities;
  - (vi) Supports to participate in opportunities focused on training and education for self-determination and self-advocacy;
  - (vii) Supports for learning to navigate the local community, including learning to use public transportation and/or private transportation available in the local area; and
  - (viii) Supports to maintain relationships with members of the broader community (e.g., neighbors, co-workers and other community members who do not have disabilities and who are not paid or unpaid caregivers) through natural opportunities and invitations that may occur.
5. This service includes a combination of training and supports as needed by the individual. The Community Integration Support Services provider shall be responsible for any personal assistance needs during the hours that Community Integration Support Services are provided; however, the personal assistance services may not comprise the entirety of the Community Integration Support Service. All providers of personal care under Community Integration Support Services meet the Personal Assistance provider qualifications.

6. This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve his or her personally identified goals for community integration, involvement, exploration and for developing and sustaining a network of positive natural supports. All settings where Community Integration Support Services are provided must be non-disability specific and meet all federal standards for HCBS settings. This service is provided separate and apart from the person's place of residence. This service does not take place in licensed facilities, sheltered workshops or any type of facility owned, leased or operated by a provider of this service.
7. Payment for registration, materials and supplies for participation in classes, conferences and similar types of activities, or club/association dues can be covered, but cannot exceed \$500 per year. These costs are not included in the rates paid to the providers of Community Integration Support Services and must be prior approved before being incurred.
8. Transportation to and from the service is not included in the rate paid for the service; but transportation during the service (when no-cost forms of transportation are not available or not being accessed) is included in the rate paid for the service.

Paragraph (37) Community Support Development, Organization and Navigation of Rule 1200-13-01-.02 Definitions is amended by deleting the word "only" after the words "ECF CHOICES" and before the word "and" and by adding a comma and phrase ", and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Part B" at the end of the paragraph so as amended the paragraph shall read as follows:

- (37) Community Support Development, Organization and Navigation. For purposes of ECF CHOICES and limited to members enrolled in ECF CHOICES Group 4 (Essential Family Supports), and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B:

Paragraph (38) Community Transportation of Rule 1200-13-01-.02 Definitions is amended by adding the phrase "and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B" and by deleting the word "only" at the end of the paragraph so as amended the paragraph shall read as follows:

- (38) Community Transportation. For purposes of ECF CHOICES and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A Group or Medicaid Diversion Group Part B:

Paragraph (41) Conservatorship and Alternatives to Conservatorship Counseling and Assistance of Rule 1200-13-01-.02 Definitions is deleted in its entirety and subsequent paragraphs are renumbered accordingly.

Paragraph (43) Consumer-Directed Worker (Worker) of Rule 1200-13-01-.02 Definitions is amended by adding "or by a parent or legal guardian of a Katie Beckett Group Part A member participating in consumer direction of eligible Katie Beckett HCBS" after the word "representative" and before the words "to provide" and by adding a comma (,) and deleting the word "or" after the word CHOICES and before "ECF" and by adding a comma and words ", or Katie Beckett" so as amended the paragraph shall read as follows:

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

Paragraph (50) Department of Intellectual and Developmental Disabilities (DIDD) of Rule 1200-13-01-.02 Definitions is amended by deleting the phrase and comma (,) "Formerly known as the Division of Intellectual Disabilities Services (DIDS)," in the second sentence and by adding the word "also" after "DIDD is" and before the word "responsible" and by adding the phrase "and Katie Beckett Group Part A, and for administering Medicaid

Diversion Group Part B” after “ECF CHOICES” and by adding the words “with TennCare” at the end of the paragraph so as amended the paragraph shall read as follows

- (50) Department of Intellectual and Developmental Disabilities (DIDD). The State entity contracted by TennCare to serve as the OAA for day-to-day operation of Section 1915(c) HCBS Waivers for persons with ID. DIDD is also responsible for the performance of contracted functions for ECF CHOICES and Katie Beckett Group Part A, and for administering Medicaid Diversion Group Part B, including redeterminations, as specified in an interagency agreement with TennCare.

Paragraph (61) Eligible of Rule 1200-13-01-.02 Definitions is amended by adding a sentence at the end of the paragraph so as amended the paragraph shall read as follows:

- (61) Eligible. Any person certified by TennCare as eligible to receive services and benefits under the TennCare program. As it relates to CHOICES and ECF CHOICES a person is eligible to receive CHOICES or ECF CHOICES benefits only if he/she has been enrolled in CHOICES or ECF CHOICES by TennCare. As it relates to the Katie Beckett Program, a person is eligible to receive Katie Beckett Group Part A or Medicaid Diversion Group Part B benefits only if he/she has been enrolled into the applicable Part of the Katie Beckett Program by TennCare.

Paragraph (65) Employer of Record of Rule 1200-13-01-.02 Definitions is amended by adding “, or the parent or legal guardian of a Katie Beckett Group Part A or Medicaid Diversion Group Part B member participating in consumer direction of eligible Katie Beckett HCBS. In limited circumstances, the parent or legal guardian of a child in Katie Beckett Group Part A or Medicaid Diversion Group Part B may delegate a representative for consumer direction” at the end of the paragraph so as amended the paragraph shall read as follows:

- (65) Employer of Record. The member participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS or a representative designated by the member to assume the consumer direction of eligible CHOICES or ECF CHOICES HCBS functions on the member’s behalf, or the parent or legal guardian of a Katie Beckett Group Part A or Medicaid Diversion Group Part B member participating in consumer direction of eligible Katie Beckett HCBS. In limited circumstances, the parent or legal guardian of a child in Katie Beckett Group Part A or Medicaid Diversion Group Part B may delegate a representative for consumer direction.

Subparagraph (a) of Paragraph (72) Enrollment Target of Rule 1200-13-01-.02 Definitions is amended by deleting the word “CHOICES” after the number and word “2 or” and inserting a comma and phrase “, any ECF CHOICES Group, or Katie Beckett Group Part A or Medicaid Diversion Group Part B” after the word and number “Group 3”, so as amended Subparagraph (a) shall read as follows:

- (a) The maximum number of individuals who can be enrolled in CHOICES Group 2 or Group 3, any ECF CHOICES Group, or Katie Beckett Group Part A or Medicaid Diversion Group Part B at any given time, subject to the exceptions provided in this Chapter.

Subparagraph (b) of Paragraph (72) Enrollment Target of Rule 1200-13-01-.02 Definitions is amended by adding the words “each group” and deleting the phrase “CHOICES Group 2 or CHOICES Group 3” after the words “slots in” so as amended Subparagraph (b) shall read as follows:

- (b) The Enrollment Target is not calculated on the basis of “unduplicated participants.” Vacated slots in each group may be refilled immediately, rather than being held until the next program year, as is required in the HCBS Waiver programs.

Paragraph (76) Family Caregiver and Training of Rule 1200-13-01-.02 Definitions is amended by deleting the word “only” after the phrase “of ECF CHOICES” and by adding “and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B” at the end of the paragraph so as amended the paragraph shall read as follows:

- (76) Family Caregiver Education and Training. For purposes of ECF CHOICES and limited to members enrolled in ECF CHOICES Group 4 (Essential Family Supports) and for purposes of the Katie Beckett

Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B:

Paragraph (78) Family-to-Family Support of Rule 1200-13-01-.02 Definitions is amended by deleting the word “only” after the words of “of ECF CHOICES” and adding the phrase “and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B” at the end of the paragraph so as amended the paragraph shall read as follows:

(78) Family-to-Family Support. For purposes of ECF CHOICES and limited to members enrolled in ECF CHOICES Group 4 (Essential Family Supports) and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B:

Subparagraph (b) of Paragraph (78) Family-to-Family Support of Rule 1200-13-01-.02 Definitions is amended by adding the phrase “and Katie Beckett Group Part A and Medicaid Diversion Group Part B” after the word and number “Group 4” in the first sentence and by adding the phrase “or for children enrolled in Katie Beckett Group Part A, the comparable cost of institutional care requirement” at the end of the subparagraph so as amended the subparagraph shall read as follows:

- (b) Family-to-Family Support shall be reimbursed on a per member per month basis for each Member enrolled in ECF CHOICES Group 4 and Katie Beckett Part Group A and Medicaid Diversion Group Part B. The per member per month reimbursement of Family-to-Family Support shall not be counted against the member’s expenditure cap or for children enrolled in Katie Beckett Group Part A, the comparable cost of institutional care requirement.

Paragraph (81) Fiscal Employer Agent (FEA) of Rule 1200-13-01-.02 Definitions is amended by deleting the word “and” after the words “helps CHOICES” and replacing it with a comma “,” and by adding the comma and phrase “, and Katie Beckett Group Part A and Medicaid Diversion Group Part B” after “ECF CHOICES” and by adding a comma and phrase “, or Katie Beckett” after “ECF CHOICES” and before “HCBS” in the first sentence. Paragraph (81) is further amended by adding the phrase “and parents or legal guardians of Katie Beckett Group Part A and Medicaid Diversion Group Part B members participating in consumer direction of eligible Katie Beckett HCBS” at the end of the second sentence, and is amended in the last sentence by adding a comma and deleting the word “or” after the words “eligible CHOICES” and adding a comma and phrase “, or Katie Beckett” after “ECF CHOICES” so as amended the paragraph shall read as follows:

(81) Fiscal Employer Agent (FEA). An entity contracting with the State and/or one of the State’s contracted MCOs that helps CHOICES, ECF CHOICES, and Katie Beckett Group Part A and Medicaid Diversion Group Part B members participating in consumer direction of eligible CHOICES, ECF CHOICES, or Katie Beckett HCBS. The FEA provides both financial administration and supports brokerage functions for CHOICES and ECF CHOICES members participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS and parents or legal guardians of Katie Beckett Group Part A and Medicaid Diversion Group Part B members participating in consumer direction of eligible Katie Beckett 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, ECF CHOICES, or Katie Beckett HCBS authorized and provided.

Paragraph (84) Health Insurance Counseling/Forms Assistance of Rule 1200-13-01-.02 Definitions is amended by deleting the word “only” after the words “of ECF CHOICES” and by adding the phrase “and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B” at the end of the paragraph so as amended the paragraph shall read as follows:

(84) Health Insurance Counseling/Forms Assistance. For purposes of ECF CHOICES and limited to members enrolled in ECF CHOICES Group 4 (Essential Family Supports) and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B:

Paragraph (85) Home and Community Based Services (HCBS) of Rule 1200-13-01-.02 Definitions is deleted in its entirety and replaced with a new paragraph which shall read as follows:

(85) Home and Community-Based Services (HCBS). Services that are provided pursuant to a Section 1915(c) Waiver or the CHOICES, ECF CHOICES, or Katie Beckett program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX State Plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only specified CHOICES, ECF CHOICES, and Katie Beckett HCBS are eligible for Consumer Direction. CHOICES, ECF CHOICES, and Katie Beckett HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX State Plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES Group 2 member's needs can be safely met in the community within his or her individual cost neutrality cap, and whether the Comparable Cost of Institutional Care Requirement is met in order for a child to qualify for enrollment in Katie Beckett Group Part A or the Continued Eligibility Group Part C. The cost of home health and private duty nursing shall also be counted against the member's Expenditure Cap for members in ECF CHOICES Group 6 who are granted an exception to the Expenditure Cap based on exceptional medical and/or behavioral needs.

Paragraph (118) Level of Care (LOC) of Rule 1200-13-01-.02 Definitions is amended by deleting "NF care" and replacing it with "a particular LTSS program or service" after the words "criteria for" in the last sentence and replacing the words "the Bureau" with the word "TennCare" in the last sentence so as amended the paragraph shall read as follows:

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

Paragraph (120) Level 1 Nursing Facility (NF) Care Reimbursement of Rule 1200-13-01-.02 Definitions is deleted in its entirety and subsequent paragraphs are renumbered accordingly.

Paragraph (121) Level 2 Nursing Facility (NF) Care Reimbursement of Rule 1200-13-01-.02 Definitions is deleted in its entirety and subsequent paragraphs are renumbered accordingly.

Paragraph (131) Member of Rule 1200-13-01-02. Definitions is deleted in its entirety and replaced with a new paragraph which shall read as follows:

(131) Member. An individual who is enrolled in CHOICES, ECF CHOICES, or Katie Beckett Group Part A.

Paragraph (134) Minor Home Modification of Rule 1200-13-01-.02 Definitions is deleted in its entirety and replaced with a new paragraph which shall read as follows:

(134) Minor Home Modifications. For purposes of CHOICES, ECF CHOICES, and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B:

Paragraph (144) One-Time ECF CHOICES HCBS of Rule 1200-13-01-.02 Definitions is amended by deleting the phrase "Conservatorship and Alternatives to Conservatorship Counseling and Assistance" after "HCBS include:" and replacing it with the phrase "Decision Making Supports" so as amended the paragraph shall read as follows:

(144) One-Time ECF CHOICES HCBS. Specified ECF CHOICES HCBS other than employment services and supports which occur as a distinct event or which may be episodic in nature (occurring at less frequent irregular intervals or on an as needed basis for a limited duration of time). One-time ECF CHOICES HCBS

include: Decision Making Supports, Minor Home Modifications, Individual Education and Training Services, Specialized Consultation and Training, Adult Dental Services, Community Support Development, Organization and Navigation, Family Caregiver Education and Training, Assistive Technology, Adaptive Equipment and Supplies, Peer-to-Peer Support and Navigation for Person Centered Planning, Self-Direction, Integrated Employment/Self Employment, and Independent Community Living, Respite, Family-to-Family Support, and Health Insurance Counseling/Forms Assistance.

Paragraph (152) Person-Centered Support Plan (PCSP) of Rule 1200-13-01-.02 Definitions is deleted in its entirety and replaced with a new paragraph which shall read as follows:

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

Paragraph (163) Plan of Care of Rule 1200-13-01-.02 Definitions is amended by adding three sentences to the end of the paragraph so as amended the paragraph shall read as follows:

(163) Plan of Care. A written document that is developed in a manner consistent with 42 CFR §441.301(c)(1) 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. As it pertains to Part A of the Katie Beckett Program, the plan of care is a written document developed by the Nurse Care Manager through a person- and family-centered planning process that assesses the child's strengths, needs, goals and challenges; and outlines the services and supports (including unpaid supports voluntarily provided by family members and other caregivers, and paid services provided by private insurance, the MCO, and other payor sources) that will be provided to the child to meet the child's physical and behavioral health and long-term services and supports needs and support the child in achieving his or her individualized goals. As it pertains to Medicaid Diversion Group Part B, the plan of care is a written document developed by the DIDD Katie Beckett Case Manager through a person- and family-centered planning process that assesses the child's strengths, needs, goals and challenges; and outlines the home and community based services and supports that will be provided to the child to meet the child's needs and support the child in achieving his or her individualized goals. The child should be involved in helping to define his or her individualized goals and develop the plan of care to the maximum extent possible and appropriate. This planning process, and the resulting person-centered plan of care shall: 1) ensure the delivery of services in a manner that reflects the child and family's strengths, needs, preferences and choices; 2) assist the child in achieving personally defined outcomes in the most integrated community setting, which shall include planning and preparation for the child's transition to employment and community living with as much independence as possible upon

becoming an adult; and 3) help to engage, strengthen, support, and build the capacity and confidence of the family in order to ensure the child's safety, well-being and permanency. Services in the Katie Beckett Program shall be authorized, provided, and reimbursed only as specified in the plan of care. For purposes of Part A of the Katie Beckett Program "plan of care" shall be used interchangeably with "person-centered support plan" or "PCSP." For purposes of Medicaid Diversion Group Part B, "plan of care" shall be used interchangeably with "individual support plan" or "ISP."

Paragraph (175) Representative Agreement of Rule 1200-13-01-.02 Definitions is amended by adding the phrase "or the parent or legal guardian of a child enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B" after the words "ECF CHOICES member" and by adding a comma and deleting the word "or" after the words "eligible CHOICES" and before "ECF" and by adding a comma "," and phrase "or Katie Beckett" after "ECF CHOICES" so as amended the paragraph shall read as follows:

(175) Representative Agreement. The agreement between a CHOICES or ECF CHOICES member or the parent or legal guardian of a child enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B electing consumer direction of eligible CHOICES, ECF CHOICES, or Katie Beckett HCBS who has a representative direct and manage the consumer's worker(s) and the member's representative that specifies the roles and responsibilities of the member and the member's representative.

Paragraph (178) Respite of Rule 1200-13-01-.02 Definitions is amended by deleting the word "only" and replacing it with the phrase "and Katie Beckett Group Part A and Medicaid Diversion Group Part B only" so as amended the paragraph shall read as follows:

(178) Respite. For purposes of ECF CHOICES and Katie Beckett Group Part A and Medicaid Diversion Group Part B only:

Subparagraph (d) of Paragraph (178) Respite of Rule 1200-13-01-.02 Definitions is amended by adding "(applicable only to ECF CHOICES)" after the word and comma "caregivers, or" so as amended the subparagraph shall read as follows:

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

Part 3 of Subparagraph (a) of Paragraph (181) Safety Determination of Rule 1200-13-01-.02 Definitions is deleted in its entirety.

Subparagraph (a) of Paragraph (184) Self-Direction of Health Care Tasks of Rule 1200-13-01-.02 Definitions is amended by adding "or ECF CHOICES" after the word CHOICES and by adding the phrase "or the parent or legal guardian of a Katie Beckett Group Part A member" after "CD" and by adding a comma "," and phrase "ECF CHOICES, or Katie Beckett" after the words "Eligible CHOICES" so as amended the subparagraph shall read as follows:

- (a) The decision by a CHOICES or ECF CHOICES Member participating in CD or the parent or legal guardian of a Katie Beckett Group Part A member to direct and supervise a paid Worker delivering Eligible CHOICES, ECF CHOICES, or Katie Beckett HCBS in the performance of Health Care Tasks that would otherwise be performed by a licensed nurse.

Subparagraph (b) of Paragraph (184) Self-Direction of Health Care Tasks of Rule 1200-13-01-.02 Definitions is amended by adding the phrase "or ECF CHOICES" after the words "a CHOICES" and by adding the phrase "or the parent or other legal guardian of a child enrolled in Katie Beckett Group Part A of the Katie Beckett Program" after "CD" and by adding a comma and phrase ", ECF CHOICES, or Katie Beckett" after the words "Eligible CHOICES" so as amended the subparagraph shall read as follows:

- (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 or ECF CHOICES Member participating in CD or the parent or other legal guardian of a child enrolled in Katie Beckett Group Part A of the Katie Beckett Program may elect to have performed by a Consumer-Directed Worker as part of the delivery of Eligible CHOICES, ECF CHOICES, or Katie Beckett HCBS he is authorized to receive.

Paragraph (185) Service Agreement of Rule 1200-13-01-.02 Definitions is amended by adding a comma “,” and phrase “or the parent or legal guardian of a child enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B” after the phrase “(or the member’s representative)” the first time it appears and by adding the phrase “,parent or legal guardian,” after the phrase “member’s representative” the second time it appears so as amended the paragraph shall read as follows:

(185) Service Agreement. The agreement between a CHOICES or ECF CHOICES member (or the member’s representative), or the parent or legal guardian of a child enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B electing consumer direction of HCBS and the member’s consumer-directed worker that specifies the roles and responsibilities of the member (or the member’s representative, parent or legal guardian) and the member’s worker.

Paragraph (197) Supportive Home Care (SHC) of Rule 1200-13-01-.02 Definitions is amended by deleting the word and comma “only,” after the words “of ECF CHOICES” and adding the phrase “and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B” after the words “(Essential Family Supports)” so as amended the paragraph shall read as follows:

(197) Supportive Home Care (SHC). For purposes of ECF CHOICES and limited to members enrolled in ECF CHOICES Group 4 (Essential Family Supports) and for purposes of the Katie Beckett Program and limited to children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B:

Paragraph (198) Supports Broker of Rule 1200-13-01-.02 Definitions is amended by deleting the phrase “CHOICES or ECF CHOICES” and replacing it with the phrase “CHOICES, ECF CHOICES, or Katie Beckett” so as amended the paragraph shall read as follows:

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

Paragraph (209) Waiting List of Rule 1200-13-01-.02 Definitions is deleted in its entirety and replaced with a new paragraph which shall read as follows:

(209) Waiting List. For purposes of CHOICES and Katie Beckett Group Part A and Medicaid Diversion Group Part B, the list maintained by TennCare of individuals who have applied for CHOICES HCBS or for enrollment into the Katie Beckett Program, but who cannot be enrolled into the program (or for Katie Beckett, into the applicable program component) because an Enrollment Target has been reached.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-112, 71-5-164 and TennCare II Section 1115(a) Medicaid Demonstration Waiver Extension.

entirety.

Subparagraph (b) of Paragraph (6) of Rule 1200-13-01-.05 TennCare Choices Program is amended by deleting the phrase “Group 4 (for children under age 18) or” after “ECF CHOICES” and before “Group 5” in the third sentence so as amended Subparagraph (b) shall read as follows:

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

Subpart (iii) of Part 2 of Subparagraph (e) of Paragraph (6) of Rule 1200-13-01-.05 TennCare Choices Program is amended by deleting the phrase “, or for a child under age 18 who has an intellectual or developmental disability, how such event(s) or circumstances would impact the Applicant’s ability to remain in the family home” at the end of the subpart so as amended Subpart (iii) shall read as follows:

- (iii) Detailed explanation regarding any recent significant event(s) or circumstances that have impacted the Applicant’s need for services and supports, including how such event(s) or circumstances impact the Applicant’s ability to be safely supported within the array of covered services and supports that would be available if the Applicant were enrolled in CHOICES Group 3 or ECF CHOICES Group 5, as applicable.

Part 4 of Subparagraph (e) of Paragraph (6) of Rule 1200-13-01-.05 TennCare Choices Program is amended by deleting “, or for a child under age 18 who has an intellectual or developmental disability, why the availability of benefits in ECF CHOICES Group 4, including ECF CHOICES HCBS up to the Expenditure Cap of \$15,000, non-ECF CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care, are necessary to prevent the child’s imminent placement outside the home” at the end of the part so as amended Part 4 shall read as follows:

4. An explanation regarding why an array of covered services and supports, including CHOICES HCBS up to the Expenditure Cap of \$15,000, ECF CHOICES HCBS up to the Expenditure Cap of \$30,000 and one-time emergency assistance up to \$6,000; and non-CHOICES or non-ECF CHOICES HCBS (e.g., home health); services available through Medicare, private insurance or other funding sources; and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the Applicant’s needs in the community.

Part 1 of Subparagraph (f) of Paragraph (6) of Rule 1200-13-01-.05 TennCare Choices Program is amended by deleting “; or for a child under age 18 who has an intellectual or developmental disability, that the Applicant will not qualify financially for TennCare unless the deeming of the parent’s income to the child is waived, and absent the availability of benefits in ECF CHOICES Group 4, including ECF CHOICES HCBS up to the Expenditure Cap of \$15,000; non-ECF CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care, the child is at imminent risk of placement outside the home.” so as amended Part 1 shall read as follows:

1. A Safety Determination request shall be approved if there is sufficient evidence, as required

and determined by the Bureau, to demonstrate that the necessary intervention and supervision needed by the Applicant cannot be safely provided within the array of services and supports that would be available if the Applicant was enrolled in CHOICES Group 3 or ECF CHOICES Group 5, as applicable for the target population in which the Applicant will be enrolled, if eligible, including CHOICES HCBS or ECF CHOICES HCBS up to the Expenditure Cap of \$15,000 or \$30,000, as applicable, and one-time emergency assistance up to \$6,000, as applicable; non-CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and unpaid supports provided by family members and other caregivers who are willing and able to provide such care.

Part 1 of Subparagraph (h) of Paragraph (6) of Rule 1200-13-01-.05 TennCare Choices Program is amended by deleting “or for a child under age 18, when the child turns age 18 and the parent’s income is no longer deemed to the child” after the words and commas “Group 5, as applicable,” in the first sentence so as amended Part 1 shall read as follows:

1. Pursuant to 1200-13-01-.10(2)(h), Nursing Facility level of care based on an approved Safety Determination request may be approved by the Bureau for an open ended period of time or a fixed period of time with an expiration date based on an assessment by the Bureau of the Applicant’s medical condition and anticipated continuing need for inpatient nursing care, and how long it is reasonably anticipated that the Applicant’s needs cannot be safely and appropriately met in the community within the array of services and supports available if enrolled in CHOICES Group 3 or ECF CHOICES Group 5, as applicable. 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.

Part 2 of Subparagraph (h) of Paragraph (6) of Rule 1200-13-01-.05 TennCare Choices Program is amended by deleting the comma and phrase “,or for a child under age 18, when the child turns age 18 and the parent’s income is no longer deemed to the child” after the words “ECF CHOICES Group 5,” and before the comma and words “,the Applicant shall be” in the first sentence so as amended Part 2 shall read as follows:

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 or ECF CHOICES Group 5, the Applicant shall be provided with a Notice of appeal rights, including the opportunity to submit an appeal within 30 calendar days of receipt of this notice. Nothing in this section shall preclude the right of the Applicant to submit a new PAE (including a new Safety Determination request) establishing medical necessity of care before the Expiration Date has been reached or anytime thereafter.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-112, 71-5-164 and TennCare II Section 1115(a) Medicaid Demonstration Waiver Extension.

Item (III) of Subpart (ii) of Part 2 of Subparagraph (b) of Paragraph (4) of Rule 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for TennCare Reimbursement of Care in Nursing Facilities, Choices HCBS and PACE is amended by deleting the punctuation and word “; or” at the end of the item and replacing them with a period so as amended Item (III) shall read as follows:

- (III) For an ECF CHOICES Applicant age 21 or older, have an intellectual or developmental disability and be determined through approval of a Safety Determination Request to not be able to be safely served within the array of services and supports that would be available if the Applicant was enrolled in ECF CHOICES Group 5, including ECF

CHOICES HCBS up to the Expenditure Cap of \$30,000; one-time emergency assistance up to \$6,000; non-ECF CHOICES HCBS available through TennCare (e.g., home health); cost-effective alternative services (as applicable); services available through Medicare, private insurance or other funding sources; and natural supports provided by family members and other caregivers who are willing and able to provide such care.

Item (IV) of Subpart (ii) of Part 2 of Subparagraph (b) of Paragraph (4) of Rule 1200-13-01-.10 Medical (Level of Care) Eligibility Criteria for TennCare Reimbursement of Care in Nursing Facilities, Choices HCBS and PACE is deleted in its entirety.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-112, 71-5-164 and TennCare II Section 1115(a) Medicaid Demonstration Waiver Extension.

Rule Chapter 1200-13-01 TennCare Long - Term Care Programs is amended by adding Rule 1200-13-01-.11 Medical (Level of Care) Eligibility Criteria for TennCare Reimbursement of Care for Children in the Katie Beckett Program which shall read as follows:

1200-13-01-.11 Medical (Level of Care) Eligibility Criteria for TennCare Reimbursement of Care for Children in the Katie Beckett Program.

- (1) Definitions. See Rule 1200-13-01-.02.
- (2) PreAdmission Evaluations (PAE).
  - (a) A PAE is required in the following circumstances:
    1. To determine medical (LOC) eligibility for the Katie Beckett program. A child must have an approved PAE for the applicable LOC to be enrolled into the Katie Beckett program or to be on the waiting list for the Katie Beckett program.
    2. When a child requires continuation of the same LOC beyond an expiration date assigned by TennCare.
    3. When a child's condition has improved such that the previously approved LOC criteria may no longer be met.
    4. To determine medical (LOC) eligibility to transition from Medicaid Diversion Group Part B to Katie Beckett Group Part A, unless the child has an approved, unexpired PAE for institutional (LOC).
  - (b) A PAE is not required in the following circumstances:
    1. To transition from Katie Beckett Group Part A to Medicaid Diversion Group Part B unless the child's condition has improved such that a new PAE is needed to ensure the child would meet "at-risk" LOC.
    2. To transition from the Continued Eligibility Group Part C to Katie Beckett Group Part A.
  - (c) Medical (LOC) eligibility for children in the Katie Beckett program is determined only in accordance with these criteria established specifically for children under age 18.
  - (d) Subject to (f) below, an approved PAE for a child applying for Katie Beckett Group Part A or Medicaid Diversion Group Part B shall be valid for 365 calendar days beginning with the PAE Approval Date, unless an earlier expiration date is established by TennCare.
  - (e) A valid approved PAE that has not been used within 365 calendar days of the PAE Approval Date must be updated before it can be used for purposes of enrollment into Katie Beckett. To update a PAE for Katie Beckett, the physician 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 home-based services, including HCBS, are medically necessary and that the child's needs can be met at home. Such update need not occur until such time that there is a slot available for enrollment into Katie Beckett for which the child meets prioritization criteria. An updated PAE shall

not be required for purposes of remaining on the waiting list, unless 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 or the Applicant's LOC prioritization score.

- (f) 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 or the Applicant's LOC prioritization score, a new PAE shall be required.
- (g) A PAE must include a recent history and physical or current medical records that support the Applicant's functional and/or skilled nursing or rehabilitative needs, as reflected in the PAE. A history and physical performed within 365 calendar days of the PAE Request Date may be used if the Applicant's condition has not significantly changed. Medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed, or may be used in lieu of a history and physical, so long as the records provide medical evidence sufficient to support the functional and/or skilled or rehabilitative needs reflected in the PAE.
- (h) A PAE must be certified as follows:
  - 1. Physician certification shall be required for enrollment into Katie Beckett Group Part A and the Continued Eligibility Group Part C. Certification of the need for NF care may be performed by a nurse practitioner, clinical nurse specialist, or physician assistant, working in collaboration with a physician.
  - 2. Physician certification shall not be required for enrollment into Medicaid Diversion Group Part B.
  - 3. Certification of the level of care assessment by a Qualified Assessor shall be required for all PAEs.
- (i) A PAE may be approved by the Division for a fixed period of time with an expiration date based on an assessment by the Division 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.
- (j) 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.

(3) Level of Care Criteria for Katie Beckett Program.

- (a) Institutional Level of Care. There shall be two Tiers for Institutional LOC (Tier 1 and Tier 2).
  - 1. Tier 1 Institutional LOC. There shall be two types of Tier 1 Institutional LOC (Medical and Behavioral).

- (i) Tier 1 – Medical Institutional LOC. In order to qualify for Tier 1 – Medical Institutional LOC, all of the following must be met:
  - (I) The child has a medical diagnosis from a qualified treating medical professional of a severe, lifelong chronic medical condition with high mortality and morbidity rates resulting in severe functional limitations and complex medical needs;
  - (II) The child’s medical needs are chronic, persistent and expected to last at least twelve (12) months from the date of review;
  - (III) The child’s medical needs require high health care service needs and utilization (e.g., frequent ED visits and/or hospital admissions, multiple surgeries, multiple subspecialists);
  - (IV) The child’s overall health condition presents the constant potential for complications or rapid deterioration. As a result, the child requires continuous (round the clock) observation by an awake trained care provider—a professional nurse, parent, or others properly instructed to immediately detect potential life-threatening situations, respond promptly to render appropriate care, and perform emergency procedures to prevent hospitalization or death;
  - (V) The child’s medical needs require frequent, direct, skilled medical interventions (whether provided by a licensed nurse or by a parent or other caregiver who has been trained to provide such care), including skilled medical tasks that are performed multiple times during each 8-hour period and the use of medical equipment to sustain life and prevent life-threatening situations.
    - I. The frequency and complexity of the required skilled medical interventions must be so substantial that without these direct, continuous skilled medical interventions, the child is at imminent risk of institutionalization within an in-patient medical hospital.
    - II. The complex skilled medical interventions must include at least one (1) of the following:
      - A. Ventilator care or non-invasive positive pressure ventilation when required for at least 8 hours per day as a life-sustaining measure for chronic respiratory failure;
      - B. Tracheostomy care requiring suctioning multiple times each 8-hour period;
      - C. Oxygen administration for chronic hypoxia requiring at least 8 hours of oxygen use daily, round the clock monitoring of O<sup>2</sup> saturation levels, and titration of O<sup>2</sup> levels administered;
      - D. Parenteral Nutrition (TPN); and/or
      - E. Dialysis: hemodialysis or peritoneal, in home or at clinic.
    - III. Any interventions not specified above, including site care, shall not meet this criterion.
    - IV. The skilled care needs cannot be acute or of a short-term duration.
    - V. Tasks that are performed only when necessary (PRN) and are not required on an ongoing basis do not meet this criterion.
- (ii) Tier 1 – Behavioral Institutional LOC. In order to qualify for Tier 1 – Behavioral Institutional LOC, all of the following criteria must be met:

- (I) The child has one of the following:
  - I. Severe or profound deficits in intellectual and/or adaptive behavior functions, which must include significant communication deficits; or
  - II. Autism and a severe or profound communication disorder;
- (II) The child has severe co-occurring behavioral health support needs that have persisted for at least six (6) months and are expected to last at least twelve (12) months from the date of review and include persistent and dangerous behaviors that place the child or others at imminent and significant risk of serious physical harm. To meet this criterion, a child must demonstrate dangerous behaviors in at least one of the two dangerous behaviors categories:
  - I. Self-injurious behaviors. These behaviors include:
    - A. Self-hitting, cutting, scratching, burning, pinching, or picking. Repeated and intentional hitting one's self; cutting, burning, scratching, pinching, picking or abrading one's skin hard and frequently enough to break skin, or create a visible mark, burn or tissue damage (does not include piercing or tattooing);
    - B. Severe self-biting. Repeated, intentional and severe biting by child of child's own body parts, in attempt to rupture skin (does not include biting nails or cuticles or biting lip without intent to injure);
    - C. Tearing at or out body parts. Repeated, intentional and severe picking or tearing at body parts in a manner and degree that is likely to cause severe injury (includes rectal digging but does not include picking at a scab or scratches until a body part bleeds or hair pulling);
    - D. Inserting harmful objects into body orifices. Repeated and intentional insertion into body orifices of harmful objects that can tear or puncture the skin;
    - E. Head-banging. Repeated, intentional and severe banging one's head against hard surfaces;
    - F. Body slamming or dropping. Making contact between the body and any object with enough force to make a visible mark or forcefully falling to the floor with no visible cause to fall;
    - G. Self-gagging or strangulation. Any instance of using a hand or other object to induce gagging or vomiting, or strangulation involving the production of unconsciousness or near unconsciousness by restriction of the supply of oxygenated blood to the brain; and
    - H. Eating disorders, the effects of which must be life threatening, as determined by physician. In the case of Anorexia/Bulimia, the child must have malnutrition, electrolyte imbalances or body weight/development below 20th percentile due to the eating disorder or in the case of Pica or Prader Willi syndrome, must at least 4 days per week attempt to ingest non-edible substances or gorge self, as applicable, and require continuous (round-the-clock) "within arm's reach" supervision and immediate engagement of a paid or unpaid trained caregiver to prevent serious harm to the child.
  - II. Physically Aggressive Behaviors toward others:
    - A. A persistent pattern of physically aggressive behaviors not explained by the age or lack of maturity of the aggressor that results in serious

harm to others, or that would result in serious harm without intervention or restraints. Includes targeting of violent behaviors against a parent, sibling or other that results in serious harm, or that was intended to inflict serious harm even if actual harm did not occur, or if the act was interrupted and not carried out. May include hitting (using a hand or arm with a closed or open fist to make forceful physical contact with another person), hitting with objects (whether held or thrown), kicking (with foot or leg), headbutting (using the head or face to make forceful physical contact with another person), biting, scratching that breaks skin, pinching when hard enough to cause severe pain, forceful pushing, or hair pulling; or

- B. Sexually Aggressive Behavior. Attempts and/or successes at touching, groping, undressing others, or grabbing others in their private areas or making physical contact of a perceived sexual nature which is unwanted by the other person; sexual molestation or abuse of others.

III. The intensity and frequency of the dangerous behaviors is such that without continuous (round the clock) supervision and monitoring and direct, daily community-based therapeutic support and intervention, the child will engage in severe self-injury or physical aggression toward others and is at imminent risk for institutionalization in an inpatient psychiatric hospital or other placement outside the home (e.g., residential treatment, State custody, or incarceration), even if a formal mental health diagnosis (other than I/DD or autism) has not been made.

- A. Self-Injurious Behaviors and/or Physically Aggressive Behaviors must occur at least four days a week and require all of the following:

- (A) Continuous (round-the-clock) “eyes on” observation, supervision and immediate engagement of a paid or unpaid trained caregiver to prevent serious harm to the child or others;
- (B) Environmental or other restraints; and
- (C) Engagement of behavioral health professionals for treatment and support; or

- B. Self-Injurious behaviors and/or physically aggressive behaviors must occur at least once a week if the intensity of such behaviors routinely requires engagement of crisis supports, including behavior crisis teams, law enforcement, or emergency medical treatment to prevent or treat serious harm to the child or others.

IV. The child is involved with service systems and/or is receiving treatment from such service systems, but such involvement and/or treatment has not been effective in reducing the child’s behaviors or the significant risk of serious physical harm to the child or others, or in increasing the family’s capacity to effectively manage the child’s behaviors. Involvement with service systems must include at least one of the following:

- A. Crisis Mental Health Services. The child has an established pattern of utilization of crisis-related behavioral health services over the previous six months, which may include repeated mobile crisis calls, emergency department visits, psychiatric hospitalizations, and/or residential or intensive in-home treatment. The use of psychotropic medications (including PRN usage for purposes of chemical restraint in a behavioral crisis) is not considered a crisis-related behavioral health service. Nor is routine psychiatric care or outpatient therapy.

- B. Child Protective Services. The child has formal ongoing involvement with the child welfare system specifically related to his or her severe behavioral health needs.
  - C. Criminal Justice System. The child has been engaged with the criminal justice system in the past six months specifically related to his or her severe behavioral health needs. Includes Juvenile and Adult Justice Systems, if applicable.
2. Tier 2 Institutional LOC. There shall be three (3) standards for Tier 2 Institutional LOC (Medical, Behavioral, and Functional). A child must meet only one of these standards to meet Tier 2 Institutional LOC.
- (i) Tier 2 Institutional LOC - Standard 1: Medical. To meet Tier 2 Institutional LOC - Standard 1: Medical, a child must meet all of the following criteria:
    - (I) The child has a has a medical diagnosis from a qualified treating medical professional of a severe chronic medical condition expected to last at least twelve (12) months and which significantly diminishes his/her functional capacity and interferes with the ability to perform age appropriate activities of daily living at home and in the community;
    - (II) The child requires daily skilled nursing interventions and/or intensive therapy services as defined below:
      - I. Daily skilled nursing interventions may include any of the complex skilled medical interventions listed in Tier 1 – Medical Institutional LOC above (ventilator care or NIPPV, tracheostomy care, O<sup>2</sup> administration, TPN, and dialysis), including daily ventilator care or NIPPV for less than 8 hours per day, tracheostomy care requiring daily suctioning but not multiple times per each 8 hours, or daily O<sup>2</sup> use less than 8 hours daily.
      - II. Daily skilled nursing interventions may also include, but are not limited to, the following:
        - A. Tube feedings: G-tube, J-tube or NG-tubes;
        - B. Respiratory treatments for airway clearance: chest PT, C-PAP, Bi-PAP, vest device or cough assist device, IPPB treatments. This does not include inhalers or nebulizers.
        - C. Ileostomy, colostomy, or appendicostomy (Malone procedure) care; and
        - D. Need for urinary catheterization daily, or presence of vesicostomy or Mitrofanoff appendecovesicostomy.
      - III. PRN orders do not qualify as daily skilled nursing interventions.
      - IV. Site care, diabetes management, and medication administration, including topical or oral medication, eye drops, inhalers, nebulizers, growth hormone injections, insulin injections, or chemotherapy, shall not meet this criterion.
      - V. Intensive therapy services shall include only medically necessary physical, occupational, or speech therapy provided by a licensed professional therapist and shall apply only if the child is involved in six or more sessions per week with professional therapists.
    - (III) The child has at least two (2) substantial functional limitations in activities of daily living. For purposes of this rule, substantial functional limitations shall include only the following:
      - I. Learning: A substantial functional limitation in learning is defined as a 30% (25% if the child is under one year of age) or greater delay or a score of at

least 2 (1.5 if the child is under one year of age) standard deviations below the mean based on valid, standardized and norm referenced measures of aggregate intellectual functioning.

II. Communication: A substantial functional limitation in communication is defined as a 30% (25% if the child is under one year of age) or greater delay or a standard score of at least 2 (1.5 if the child is under one year of age) standard deviations below the mean on valid, standardized and norm referenced measures of both expressive and receptive communication functioning.

III. Self-Care: The child must demonstrate a deficit in at least one of the following five areas of self-care:

- A. Bathing
- B. Grooming
- C. Dressing
- D. Toileting
- E. Eating

If a child exhibits deficits in multiple of the self-care activities of daily living identified above, this shall still be counted as one substantial functional limitation (in self-care).

IV. Mobility: The inability to run or to move long distances or between environments related to stamina or ease of movement shall not constitute a mobility deficit.

(IV) The child requires an extraordinary (continuous or nearly continuous) level of hands on assistance from others throughout their day to complete everyday activities and supervision/intervention that is significantly beyond that which is routinely provided to other children of the same age; and

(V) The intensity and frequency of required skilled interventions and assistance with activities of daily living must be so substantial that it would require at least the level of direct, daily intervention that would be provided in a medical institution, i.e., a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(ii) Tier 2 Institutional LOC - Standard 2: Behavioral. To meet Tier 2 Institutional LOC - Standard 2: Behavioral, a child must meet all of the following criteria:

(I) The child has severe or profound deficits in intellectual or adaptive behavior functions, which must include significant communication deficits, or has autism and a severe or profound communication disorder;

(II) The child has severe co-occurring behavioral health support needs that have persisted for at least six (6) months and are expected to last at least twelve (12) months from the date of review, including self-injurious behaviors or physically aggressive behaviors toward others as defined in Subpart (3)(a)1(ii) above, including the intensity and frequency of behaviors, except that an extraordinary level of hands on assistance shall be required as defined in (IV) below;

(III) The child has at least two (2) substantial functional limitations in activities of daily living;

(IV) The child requires an extraordinary (continuous or nearly continuous) level of hands on assistance to complete everyday activities and supervision/intervention

from others throughout their day that is significantly beyond that which is routinely provided to other children of the same age; and

- (V) The intensity and frequency of required behavioral interventions and assistance with activities of daily living must be so substantial that it would require at least the level of direct, daily intervention that would be provided in a medical institution, i.e., a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).
- (iii) Tier 2 Institutional LOC - Standard 3: Functional. To meet Tier 2 Institutional LOC – Standard 3: Functional, a child must meet all of the following criteria:
  - (I) The child has an intellectual or developmental disability as defined in Rule 1200-13-01-02 and at least four (4) substantial functional limitations in activities of daily living that are expected to continue for at least 12 months;
  - (II) The child requires an extraordinary (continuous or nearly continuous) level of hands on assistance to complete everyday activities and supervision/intervention from others throughout their day that is significantly beyond that which is routinely provided to other children of the same age; and
  - (III) The intensity and frequency of assistance with activities of daily living must be so substantial that it would require at least the level of direct, daily intervention that would be provided in a medical institution, i.e., a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).
- (b) At-Risk Level of Care. There shall be two (2) standards for At-Risk LOC (I/DD and Medical). A child must meet only one of these standards to meet At-Risk LOC.
  - 1. At-Risk Level of Care Standard 1: I/DD. To meet At-Risk LOC – Standard 1: I/DD, a child must meet both of the following criteria:
    - (i) The child has an intellectual or developmental disability as defined in State law and regulation which significantly diminishes his/her functional capacity and interferes with the ability to perform age appropriate activities of daily living at home and in the community.
    - (ii) This child requires daily intermittent (not continuous) assistance from others to complete everyday activities that is significantly beyond that which is routinely provided to children of that age; or
  - 2. At-Risk Level of Care Standard 2: Medical. To meet At-Risk LOC – Standard 2: Medical, a child must meet both of the following criteria:
    - (i) The child has a medical diagnosis from a qualified treating medical professional of a severe chronic medical condition expected to last at least twelve (12) months and which significantly diminishes his/her functional capacity and interferes with the ability to perform age appropriate activities of daily living at home and in the community.
    - (ii) The child requires daily skilled nursing interventions and/or intensive therapy services as defined in Tier 2 Institutional LOC Standard 1: Medical above.
    - (iii) The child has at least one (1) substantial functional limitation in activities of daily living requiring daily intermittent (not continuous) assistance from others to complete everyday activities that is significantly beyond that which is routinely provided to children of that age.
- (4) Katie Beckett LOC Determinations
  - (a) An Applicant for Katie Beckett shall first be reviewed for At-Risk LOC.

- (b) All At-Risk LOC determinations for Katie Beckett Applicants shall be made by DIDD in accordance with these rules.
  - (c) An Applicant must be approved for At-Risk LOC in order to be reviewed for Institutional LOC.
  - (d) DIDD will refer an Applicant approved for At-Risk LOC to also be reviewed for Institutional LOC if the Applicant meets certain triggers which indicate he or she may also meet Institutional LOC.
  - (e) The parent or legal guardian of a child applying for Katie Beckett may request that the child is reviewed for Institutional LOC, even if such triggers are not met.
  - (f) All initial Institutional LOC determinations for Katie Beckett Applicants shall be made by a neutral third party contracted with TennCare.
  - (g) All denials of Institutional LOC for Katie Beckett Applicants by the neutral third party shall be reviewed by a licensed physician before a denial can be issued.
  - (h) All Institutional LOC determinations are subject to final review and approval by TennCare.
- (5) PreAdmission Evaluation Denials and Appeal Rights.
- (a) An Applicant or the legal representative of the Applicant has the right to appeal the denial of a PAE and to request an Administrative Hearing by submitting a written letter of appeal to TennCare, Division of Long-Term Services and Supports, within thirty (30) calendar days of receipt of the notice of denial.
  - (b) If an Applicant or the legal representative of the Applicant appeals the denial of Institutional LOC, the appellant may request and TennCare will arrange as part of the appeal review, a peer-to-peer review with the child's treating physician in order to gather any additional information regarding the child's medical, behavioral, or functional needs. This information shall be reviewed to determine whether the denial should be overturned prior to the case proceeding to hearing.
  - (c) If TennCare 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. This notice shall advise the Applicant of the right to appeal the denial decision within thirty (30) calendar days and the opportunity to request a peer-to-peer review with the child's treating physician. 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.
    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 (5)(b)1.
  - (d) 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.
  - (e) Reasonable accommodations shall be made for Applicants with disabilities who require assistance with an appeal.
  - (f) Any Notice required pursuant to this section shall be a plain language written Notice.
  - (g) 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.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-112, 71-5-164 and TennCare II Section 1115(a) Medicaid Demonstration Waiver Extension.

First column "Service" of Part 7 Conservatorship Counseling and Assistance of Subparagraph (d) of Paragraph (7) of Rule 1200-13-01-.31 TennCare Employment and Community First CHOICES (ECF CHOICES) Program is amended by deleting the phrase "Conservatorship Counseling and Assistance" and replacing it with the phrase "Decision Making Supports" so as amended Part 7 shall read as follows:

Service	Benefits for ECF CHOICES Members	Benefits for Consumer Direction  ("Eligible ECF CHOICES HCBS")
7. Decision Making Supports	Covered. Limited to five hundred dollars (\$500) in one-time assistance per member.  Legal or court fees may be reimbursed only upon completion of counseling services to protect and preserve individual rights and freedoms.	No

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-112, 71-5-164 and TennCare II Section 1115(a) Medicaid Demonstration Waiver Extension.

Rule Chapter 1200-13-01 TennCare Long - Term Care Programs is amended by adding Rule 1200-13-01-.32 TennCare Katie Beckett Program which shall read as follows:

1200-13-01-.32 TennCare Katie Beckett Program.

- (1) Definitions. See Rule.02.
- (2) Program components. The TennCare Katie Beckett Program offers services and supports to children under age 18 with disabilities and/or complex medical needs who are not Medicaid eligible because of their parents' income or assets. The program has two primary components:
  - (a) Katie Beckett Group Part A is a "traditional" Katie Beckett model, providing full Medicaid eligibility by waiving the deeming of the parents' income and assets to the child, as well as wraparound HCBS to children with the most significant disabilities or complex medical needs who meet institutional level of care, and for whom the estimated amount that would be expended by the Medicaid program for care outside an institution is not greater than the estimated amount that would otherwise be expended by the Medicaid program to provide the child's care within an appropriate institution. The program is designed to supplement a child's primary insurance coverage in order to help fill gaps between the child's needs and what private insurance will cover, including essential wraparound services not typically covered by insurers, including Medicaid. Children in Katie Beckett Group Part A are enrolled in a special component of TennCare Select called Select Community, developed specifically for people with I/DD. TennCare Select is responsible for coordinating all medically necessary, covered physical and behavioral health services, including EPSDT benefits, and wraparound HCBS for children who qualify for and are enrolled in Katie Beckett Group Part A.
  - (b) Medicaid Diversion Group Part B is a Medicaid diversion program, offering a capped package of essential wraparound services and supports, as well as premium assistance on a sliding fee scale to a broader group of children with disabilities, including those "at risk" of institutionalization. These

children do not qualify for Medicaid state plan benefits and are not assigned to a TennCare MCO. DIDD is responsible for coordinating all covered wraparound services and supports for children who qualify for and are enrolled in Medicaid Diversion Group Part B.

- (c) In addition to the two primary components of the Katie Beckett program, a demonstration population category, called the Continued Eligibility Group Part C, provides continuity of coverage, benefits, and providers, by allowing a child to continue receiving TennCare state plan services upon being determined to no longer qualify for Medicaid in any other eligibility category if the child meets the Katie Beckett Group Part A group eligibility criteria, but a slot is not available for the child at the time Medicaid financial eligibility would otherwise end. The child may only remain in this Group until a slot is available in Katie Beckett Group Part A. For a child who qualifies for and is enrolled in the Continued Eligibility group Part C, the child's MCO is responsible for coordinating all covered physical and behavioral health services, including EPSDT benefits.

(3) Eligibility for Katie Beckett. There are three (3) groups in the Katie Beckett Program:

- (a) Katie Beckett Group Part A, a "traditional" Katie Beckett program. To be eligible for Katie Beckett Group Part A, an Applicant must meet all of the following criteria:

1. Must be under age 18;
2. Have medical needs that are likely to last at least 12 months or result in death and which result in severe functional limitations;
3. Qualify for the level of care provided in a medical institution according to criteria established by TennCare for children, as described in Rule .11;
4. A licensed physician must agree and certify that in-home care will meet the child's needs;
5. Would qualify for SSI on the basis of the child's disability, except for the parents' income and/or assets;
6. Is not otherwise Medicaid eligible or receiving LTSS in another Medicaid program;
7. Qualify financially in the Katie Beckett Group Part A demonstration population category;
8. The estimated amount that would be expended by the Medicaid program for the child's care outside an institution is not greater than the estimated amount that would otherwise be expended by the Medicaid program for the child's care within an appropriate institution, as described in Paragraph (4)(d);
9. Purchase and maintain minimum essential coverage private or employer-sponsored insurance; however, TennCare may choose to offer Assistance with Premium Payments for such coverage if the child requests and qualifies for a hardship exception;
10. Pay premiums as described in Rule Chapter 1200-13-20, if family income is above 150% FPL; and
11. Have the most significant disabilities and/or complex medical needs and be prioritized for enrollment into an available slot in Katie Beckett Group Part A in accordance with prioritization criteria described in Paragraph (4)(c).

- (b) Medicaid Diversion Group Part B, a Medicaid Diversion program. To be eligible for enrollment in Medicaid Diversion Group Part B, Applicants must meet the following criteria:

1. Must be under age 18;

2. Have medical needs that are likely to last at least 12 months or result in death and which result in severe, functional limitations;
  3. Qualify for the level of care provided in a medical institution or be at risk of institutionalization, according to criteria established by TennCare for children, as described in Rule .11;
  4. Not otherwise Medicaid eligible or receiving LTSS in another Medicaid program;
  5. Qualify financially in the Medicaid Diversion Group Part B demonstration population category;
  6. Not eligible for Katie Beckett Group Part A or not enrolled in Katie Beckett Group Part A due to program enrollment targets; and
  7. Next in line for enrollment into an available slot in Medicaid Diversion Group Part B based on date of referral or once a Medicaid Diversion Group Part B waiting list is established, the date of placement on the Medicaid Diversion Group Part B waiting list.
- (c) Continued Eligibility Group Part C. To be eligible for enrollment in the Continued Eligibility Group Part C, Applicants must meet the following criteria:
1. All of the criteria specified in (3)(a)(1-8) above;
  2. Enrolled in Medicaid, but determined by TennCare to no longer qualify in any other Medicaid category; and
  3. Cannot be enrolled into Katie Beckett Group Part A, because there is not a Katie Beckett Group Part A program slot available based on program funding or the state's prioritization criteria. Once a Katie Beckett Group Part A slot is available for which the child is prioritized for enrollment, the child must transition to Katie Beckett Group Part A or be disenrolled from Medicaid unless eligible in another open Medicaid category, and shall no longer qualify in the Continued Eligibility Group Part C.
- (d) Level of Care (LOC). All Enrollees in Katie Beckett must meet the applicable LOC criteria, as determined by Rule.11.
- (4) Enrollment in Katie Beckett. Enrollment into the Katie Beckett Program shall be processed by TennCare as follows:
- (a) Enrollment Targets. There shall be separate Enrollment Targets for Katie Beckett Group Part A and Medicaid Diversion Group Part B. The Enrollment Target for each Part shall function as a cap on the total number of children who can be enrolled into that Part at any given time.
1. TennCare shall set the Enrollment Target for each Part (Katie Beckett Group Part A and Medicaid Diversion Group Part B) based on the funding appropriated for the Katie Beckett program. The Enrollment Target for each Part shall be limited as necessary to ensure that program spending does not exceed the funding appropriated for the program.
  2. TennCare shall post the Enrollment Target for each Part publicly on the TennCare website. DIDD shall also post the Enrollment Target for each Part publicly on the DIDD website.
  3. There shall be no Enrollment Target for the Continued Eligibility Group Part C.
  4. In order to enroll in Katie Beckett Group Part A or Medicaid Diversion Group Part B, 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.
  5. Once the Enrollment Target, including Reserve Capacity as described in this Rule, is reached for a particular Katie Beckett Part, Applicants shall not be enrolled into that Part or qualify in the

Katie Beckett Group Part A demonstration population or the Medicaid Diversion Group Part B demonstration population, until such time that capacity within the Enrollment Target is available, and the person is prioritized for enrollment into an available slot, as described in Subparagraph (c).

- (i) There are no exceptions to this Rule.
- (ii) If an Applicant is not permitted to proceed with enrollment into Katie Beckett Group Part A or Medicaid Diversion Group Part B because the applicable Enrollment Target has been reached, the Applicant shall remain on the Waiting List for the applicable Katie Beckett Part(s).

(b) Reserve Capacity.

1. At program implementation, TennCare shall reserve all available slots within the Katie Beckett Group Part A Enrollment Target. These slots will be available only to children who have a level of care prioritization criteria of one (1) through four (4), as described below in Subparagraph (c). The purpose of these reserve capacity slots shall be to ensure that children with the most significant medical needs and disabilities are enrolled into Katie Beckett Group Part A.
2. Only Applicants who meet specified reserve capacity criteria may be enrolled into reserve capacity slots.
3. Once all reserve capacity slots set aside have been filled, persons who meet such criteria shall not proceed with the enrollment process, but shall remain on the Waiting List for Katie Beckett Group Part A.
4. If an Applicant determined to meet medical eligibility for Katie Beckett Group Part A does not meet criteria for a Reserve Capacity slot, the Applicant shall not proceed with the enrollment process, but shall remain on the Waiting List for Katie Beckett Group Part A.

(c) Prioritization

1. Katie Beckett Group Part A
  - (i) Each child who meets any institutional level of care for enrollment into Katie Beckett Group Part A shall be prioritized for an available slot.
  - (ii) Each child shall have two (2) prioritization scores.
    - (I) Level of Care Prioritization.
      - I. The first prioritization score shall be based solely on the child's level of care eligibility, as follows:
        - A. A LOC prioritization score of one (1) shall be assigned to any child who meets Tier 1 – Medical Institutional LOC and requires ventilator care or non-invasive positive pressure ventilation for at least eight (8) hours per day as a life-sustaining measure for chronic respiratory failure.
        - B. A LOC prioritization score of two (2) shall be assigned to a child who meets Tier 1 – Medical Institutional LOC based on other complex skilled medical interventions.
        - C. A LOC prioritization score of three (3) shall be assigned to a child who meets Tier 1 – Behavioral Institutional LOC based on both self-injurious behaviors and physically aggressive behavior toward others.

- D. A LOC prioritization score of four (4) shall be assigned to a child who meets Tier 1 – Behavioral Institutional LOC based on either self-injurious behaviors or physically aggressive behavior toward others.
  - E. A LOC prioritization score of five (5) shall be assigned to a child who meets Tier 2 Institutional LOC - Standard 1: Medical.
  - F. A LOC prioritization score of six (6) shall be assigned to a child who meets Tier 2 Institutional LOC - Standard 2: Behavioral.
  - G. A LOC prioritization score of seven (7) shall be assigned to a child who meets Tier 2 Institutional LOC - Standard 3: Functional.
- II. Children will be enrolled into an available Katie Beckett Group Part A program slot in numerical order in accordance with their LOC prioritization score. (For example, a child with a LOC prioritization score of 1 would be enrolled first; then a child with a LOC prioritization score of 2, then 3, etc.)
- (II) Other Prioritization Criteria.
- I. The second prioritization score shall be based solely on other prioritization criteria, as follows:
    - A. Prognosis of the child’s medical condition;
    - B. Intensive interventions;
    - C. Transportation and primary/specialty care needs;
    - D. Non-febrile seizures;
    - E. Nutrition/feeding;
    - F. Medications;
    - G. Caregiving; and
    - H. Additional caregiver burden.
  - II. Items considered within each domain, the value of the items, and the maximum scores and weightings of each domain shall be determined with input from a Technical Advisory Group comprised of clinical experts in treating children with complex medical needs and disabilities, parents of children with complex medical needs and disabilities; and advocacy representatives.
  - III. Each child determined eligible for Katie Beckett Group Part A shall have an other prioritization score between 0 and 100.
  - IV. The other prioritization score shall be taken into account only when two or more children have the same LOC prioritization score, it is the highest LOC prioritization score for an available program slot, and there are insufficient slots available to enroll all children with that LOC prioritization score. In that case, enrollment shall be based on the other prioritization criteria score for each child. The child with the highest other prioritization score would be enrolled first.

(III) In the event that two or more children have the same LOC prioritization scores, it is the highest LOC prioritization score for an available program slot, there are insufficient slots available to enroll all children with that LOC prioritization score, and two or more of the children also have the same other prioritization score, enrollment shall proceed in order based on the date each child was placed on the Katie Beckett Group Part A Waiting List..

2. Prioritization for Medicaid Diversion Group Part B shall be on a first come, first serve basis.
3. An Applicant or the Applicant's legal representative may request an administrative review of the Katie Beckett Group Part A prioritization score(s) at any time. This request shall be submitted to TennCare in writing.
4. An Applicant may submit additional information that may affect the Katie Beckett Group Part A prioritization score(s) to DIDD at any time.
5. An Applicant shall not be granted a fair hearing regarding his or her prioritization score(s).
6. An Applicant shall be entitled to a determination regarding his or her eligibility to enroll in the Katie Beckett program. If the application is denied, the Applicant is entitled to due process, including notice and the right to request a fair hearing, only when the Applicant is determined to meet prioritization criteria for an available program slot and will be enrolled into the program if all applicable eligibility and enrollment criteria are met.

(d) Comparable Cost of Institutional Care.

1. To qualify for enrollment in Katie Beckett Group Part A or in the Continued Eligibility Group Part C, the estimated amount that would be expended by the Medicaid program for the child's care outside an institution cannot be greater than the estimated amount that would otherwise be expended by the Medicaid program for the child's care within an appropriate institution. This shall be called the "Comparable Cost of Institutional Care Requirement."
2. The appropriate institution depends on the institutional level of care the child would otherwise qualify to receive, as determined by LOC eligibility criteria in Rule .11. For a child who meets either Tier 1 – Medical Institutional LOC or Tier 1 – Behavioral Institutional LOC, the appropriate institution shall be based on the level of care the child is at imminent risk of needing if medical assistance is not provided in the child's home.
  - (i) For a child determined to meet Tier 1 – Medical Institutional LOC, the comparable cost of institutional care shall be based on the average cost of pediatric inpatient medical hospitalization as determined by TennCare. The basis of such cost shall be for non-critical care (i.e., outside the intensive care unit).
  - (ii) For a child determined to meet Tier 1 – Behavioral Institutional LOC, the comparable cost of institutional care shall be based on the average cost of pediatric inpatient psychiatric hospitalization as determined by TennCare.
  - (iii) For a child determined to meet Tier 2 – Institutional LOC, the comparable cost of institutional care shall be based on the average cost of services in a private Intermediate Care Facility for Individuals with Intellectual Disabilities, as determined by TennCare.
  - (iv) The comparable cost of institutional care for each applicable type of medical institution specified above may be adjusted annually as determined by TennCare.
3. Application of the Comparable Cost of Institutional Care Requirement.

- (i) As part of the LOC eligibility determination process, TennCare or its third party contractor shall gather information regarding the Medicaid services expected to be needed upon enrollment in Katie Beckett. This may include but is not limited to review of medical records, recommendations of the child's treating physician, or information provided by the child's parent or legal guardian.
- (ii) For children enrolled in Medicaid but determined to no longer qualify in any other open Medicaid category that are seeking enrollment in Katie Beckett Group Part A or the Continued Eligibility Group Part C, actual Medicaid utilization and expenditures shall be considered in estimating the cost of providing care in the home and community.
- (iii) In order to qualify for enrollment in Katie Beckett Group Part A or the Continued Eligibility Group Part C, the child's parent or legal guardian must sign a form confirming understanding of the Comparable Cost of Institutional Care Requirement and acknowledging that the child's eligibility for initial and continued enrollment in Katie Beckett Group Part A or the Continued Eligibility Group Part C is dependent on the child meeting and continuing to meet the Comparable Cost of Institutional Care Requirement as described in this rule.
- (iv) If the actual cost of a child's Medicaid services exceeds the comparable cost of institutional care (prior to or during enrollment in the Katie Beckett Program), TennCare may reasonably expect that the estimated cost of services Medicaid would provide is greater than the comparable cost of institutional care, unless the child's needs have changed significantly such that the same level of services will no longer be required going forward.
- (v) The estimated cost of Medicaid services outside an institution shall include at least the following:
  - (I) The estimated cost of pediatric home health or private duty nursing services that would be provided by TennCare;
  - (II) The estimated cost of physical, occupational, speech, language and hearing services that would be provided by TennCare;
  - (III) The estimated cost of community-based behavioral health services that would be provided by TennCare (i.e., all non-hospital services, including community-based residential treatment, when applicable);
  - (IV) The estimated cost of durable medical equipment;
  - (V) For children who will be enrolled in Katie Beckett Group Part A only, the estimated cost of any wraparound HCBS the child will receive.
- (vi) Services for a child enrolled in Katie Beckett Group Part A or the Continued Eligibility Group Part C shall not be denied on the basis that the comparable cost of institutional care would be exceeded.
- (vii) TennCare shall take action as appropriate to deny enrollment or to disenroll a child who no longer qualifies for enrollment in Katie Beckett Group Part A or the Continued Eligibility Group Part C because the Comparable Cost of Institutional Care Requirement is not met.
- (viii) The Comparable Cost of Institutional Care Requirement shall be applied on a calendar year basis. For children enrolled in Katie Beckett Group Part A and the Continued

Eligibility Group Part C, TennCare and the child's MCO shall estimate and track actual cost of services as provided in subpart (v) across each calendar year.

- (ix) The Comparable Cost of Institutional Care Requirement shall also be applied prospectively on a twelve (12) month basis. This is to ensure that a child's PCSP does not establish a threshold level of supports that cannot be sustained over the course of time. This means that, for purposes of person and family-centered support planning, the child's MCO will always estimate the actual cost of services forward for twelve (12) months in order to determine whether the Comparable Cost of Institutional Care Requirement will continue to be met based on the most current PCSP that has been developed. The cost of one-time services such as short-term services or short-term increases in services must be counted as part of the total cost of services for a full twelve (12) month period following the date of service delivery.
  - (x) If it can be reasonably anticipated, based on the services actually received or determined to be needed that the cost of Medicaid services in the community will exceed the comparable cost of Medicaid services in the appropriate institution, the child does not qualify to enroll in or to remain enrolled in Katie Beckett Group Part A or the Continued Eligibility Group Part C.
  - (xi) As the setting of a child's Comparable Cost of Institutional Care does not, in and of itself, result in any increase or decrease in a child's services, it is not considered an adverse action or give rise to appeal rights unless it will result in an adverse enrollment action.
  - (xii) Denial of enrollment and/or involuntary disenrollment because a child's comparable cost of institutional care will be exceeded shall constitute an eligibility/enrollment action, and shall give rise to notice of action and due process rights to request a fair hearing in accordance with this rule.
- (5) Disenrollment from Katie Beckett. A Member may be disenrolled from Katie Beckett voluntarily or involuntarily.
- (a) Voluntary disenrollment from Katie Beckett means the child's parent or legal guardian has chosen to disenroll the child from the program, including all applicable benefits the child is receiving (see Paragraph (6)). Voluntary disenrollment from Katie Beckett Group Part A or the Continued Eligibility Group Part C includes voluntary disenrollment from Medicaid. No notice of action shall be issued regarding a parent or legal guardian's decision to voluntarily disenroll the child from Katie Beckett. Voluntary disenrollment shall proceed only upon one of the following:
    - 1. Receipt of a statement signed by the child's parent or legal guardian voluntarily requesting disenrollment;
    - 2. The child's admission to a medical institution for a period of at least thirty (30) days unless the child is reasonably expected to discharge home soon, and upon determination of Medicaid eligibility in another category; or
    - 3. Election by the parent or legal guardian to enroll a child in Katie Beckett Group Part A in an MCO that does not administer Part A of the Katie Beckett program (i.e., any MCO other than TennCare Select.
  - (b) A child may be involuntarily disenrolled from Katie Beckett only by TennCare, although such process may be initiated by DIDD or TennCare's Contracted MCO. Reasons for involuntary disenrollment include but are not limited to:
    - 1. The child no longer meets one or more criteria for eligibility and/or enrollment as specified in this Rule.

2. The child is deceased.
3. The child is no longer a resident of Tennessee.

(6) Benefits in the Katie Beckett Program.

(a) Katie Beckett Group Part A

1. Children enrolled in Katie Beckett Group Part A are eligible to receive all medically necessary covered benefits available for children enrolled in TennCare Medicaid, as specified in Rule 1200-13-13-.04, including EPSDT, and medically necessary covered wrap around HCBS as specified below.
2. All Katie Beckett Group Part A HCBS must be specified in an approved Person-Centered Support Plan and authorized by the MCO prior to delivery of the service in order for MCO payment to be made for the service.
3. Katie Beckett Group Part A HCBS shall be limited to a maximum of \$15,000 per child per calendar year. There are no exceptions to this limit.

(b) Medicaid Diversion Group Part B

1. Children enrolled in Medicaid Diversion Group Part B are not eligible to receive Medicaid State Plan services or EPSDT.
2. Children enrolled in Medicaid Diversion Group Part B are eligible to receive a capped package of HCBS only, as specified below.
3. Medicaid Diversion Group Part B HCBS shall be limited to a maximum of \$10,000 per child per calendar year. There are no exceptions to this limit.
4. All Medicaid Diversion Group Part B HCBS must be specified in an approved ISP and authorized by DIDD prior to delivery of the service in order for payment to be made for the service.

(c) Continued Eligibility Group Part C

1. Children enrolled in the Continued Eligibility Group Part C are eligible to receive all medically necessary covered benefits available for children enrolled in TennCare Medicaid, as specified in Rule 1200-13-13-.04, including EPSDT.
2. Children enrolled in the Continued Eligibility Group Part C are not eligible to receive any wraparound HCBS.

(d) Katie Beckett Group Part A (“Part A”) wraparound HCBS and Medicaid Diversion Group Part B (“Part B”) HCBS covered under the Katie Beckett Program and applicable individual benefit limits are specified below. The benefit limits are applied across all services received by the child 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. Limitations on the total of all HCBS that can be received in a calendar year are specified in (a) and (b) above.

Katie Beckett HCBS Benefits	Katie Beckett Coverage	Available through Consumer Direction?  ("Eligible Katie Beckett HCBS")

Respite	<p>Covered as medically necessary in Part A and Part B with limitations as follows:</p> <p>Up to thirty (30) days of service per person per calendar year or up to two hundred sixteen (216) hours per person per calendar year, depending on needs and preferences as reflected in the PCSP, or in the DIDD-approved ISP for Part B members.</p> <p>The two (2) limits cannot be combined in a calendar year.</p>	Yes, hourly only. Daily respite is not available in Consumer Direction.
Supportive Home Care	Covered as medically necessary in Part A and Part B.	Yes
Assistive Technology, Adaptive Equipment and Supplies	<p>Covered as medically necessary in Part A and Part B with a limit of five thousand dollars (\$5,000) per child per calendar year.</p> <p>Not covered under Katie Beckett if available under Section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. §§ 1401 et seq.).</p>	No
Minor Home Modifications	Covered as medically necessary in Part A and Part B in accordance with limitations specified in Rule .02 and with limits of \$6,000 per project, \$10,000 per calendar year, and \$20,000 per lifetime.	No
Vehicle Modifications	Covered as medically necessary in Part A and Part B in accordance with limitations specified in Rule .02 and with limits of \$10,000 per calendar year and \$20,000 per lifetime.	No
Community Integration Support Services	<p>Covered as medically necessary in Part A and Part B in accordance with limitations specified in Rule .02.</p> <p>Payment for attendance and materials and supplies at classes and conferences and club/association dues can be covered, but cannot exceed five hundred dollars (\$500) per year.</p>	No
Community Transportation	<p>Covered as medically necessary in Part A and Part B for transportation to support participation in community activities when family, public or other community-based transportation services are not available or when assistance is needed in order to access such benefits.</p> <p>Shall not supplant NEMT available for medical appointments.</p> <p>Limited to \$225 per month for a child whose parent or legal guardian elects to receive this benefit through Consumer Direction.</p>	Yes
Family Caregiver Education and Training	<p>Covered as medically necessary in Part A and Part B only when approved in advance by the child's MCO.</p> <p>Limited to five hundred dollars (\$500) per calendar year.</p>	No

Decision Making Supports	<p>Covered as medically necessary in Part A and Part B. Limited to five hundred dollars (\$500) in one-time assistance per child.</p> <p>Legal fees may be reimbursed only upon completion of counseling services to protect and preserve the child's rights and freedoms upon attaining age 18.</p>	No
Family-to-Family Support	Covered as medically necessary in Part A and Part B.	No
Community Support Development, Organization and Navigation	Covered as medically necessary in Part A and Part B.	No
Health Insurance Counseling/Forms Assistance	<p>Covered as medically necessary in Part A and Part B.</p> <p>Limited to fifteen (15) hours per child per calendar year.</p>	No
Assistance with Premium Payments	<p>Covered as medically necessary in Part B.</p> <p>Limited to the amount determined to be the child's portion of third party liability (TPL) coverage premiums, when other family members are also covered by the same premium.</p> <p>Assistance with Premium Payments may be offered to a child upon enrollment in Part A only if the child does not have TPL at the time of enrollment and a hardship exception to the requirement to obtain/maintain TPL is requested and would otherwise be approved. In such cases, the Assistance with Premium Payments shall be limited to the amount by which the child's portion of the family's monthly TPL premium exceeds the Katie Beckett Group Part A premiums, and shall not count against the \$15,000 per calendar year expenditure cap for Part A wraparound HCBS. Assistance with Premium Payments shall not be covered for a child who already has private insurance upon enrollment into Katie Beckett Group Part A, even if such coverage is later lost and new coverage must be obtained.</p>	No

Automated health care and related expenses reimbursement	<p>Covered as medically necessary in Part B only.</p> <p>Limited to medical and dental expenses determined by the IRS to be qualified for reimbursement under a Healthcare Reimbursement Account or that would qualify for the medical and dental expenses income tax deduction, except that health insurance premiums shall be covered only as described above as part of the Health Insurance Premium Assistance benefit (and not as part of this benefit).</p> <p>Acceptable documentation must be provided to the contracted entity administering the benefit in order for the benefit to be covered and reimbursement approved. The child's parent or legal guardian shall comply with all applicable requirements of the administering entity in order to receive this benefit.</p>	No
Individualized therapeutic support reimbursement	Covered in Part B only for items determined to be medically necessary for the child but not eligible for reimbursement as part of the automated health care and related expenses reimbursement benefit above (i.e., does not meet IRS guidelines).	No

(7) Medical Necessity for Covered Katie Beckett Services

- (a) State Plan and EPSDT benefits. Medical necessity for all covered State Plan and EPSDT benefits, including physical and behavioral health, pharmacy, and dental services, for children enrolled in Katie Beckett shall be determined in accordance with Rule Chapter 1200-13-16. This includes all benefits for children eligible for Medicaid in the Continued Eligibility Group Part C.
- (b) Katie Beckett Group Part A wraparound HCBS and Medicaid Diversion Group Part B Benefits. For Katie Beckett Group Part A wraparound HCBS and all Medicaid Diversion Group Part B Benefits, pursuant to Rule 1200-13-16-.05(8), the following guidelines shall apply:
- (c) In order to be medically necessary and therefore reimbursable as a covered Katie Beckett HCBS benefit, all of the following criteria must be met.
  - 1. The service, including the type, amount, frequency and duration, must be specified in an approved PCSP, or for Medicaid Diversion Group Part B members, in the ISP approved by DIDD.
  - 2. The service must be authorized by the appropriate entity, which shall be as follows:
    - (i) For Katie Beckett Group Part A wraparound HCBS, the person's MCO;
    - (ii) For Medicaid Diversion Group Part B benefits, the Department of Intellectual and Developmental Disabilities;
  - 3. The service, including the type, amount, frequency and duration, must meet one or more of the following:
    - (i) Be of direct therapeutic or ameliorative benefit to the child's medical needs or disabilities;
    - (ii) Support the child's full integration and participation in the community;

- (iii) Help to prepare the child for transition to employment and community living, with as much independence as possible; or
    - (iv) Support and sustain the family's ability to meet the child's medical, physical, behavioral, functional and other support needs and reduce or prevent the risk of out-of-home placement.
  - 4. The service must be the most cost-effective way of safely and effectively meeting the child's needs in the home or community setting. If a less costly service or support or mix of services and supports that is available would safely meet the child's needs in the community, the more expensive service requested is therefore not medically necessary and will not be provided.
  - 5. The service must not supplant assistance that family members, friends, or others are able and willing to provide or that is available through other paid or unpaid supports. This includes services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act, regardless of whether the family chooses to receive such services.
  - (d) TennCare or the entity responsible for authorizing HCBS may develop and implement guidelines which can be used to further clarify how these decisions are made with respect to a particular benefit.
  - (e) Notwithstanding (c) 1-6 above, any medical or related item or service purchased for a child enrolled in Medicaid Diversion Group Part B and determined by the IRS to be eligible as an itemized deduction on Schedule A (Form 1040 or 1040-SR), or eligible for payment or reimbursement through a Health Reimbursement Account, Health Savings Account or Flexible Spending Account shall meet medical necessity requirements.
- (8) Each child enrolling or enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B shall be subject to an Expenditure Cap on the HCBS benefit package the child is eligible to receive. Each benefit package has a distinct Expenditure Cap, outlined below:
- (a) For a child enrolled in Katie Beckett Group Part A, the expenditure cap shall be fifteen thousand dollars (\$15,000) per calendar year. The Expenditure Cap shall apply to Katie Beckett wraparound HCBS only (not other Medicaid services). All Katie Beckett Group Part A wraparound HCBS shall be counted against the Expenditure Cap, including the cost of minor home modifications.
  - (b) For a child enrolled in Medicaid Diversion Group Part B, the Expenditure Cap shall be ten thousand dollars (\$10,000) per calendar year. The Expenditure Cap shall apply to Medicaid Diversion Group Part B HCBS only (these are the only benefits the child is eligible to receive). All Medicaid Diversion Group Part B HCBS shall be counted against the Expenditure Cap, including the cost of minor home modifications.
    - 1. The Expenditure Cap shall be used to determine the total cost of Katie Beckett HCBS a child can receive while enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B. The Expenditure Cap functions as a limit on the total cost of Katie Beckett Group Part A or Medicaid Diversion Group Part B HCBS that can be provided by the MCO or DIDD to the child in the home or community setting. Katie Beckett HCBS in excess of a child's Expenditure Cap are non-covered benefits.
    - 2. For a child in Katie Beckett Group Part A, the total cost of Katie Beckett wraparound HCBS shall also be counted in applying the Comparable Cost of Institutional Care Requirement.
    - 3. A child shall not be entitled to receive services up to the amount of the Expenditure Cap. A child shall receive only those services that are medically necessary, as described in this Rule. Determination of the services that are medically necessary shall be based on a comprehensive assessment of the child's needs and the availability of Natural Supports and other (non-TennCare reimbursed) services to meet identified needs, which shall be conducted by the

child's Nurse Care Manager or DIDD Case Manager and subject to any applicable utilization management review and approval processes.

4. Application of the Expenditure Cap.

- (i) For a child enrolled in Katie Beckett Group Part A, TennCare State Plan services shall not be counted against the child's Expenditure Cap for Katie Beckett Group Part A wraparound HCBS.
- (ii) The annual HCBS Expenditure Cap shall be applied on a calendar year basis. TennCare and the child's MCO or DIDD will track utilization of HCBS across each calendar year.
- (iii) The HCBS Expenditure Cap shall also be applied prospectively on a twelve (12) month basis. This is to ensure that a child's PCSP/ISP does not establish a threshold level of supports that cannot be sustained over the course of time. This means that, for purposes of person and family-centered support planning, the child's MCO or DIDD will always estimate the actual cost of services forward for twelve (12) months in order to determine whether the Expenditure Cap will continue be met based on the most current PCSP/ISP 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 services for a full twelve (12) month period following the date of service delivery.
- (iv) Denial of or reductions of Katie Beckett HCBS based on a child's Expenditure Cap shall constitute an adverse action, as defined in Rule 1200-13-13-.01 and shall give rise to notice of action and due process rights to request a fair hearing in accordance with Rule 1200-13-13-.11.

(9) Consumer Direction (CD).

- (a) CD is a model of service delivery that affords the parent or legal guardian of a child enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B the opportunity to have more choice and control with respect to Eligible Katie Beckett HCBS that are needed by the child, in accordance with this Rule. CD is not a service or set of services.
- (b) Katie Beckett HCBS eligible for CD (Eligible Katie Beckett HCBS).
  - 1. CD shall be limited to the following HCBS:
    - (i) Supportive Home Care.
    - (ii) Hourly Respite. (Daily Respite shall not be available through CD.)
    - (iii) Community Transportation.
  - 2. Katie Beckett Group Part A or Medicaid Diversion Group Part B Members determined to need Eligible Katie Beckett HCBS may elect to receive one or more of the Eligible Katie Beckett HCBS through a Contract Provider, or they may participate in CD.
  - 3. Katie Beckett Members who do not need Eligible Katie Beckett HCBS shall not be offered the opportunity to enroll in CD.
  - 4. The model of CD that will be implemented in Katie Beckett is a modified budget authority model.
  - 5. Each Eligible Katie Beckett HCBS identified in the child's PCSP/ISP, that the child's parent or legal guardian elects to receive through CD shall have an individual monthly or annual budget, as specified below.

6. The amount of the budget authorized for each Eligible Katie Beckett HCBS the child's parent or legal guardian elects to receive through CD shall be based on a comprehensive needs assessment performed by the MCO Nurse Care Manager or DIDD Case Manager that identifies the child's needs, the availability of family and other unpaid caregivers to meet those needs, and the gaps in care for which paid Katie Beckett HCBS may be authorized.
  - (i) Each Eligible Katie Beckett HCBS received through CD shall have a separate budget.
  - (ii) The budget for each Eligible Katie Beckett HCBS received through CD shall be based on the number of units of that service the child is assessed to need, subject to applicable benefit limits and the child's Expenditure Cap.
  - (iii) Once the budget for each Eligible Katie Beckett HCBS is determined and authorized, the child's parent or legal guardian shall have flexibility to determine the rate of reimbursement for that service (subject to any limitations established by TennCare), and to purchase additional units of the service so long as the budget for that service is not exceeded.
  - (iv) The budget for each Eligible Katie Beckett HCBS shall be separately maintained. A child's parent or legal guardian shall not direct money from the budget for one Eligible Katie Beckett HCBS to purchase a different Eligible Katie Beckett HCBS, provided however, that a child's PCSP/ISP (and consequently, the budget for any affected Eligible Katie Beckett HCBS) may be amended based on the child's needs, as appropriate.
  - (v) Any money remaining in a child's monthly budget for Supportive Home Care or Community Transportation at the end of a month shall not be carried over to the next month, and cannot be used to purchase units of service in any other month.
  - (vi) Any money remaining in a child's annual budget for hourly Respite at the end of the calendar year shall not be carried over to the next year, and cannot be used to purchase additional units of service in a subsequent calendar year.
7. The amount of the budget for each Eligible Katie Beckett HCBS shall be authorized as follows:
  - (i) Supportive Home Care shall have a monthly budget if provided through Consumer Direction.
    - (I) A child's parent or legal guardian shall only direct CD Workers to provide Supportive Home Care up to the amount of the authorized monthly budget for that service.
    - (II) A child's parent or legal guardian shall not ask or allow a CD Worker to provide services in excess of the authorized monthly budget for that service.
    - (III) If a child's parent or legal guardian exhausts the child's authorized monthly budget for a service before the month has ended, additional services shall not be authorized for the remainder of the month.
    - (IV) If a child's parent or legal guardian is not able to manage services within the approved budget for the service, the child may not be able to remain in CD.
  - (ii) Community Transportation for children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B shall have a monthly budget if provided through CD.
    - (I) The monthly budget shall be based on the number of days in the month that the child is expected to need Community Transportation services.

- (II) The child's parent or legal guardian may receive the first month's budget allotment in advance. The advance monthly budget allotment shall be used to purchase only Community Transportation services as defined in this Rule Chapter.
  - (III) A child's parent or legal guardian may purchase Community Transportation services in the most cost-efficient manner possible, including public transportation (e.g., bus passes), paying a co-worker to share gas expenditures, etc.
  - (IV) A child's parent or legal guardian shall not reimburse any person who resides with the child for Community Transportation.
  - (V) The child's parent or legal guardian is obligated to maintain a Community Transportation log and receipts for Community Transportation expenditures as required by TennCare and to submit such information on a monthly basis to his MCO.
  - (VI) A child's parent or legal guardian shall only purchase Community Transportation up to the amount of the authorized monthly budget for that service.
  - (VII) The child's parent or legal guardian shall be reimbursed only for documented purchases of Community Transportation services submitted to the MCO.
  - (VIII) A child's parent or legal guardian shall not be reimbursed for Community Transportation services in excess of the authorized monthly budget for that service.
  - (IX) If a child's parent or legal guardian exhausts the child's authorized monthly budget for Community Transportation services before the month has ended, additional services shall not be authorized for the remainder of the month.
  - (X) If a child's parent or legal guardian is not able to manage services within the approved budget for the service, the child may not be able to remain in CD.
- (iii) Respite services for children enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B shall have an annual budget if provided through Consumer Direction.
- (I) The annual budget shall operate on a calendar year (January 1 through December 31).
  - (II) A child's parent or legal guardian who elects to receive the child's Respite through CD shall receive up to 216 hours per year of Respite services. (Daily Respite shall not be available through CD.)
  - (III) A child's parent or legal guardian shall only direct CD Workers to provide Respite services up to the amount of the authorized annual budget for that service.
  - (IV) A child's parent or legal guardian shall not ask or allow a CD Worker to provide services in excess of the authorized annual budget for that service.
  - (V) If a child's parent or legal guardian exhausts the child's authorized annual budget for Respite services before the calendar year has ended, additional services shall not be authorized for the remainder of the year.
  - (VI) If a child's parent or legal guardian is not able to manage services within the child's approved budget for the service, the child may not be able to remain in CD.

8. HH Services, PDN Services, and Katie Beckett HCBS other than those specified above shall not be available through CD.
- (c) Eligibility for CD. To be eligible for CD, a child must meet all of the following criteria:
1. Be a Member of Katie Beckett Group Part A or Medicaid Diversion Group Part B.
  2. Be determined by an MCO Nurse Care Manager or DIDD Case Manager, based on a comprehensive needs assessment, to need one or more Eligible Katie Beckett HCBS.
  3. The child's parent or legal guardian must be willing and able to serve as the Employer of Record for the child's Consumer-Directed Workers and to fulfill all of the required responsibilities for CD. In limited exceptional circumstances, TennCare may permit the child's parent or legal guardian to designate 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 child's parent or legal guardian or in limited exceptional circumstances, the Representative for CD by the FEA.
  4. The child's parent or legal guardian or in limited exceptional circumstances, the Representative for CD and any Workers employed to provide services through CD must agree to use the services of TennCare's contracted FEA to perform required Financial Administration and Supports Brokerage functions.
- (d) Enrollment in CD.
1. The parent or legal guardian of a child enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B assessed to need one or more Eligible Katie Beckett HCBS may elect to participate in CD at any time.
  2. Only the child's parent or legal guardian may make the decision whether the child will participate in CD. The child's parent or legal guardian must sign a CD participation form reflecting the decision.
  3. Representative. In limited exceptional circumstances, TennCare may permit the child's parent or legal guardian to designate a Representative for CD.
    - (i) A Representative for CD must meet all of the following criteria:
      - (I) Be at least eighteen (18) years of age;
      - (II) Have a personal relationship with the child and understand the child's support needs;
      - (III) Know the child's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, strengths and weaknesses; and
      - (IV) Be physically present in the child's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each Consumer-Directed Worker.
    - (ii) If a child's MCO Nurse Care Manager or DIDD Case Manager believes that the person selected as the Representative for CD does not meet the specified requirements (e.g., the Representative is not physically present in the child's residence at a frequency necessary to adequately supervise Workers), the MCO Nurse Care Manager or DIDD Case Manager may request that the child's parent or legal guardian select a different Representative who meets the specified requirements. If the child's parent or legal guardian does not select another Representative who meets the specified requirements,

the MCO or DIDD may, in order to help ensure the child's health and safety, submit to TennCare, for review and approval, a request to deny the child's participation in CD.

- (iii) A Representative for CD shall not receive payment for serving in this capacity and shall not serve as the child's paid Worker for any Consumer-Directed Service.
  - (iv) Representative Agreement. A Representative Agreement must be signed by the child's parent or legal guardian and the Representative in the presence of the MCO Nurse Care Manager or DIDD Case Manager. By completing a Representative agreement, the Representative confirms that he agrees to serve as the Representative for CD and that he accepts the responsibilities and will perform the duties associated with being a Representative for CD.
  - (v) A child's parent or legal guardian may change the Representative at any time by notifying the child's MCO Nurse Care Manager or DIDD Case Manager and the child's Supports Broker that he intends to change Representative. The child's MCO Nurse Care Manager or DIDD Case Manager 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 the child's MCO Nurse Care Manager or DIDD Case Manager, prior to the new Representative assuming his respective responsibilities.
- (e) Employer of Record.
- 1. If a child's parent or legal guardian elects to participate in CD, he must serve as the Employer of Record. In limited exceptional circumstances where TennCare permits the parent or legal guardian to designate a Representative for CD, the Representative must serve as the Employer of Record.
  - 2. The Employer of Record is responsible for the following:
    - (i) Finding, interviewing, hiring and firing Workers;
    - (ii) Determining Workers' duties and developing job descriptions;
    - (iii) Training Workers to provide personalized support based on the Member's needs and preferences;
    - (iv) Scheduling Workers;
    - (v) Ensuring there are enough Workers hired to provide all of the support needed by the child (including when the worker scheduled is unable to report to work);
    - (vi) Ensuring the Worker(s) keep correct time sheets for the services and supports provided;
    - (vii) Reviewing and approving hours reported by Consumer-Directed Workers;
    - (viii) Ensuring Workers provide only as much support as assigned to provide and as needed by the child;
    - (ix) Ensuring that no Worker provides more than 40 hours of support each week unless the parent or legal guardian of a child enrolled in Katie Beckett Group Part A or the Representative for CD has decided to pay overtime out of the child's approved budget (a Worker delivering services to a child enrolled in Medicaid Diversion Group Part B shall not be permitted to provide more than 40 hours of support each week);
    - (x) Managing the services the child needs within the child's approved budget for each service;

- (xi) Supervising Workers;
  - (xii) Evaluating Worker performance and addressing any identified deficiencies or concerns;
  - (xiii) Setting wages from a range of reimbursement levels established by TennCare;
  - (xiv) Reviewing and ensuring proper documentation for services provided; and
  - (xv) Developing and implementing as needed a Back-up Plan to address instances when a scheduled Worker is not available or fails to show up as scheduled.
- (f) Denial of Enrollment in CD.
1. Enrollment into CD may be denied by TennCare when:
    - (i) The child is not enrolled in TennCare or in Katie Beckett Group Part A or Medicaid Diversion Group Part B.
    - (ii) The child does not need one or more of the HCBS eligible for CD, as specified in the PCSP/ISP.
    - (iii) The child's parent or legal guardian is not willing or able to serve as the Employer of Record for the child's Consumer-Directed Workers and to fulfill all of the required responsibilities for CD, and does not meet limited exceptional circumstances as determined by TennCare or 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 child does not have an adequate Back-up Plan for CD.
    - (v) The child's parent or legal guardian or in limited exceptional circumstances, the Representative for CD, or the Consumer-Directed Workers he wants to employ, are unwilling to use the services of TennCare's contracted FEA to perform required Financial Administration and Supports Brokerage functions.
    - (vi) Other significant concerns regarding the child's participation in CD which jeopardize the health, safety or welfare of the child.
  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 Katie Beckett Group Part A or Medicaid Diversion Group Part B enrollees participating in CD:
    - (i) Financial Administration functions in the performance of payroll and related tasks; and
    - (ii) Supports Brokerage functions to assist the child's parent or legal guardian (or the Representative for CD) with other non-payroll related tasks such as the completion of CD enrollment paperwork and assistance with employer functions as requested.
  2. The FEA shall:
    - (i) Assign a Supports Broker to each Katie Beckett Member electing to participate in CD of Eligible Katie Beckett HCBS.
    - (ii) Provide initial and ongoing training to the child's parent or legal guardian (or the Representative for CD) on CD and other relevant issues.

- (iii) Verify Worker qualifications, including conducting background checks on Workers, enrolling Workers into TennCare, requesting from TennCare the assignment of Medicaid provider ID numbers, and holding TennCare provider agreements.
  - (iv) Provide initial and ongoing training to workers on CD and other relevant issues such as the use of the FEA time keeping system.
  - (v) Assist the child's parent or legal guardian (or the Representative for CD) 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. The parent or legal guardian of each child participating in CD is responsible for the development and implementation of a Back-up Plan that identifies how the parent or legal guardian or the Representative for CD will address situations when a scheduled Worker is not available or fails to show up as scheduled.
  2. The child's parent or legal guardian may not elect, as part of the Back-up Plan, to allow the child 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 child's parent or legal guardian or his Representative for CD 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 child's Back-up Plan for Consumer-Directed Workers shall be integrated into the child's Back-up Plan for services provided by Contract Providers and the child's PCSP/ISP.
  6. The MCO Nurse Care Manager or DIDD Case Manager shall review the Back-up Plan developed by the child's parent or legal guardian or his Representative for CD to determine its adequacy to address the child'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 Katie Beckett HCBS or the schedule at which such services are needed, changes in Workers (when such Workers also serve as a back-up to other Workers) and changes in the availability of paid or unpaid back-up Workers to deliver needed support.
  8. A child's parent or legal guardian may use Contract Providers to serve as back-up to Consumer Directed Workers only upon prior arrangement by the child's parent or legal guardian or Representative for CD with the Contract Provider, inclusion in the child's back-up plan, verification by the MCO Nurse Care Manager or DIDD Case Manager, prior approval by the MCO or DIDD, and subject to the child's Expenditure Cap as described in Rule 1200-13-01-.32(8). If the higher cost of services delivered by a Contract Provider would result in a child's Expenditure Cap being exceeded, the child's parent or legal guardian shall not be permitted to use Contract Providers to provide back-up workers. A child's MCO or DIDD 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) A child’s parent or legal guardian 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) A child’s parent or legal guardian 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 child’s parent or legal guardian shall not be permitted to employ any person who resides with the child enrolled in Katie Beckett to deliver Supportive Home Care or hourly Respite services. A child’s parent or legal guardian shall not reimburse any person who resides with the child for Community Transportation.
    - (iii) The child’s parent or legal guardian may elect to have a Worker provide more than one service, have multiple Workers, or have both a Worker and a Contract Provider for a given service, in which case, there must be a set schedule which clearly defines when Contract Providers will be used.
  - 2. Qualifications of Consumer-Directed Workers. Workers must meet the following requirements prior to providing services:
    - (i) Be at least eighteen (18) years of age or older;
    - (ii) Complete a background check that includes a criminal background check (including fingerprinting), or, as an alternative, a background check from a licensed private investigation company;
    - (iii) Verification that the person’s name does not appear on the State abuse registry;
    - (iv) Verification that the person’s name does not appear on the State and national sexual offender registries;
    - (v) Licensure verification, as applicable;
    - (vi) Verification that the person has not been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 128B(f) of the Social Security Act);
    - (vii) Complete all required training;
    - (viii) Complete all required applications to become a TennCare provider;
    - (ix) Sign an abbreviated Medicaid agreement;
    - (x) Be assigned a Medicaid provider ID number;
    - (xi) Sign a Service Agreement; and
    - (xii) If the Worker will be transporting the child 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 child's parent or legal guardian cannot waive the completion of a background check for a potential Worker. A background check may reveal a potential Worker's past criminal conduct that may pose an unacceptable risk to the child. Any of the following findings may place the child at risk and may disqualify a person from serving as a Worker:
  - (i) Conviction of an offense involving physical, sexual or emotional abuse, neglect, financial exploitation or misuse of funds, misappropriation of property, theft from any person, violence against any person, or manufacture, sale, possession or distribution of any drug; and/or
  - (ii) Entering of a plea of nolo contendere or when a jury verdict of guilty is rendered but adjudication of guilt is withheld with respect to a crime reasonably related to the nature of the position sought or held.
4. Individualized Assessment of a Consumer-Directed Worker with a Criminal Background.
  - (i) If a potential Worker's background check includes past criminal conduct, the child's parent or legal guardian or Representative for CD must review the past criminal conduct with the help of the FEA. The child's parent or legal guardian or Representative for CD, with the assistance of the FEA, will consider the following factors:
    - (I) Whether or not the evidence gathered during the potential Worker's individualized assessment shows the criminal conduct is related to the job in such a way that could place the child at risk;
    - (II) The nature and gravity of the offense or conduct, such as whether the offense is related to physical or sexual or emotional abuse of another person, if the offense involves violence against another person, or the manufacture, sale, or distribution of drugs; and
    - (III) The time that has passed since the offense or conduct and/or completion of the sentence.
  - (ii) After considering the above factors and any other evidence submitted by the potential Worker, the child's parent or legal guardian or Representative for CD must decide whether to hire the potential Worker.
  - (iii) If a child's parent or legal guardian or Representative for CD decides to hire the Worker, the FEA shall assist the child's parent or legal guardian or Representative for CD in notifying the child's MCO or DIDD of this decision and shall collaborate with the child's MCO or DIDD to amend the child's PCSP/ISP to reflect the parent's or legal guardian's or CD Representative's decision to voluntarily assume the risk associated with hiring an individual with a criminal history and that the child's parent or legal guardian or Representative for CD is solely responsible for any negative consequences stemming from that decision. The FEA shall also collaborate with the child's MCO or DIDD, as applicable, on a risk mitigation strategy.
5. Service Agreement.
  - (i) The child's parent or legal guardian or Representative for CD shall develop a Service Agreement with each Worker which includes, at a minimum:
    - (I) The roles and responsibilities of the Worker and the EOR;

- (II) The Worker's typical schedule, as developed by the parent or legal guardian or Representative for CD, including hours and days;
  - (III) The scope of each service, i.e., the specific tasks and functions the Worker is to perform;
  - (IV) The service rate; and
  - (V) The requested start date for services.
- (ii) The Service Agreement must be in place for each Worker prior to the Worker providing services.
6. Payments to Consumer-Directed Workers.
- (i) Rates. The parent or legal guardian of children participating in CD have the flexibility to set wages for the child's Workers from a range of reimbursement levels established by TennCare.
  - (ii) Payments to Consumer-Directed Workers. In order to receive payment for services rendered, all Workers must:
    - (I) Deliver services in accordance with the services specified in the child's PCSP or DIDD-approved ISP, the monthly or annual budget as approved in the MCO's or DIDD's service authorization, and in accordance with the schedule set by the child's parent or legal guardian or the Representative for CD and Worker assignments determined by the parent or legal guardian or the Representative for CD.
    - (II) Use the FEA time keeping system to record in and out times for each visit in a manner compliant with the 21<sup>st</sup> Century Cures Act.
    - (III) Provide detailed documentation of service delivery including but not limited to the specific tasks and functions performed for the child at each visit, which shall be maintained in the child's home.
    - (IV) Provide no more than forty (40) hours of services within a consecutive seven (7) day period, unless explicitly directed by the Employer of Record who by such direction, agrees to pay the worker over-time pay out of the child's budget in accordance with the Fair Labor Standards Act. This shall reduce the amount of services that may be purchased for the child during that month.
  - (iii) Termination of Consumer-Directed Workers' Employment.
    - (I) The Employer of Record may terminate a Worker's employment at any time.
    - (II) The MCO or DIDD may not terminate a Worker's employment, but may request that a child be involuntarily withdrawn from CD if it is determined that the health, safety and welfare of the child may be in jeopardy if the child's parent or legal guardian or the Representative for CD continues to employ a Worker but the Employer of Record does not want to terminate the Worker.
- (j) Withdrawal from Participation in Consumer Direction (CD).
- 1. General.

- (i) Voluntary Withdrawal from CD. The parent or legal guardian of a child participating in CD may voluntarily withdraw the child from participation in CD at any time. The request must be in writing. Whenever possible, notice of the parent's or legal guardian's decision to withdraw the child 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 child from CD of Eligible Katie Beckett HCBS shall not affect the child's eligibility for Katie Beckett HCBS or enrollment in Katie Beckett Group Part A or Medicaid Diversion Group Part B, provided the child continues to meet all requirements for enrollment in Katie Beckett as defined in this Chapter.
- (iii) If a child is voluntarily or involuntarily withdrawn from CD, any Eligible Katie Beckett HCBS he receives shall be provided through Contract Providers, subject to the requirements in this Chapter.

2. Involuntary Withdrawal.

- (i) A child may be involuntarily withdrawn from participation in CD of HCBS for any of the following reasons:
  - (I) The child is no longer enrolled in TennCare.
  - (II) The child is no longer enrolled in Katie Beckett Group Part A or Medicaid Diversion Group Part B.
  - (III) The child no longer needs any of the Eligible Katie Beckett HCBS, as specified in the PCSP or DIDD-approved ISP.
  - (IV) The child's parent or legal guardian is no longer willing or able to serve as the Employer of Record for the child's Consumer-Directed Workers and to fulfill all of the required responsibilities for CD, and does not meet limited exceptional circumstances or 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 child's parent or legal guardian is unwilling to work with the MCO Nurse Care Manager or DIDD Case Manager to identify and address any additional risks associated with the decision to participate in CD, or the risks associated with the decision to participate in CD pose too great a threat to the child's health, safety and welfare.
  - (VI) The health, safety and welfare of the child may be in jeopardy if the child's parent or legal guardian or the Representative for CD continues to employ a Worker but the child's parent or legal guardian or the Representative for CD does not want to terminate the Worker.
  - (VII) The child does not have an adequate Back-up Plan for CD.
  - (VIII) The child's needs cannot be safely and appropriately met in the community while participating in CD.
  - (IX) The child's parent or legal guardian or the Representative for CD, or Consumer-Directed Workers he wants to employ are unwilling to use the services of TennCare's contracted FEA to perform required Financial Administration and Supports Brokerage functions.
  - (X) The child's parent or legal guardian or the Representative for CD is unwilling to abide by the requirements of the Katie Beckett CD program.

- (XI) If the Representative for CD fails to perform in accordance with the terms of the Representative Agreement and the health, safety and welfare of the child is at risk, and the child's parent or legal guardian wants to continue to use the Representative.
- (XII) A Support Coordinator has determined that the health, safety and welfare of the child may be in jeopardy if the child's parent or legal guardian or the Representative for CD continues to employ a Worker but the Employer of Record does not want to terminate the Worker.
- (XIII) Other significant concerns regarding the child's participation in CD which jeopardize the health, safety or welfare of the child.
- (ii) TennCare must review and approve all MCO requests for involuntary withdrawal from CD of eligible Katie Beckett HCBS before such action may occur. If TennCare approves the request, written notice shall be given to the child and parent or legal guardian 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 child to Contract Provider services as seamlessly as possible.
- (iii) The child and parent or legal guardian shall have the right to appeal involuntary withdrawal from CD.
- (iv) If a child is no longer enrolled in TennCare or in Katie Beckett Group Part A or Medicaid Diversion Group Part B, participation in CD shall be terminated

(10) Appeals.

- (a) Appeals related to determinations of financial eligibility for TennCare Medicaid (including financial eligibility via the Katie Beckett program) are processed by TennCare, in accordance with Chapter 1200-13-19.
- (b) Appeals related to the denial, reduction, suspension, or termination of a covered service are processed by TennCare in accordance with Rule 1200-13-13-.11 provided however that medical necessity for Katie Beckett Group Part A and Medicaid Diversion Group Part B HCBS shall be determined as provided in Paragraph (7). A child's parent or legal guardian may request a fair hearing regarding any covered benefit not approved in the PCSP or DIDD-approved ISP that he believes the child needs.
- (c) Appeals related to determinations of medical (or level of care) eligibility are processed by TennCare's Division of Long-Term Services and Supports in accordance with Rule .11.
- (d) Appeals related to a child's enrollment or disenrollment of an individual in Katie Beckett or to denial or involuntary withdrawal from participation in CD are processed by the TennCare Division of Long-Term Services and Supports in accordance with the following procedures:
  1. If enrollment into Katie Beckett 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 Katie Beckett, 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 Katie Beckett, involuntary disenrollment from Katie Beckett, 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 TennCare by fax, and within forty (40) days of issuance of the written notice if the appeal is mailed to TennCare. 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 Katie Beckett only, if the appeal is received prior to the date of action, continuation of Katie Beckett 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 child's health, safety and welfare, in which case, services specified in the PCSP or DIDD-approved ISP shall be made available through Contract Providers pending resolution of the appeal.
- (e) A member may present all relevant and material evidence pertaining to the adverse action.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105, 71-5-106, 71-5-109, 71-5-110, 71-5-111, 71-5-112, 71-5-164 and TennCare II Section 1115(a) Medicaid Demonstration Waiver Extension.

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: November 18, 2020

Signature: 

Name of Officer: Stephen Smith

Director, Division of TennCare

Title of Officer: Tennessee Department of Finance and Administration

**Department of State Use Only**

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Secretary of State

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