DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

MAR 31 2014

Mr. Darin Gordon
Director
Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to amend the TennCare II section 1115 of the Social Security Act demonstration (Project No. 11-W-00151/4). This amendment is effective as of the date of this letter.

This award is in response to Tennessee's request in which several changes to the TennCare II demonstration were requested. At this time, CMS is approving the authority to add a third public hospital, Erlanger Medical Center in Chattanooga, to the Public Hospital Supplemental Payment (PHSP) Pool beginning in the current demonstration year. Erlanger Medical Center, as an urban hospital that services a large population of Medicaid and indigent patients, shares the characteristics of the other two hospitals that already participate in the pool. As a result, the $70 million total computable cap will increase to $100 million total computable.

Additionally, the CMS is agreeing to raise the annual cap for one year for the pool payments for the Essential Access Pool to $621.3 million for the period of April 1, 2014, through March 31, 2015 due to Tennessee's unique circumstance as the only state not provided a disproportionate share hospital allotment by law.

The demonstration expenditure authorities and Special Terms and Conditions (STCs) have been changed to reflect the additions. The approval for the amendment is conditioned upon compliance with the enclosed STCs and is subject to our receiving your acknowledgement of the award and the acceptance of the STCs within 30 days of the date of this letter.

Your acceptance and any questions regarding the TennCare II program may be directed to your project officer, Jessica Woodard. Ms. Woodard can be reached at (410) 786-9249, or Jessica.Woodard@cms.hhs.gov. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Ms. Woodard at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communications regarding program matters should be sent simultaneously to Ms. Woodard and to Ms. Jackie Glaze, Associate Regional Administrator, in our Atlanta Regional Office. Ms. Glaze's contact information is as follows:

Centers for Medicare & Medicaid Services
Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909
Telephone: (404) 562-7359
E-mail: Jackie.Glaze@cms.hhs.gov

We look forward to continuing to work with you and your staff on future amendments to your demonstration.

Sincerely,

Cindy Mann
Director

Enclosure

cc: Jackie Glaze, Associate Regional Administrator, CMS Atlanta Regional Office
Kenni Howard, CMS Atlanta Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**WAIVER LIST**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or specified as not applicable in the following list, shall apply to all TennCare II populations identified in paragraph 17 *(Eligibility)* of the Special Terms and Conditions.

The TennCare II Demonstration will operate under these waiver authorities and those provisions specified as "not applicable." The waiver authorities and the provisions specified as "not applicable" will continue through June 30, 2016, unless otherwise stated.

The following waivers shall enable Tennessee to implement the TennCare II Medicaid Section 1115 demonstration.

**WAIVERS OF TITLE XIX REQUIREMENTS FOR TENNCARE MEDICAID TITLE XIX STATE PLAN GROUPS**

**1. Statewideness/Uniformity** **Section 1902(a)(1)**
**42 CFR § 431.50**

To the extent necessary to enable the state to provide managed care plans or certain types of managed care plans only in certain geographical areas of the state. Certain managed care plans or certain types of managed care plans (e.g., risk-based plans) are only available in certain areas of the state.

**2. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR § 438.52**

To the extent necessary to permit the state to have only one pharmacy benefits manager and one dental benefits manager to provide services in a region of the state or statewide.

**3. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR § 435.831**

To the extent necessary to enable Tennessee to use streamlined eligibility procedures that provide for coverage of optional Medically Needy children and pregnant women and the Standard Spend Down demonstration population for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. In accordance with the Code of Federal Regulations, the "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

**4. Reasonable Promptness** **Section 1902(a)(8)**

To the extent necessary to enable the state to limit enrollment in CHOICES 2 and 3 to the enrollment target(s) established by the state, as authorized under 32.d. (*Enrollment Targets for TennCare CHOICES)* of the Special Terms and Conditions, and to allow the state to require applicants for long-term services and supports to complete a person-centered assessment and options counseling process.

**5. Access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Benefits** **Section 1902(a)(10) 42 CFR §§ 440.210 and 440.220**

To the extent necessary to enable the state to permit managed care contractors to limit coverage of FQHC and RHC services, so long as access to care is assured from other providers.

**6. Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B) 42 CFR 440 Subpart B**

To the extent necessary to enable the state to offer a reduced benefit package, a different benefit package, or cost-effective alternative benefit packages to different populations under the demonstration (except for individuals specified in Section 1902(l)(4) of the Act), to the extent authorized under Section V of the Special Terms and Conditions.

**7. Comparability and Amount Duration and Scope** **Sections 1902(a)(17) and 1902(a)(10)(B)**

Should the state change the level of care criteria for admission to nursing facilities, to the extent necessary to enable the state to determine whether an individual has a continuing need for nursing facility services, PACE services, or home and community-based services for the elderly and disabled, based on the criteria in use when the individual first was determined to need the service.

**8. Freedom of Choice** **Section 1902(a)(23)(A) 42 CFR § 431.51**

To enable the state to restrict freedom of choice of provider, through the use of mandatory enrollment in managed care plans or TennCare Select for the receipt of TennCare II and TennCare CHOICES covered services, including for individuals specified at Section 1932(a)(2) of the Social Security Act (the Act). No waiver of freedom of choice is authorized for family planning providers.

**9. Retroactive Eligibility** **Section 1902(a)(34) 42 CFR § 435.914**

To enable the state not to extend eligibility prior to the date that an application for assistance is made. This waiver authority will expire at the end of the extension period of the demonstration, June 30, 2016, unless otherwise approved based on the requirements of paragraph 8 (*Extension of the Demonstration*) of the STCs.

**10. Payment for Outpatient Drugs** **Section 1902(a)(54)**

**42 CFR §§ 440.120,**
**447.331-447.334,**
**and 456 Subpart K**

To the extent necessary to enable the state to establish a drug formulary that does not comply with the requirements of Section 1927(d)(4) of the Act.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under Section 1903, shall, for the period of this demonstration extension, be regarded as expenditures under the state's Medicaid title XIX state plan.

The following expenditure authorities shall enable Tennessee to implement the Medicaid Section 1115 demonstration (TennCare II).

**1. Expenditures Related to MCO Enrollment and Disenrollment.**
Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the Act specified below. Tennessee managed care plans will be required to meet all requirements of Section 1903(m) except the following:

- Section 1903(m)(2)(A)(vi) of the Act, Federal regulations at 42 CFR § 438.56, to the extent that the rules in Section 1932(a)(4) are inconsistent with the enrollment and disenrollment rules contained in paragraph 39 *(Plan Enrollment and Disenrollment)* of the demonstration's Special Terms and Conditions (STCs), such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 45 days of enrollment in an MCO. After 45 days, enrollees may disenroll from an MCO with cause at any time.

**2. Expenditures Related to Expansion of Existing Eligibility Groups.**
To enable Tennessee to use streamlined eligibility procedures and include eligibility standards and requirements that differ from those required by law.

a. Expenditures for Medical Assistance furnished to state plan optional Medically Needy children and pregnant women for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. The "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

b. Expenditures for Medical Assistance furnished to mandatory state plan Transitional Medical Assistance beneficiaries, who are eligible in accordance with section 1931(c)(1) of the Act, for the remainder of a 12-month eligibility period after the 4-month period specified in the statute.

**3. Expenditures for Expanded Benefits and Coverage of Cost-Effective Alternative Services.**

a. Expenditures for TennCare Medicaid and TennCare Standard child enrollees for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*. and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

b. Expenditures for TennCare Medicaid and TennCare Standard adult enrollees for optional services not covered under Tennessee's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*., paragraph 28 *(TennCare Benefits)*, and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

**4. Expenditures for Pool Payments.**
Expenditures for Graduate Medical Education, Essential Access Hospital, Critical Access Hospital, Meharry Medical College, Unreimbursed Public Hospital Costs for Certified Public Expenditures, Unreimbursed Hospital Cost, and Public Hospital Supplemental Payment pool payments to the extent specified in paragraph 55.d. through h. and j. through l. *(Extent of Federal Financial Participation for the Demonstration)* of the demonstration's STCs. This expenditure authority will expire December 31, 2015, unless otherwise approved based on the requirements of paragraph 8 *(Extension of the Demonstration)* of these STCs.

**5. Indirect Payment of Graduate Medical Education.**
Expenditures, up to $50 million in total computable expenditures for each demonstration year, for payments to universities that operate graduate physician medical education programs, which are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics.

**6. Payments for Non-Risk Contractor.**
Payments to the TennCare Select prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor more than what Medical Assistance would have paid fee-for-service under the state plan in accordance with the upper limits at 42 CFR § 447.362.

**7. Expenditures Related to Eligibility Expansion.**
Expenditures to provide Medical Assistance coverage to the following demonstration populations that are not covered under the Medicaid state plan and are enrolled in TennCare Standard :

a. **Medically Eligible Demonstration Population Children, Not CHIP Eligible.**
Uninsured children under age 19 who lose eligibility in TennCare Medicaid, have been determined to be "medically eligible" (uninsurable), have family income at

or above 200 percent of the Federal poverty level (FPL), and do not meet the definition of an optional targeted low-income child.

b. **Adult Demonstration Population Eligibles-Standard Spend Down (SSD):** Non-pregnant, non-postpartum adults aged 21 or older who have been determined to meet criteria patterned after the state plan Medically Needy requirements (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category* of the STCs), comprising:
   - Aged, blind, or disabled individuals; or
   - Caretaker relatives.

**8. CHIP-Related Medicaid Expansion Demonstration Population Children.**
Expenditures to provide Medical Assistance coverage to uninsured children who lose eligibility under TennCare, who meet the definition of optional targeted low-income child, and who have family income up to 200 percent of the FPL.

**9. The CHOICES 217-Like HCBS Group.**
Expenditures for TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with Section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under TennCare CHOICES were provided under an HCBS waiver granted to the state under Section 1915(c) of the Act, as of the initial approval date of the TennCare CHOICES component of this demonstration. This includes the application of the spousal impoverishment eligibility rules. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the STCs;

b. Home and community-based waiver-like services as specified in Table 2b, subject to the definitions in Attachment D of the STCs, net of beneficiary regular and spousal impoverishment post-eligibility responsibility for the cost of care, and with post-eligibility treatment of income for individuals receiving short-term nursing facility care calculated as if they were receiving HCBS in the community.

**10. HCBS Services for SSI-Eligibles.**
Expenditures for the provision of home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs that are not described in Section 1905(a) of the Act and not otherwise available under the approved state plan but could be provided under the authority of Section 1915(c) waivers, that are furnished to TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities with income at 100 percent of the Supplemental Security Income/Federal Benefit Rate and resources at or below $2,000 who either:

a. Meet the nursing facility institutional level of care; or

b. Do not meet the nursing facility institutional level of care but who, in the absence of TennCare CHOICES services, are "at risk" of institutionalization.

**11. The At Risk Demonstration Group.**

Elderly adults and adults age 21 and older with physical disabilities who have not been otherwise determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012. The At Risk Demonstration Group is open to new enrollment until June 30, 2015.

Expenditures allowable under this demonstration for these individuals are for the following benefits:

a. Services as presented in Table 2a of the STCs.

b. Home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs, net of beneficiary post-eligibility responsibility for the cost of care (including application of spousal impoverishment rules), as set forth in the STCs.

**12. Continuing Receipt of Nursing Facility Care.**

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**13. Continuing Receipt of Home and Community-Based Services.**

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**14. Continuing Receipt of Program of All-Inclusive Care for the Elderly (PACE) Services.**

Expenditures for PACE-enrolled individuals, who upon redetermination do not meet the current nursing facility level of care criteria, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the PACE Carryover Group.

**15. LTC Partnership.**

Expenditures for individuals in CHOICES 2 to participate in the Long Term Care Partnership Program.

**REQUIREMENTS NOT APPLICABLE TO TENNCARE STANDARD TITLE XIX DEMONSTRATION ELIGIBLE GROUPS**

All Title XIX requirements that are waived for the TennCare Medicaid Groups are also not applicable to the TennCare Standard Title XIX Demonstration Eligible Groups. In addition, the following is not applicable to the Title XIX Demonstration Eligible Groups.

| | |
|---|---|
| **Cost Sharing** | **Section 1902(a)(14) and Section 1916**<br>**42 CFR §§ 447.51 – 447.56** |

To enable the state to charge cost sharing beyond applicable Medicaid limits to TennCare Standard demonstration populations, with cost-sharing subject to a quarterly aggregate cap of 5 percent of family income for children.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS (STCs)**

**NUMBER:** **11-W-00151/4 (Title XIX)**

**TITLE:** **TennCare II**

**AWARDEE:** **Tennessee Department of Finance and Administration**

**DEMONSTRATION EXTENSION PERIOD:** **July 1, 2013 through June 30, 2016**

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**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS**

**NUMBER:** **Title XIX No. 11-W-00151/4**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for Tennessee's TennCare II Section 1115(f) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to this agreement are the Tennessee Department of Finance and Administration, Bureau of TennCare ("state") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the demonstration project. The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the approval letter's date, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This demonstration extension is approved through June 30, 2016.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits; CHOICES Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality for the Demonstration; Evaluation of the Demonstration; TennCare Eligibility Redetermination and Disenrollment and Rights; Appeals Process for Changes in Benefits; Enrollment in Standard Spend Down; and the Schedule of State Deliverables During the Demonstration Extension.

## II. PROGRAM DESCRIPTION AND OBJECTIVES

TennCare II is a continuation of the state's demonstration, funded through titles XIX and XXI of the Social Security Act (the Act). TennCare began as an 1115(a) demonstration project in January 1994. A 3-year extension was approved for 1999-2001, and a 1-year extension was approved early in 2002. A new TennCare II 1115(a) demonstration was approved by CMS on May 30, 2002, and initiated on July 1, 2002, for a 5-year period. On October 5, 2007, an extension was granted under Section 1115(a) through June 30, 2010, with revised waiver and expenditure authorities and STCs. (Note: Temporary extensions under the existing TennCare II STCs were granted for the July 1 through October 5, 2007 period, in order to provide additional time to conclude discussions on a longer extension.) The most recent extension, granted in December 2009 under the authority of Section 1115(e) of the Act, was in effect from July 1, 2010 through June 30, 2013. The current extension is granted under the authority of Section 1115(f) of the Act and is in effect from July 1, 2013 through June 30, 2016.

As of October 2012, the TennCare II program had 1.213 million enrollees, about half of whom were children. All mandatory and optional populations eligible under Tennessee's state plan are enrolled in TennCare II, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only").

There are three components to the TennCare II demonstration program. **TennCare Medicaid** is the component that serves enrollees who are Medicaid-eligible under Tennessee's title XIX state plan. **TennCare Standard** is the component that serves title XIX Medicaid enrollees who are eligible only through the demonstration's expenditure authorities**.** Title XXI Medicaid expansion children are also served under TennCare Standard, with a more extensive benefits package and a different service delivery system than the children served under the title XXI stand-alone Children's Health Insurance Program (CHIP). Both TennCare Medicaid and TennCare Standard deliver all Medicaid services, except for services specified at paragraphs 28 *(TennCare Benefits)* and 30 *(Medicaid Benefits Carved Out of TennCare II Demonstration)* as excluded from the TennCare benefits package for specified populations.

The **CHOICES** Program is the newest component. CHOICES utilizes the existing for-risk, Medicaid managed care organizations to provide eligible individuals with nursing facility services or home and community based services. With the implementation of the CHOICES program in 2010, home and community based services and nursing facility services were added to the existing TennCare II benefit package of primary, acute, and behavioral health services for qualifying state plan and demonstration eligible individuals. This provides participating individuals with an integrated package of acute and long-term services and supports, through a managed care delivery system.

The goals of TennCare are the following:

- Use a managed care approach to provide services to Medicaid state plan and demonstration enrollees at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.

- Assure appropriate access to care for enrollees.
- Provide quality care to enrollees.
- Assure enrollees' satisfaction with services.
- Improve health care for program enrollees.
- Assure that participating health plans maintain stability and viability, while meeting all contract and program requirements.
- Provide appropriate, and cost-effective home and community based services that will improve the quality of life for persons who qualify for nursing facility care, as well as for persons who do not qualify for nursing facility care but who are "at risk" of institutional placement and that will help to rebalance long-term services and supports expenditures.

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with Section 1115 of the Act. The state must

not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 *(Amendment Process)* below.

**7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following

a. An explanation of the public process used by the state, consistent with the requirements of paragraph 15 *(Public Notice and Consultation with Interested Parties)*, to reach a decision regarding the requested amendment;

b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

Changes to TennCare II benefits described in the state plan shall be made by state plan amendment. Changes to TennCare II benefits not described in the state plan shall be made by amendment to the demonstration. Changes in benefits shall be implemented in accordance with the process set forth in Section XIII of these STCs.

Additions or Changes to CHOICES Benefits. All requests for changes in coverage of CHOICES benefits are subject to CMS approval. Changes in benefits defined in Attachment D must be submitted to CMS for approval at least 60 days in advance of the state's desired implementation date. Requests for services that are not defined in Attachment D must be submitted by the state to CMS as a request to amend the demonstration.

The state must send a courtesy copy of all Medicaid state plan amendment requests to the Project Officer. This requirement is in addition to the submissions that the state must make as part of the usual state plan amendment process, and is not meant to substitute for or supplant that process in any way.

**8. Extension of the Demonstration.**

a. Should the state intend to request an extension of the demonstration, the state must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9 *(Demonstration Phase-Out).*

b. Compliance with Transparency Requirements 42 CFR § 431.412. Effective April 27, 2012, as part of demonstration extension requests the state must provide documentation of compliance with the transparency requirements of 42 CFR § 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15 *(Public Notice and Consultation with Interested Parties).*

**9. Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, only consistent with the following requirements:

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of the phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §§ 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §§ 431.220 and 431.221. If a demonstration participant requests a hearing

before the date of action, the state must maintain benefits as required in 42 CFR § 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010 State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

**10.** **Post Award Forum**. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this paragraph. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 45 *(Quarterly Progress Reports)* associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 46 *(Annual Report).*

**11.** **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

**12.** **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

**13.** **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

**14.** **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

**15.** **Public Notice and Consultation with Interested Parties.** The state must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6 *(Changes Subject to the Amendment Process)*, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR § 431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 CFR § 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR § 447.205 for changes in statewide methods and standards for setting payment rates.

**16.** **FFP.** No Federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

## IV. ELIGIBILITY

**17. Eligibility.** Tennessee includes in the TennCare II demonstration all of the mandatory and optional populations eligible under the Tennessee Medicaid state plan, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only"). Also included in TennCare II are several title XIX demonstration-only eligible populations and one title XXI Medicaid Expansion demonstration population. Medicaid state plan-eligible individuals are served in the component of the program called TennCare Medicaid. Other demonstration-only eligible populations are served in the component called TennCare Standard.

The mandatory and optional Medicaid state plan populations described below derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the demonstration to generate savings for covering the Expansion populations, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.

The title XXI Medicaid Expansion demonstration population is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as otherwise listed as not applicable.

Under the TennCare II demonstration, Tennessee is not required to extend eligibility for medical assistance prior to the date that an application for assistance is made; however, the state may provide retroactive coverage for up to 3 months for class members in *Daniels, et al. v. Tenn. Dept. of Health and Env't., et al.*, (1) who have been terminated from TennCare on or before March 31, 2010, for failure to respond to a Request for Information and Expiration Notice in accordance with the process approved in the Federal court order dated January 8, 2009; (2) who subsequently complete a Request for Information within 60 days of termination; and (3) who are determined to have been eligible at the time of termination. The state must notify the Project Officer by letter if it intends to extend retroactive eligibility to Daniels class members as described above.

Any changes to eligibility must be submitted to CMS as an amendment request, subject to the process set forth in paragraphs 6 (*Changes Subject to the Amendment Process)* and 7 *(Amendment Process)* of these STCs.

The criteria for TennCare eligibility groups are as follows (Table 1a).

**Table 1a**
**TennCare Eligibility Groups**

Note: This table does not change the state plan requirements.

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **Title XIX State Plan Mandatory Groups – TennCare Medicaid** | | |
| 1931 recipients including:<br>• Children younger than 18/19<br>• Caretaker relatives<br>• Pregnant women with no other eligible children (coverage for third trimester) | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Transitional Medical Assistance – Medicaid Extension for families who lose TANF benefits due to:<br>• income from employment or work hours or loss of "income disregard"<br>• increased child or spousal support collections | 6 initial months + 6 months continued coverage<br>4 months continued coverage *and expenditure authority for 8 additional months* | 1, 2, 5, 6, 8, 9, 10 |
| Individuals who are ineligible for AFDC benefits solely due to requirements that are prohibited under Medicaid, including AFDC time limits | Income up to and including 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Poverty level pregnant & postpartum women | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level newborns under age 1 | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 1-5 | Income up to and including 133% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 6-18 | Income up to and including 100% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Deemed categorically eligible newborns: born to & living with a woman who was eligible and received Medicaid on the date of the child's birth | Eligible for 1 year as long as mother is eligible or would be if pregnant | 1, 2, 5, 8, 10 |
| Pregnant woman who would otherwise lose eligibility because of an increase in income remains eligible through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Woman who was eligible while pregnant continues eligibility through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Title IV-E eligible children in adoption subsidy or foster care | AFDC income standard | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash recipients: aged, blind or disabled (may or may not be receiving CHOICES benefits) | | 1, 2, 4, 5, 6, 7, 8, 9, 10, |
| Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87 | | 1, 2, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| "DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash ineligible for reasons prohibited by Title XIX. | | 1, 2, 5, 6, 8, 9, 10 |
| "Pickle" SSA Beneficiaries who lost SSI cash benefits due to cost of living adjustment (COLA) increase in Title II OASDI benefits | | 1, 2, 5, 6, 8, 9, 10 |
| "DWB" Disabled widow/widower who lost SSI or state supplement due to early receipt of OASDI benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| **Title XIX State Plan Optional Groups – TennCare Medicaid** | | |
| Presumptively eligible pregnant & postpartum women | Income up to 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Children under 21 who meet AFDC income & resource criteria—children in state custody, foster care, subsidized adoptions, institutionalized | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Persons who would be eligible for AFDC or SSI cash assistance except for their institutional status | | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Special income level group: individuals who are in a medical institution at least 30 consecutive days with income that does not exceed 300% of SSI income standard under 1902(a)(10)(ii)(V) of the Act. | Income no more than 300% of SSI rate; resources $2000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Categorically needy individuals under the state plan who are receiving home and community based services in accordance with 42 CFR § 435.217. (This group consists solely of enrollees in the ID waivers.) | | 1, 2, 5, 6, 8, 9, 10 |
| Non-IV-E children with special medical needs who receive a state adoption subsidy payment | | 1, 2, 5, 6, 8, 9, 10 |
| Women under 65 who need treatment for breast or cervical cancer, and are not otherwise eligible for Medicaid. State utilizes presumptive eligibility for this population. | | 1, 2, 5, 6, 8, 9, 10 |
| Medically needy children under 21 *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| Medically needy pregnant or postpartum women *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |
| **Title XIX Demonstration Eligible Groups– Carryover** | | |
| **CHOICES 1 and 2 Carryover Group:** Individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **PACE Carryover Group:** Individuals who were enrolled in a PACE program as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | As required under the state plan. | |
| **Title XIX Demonstration Eligible Groups – TennCare Standard** | | |
| **Medically Eligible Children:** uninsured children under 19 who have been determined to be "medically eligible" (uninsurable) (category is currently closed to new enrollment except for Medicaid rollovers *[*as defined in paragraph 20, *Rollover Definition]* who are not otherwise eligible for TennCare. See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*. | Income 200% FPL or higher without limit; no resource test | 1, 2, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Standard Spend Down (SSD):** non-pregnant/postpartum adults 21 or older who have been determined to meet criteria patterned after the medically needy requirements *(enrollment target: 100,000)*<br>• aged, blind, or disabled<br>• caretaker relatives<br>CMS approved an amendment to add this expansion population in Nov. 2006.<br>(Expenditure authority for 12-month coverage based on 1-month budget period.)<br>See paragraph 21.a. *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*. | Medically needy spend-down level ($241 for 1, etc.); resources $2000 | 1, 2,, 3, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Title XIX Demonstration Eligible Groups – CHOICES** | | |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **CHOICES 217-Like HCBS Group:** Aged and / or disabled categorically needy adults who meet the CHOICES NF level of care requirement, are receiving home and community based services and who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236, and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915 (c) waiver. This group is subject to the enrollment target for CHOICES 2 in paragraph 32.d *(Enrollment Targets for TennCare CHOICES)*. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **At Risk Demonstration Group:** Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of the TennCare Interim Choices 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open to enrollment starting July 1, 2012, and closed to new enrollment on June 30, 2015. [1] | Income no more than 300% SSI/FBR; resources $2,000 | 1,2,4,5,6,7,8,9,10 |
| **Title XXI Medicaid Expansion Demonstration Eligible Group – TennCare Standard** | | |
| Optional Targeted Low-Income Children: uninsured children under 19 who:<br>• have lost Medicaid eligibility under the approved Medicaid state plan and who do not have access to insurance or<br>• were uninsured and enrolled in this category in the original TennCare demonstration as of 12/31/01, even if they had access to insurance, and have been continuously enrolled in this category since 12/31/01<br>See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*.. | Income up to 200% FPL | 1, 2, 5, 6, 8, 9, 10, and cost sharing "not applicable" |

## 18. TennCare CHOICES Eligibility Groups.

As further set forth in paragraph 32 *(Operations of the TennCare CHOICES Program)*, eligibility for enrollment in TennCare CHOICES depends on (a) the individual's

[1] Although the state is approved to determine CHOICES eligibility using a more restrictive nursing facility level of care standard beginning July 1, 2012, the state has not yet instituted the more restrictive nursing facility level of care. Individuals enrolled in Interim CHOICES 3 until June 30, 2015 meet the nursing facility level of care in place on June 30, 2012

TennCare Eligibility Group, (b) the nursing facility (NF) (or "At Risk," as applicable) level-of-care (LOC) criteria as established by the state, and (c) the type of long-term services and supports (LTSS) to be provided.

There are three principal eligibility groups for TennCare CHOICES. CHOICES 1 is for individuals receiving NF services. CHOICES 2 is for individuals who meet the NF LOC that are receiving HCBS as an alternative to NF care. CHOICES 3 is for individuals who do not meet the NF LOC, but are at risk of NF placement and are receiving HCBS to delay or prevent NF placement.

Effective July 1, 2012, the state elected to change the level of care that is medically necessary for admission to a NF. CHOICES 3 serves SSI eligibles enrolled after the implementation of the LOC change who do not meet the new LOC standard but who are "at risk" of institutionalization. Individuals in CHOICES 1 and CHOICES 2 who continue to meet the standard in place at the time of the individual's enrollment will continue to qualify for those services.

Between July 1, 2012, and December 31, 2013, the state opened Interim CHOICES 3 to serve SSI eligibles and other adults who meet the LOC standard and financial eligibility requirements in place prior to the change, allowing the state to abide by the "Maintenance of Effort" (MOE) requirements as specified by the Affordable Care Act, Section 2001. The Interim CHOICES 3 group has since been extended through June 30, 2015.

Table 1b summarizes the CHOICES Eligibility Groups and addresses how a change in LOC criteria is taken into account in determining eligibility for each group.

**Table 1b**
**TennCare + CHOICES Eligibility Groups**

Note: This table does not change the state plan requirements. CHOICES 1, CHOICES 2, CHOICES 3, and Interim CHOICES 3 are defined in paragraph 32 *(Operations of the TennCare CHOICES Program)*. The CHOICES 1 and 2 Carryover Group and the PACE Carryover Group are defined in Table 1a of paragraph 17 *(Eligibility)*. With respect to benefits, cost-sharing, and similar issues, persons in the CHOICES 1 Carryover Group are treated as though they were in CHOICES 1; persons in the CHOICES 2 Carryover Group are treated as though they were in CHOICES 2; and persons in the PACE Carryover Group are treated as though they were in PACE.

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 1 | • Nursing facility residents who meet the NF LOC in place at the time of enrollment* | Yes | Yes, CHOICES 1 and 2 Carryover Group |

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 2 | • Meet NF LOC in place at the time of HCBS<br>• Receive HCBS as alternative to NF care<br>• Age 65+ or 21+ and disabled | Yes, SSI only | Yes, CHOICES 217-Like HCBS Group and CHOICES 1 and 2 Carryover Group |
| CHOICES 3 | • "At risk" for institutionalization (as defined in Attachment D)<br>• Age 65+ or age 21+ and disabled | Yes, SSI only | No |
| INTERIM CHOICES 3 (open to enrollment starting July 1, 2012 and closed to new enrollment on June 30, 2015) | • Same as CHOICES 3, but not limited to SSI recipients<br>• Must meet nursing facility financial eligibility criteria | Yes, SSI only | Yes, At Risk Demonstration Group |

***** The state may grant an exception for persons in the community seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

**19. Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed.** The state has closed enrollment into the following demonstration categories, except for "rollovers" (as defined in paragraph 20, *Rollover Definition*). Therefore, children are only eligible for a non-state plan demonstration population as a "rollover." If children lose Medicaid state plan eligibility, they may qualify for one of these demonstration-only groups rather than for the stand-alone title XXI CHIP program.

- Title XIX Medically Eligible Children: Individuals who are under age 19, are uninsured, have income that is 200 percent of the FPL or higher without limit, are not otherwise eligible for TennCare, and meet the state-defined criteria of "medically eligible" as having medical conditions that make them uninsurable. (There is no income or resource limit for this group.)

- Title XXI Medicaid Expansion Children: Individuals under age 19 who are uninsured, have family income less than 200 percent of the FPL, and meet the definition of an optional targeted low-income child. (There is no resource limit for this group.)

Individuals under age 19 who lose eligibility for a Medicaid category may roll over into a TennCare Standard category if they meet the criteria for the category.

**20. Rollover Definition.** For the purpose of this demonstration, a "rollover" eligible is an individual who qualifies for continued coverage through a TennCare Standard demonstration category upon losing Medicaid eligibility under any category included in Tennessee's title XIX state plan.

**21. Adult Non-State Plan Demonstration Population Categories.**

a. **Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category.** The SSD eligibility category is open to non-pregnant/postpartum adults ages 21 or older who are Caretaker Relatives or Aged, Blind, or Disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the state plan. The SSD demonstration eligibility group has an enrollment cap of 105,000, with a target enrollment of 100,000. The state shall establish eligibility and enroll individuals into the SSD group in accordance with the process set forth in Section XIII of these STCs.

b. **CHOICES 217-Like HCBS Group**. This group consists of persons aged 65 and older or persons aged 21+ and who are disabled who: (1) meet the CHOICES NF level of care requirement; (2) are receiving home and community-based services; and (3) would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal Regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915(c) waiver. Paragraph 18 *(TennCare CHOICES Eligibility Groups)* and paragraph 32.b. *(Eligibility for TennCare CHOICES Benefits)* describe how the NF LOC requirements shall be determined for individuals in this group. The state retains the discretion to apply an enrollment target as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES).*

c. **At Risk Demonstration Group.** As of July 1, 2012, this group consists of elderly adults and adults age 21 and older with physical disabilities who (1) meet nursing facility financial eligibility; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization.

d. **CHOICES 1 and 2 Carryover Group.** This group consists of individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who no longer qualify for CHOICES enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in CHOICES 1 or CHOICES 2 if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, (2) meet all the eligibility requirements for a CHOICES program; and (3) remain continuously enrolled in CHOICES 1 and/or 2, as specified below:

i. Persons enrolled in CHOICES 1 can continue in CHOICES 1 or transition to CHOICES 2, and persons enrolled in CHOICES 2 can continue in CHOICES 2; and

ii. The state may grant an exception to i. for persons in CHOICES 2 seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

e. **PACE Carryover Group.** This group consists of individuals who were enrolled in PACE as of June 30, 2012, but who no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in PACE if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, and (2) meet all other eligibility requirements for PACE in the Medicaid state plan. PACE remains under the Medicaid state plan.

**22. Medically Needy Eligibility Period.** Financial eligibility for state plan medically needy pregnant women and children and for Standard Spend Down adults is based on a 1-month budget period described in the state plan. Those determined eligible remain eligible for up to 1 year from the effective date of eligibility.

**23. Quality Review of Eligibility**. At least annually, the state shall submit a plan for a Medicaid Eligibility Quality Control (MEQC) pilot project to the CMS Regional Office for approval. When each pilot is complete, the state shall send a report to the CMS Regional Office for approval, and shall submit a plan for the next pilot project. The MEQC pilots must be conducted in accordance with Federal law, regulations, and policy.

**24. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.**

a. Except as specified in paragraph 24.b. below, in determining eligibility for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in Section 1924 of the Act and 42 CFR § 435.725 of the Federal regulations.

b. For an individual in CHOICES 2 or CHOICES 3 who is admitted for short-term nursing facility care (as defined in Attachment D), in order to ensure that the individual can maintain a community residence for transition back to the community, the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. After 90 days, or as soon as it appears that the inpatient stay will not be short-term, whichever comes first, the person will be transitioned to CHOICES 1 and the institutional post-eligibility calculation shall apply.

25. **Eligibility/Post-Eligibility Treatment of Income and Resources for the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group.** For individuals receiving 1915(c) like services in CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, or the PACE Carryover Group, the state must use institutional eligibility and post-eligibility rules for individuals who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a Section 1915(c) waiver.

26. **Post-Eligibility and Patient Liability for the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group.** The state assures that, for individuals receiving 1915(c) like services, under the post-eligibility process, the state must have a method to carve out / identify the cost of the 1915(c) like services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of the 1915(c) like services.

27. **Non-Payment of Patient Liability.** A provider (including an MCO) may decline to continue to provide services to an individual who fails to pay his or her patient liability. If an enrollee who has failed to pay patient liability is unable to find another provider or MCO who is willing to provide LTSS, then the individual may be disenrolled from the CHOICES program. If the beneficiary's eligibility for TennCare is dependent on the receipt of long-term institutional care or HCBS through TennCare CHOICES, as would be the case if an enrollee is a member of the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group, such individual may be disenrolled from TennCare if he or she is no longer able to receive such services, unless he/she qualifies in another Medicaid category. The consequences for failing to pay patient liability must be clearly explained to members upon enrollment in CHOICES. Nothing herein shall prejudice any individual from fully exercising his or her rights to reapply for Medicaid coverage.

## V. BENEFITS

**28. TennCare Benefits.** With the implementation of the CHOICES program, TennCare covers physical, behavioral, and long-term care benefits provided through managed care delivery systems.

a. All mandatory and optional Medicaid state plan eligible adults aged 21 or older, are enrolled in TennCare Medicaid, and receive all services covered under Tennessee's state plan according to the limitations specified in the state plan, including the services identified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration)* as appropriate. Additional TennCare benefits are provided as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)*.

b. Members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group or the CHOICES 1 and 2 Carryover Group, all of which are demonstration-only groups, are enrolled in TennCare Standard, but receive all benefits described in a. above. In addition, individuals in the CHOICES 217-Like HCBS Group are members of CHOICES 2 and members of the At Risk Demonstration Group are members of Interim CHOICES 3.

c. Demonstration-only eligible adults who are members of the Standard Spend Down population (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*) are enrolled in TennCare Standard and receive all state plan services, plus additional TennCare benefits as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)* as appropriate, except that they do not have access to the services discussed in Table 2b or Table 3. Medicare Parts A and B premiums and Medicare co-payments and deductibles are covered in accordance with paragraphs 30.b. and c.

d. All mandatory and optional Medicaid state plan eligible children younger than 21 years old enrolled in TennCare Medicaid receive all state plan and EPSDT covered services.

e. The demonstration-only eligible children enrolled in TennCare Standard receive the same benefits as the state plan eligible children enrolled in TennCare Medicaid, except as specified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration)*.

f. The Medicaid state plan mandatory and optional eligibility categories for poverty level pregnant or postpartum women receive all TennCare Medicaid benefits, because the state considers that all of these services are pregnancy-related services.

g. The following table (Table 2a) lists benefits for TennCare Medicaid and TennCare Standard adults aged 21 and older that are different from those

identified in the state plan. All benefits are limited by medical necessity as defined by the state. "State Plan Coverage for Adults" is provided for informational purposes only, and does not supersede the approved Medicaid state plan. CMS will issue an updated version of Table 2a in the event that future SPAs cause the Medicaid state plan to be in conflict with what appears in Table 2a.

**Table 2a**
**TennCare Medicaid and TennCare Standard Benefits for Adults Aged 21 and Older That Are Different Than State Plan Covered Services and Limitations**

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Diagnostic services not included in other service categories | Covered as medically necessary. | Not covered. |
| Home health | Covered as medically necessary, and in accordance with the definitions and limitations included in Attachment B. | Coverage limited to 60 visits per enrollee per state fiscal year. |
| Hospice care | Covered as medically necessary. | Coverage limited to 210 days per enrollee per state fiscal year. |
| Inpatient and outpatient substance abuse services | Covered as medically necessary | Not covered. |
| Inpatient hospital services | Covered as medically necessary. | Coverage limited to 43 days for heart transplants, 67 days for liver transplants, and 40 days for bone marrow transplants, per enrollee, per state fiscal year. |
| Lab and X-ray services | Covered as medically necessary. | Coverage limited to 30 occasions per enrollee per state fiscal year. |
| Medicare premiums and cost-sharing | Covered for state plan eligibles, SSD enrollees, members of the CHOICES 217-Like HCBS Group, and members of the At Risk Demonstration Group, in accordance with paragraphs 30.b. and c. | Covered for Medicare beneficiaries who are dually eligible for Medicaid according to their classification under the state plan (QMB, SLMB, Other Medicaid/Medicare Duals, etc.) |
| Mental health case management services | Covered as medically necessary. | Coverage limited to Targeted Case Management for persons who are Severely and/or Persistently Mentally Ill. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Occupational therapy | Covered as medically necessary. | Not covered. |
| Organ and tissue transplants | Covered as medically necessary, except that experimental or investigational transplants are not covered. | Coverage limited to renal, heart, liver, corneal, and bone marrow transplants. |
| Outpatient hospital services | Covered as medically necessary. | Coverage limited to 30 visits per enrollee per fiscal year. |
| Outpatient rehabilitation services | Covered as medically necessary. | Coverage limited to mental health services provided by Community Mental Health Agencies. |
| Pharmacy services | • Not covered for dually eligible adults.<br>• Covered for non-dual state plan eligibles in accordance with the state plan.<br>• Covered for non-dual SSD eligibles and non-dual At Risk Demonstration Group members, with the co-payments specified in Table 6 of paragraph 34.b. *(Co-Pays on Pharmacy).*<br>• Covered for non-dual CHOICES 217-Like HCBS Group enrollees, CHOICES 1 and 2 Carryover Group enrollees, and PACE Carryover enrollees in accordance with the state plan for Medicaid enrollees. | Coverage as specified in state plan. |
| Physical therapy services | Covered as medically necessary. | Not covered. |
| Physicians' services (including medical and surgical services furnished by a dentist) | Outpatient services: Covered as medically necessary.<br><br>Inpatient services: Covered as medically necessary. | Outpatient services: Coverage limited to 24 outpatient office visits per year, which includes 2 office visits for podiatrists and 4 office visits for optometrists.<br><br>Inpatient services: Coverage limited to 20 visits per enrollee per state fiscal year for services other than heart, liver, and bone marrow transplants, which are limited to 43, 67, and 40 days, respectively. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Preventive services | Covered as medically necessary. | Not covered. |
| Private duty nursing services | Covered when medically necessary to support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Definitions and limitations applicable to this service are contained in Attachment C. | Not covered. |
| Psychiatric residential treatment services (outside of an IMD) | Covered as medically necessary. | Not covered. |
| Screening services | Covered as medically necessary. | Not covered. |
| Speech, hearing, and language services | Covered as medically necessary. | Not covered. |
| Vision services | Covered for the first pair of cataract glasses following cataract surgery. | Not covered. |

h. The following table (Table 2b) lists HCBS benefits for TennCare Medicaid enrollees and CHOICES demonstration eligibles who are enrolled in the designated CHOICES groups (specified in paragraph 32.a., *Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition, the following rules apply to the CHOICES benefit.

i. The cost of medical assistance provided to an eligible participant in CHOICES 2 is limited to the amount calculated in the individual cost-neutrality test used in Section 1915(c) waivers as set forth in Section 1915(c)(4)(A). The state may delegate implementation of the cost neutrality test to the MCOs.

ii. For purposes of determining capitation rates, the cost of room and board, as defined in Attachment D, is not included in non-institutional care costs.

iii. For persons in CHOICES 3 or Interim CHOICES 3, in addition to the service limits stated in Table 2b, the total cost of the HCBS identified in

Table 2b shall not exceed $15,000 per calendar year, excluding the cost of minor home modifications.

iv. Definitions for CHOICES benefits are provided in Attachment D of these STCs.

**Table 2b**
**Benefits for Persons Enrolled in the CHOICES Program**

| **Benefit** (Definitions provided in Attachment D) | **CHOICES 1** | **CHOICES 2** | **CHOICES 3*** |
|---|---|---|---|
| Nursing facility care | X | Short-term only | Short-term only |
| Community-based residential alternatives | | X | |
| Personal care visits (up to 2 visits per day) | | X | X |
| Attendant care (up to 1080 hours per calendar year); up to 1400 hours per calendar year ONLY when Homemaker services are needed in addition to hands-on care | | X | X |
| Home-delivered meals (up to 1 meal per day) | | X | X |
| Personal Emergency Response Systems | | X | X |
| Adult day care (up to 2080 hours per calendar year) | | X | X |
| In-home respite care (up to 216 hours per calendar year) | | X | X |
| In-patient respite care (up to 9 days per calendar year) | | X | X |
| Assistive technology (up to $900 per calendar year) | | X | X |
| Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) | | X | X |
| Pest control (up to 9 units per calendar year) | | X | X |

*Subject to the limitations in 28.h.iii.

**29. Cost-Effective Alternatives.** TennCare MCOs and TennCare Select may provide services not listed in, or exceeding the individual service limits in, the Medicaid state plan or paragraph 28 (*TennCare Benefits*) of these STCs as allowed under their contracts with the TennCare program. Provision of these services is at the sole discretion of the MCO and TennCare Select. Capitation for the MCOs must be certified as actuarially sound (in accord with 42 CFR § 438.6), and comply with the Federal managed care regulations at 42 CFR §§ 438 et seq. TennCare Select must demonstrate to the state that a service not listed as covered in the Medicaid state plan or in paragraph 28 (TennCare Benefits) is a cost-effective alternative, in order for the state to reimburse TennCare Select for the service. The state must demonstrate to CMS annually as part of the annual report described in paragraph 46 (*Annual Report*) that utilization of these services by the MCOs and TennCare Select is cost-effective and is reimbursed in compliance with the Federal managed care regulations at 42 CFR §§ 438 et seq. Under the CHOICES program, cost-effective alternatives may include a Transition Allowance, as defined in Attachment D.

**30. Medicaid Benefits Carved Out of the TennCare II Demonstration.**

a. **"Base" Medicaid State plan services.** Base services are services carved out of TennCare II, and are provided, in accordance with the provisions of the Medicaid state plan, only to the mandatory and optional state plan eligibles and members of the PACE Carryover Group (in the case of PACE services only). The other TennCare II demonstration-only populations, which are eligible through the demonstration's expenditure authorities and enrolled in TennCare Standard, are not eligible for any of the services listed in Table 3. Expenditures for these "Base" services are not demonstration expenditures (see paragraph 51.a., *Tracking Expenditures*), are not included in the demonstration's budget neutrality, and should, therefore, be reported on the "Base" reporting schedules of the Form CMS-64 reports (or in the case of 1915(c) waiver services, the appropriate 1915(c) waiver schedule). Some carved out services were carved in as of the initial implementation of CHOICES (i.e., March 1, 2010), however, as indicated in Table 3, and must from that point forward be reported as TennCare II demonstration expenditures.

**Table 3**
**Base Services**

| **Services Carved Out of TennCare II** | |
|---|---|
| Nursing facility services | Services moved from the base to the demonstration as of March 1, 2010 (in Middle Tennessee) and August 1, 2010 (in East and West Tennessee) |
| Services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) | Base |
| State Plan targeted case management services | Base |
| Program of All Inclusive Care for the Elderly (PACE) | Base |
| Services covered by the home and community-based services waiver for individuals with intellectual disabilities under 1915(c) of the Social Security Act. | Base |
| Services covered through the state's agreement under Title V of the Social Security Act | Base |

b. **Medicare Parts A and B Buy-In Premiums.** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the Standard Spend Down group, the CHOICES 1 and 2 Carryover Group

and the PACE Carryover Group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare Buy-In premiums are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles as permitted in Section 1902(a)(10)(E) of the Act and 42 CFR § 431.625,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals),

(C) Dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the Standard Spend Down group (QMBs/SLMBs and Demo Duals), and

(E) Dually eligible members of the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group (QMBs, SLMBs, and Demo Duals).

ii. Medicare premiums paid on behalf of Demo Duals are demonstration expenditures, and must be reported on an appropriate Form CMS-64.9 or 9p Waiver, as described in paragraph 51.e. *(Use of Forms).*

iii. Medicare premium payments for other beneficiaries are excluded from TennCare II and must be reported as "Base" Medicaid expenditures on the CMS-64 reports.

iv. Records in CMS's Master Billing Record for Demo Duals and all buy-in transactions for Demo Duals must be identified using a specific Buy-In Eligibility Code (BIEC) value as agreed upon between the state and the Project Officer.

c. **Medicare Co-payments and Deductibles (i.e., Medicare crossover claims).** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, At Risk Demonstration Group, CHOICES 1 and 2 Carryover Group, the PACE Carryover Group or the Standard Spend Down group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare crossover claims are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs, and Demo Duals),

(C) Dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the CHOICES 1 and 2 Carryover Group and PACE Carryover Group, and

(E) Standard Spend Down enrollees (QMBs/SLMBs and Demo Duals).

The SSD population, the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group are the only demonstration populations for whom the state pays Medicare cost-sharing.

ii. For TennCare Medicaid enrollees, members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals), members of the At Risk Demonstration Group (QMBs, SLMBs, and Demo Duals), members of the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group (QMBs/SLMBs and Demo Duals), these expenditures are not demonstration expenditures and are not included in the budget neutrality calculations, so report these as "Base" Medicaid expenditures on the CMS-64 reports.

iii. For dually eligible SSD enrollees (QMBs/SLMBs and Demo Duals), these expenditures are included as demonstration expenditures that are subject to budget neutrality, so report these demonstration expenditures as "EG6E Expan Adult" on the CMS-64 reports. Medicare cost-sharing for SSD dual eligibles is covered in the same manner as Medicare cost-sharing would be covered for Medically Needy aged, blind, or disabled individuals and caretaker relatives, had these groups been included in the Medicaid state plan.

**31. Additional Provisions Related to Institutions for Mental Diseases (IMDs).** Expenditures for services rendered to TennCare II enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.

## VI. CHOICES ENROLLMENT

### 32. Operations of the TennCare CHOICES Program.

a. **Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group.** The CHOICES Program provides long-term services and supports (LTSS) as identified in Table 2b to four groups of people, as defined below:

i. **CHOICES 1.** This group consists of persons who are receiving Medicaid-reimbursed care in a nursing facility (NF).

ii. **CHOICES 2.** Persons age 65 and older and adults age 21 and older with physical disabilities who meet the NF level of care (LOC), who qualify either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to NF care. The demonstration population includes persons who could have been eligible under 42 CFR § 435.217 had the state continued its 1915(c) HCBS waiver for persons who are elderly and/or physically disabled.

iii. **CHOICES 3.** Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles, who do not meet the NF LOC, but who, in the absence of HCBS, are "at risk" for institutionalization, as defined by the state. The state must notify CMS when it determines that it will institute the more restrictive nursing facility level of care standards approved on July 1, 2012 and open CHOICES 3 for enrollment prior to implementation.

iv. **Interim CHOICES 3.** Elderly adults and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of the At Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. This group will close to new enrollment on June 30, 2015.

b. **Eligibility for TennCare CHOICES Benefits.** Individuals can be eligible for one of the four TennCare CHOICES groups defined in a. above depending upon their medical and / or functional needs, their TennCare eligibility group, and the ability of the state to provide them with safe, appropriate, and cost-effective LTSS.

i. Medical and / or functional needs are assessed according to LOC criteria published by the state in state rules.

(A) There will be one set of LOC criteria for NF care, which will be used in assessing eligibility for CHOICES 1 and CHOICES 2.

(B) On July 1, 2012, the state opened enrollment in CHOICES 3, which is subject to a separate set of criteria to determine the "At-Risk" population.

(C) For the purposes of redetermining whether a recipient of NF services (CHOICES 1) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial LOC determination for that individual at the time of enrollment into CHOICES 1.

(D) For the purposes of determining whether a recipient of HCBS for elderly and disabled (CHOICES 2) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial level of care determination for that individual at the time of HCBS enrollment, or for persons transitioning from a NF, at the time of enrollment into CHOICES 1.

(E) For purposes of enrollment into CHOICES 1, the state may grant an exception for persons in the community who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely be met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of initial enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

ii. Financial eligibility:

(A) Financial eligibility for CHOICES 1 is established according to the Medicaid state plan.

(B) In order to be financially eligible for CHOICES 2, an individual must be eligible for TennCare as an SSI recipient or meet the criteria for the CHOICES 217-Like HCBS Group, individuals who qualify under institutional income and resource rules, and who are receiving home and community-based services and would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.726, and 435.236 of the Federal regulations and Section 1924 of the Act, if the home and community based services were provided under a 1915(c) waiver.

(C) In order to be financially eligible for CHOICES 3, an individual must be eligible for TennCare as an SSI recipient.

(D) In order to be financially eligible for Interim CHOICES 3, an individual must be eligible for TennCare as an SSI recipient or as a member of the At Risk Demonstration Group. Members of the At Risk Demonstration Group must meet institutional income and resource criteria.

iii. The state's ability to provide applicants with appropriate home and community based services is determined by the availability of slots under an established enrollment target (see paragraph 32.d., *Enrollment Targets for TennCare CHOICES*) and, for persons in CHOICES 2, the determination by the MCO that the individual can be served appropriately at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i), and for persons in CHOICES 3 and Interim CHOICES 3, the determination by the MCO that the cost of HCBS will not exceed the limit in paragraph 28.h.iii. There is no enrollment target for Interim CHOICES 3.

c. **Enrollment in TennCare CHOICES.** The effective date of enrollment in TennCare CHOICES must be established by the state based on a determination that an applicant is eligible for and must begin receiving LTSS. Enrollment procedures differ depending upon whether or not the person is already enrolled in TennCare Medicaid.

i. **Persons Not Already Enrolled in TennCare.** Persons not already enrolled in TennCare who wish to enroll in TennCare CHOICES must enroll through the State's Single Point of Entry (SPOE). The SPOE must provide counseling and assistance in evaluating LTSS options, screening and intake for LTSS programs offered by the state (TennCare CHOICES as well as other programs), assistance in evaluating the individual's functional LOC for LTSS, and facilitation of Medicaid eligibility determination by the state.

(A) Individuals who are determined to be both medically and financially eligible for NF placement will always be allowed to receive TennCare CHOICES services in a NF as members of CHOICES 1, if they choose.

(B) Those individuals who meet the criteria for CHOICES 2 subject to the limitations set out in these STCs, will be allowed to choose HCBS as an alternative to NF placement if the determination is made that the individual can be served appropriately in CHOICES 2 at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i).

ii. **Persons Already Enrolled in TennCare.**

(A) **Nursing Facility Residents.** MCOs will conduct an assessment of NF residents who wish to move to HCBS to determine if they can be served appropriately in the community at a cost that does not exceed the cost neutrality test set forth in Section 1915(c)(4)(A), as individually applied. Even if an enrollment target has been reached for CHOICES 2, an MCO may transition persons from CHOICES 1 to CHOICES 2 in accord with subparagraph 32.d.iii.(C) *(Transition from CHOICES 1 to CHOICES 2)*.

(B) TennCare enrollees who are not already participating in CHOICES may request enrollment in CHOICES through their MCOs, or they may be identified through other mechanisms that would trigger an assessment of their need for LTSS by the MCO. The MCO will provide counseling and assistance in evaluating LTSS options, and assistance in evaluating the individual's functional LOC eligibility for LTSS. The functional LOC determination for LTSS will be made by the Bureau of TennCare, using criteria published in state rules. Once individuals have established LOC and financial eligibility for LTSS, they can be enrolled in CHOICES in accordance with paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*).

d. **Enrollment Targets for TennCare CHOICES.** The state may establish enrollment targets for CHOICES 2 and CHOICES 3. (There will be no enrollment target for CHOICES 1 or Interim CHOICES 3.) The purpose of the targets is to permit the CHOICES program to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available state and Federal resources. Information on CHOICES Groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Progress Report as set forth in paragraphs 45 *(Quarterly Progress Reports)*, 49 *(Enrollment Reporting)* and Attachment A.

i. The state may establish an enrollment target for CHOICES 2, consistent with the upper and lower limits shown in the table below; with the actual target number to be published in state rules. The state may adjust the target as appropriate from time to time upon notification to CMS at least 30 days prior to the desired effective date of the change. Except as set forth in paragraph 32.d.iii., an increase in the enrollment target above the upper limit appropriate to the DY or a decrease below the lower limit will require an approved waiver amendment prior to implementation.

**Table 4**
**Enrollment Targets for Demonstration Years 12 Through 14**

| Demonstration Year | Lower Limit | Upper Limit |
|---|---|---|
| DY 12 | 12,000 | 16,000 |

| | | |
|---|---|---|
| DY 13 | 13,500 | 17,500 |
| DY 14 | 15,000 | 18,500 |

ii. The state may also establish an enrollment target for CHOICES 3, if this group is established after a change in the level of care criteria. At a minimum, this target will be set at 10% of the enrollment target for CHOICES 2. There will be no enrollment target for Interim CHOICES 3.

iii. If the enrollment target established by the state for CHOICES 2 or CHOICES 3 is reached or exceeded, the state shall not enroll additional persons in CHOICES 2 or CHOICES 3, except as indicated below. The state may also establish a waiting list for CHOICES, subject to the following:

(A) **Reserve Capacity.** The state may reserve slots in CHOICES 2 for individuals being discharged from a NF and for individuals being discharged from an acute care setting who are in imminent risk of being placed in a nursing facility setting absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved must be included as an attachment to the Annual Report (see paragraph 46). The state may establish additional criteria or modify procedures for allocating reserve slots upon 30 day advance written notification to CMS; the operational procedure documents included as attachments to subsequent Annual Reports must reflect any such changes. In each Quarterly Progress Report, the state must provide an accounting of their management of the reserve capacity, including a summary (as of the last day of the quarter) that states the total enrollment targets for CHOICES 2 and 3, the number enrolled in each CHOICES group, and the numbers of slots being held in reserve for various purposes.

(B) **HCBS as a Cost-Effective Alternative.** An MCO with a TennCare enrollee who meets the criteria for CHOICES 2, but which cannot enroll the individual in CHOICES 2 because the enrollment target for CHOICES 2 has been met, has the option, at its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care, in accordance with paragraph 29 *(Cost-Effective Alternatives).* (Consistent with paragraph 32.d.iii.(C), this person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.) The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. The state may require the MCO to provide documentation of its cost-effective alternative determination and assurance of

provider capacity to meet the member's needs prior to enrollment in CHOICES.

(C) **Transition from CHOICES 1 to CHOICES 2.** An enrollee being served in CHOICES 1 who meets the requirements to enroll in CHOICES 2 can enroll in CHOICES 2 at any time such a transition can be accomplished, even if an enrollment target for CHOICES 2 has been reached. This person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.

e. **Waiting Lists for TennCare CHOICES.** The use of enrollment targets as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*) may mean that there will be waiting lists for CHOICES 2 and/or 3. (There will be no enrollment target or waiting list for CHOICES 1 or the Interim CHOICES 3 Group.) These lists must be managed on a statewide basis using a standardized assessment tool and in accord with criteria to be established by the state. Waiting list policies must be based on objective criteria and applied consistently in all geographic areas served. The state may use separate criteria for prioritization of services under CHOICES 2 and CHOICES 3, and may revise these upon notification to CMS.

f. **Consumer Direction.** CHOICES members who have been determined by a care coordinator, as a part of the needs assessment and plan of care processes, to require attendant care, personal care, in-home respite services, companion care or other services specified by the state as eligible for consumer direction, will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e., consumer direction of HCBS). The state will notify CMS in advance of any changes to the list of services eligible for consumer direction. All CHOICES members requiring these services will be offered the option to participate in consumer direction of HCBS. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E.

g. **Miscellaneous Provisions Related to CHOICES Enrollment and Implementation**

i. The state will maintain an electronic visit verification system (as defined in Attachment D) as part of the CHOICES quality program.

ii. The state must ensure that the Care Plan is considered part of the medical record of a CHOICES participant, subject to all associated requirements and protections, and available for review by the state upon request.

## VII. COST SHARING

### 33. Cost Sharing.

a. TennCare Medicaid enrollees under the state plan are subject to cost sharing for pharmacy services (see Table 6 below).

b. Demonstration-only eligible adults enrolled in the SSD category or the At Risk Demonstration Group are subject to cost sharing for pharmacy services (see Table 6 below).

c. TennCare Standard children are subject to cost sharing for both non-pharmacy services and pharmacy services (see Table 5 and Table 6).

d. Individuals participating in CHOICES 1 or CHOICES 2 are exempt from all cost sharing.

e. Individuals participating in CHOICES 3 or Interim CHOICES 3 are subject to cost sharing for pharmacy services (see Table 6 below), similar to other Medicaid state plan adult enrollees.

**34. Co-Payments.** For demonstration-only eligible children in TennCare Standard (title XXI Medicaid Expansion children and medically eligible title XIX children), co-payments are collected by the provider when services are rendered. The requirements at Section 1916A of the Act and at 42 CFR §§ 447.50, 57, 58, and 62 through 82 will apply to cost sharing for this group.

a. **Non-Pharmacy Co-pays.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), the non-pharmacy co-pay amounts are presented in Table 5 (*TennCare Non-Pharmacy Co-Pays).*

**Table 5**
**TennCare Non-Pharmacy Co-pays**

| Poverty Level | Co-payment Amounts |
|---|---|
| 0%-99% | $0.00 |

| Poverty Level | Co-payment Amounts |
|---|---|
| 100% - 199% | $10.00 Non-emergency Hospital Emergency Room (waived if admitted)<br><br>$5.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$5.00 Physician Specialists (including Psychiatrists and Dentists)<br><br>$5.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |
| 200% and above | $50.00 Non-emergency Hospital Emergency Room (waived if admitted)<br><br>$15.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$20.00 Physician Specialists (including Psychiatrists and Dentists)<br><br>$100.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |

b. **Co-Pays on Pharmacy.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), and adults in the Standard Spend Down Demonstration Group, and persons in the At Risk Demonstration Group, co-pays on outpatient pharmacy services are presented in Table 6 (*Co-Pays on Pharmacy)*.

**Table 6**
**Co-Pays on Pharmacy**

| Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| TennCare Medicaid adults who are not exempt from cost-sharing under 42 CFR § 447.53 | $3.00 | $1.50 |
| TennCare Standard under age 21 with incomes below 100% FPL | $0 | $0 |
| TennCare Standard under age 21 with incomes at or above 100% FPL | $3.00 | $1.50 |
| TennCare Standard aged 21 and older -- SSD | $3.00 | $1.50 |

| Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| enrollees | | |
| CHOICES 1 and CHOICES 2 | $0 | $0 |
| Interim CHOICES 3 | $3.00 | $1.50 |
| CHOICES 3 | $3.00 | $1.50 |

**35. Compliance of TennCare Standard Cost Sharing With Federal Regulations.** The state submitted a plan for ensuring that cost sharing for TennCare Standard complies with the statutory and regulatory requirements, including the implementation of an aggregate cost sharing cap as described in 42 CFR § 447.78. The state implemented its plan on January 1, 2013.

## VIII. DELIVERY SYSTEMS

**36. Managed Care Entities.** TennCare II operates totally in a managed care environment and uses various types of managed care entities for delivering covered services to TennCare enrollees. The types of managed care entities used are listed in Table 7 below, with the reimbursement and rate-setting methodologies for each one. Title XXI Medicaid Expansion demonstration population children use the same delivery systems as other enrollees.

**Table 7– Types of Managed Care Entities**

| Type of Entity | BBA Definition | Description of Services Covered | Reimbursement and Rate-Setting Methodology |
|---|---|---|---|
| Managed Care Organizations (MCOs)—at full risk | MCO | All TennCare physical health, behavioral health, and LTSS* | MCO rates are actuarially certified by an independent third party actuary |
| TennCare Select—non-risk or partial risk | Prepaid Inpatient Health Plan (PIHP) | All TennCare physical health, behavioral health, and LTSS* for enrollees selected for participation in TennCare Select rather than enrolled in MCOs (see paragraph 38, *TennCare Select*) | Provider payment rates are negotiated between the PIHP and providers; an administrative fee is approved by CMS and paid to the PIHP |
| Dental Benefits Manager (DBM)—non-risk (may be renegotiated as at risk) | Prepaid Ambulatory Health Plan (PAHP) | Dental benefits for all TennCare enrollees with this coverage | Provider payment rates are established within DBM contract as approved by CMS; an administrative fee, approved by CMS, is paid to the DBM |
| Pharmacy Benefits Manager (PBM)—non-risk (may be renegotiated as at risk) | PAHP | Pharmacy benefits for all TennCare enrollees with this coverage. | Provider payment rates are established in accordance with the state plan; an administrative fee, approved by CMS, is paid to the PBM |

***LTSS refers to services for persons who are elderly or who have physical disabilities.

**37. Enrollment in Managed Care Organizations (MCOs).** With the exception of individuals enrolled in TennCare Select, all individuals eligible for TennCare (TennCare Medicaid or TennCare Standard), including those dually eligible for Medicare, shall be enrolled in a managed care organization providing the benefits described in paragraphs 28 *(TennCare Benefits)* and 29 *(Cost-Effective Alternatives)* of these STCs. In addition to the managed care organization, enrollees are enrolled with a Pharmacy Benefits Manager for covered pharmacy services and a Dental Benefits Manager for covered dental services. The Pharmacy Benefits Manager administers the pharmacy benefits program, using a preferred drug list that is established by the state (in consultation with a Pharmacy

Advisory Committee), taking into account the cost, therapeutic equivalency, and clinical efficacy in accordance with waiver authority.

**38. TennCare Select.** TennCare Select is a prepaid inpatient health plan (PIHP) (as defined in 42 CFR § 438.2) which operates in all areas of the state and covers the same services as the MCOs. The state's TennCare Select contractor is reimbursed on a non-risk, non-capitated basis or a partial risk basis for services rendered to covered populations, and in addition receives fees from the state to offset administrative costs.

a. The TennCare Medicaid and TennCare Standard populations included in the TennCare Select delivery system and the services provided to these populations by the TennCare Select contractor are as follows:

i. Children who are eligible for Supplemental Security Income. TennCare Select provides medical case management and all MCO covered services.

ii. Children in state custody and children leaving state custody for 6 months post-custody as long as the child remains eligible. TennCare Select provides medical case management, all MCO covered services, and coordination with the Department of Children's Services (DCS) around medical and behavioral services.

iii. Children who are receiving care in a nursing facility or an intermediate care facility for individuals with intellectual disabilities. For children and adults in a Home and Community Based Services 1915(c) waiver for individuals with intellectual disabilities, current enrollees may opt-in to receive services through TennCare Select, and new participants may opt-out of TennCare Select in order to receive services through another MCO. TennCare Select provides medical case management and all MCO covered services.

iv . Enrollees living in areas where there is insufficient capacity to serve them. TennCare Select provides medical case management and all MCO covered services.

After being assigned to TennCare Select, persons in categories i. and iii. above may choose to disenroll from TennCare Select and enroll in an MCO if one is available. Persons in categories ii. and iv. must remain in TennCare Select. The state must request a demonstration amendment (as described in paragraphs 6 and 7 regarding amendments) in order to change the list of populations included in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

b. TennCare Select also provides the following functions:

i. It is the back-up plan should one of the MCOs have to leave the TennCare program unexpectedly. For TennCare enrollees previously enrolled with

the MCO, TennCare Select provides medical case management and all MCO covered services.

ii. It is the only entity responsible for payment of the services described in 42 CFR § 431.52 (regarding services provided to residents temporarily absent from the state), and provides all MCO covered services (primarily emergency services).

iii. It is also the only entity responsible for payment of the services described in 42 CFR § 440.255 (regarding emergency services for aliens), and is responsible for payment of emergency medical services only. TennCare Select is paid an administrative fee for processing these claims.

**39. Plan Enrollment and Disenrollment.** The state maintains a managed care enrollment and disenrollment process that must comply with 42 CFR Part 438, except that, in accordance with waiver authority, TennCare participants have 45 days in which to disenroll from an MCO without cause. After 45 days, a participant may disenroll from an MCO only for cause, as set forth in 42 CFR § 438.56(d)(2). The "other reasons" that will be considered cause under 42 CFR § 438.56(d)(2)(iv) do not include the following:

- The enrollee is unhappy with the current plan or primary care provider (PCP), but there is no hardship medical situation (as defined by the state);
- The enrollee claims lack of access to services but the plan meets the state's access standards;
- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- The enrollee is concerned that a current provider might drop out of the plan in the future;
- The enrollee is a Medicare recipient who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation; and
- The enrollee's Primary Care Provider (PCP) is no longer in the MCO's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO.

In the event that a CHOICES member is determined, based on an assessment of needs, to require long term services and supports that are not currently available under the MCO in which he is currently enrolled, but that are available through another MCO, the state shall work with the current MCO to arrange for the provision of the required services, which may involve providing such services out-of-network. It shall be considered to be cause for disenrollment only if the current MCO, after working with the state, is unable to provide the required services. In such cases, the MCO that is unable to provide the required services after working with the state may be subject to sanctions.

**40. Contracts.** The following subparagraphs provide additional requirements pertaining to contracts awarded by the state for the provision of health care services under TennCare II.

a. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation.

b. Payments under contracts with public agencies that are not competitively bid in a process involving multiple bidders shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

c. With respect to CHOICES, the state established minimum guidelines regarding the person-centered service plan, the processes for the development of the plan, and the monitoring of its implementation. These expectations were submitted to CMS and are reflected in the MCO contract. Any changes in the contract requirements related to the subjects enumerated below will be submitted to CMS for review prior to executing a contract amendment with an MCO. CMS will respond within 15 working days of receipt of the draft. The required subject areas are as follows:

   i. The individuals who develop the person-centered service plan (and their requisite qualifications);

   ii. The individuals who are expected to participate in the plan development process;

   iii. Timing of the plan, how and when it is updated, including mechanisms to address changing circumstances and needs (and expectations regarding scheduling and location of meetings to accommodate individuals receiving services);

   iv. Types of assessments that are conducted as a part of the service plan development process;

   v. How participants are informed of the services available to them;

   vi. How the process ensures that the service plan addresses the participants' desired outcomes, needs and preferences; and

   vii. The plans' responsibilities for implementing and monitoring the plan of care.

d. The state will require the MCOs to develop and maintain emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. These contingency plans will be available for inspection by state officials upon request.

e. The state will monitor loss ratios of the managed care plans.

## IX. GENERAL REPORTING REQUIREMENTS

**41. General Financial Requirements.** The state shall comply with all general financial requirements under title XIX and title XXI set forth in these STCs.

**42. Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request.

**43. Additional Reporting Requirements.**

a. **Compliance with Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR §§ 438 *et seq.*

b. **Compliance with Specified HCBS Requirements.** The following regulations, which govern the provision of HCBS under Section 1915(c) waivers, shall apply to the HCBS program authorized under Section 1115 and provided through CHOICES:

- 42 CFR § 440.180(a);
- 42 CFR § 441.302;
  (a),
  (c) (insofar as it relates to NF level of care, and applying only to CHOICES 2),
  (d) (consistent with a waiver of Section 1902(a)(23) of the Act),
  (g) (applies only to CHOICES 2), and
  (j);
- 42 CFR § 441.303
  (a),
  (c) (except that the requirements following the semi-colon in (c)(2) do not apply to CHOICES 3 or Interim CHOICES 3),
  (d) (consistent with Table 2b, paragraph 28), and
  (e); and
- 42 CFR § 441.310.

Any conflict between the regulations listed in this subparagraph and these STCs shall be resolved in favor of the STCs. The state shall include a description of the steps taken to ensure compliance with these regulations as part of the Annual Report discussed in paragraph 46 *(Annual Report)*.

c. **Quality Improvement Strategy for the CHOICES Program.** The state must submit to CMS an integrated quality improvement (QI) strategy which builds on existing managed care quality requirements as defined in 42 CFR § 438, Subpart E, and incorporates applicable 1915(c) Home and Community-Based Services

waiver regulatory assurances as discussed in paragraph 43.b.

The state must identify: 1) measures of process, health outcomes, functional status, quality of life, member choice, autonomy, satisfaction, and TennCare and CHOICES system performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

The MCOs must be required to establish methods for discovery, remediation and systems improvement and, per state prescribed timeframes, regularly report on outcomes associated with continuous quality improvements.

The state must clearly demonstrate its oversight of the process.

The QI strategy must be submitted to CMS for approval prior to implementation.

No less frequently than annually, the state must provide to CMS information regarding QI activities which must include evidence regarding system performance based on identified objectives and measures, and which demonstrates efficacy in implementing the quality strategy, including but not limited to external quality review, discovery, remediation and systems improvement activities.

d. **CHOICES Data.**

i. **CHOICES Data Plan.** The state will collect and submit data to CMS, including the following data elements:

(A) Numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services at a point in time,

(B) Unduplicated numbers of persons receiving HCBS and unduplicated numbers of persons receiving NF services during a 12 month period,

(C) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period,

(D) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period as a percentage of total long-term services and supports expenditures (excluding expenditures on the population of persons with intellectual disabilities),

(E) Average per person HCBS expenditures and NF expenditures on the elderly and disabled populations during a 12 month period,

(F) Average length of stay in HCBS during a 12 month period,

(G) Percent of new LTSS recipients admitted to NFs during a 12 month period,

(H) Average length of stay in NFs during a 12 month period,

(I) Number of persons transitioned from NFs to HCBS during a 12 month period.

"Point in time" refers to June 30 of each year.

ii. **Electronic Collection of Choices Data.** The systems must be in place to record the requisite data elements for the CHOICES Program.

iii. **CHOICES Data Reporting.** The state must report to CMS, in the Quarterly and Annual Progress Reports, on data and trends of the designated CHOICES data elements. An electronic copy of the actual data addressing the required data elements must be submitted to CMS within 3 months following each point in time (e.g., by September 30 of each DY).

e. **Requirements Related to the Affordable Care Act.** Subparagraphs i. and ii. below describe elements that must be included in an extension proposal or phase-out plan, as discussed in paragraph 8 *(Extension of the Demonstration)* and paragraph 9 *(Demonstration Phase-Out)*.

i. **Affordable Care Act Transition Plan for Extension.** The extension proposal submitted to CMS in June 2012 included a Transition Plan. This plan will be updated consistent with the provisions of the Affordable Care Act and CMS regulations for any individuals enrolled in Demonstration Eligible Groups (as defined in paragraph 17, Table 1a) who will be eligible for coverage under the state plan as of January 1, 2014, including under the new Medicaid eligibility group identified in Section 1902(a)(10)(A)(i)(VIII) of the Act, or who elect to move to an Exchange plan. Persons who are demonstration eligibles at the time of transition will continue to receive demonstration benefits as long as they are enrolled in a Medicaid category and they continue to meet the criteria for their particular demonstration program. The updated Transition Plan will include procedures for ensuring that these individuals transition to their new eligibility status without interruption in coverage to the maximum extent possible.

ii. **Demonstration Phase-Out and Affordable Care Act Transition.** As part of a phase-out plan submitted under paragraph 9, the state must include a plan for using information already in its possession on members of demonstration Eligible Groups to make advance determinations of

eligibility for TennCare under its Medicaid state plan on January 1, 2014, consistent with guidance to be issued by CMS.

**44.** **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the state's progress on enrolling individuals into the TennCare Standard Spend Down Demonstration Group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

**45.** **Quarterly Progress Reports.** The state must submit progress reports containing the items listed below (see also Attachment A for format), no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. An updated CHIP allotment neutrality monitoring spreadsheet, if necessary;

c. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the TennCare Standard Spend Down Demonstration Group; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the demonstration; pertinent legislative or litigation activity; and other operational issues;

d. Action plans for addressing any policy, administrative, or budget issues identified;

e. Quarterly enrollment reports for demonstration eligibles that include the member months for each demonstration population;

f. Quarterly enrollment reports for individuals who would otherwise be eligible for Interim CHOICES 3 but who meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual;

g. Evaluation activities and interim findings; and

h. Other reports as indicated in these STCs.

**46. Annual Report.** The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The state shall also submit the title XXI annual state report for its Medicaid Expansion children in the demonstration, by December 31 of each year.

**47. Beneficiary Survey.** The state shall conduct a beneficiary survey each demonstration year for a statistically valid sample of all TennCare enrollees. The survey shall measure satisfaction, enrollee efforts to secure out-of-network care, average waiting time for physician office visits, and enrollee efforts to change plans, along with reasons for requesting plan changes. Results of the survey must be provided to CMS by September after the end of in each demonstration year (e.g. survey results for demonstration year 12 are due no later than September 30, 2014).

**48. Final Evaluation Report.** The state shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act and as specified in Section XII of these STCs.

**49. Enrollment Reporting.**

a. Each quarter the state will provide CMS with an enrollment report for the title XXI Medicaid Expansion demonstration population and for title XIX Medicaid children, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the state into the Statistical Enrollment Data System (SEDS) within 30 days after the end of each quarter. SEDS reporting is required for any title XXI-funded population, including Medicaid Expansions, and is also required for title XIX Medicaid child enrollment.

b. Enrollment reporting in the Quarterly and Annual Reports (see paragraphs 45 *Quarterly Progress Reports* and 46 *Annual Report*) is required by Eligibility Group (EG) and Type for the TennCare title XIX and XXI state plan and demonstration populations.

## X. GENERAL FINANCIAL REQUIREMENTS

**50. Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under Section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period and pool payments and certified public expenditures made for the demonstration period. CMS shall provide Federal financial participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X of these Terms and Conditions.

**51. Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Tennessee must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which capitation payments were made. For this purpose, demonstration year 1 (DY 1) is defined as the year beginning July 1, 2002, and ending June 30, 2003. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures should be reported on Forms CMS-64.9 Base/64.9P Base.

Expenditures for Medicaid Expansion children claimed under the authority of title XXI of the Act shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

b. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by demonstration year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the eligibility groups (EGs) from which collections were made (see paragraph 53, *Assignment of Expenditures and Member Months to EGs*). In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations shall be offset

against expenditures. These Section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver or 64.9P Waiver schedules, and allocated to forms named for the different EGs described in e.i. through e.xii. below as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to demonstration populations shall be offset against expenditures.

e. **Use of Forms**. The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration and title XIX expenditures made in other payment categories as follows. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system. The terms "EG1" through "EG12" refer to the demonstration Eligibility Groups defined in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)* of these STCs.

i. "EG1 Disabled" expenditures (see paragraph 53.a.i.)

ii. "EG2 Over 65" expenditures (see paragraph 53.a.ii.)

iii. "EG3 Children" expenditures (see paragraph 53.a.iii.)

iv. "EG4 Adults" expenditures (see paragraph 53.a.iv.)

v. "EG5 Duals" expenditures (see paragraph 53.a.v.)

vi. "EG6E Expan Adult" expenditures (see paragraph-53.b.i.)

vii. "EG7E Expan Child" expenditures (see paragraph 53.b.ii.)

viii. "EG8 Med Exp Child" expenditures (see paragraph 53.b.iii.)

ix. "EG9 H-Disabled" expenditures (see paragraph 53.b.iv.)

x. "EG10 H-Over 65" expenditures (see paragraph 53.b.v.)

xi. "EG11 H-Duals" expenditures (see paragraph 53.b.vi.)

xii. "EG12E Carryover" expenditures (see paragraph 53.b.vii.)

xiii. "GME" (Graduate Medical Education) (see paragraph 55.d.)

xiv. "EAH Pool" (Essential Access Hospital Pool) (see paragraph 55.e.)

xv. "CAH Pool" (Critical Access Hospital Pool) (see paragraph 55.f.)

xvi. "Meharry Pool" (see paragraph 55.g.)

xvii. "CPE" (Certified Public Expenditures) for Unreimbursed Public Hospital Costs Pool (see paragraph 55.h.)

xviii. "DSH" (Disproportionate Share Hospital Payments) (see paragraph 55.i.)

xix. "UHC Pool" (Unreimbursed Hospital Cost Pool) (see paragraph 55.k.)

xx. "PHSP Pool" (Public Hospital Supplemental Payment Pool) (see 55.l.)

f. **Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population.**

i. **Expenditures Subject to the Allotment Neutrality Limit.** The state will be subject to a limit on the amount of Federal title XXI funding that the state may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including available reallocated funds published in the *Federal Register*. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of demonstration until the next allotment becomes available.

ii. The state is eligible to receive title XXI funds for expenditures for TennCare Medicaid Expansion children described on the last row of Table 1a in Section IV, paragraph 17 *(Eligibility)*, up to the amount of its title XXI allotment. Waiver expenditures for these children under title XXI must be reported as a Medicaid expansion population on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver, in accordance with the instructions in Section 2115 of the State Medicaid Manual, under waiver name "Med Exp Child," identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which

capitation payments were made. They are reported in Column C for the enhanced match under title XXI.

iii. If the state exhausts its title XXI allotment, title XIX funds are available for title XXI children in this demonstration. To access this funding, the state must submit for approval a written request to CMS, referencing this STC, to access title XIX funds for the title XXI Medicaid Expansion Demonstration Group. This request must be submitted at least 90 days prior to the date on which the state anticipates its title XXI allotment will be exhausted, and must include:

(A) An updated budget neutrality assessment that adds Medicaid Expansion children to budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that removes Medicaid Expansion children.

iv. Once the title XXI allotment is again available, the state will claim title XXI funding for the title XXI children in this demonstration. To access this funding, the state shall submit for approval a written request to CMS, referencing this STC, to access title XXI funds for the title XXI Medicaid Expansion Demonstration Group, which includes a request to update the STCs related to claiming. This formal request must be submitted prior to the change in funding source and include:

(A) An updated budget neutrality assessment that removes Medicaid Expansion children from budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that adds Medicaid Expansion children.

v. During periods in which the state is claiming title XIX funds for Title XXI Medicaid Expansion demonstration population children, the member months attributable to this demonstration population will count toward calculation of the budget neutrality expenditure limit, using the per member per month (PMPM) amounts for "EG8 Med Exp Child." The expenditures will be considered expenditures subject to the budget neutrality expenditure limit, so that the state is not fully at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

g. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to:

i. All TennCare title XIX expenditures on behalf of individuals who are enrolled in this demonstration (excluding the services specified in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*), including all service expenditures and applicable administrative costs (see subparagraph h. below) net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse), and

ii. All expenditures described in paragraph 55.d. through i. *(Extent of Federal Financial Participation for the Demonstration).*

All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver, with the exception of those described in h. below.

h. **Administrative Costs.** In general, administrative costs are not included in the budget neutrality expenditure limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. Administrative costs subject to budget neutrality (see below) must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, according to the EGs for which the expenditure was made (following the list in e.i. through e.xii. above). Other administrative costs not subject to budget neutrality will not be broken out by EG, and will be reported under waiver name "TennCare II."

In accordance with Federal regulations at 42 CFR § 438.812(b)(2), during the periods that services are provided in accordance with MCO, pharmacy benefit manager, or dental benefit manager non-risk contracts, the portion of the state's payments that is for reimbursement of the non-risk contractors' administrative services can only be claimed by the state as an administration cost at the Federal matching rates available for the costs of administration of the Medicaid program. The administrative services portion of the amounts paid by the state to compensate any non-risk contractors for their administration costs incurred in accordance with non-risk contracts are costs of the demonstration waiver that are subject to the budget neutrality expenditure limit explained in Section XI of these STCs.

i. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the Section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.

**52. Reporting Member Months.** The following describes the reporting of member months for TennCare Medicaid and TennCare Standard enrollees:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 45 *(Quarterly Progress Reports)* of these STCs, the actual number of eligible member months for all TennCare Medicaid and TennCare Standard Eligibility Groups (EGs) defined in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)*. The state must submit a statement accompanying the quarterly report, which recognizes the accuracy of this information. Member months should be reported only for individuals who are included in TennCare, as defined in paragraph 17 *(Eligibility)*. Persons for whom Medicaid only pays for services carved out of TennCare (as described in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*) are not enrolled in TennCare (e.g., QMBs, SLMBs).

b. A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for Type 1 and Type 2 eligibles (as defined in paragraph 61, *Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement*) are reported in Section VIIIA of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for Type 3 demonstration expansion populations and for title XXI Medicaid Expansion demonstration eligibles are reported in Section VIIIB of the template, and are not used to calculate the budget neutrality expenditure limit. Detailed instructions for

assigning member months to Types and to EGs are provided in paragraphs 53 *(Assignment of Expenditures and Member Months to EGs)* and 61 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)*.

c. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the state must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

d. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

e. The state will ensure that eligible member month totals reported to CMS for the TennCare II demonstration from July 1, 2002, forward conform to the EG definitions contained in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)*.

**53. Assignment of Expenditures and Member Months to EGs:** The following rules govern the:

- Reporting of expenditures subject to the budget neutrality expenditure limit on separate waiver forms by EG, as described in paragraph 51.e. *(Use of Forms)* above, for the period beginning July 1, 2007, through the end of the TennCare II demonstration, and
- Reporting of eligible member months for the TennCare II demonstration from July 1, 2002, forward.

Beginning July 1, 2007, and as subsequently modified, the quarterly progress report template in Attachment A, Part VIII should be used to report separate member month totals for Type 1, Type 2, and Type 3 eligibles, and for other subgroups as specified below.

a. **<u>Title XIX State Plan Mandatory or Optional Groups (Type 1 Eligibles)– TennCare Medicaid:</u>**

i. For Medicaid eligibles of any age who have qualified for Medicaid on the basis of disability but who are not eligible for Medicare, report under **EG1 Disabled, Type 1.** This includes non-dual SSI eligibles in CHOICES 1, 2, and 3, the CHOICES 1 and 2 Carryover Group, or the PACE Carryover Group.

ii. For Medicaid eligibles who have not qualified for Medicaid on the basis of

disability, who are not eligible for Medicare, and who are 65 years of age or older, report under **EG2 Over 65, Type 1.**

iii. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are age 18 or younger, report under **EG3 Children, Type 1.**

iv. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are between the ages of 19 and 64, report under **EG4 Adults, Type 1.**

v, For Medicaid eligibles of any age who are also eligible for Medicare, report under **EG5 Duals, Type 1.** This category includes dually eligible Medicaid/Medicare individuals who have been classified as "disabled." It does not include any dually eligible members of demonstration populations such as the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group.

b. **Title XIX Demonstration Eligible Groups (Type 2 or 3 Eligibles) – TennCare Standard**

i. For demonstration eligibles who are enrolled in the Standard Spend Down category, report under **EG6E Expan Adult, Type 3.** This category includes SSD enrollees who have Medicare or who have been classified as "disabled."

ii. For demonstration eligible children under age 19 who have been determined to be "Medically Eligible" and who have incomes at or above 200 percent of poverty, report under **EG7E Expan Child, Type 3.**

iii. For demonstration eligible children under age 19 who have been determined to be uninsured and who have incomes below 200 percent of poverty, report under **EG8 Med Expan Child, Type 2, only when Title XIX funds are being used.** This is the Title XXI population. This EG is in effect only when the state is using Title XIX funds for this population. In periods when the state is using Title XXI funds, these children would not be included in any EG but would be reported as indicated in c. below.

iv. For persons in the CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are under age 65, report under **EG9 H-Disabled, Type 2.** This category should also be used for members of any age in the At Risk Demonstration Group who are not eligible for Medicare.

v. For persons in the CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are age 65 or older, report under **EG10 H-Over 65,**

**Type 2.**

vi. For persons in the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group who are also eligible for Medicare, report under **EG11 H-Duals, Type 2.**

vii. For demonstration eligible (non-SSI) persons in the CHOICES 1 and 2 Carryover Group or the PACE Carryover Group, report under **EG12E Carryover, Type 3.** This category should be used for both duals and non-duals in the Carryover Groups.

c. Expenditures for title XXI Medicaid Expansion children matched at the title XXI enhanced FMAP should be reported on Forms 64.21U Waiver/64.21UP Waiver, using waiver name "Med Exp Child." Report member months for quarterly reporting using Attachment A, Part VIII. For periods in which the state claims title XIX FMAP for this population (paragraph 51.f. *Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population*), follow the instructions in b.iii. above.

d. Type 2 eligibles can be identified as disabled for reporting purposes (see b.iv. above) if information exists in their enrollment record that would result in a capitation rate for disabled populations being paid on their behalf.

**54. Standard Funding Process.**

a. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

b. **Standard CHIP Funding Process.** The standard CHIP funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the allotment neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by

CMS. Within 30 days after the end of each quarter, the state must submit quarterly CHIP expenditure reports as described in paragraph 51.f. *(Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population)*, showing CHIP expenditures made in the quarter just ended. CMS shall reconcile expenditures with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

**55. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding (see Section X, paragraph 57, *Sources of Non-Federal Share*), CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section XI of these STCs.

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

d. **Graduate Medical Education (GME) Pool.** Actual cash disbursements, up to $50 million in total computable expenditures for each demonstration year, paid by the state from a supplemental pool to pay for GME costs in accordance with the pool distribution methodology described below. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology, authorized by the demonstration's expenditure authorities. Should CMS promulgate new regulations, the TennCare GME program must come into compliance in accordance with the effective date of the new regulations.

*GME Pool Methodology*: GME Pool payments will be made to the following medical universities that operate graduate physician medical education programs. These payments are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics: East Tennessee State University, Meharry Medical College, University of Tennessee at Memphis, and Vanderbilt University. The annual GME Pool funds will be allocated based on the annual ratio derived by dividing each hospital's average of its Primary Care Position Allocation and its Total Filled Positions Allocation by the aggregate of the medical hospitals' averages. The Primary Care Position Allocation is computed by taking each hospital's total number of primary care residents in years 1 through 4 of residency and dividing it by the total of all primary care residents in the medical hospitals in years 1 through 4 of residency.

The Total Filled Positions Allocation is computed by taking each hospital's total number of residents in years 1 through 4 of residency and dividing it by the total of the medical hospitals' number of residents in years 1 through 4 of residency. This annual ratio is applied to the total GME Pool funding to be allocated. The annual GME Pool funds will be disbursed quarterly. The state must make these payments directly to the universities, and not through any third party or intermediary.

e. **Essential Access Hospital (EAH) Pool.** Actual cash disbursements paid each quarter from a $25 million quarterly supplemental pool to pay for the uncompensated costs of the designated EAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and appropriate charity care patients in accordance with the pool distribution methodology described below. The purpose of this pool is to address the uncompensated care situation of high volume and charity hospitals that serve a disproportionate number of low-income patients with special needs. Hospitals designated as Critical Access Hospitals (CAHs) or as state mental health institutes do not participate in this pool. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

For FFYs 2008 and beyond, EAH Pool payments will be assumed to pertain to the FFY during which the payments were made. To the extent required by Federal law, EAH Pool payments made during a given FFY shall be reduced on a dollar for dollar basis by the amount of DSH payments made under the DSH allotment for that FFY.

*EAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Essential Access Hospitals.

*Qualifications* -- Hospitals eligible to receive EAH Pool payments include all hospitals licensed to operate in the State of Tennessee excluding the four (4) state mental health institutes and the CAHs. The four regional mental health institutes are Memphis Mental Health Institute, Moccasin Bend Mental Health Institute, Western Mental Health Institute, and Middle Tennessee Mental Health Institute. The CAHs receive cost-based reimbursement from the TennCare program subject to limitations outlined in subsection f. of this paragraph.

- All hospitals, with the exception of free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program.
- The free standing psychiatric hospitals must be a contracted provider with at least one of the Managed Care Organizations in the TennCare program and at least 30% of their total adjusted days must be covered by TennCare.

- All acute care hospitals must have either of the following: (i) at least 13.5% or more of their total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days.
- All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare cost.

*Allocation of the EAH Pool to Segments of Hospitals* -- The $25 million Pool should be segmented into 4 distinct parts as follows:

- Essential Service Safety Net – $12.5 Million -- These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved.
- Children's Safety Net – $1.25 Million -- These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children under the age of 21 in Tennessee.
- Free Standing Psychiatric Hospitals - $0.5 Million -- These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health for the provision of psychiatric hospital services in Tennessee, excluding the state mental health institutes.
- Other Essential Acute Care – $10.75 Million -- These hospitals include all other hospitals licensed by the Tennessee Department of Health to provide services in Tennessee, excluding the Critical Access Hospitals.

*Quarterly Reports* – The state must include in its Quarterly Progress Reports a list of the current hospitals in each of the above categories (see Attachment A).

*Data* -- Calculation of the quarterly payment amounts will be based on the most recently completed Joint Annual Report of Hospitals at the time of the first quarterly payment for a given fiscal year.

*Allocation will be based on an assignment of points for*:
- TennCare adjusted days expressed as a percent of total adjusted patient days; and
- Charity, medically indigent care, and bad debt expressed as a percent of total expenses.

*Calculation of Points*
**(1)** TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:

- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the critical access, pediatric and safety net providers;
- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 34.5%;
- 3 points – greater that 34.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

**(2)** Bad Debt, Charity and Medically Indigent – BDCHMI costs as a percent of total expenses

- 0 points - less than 4.5%
- 1 point - greater than or equal to 4.5% and less than 9.5%
- 2 points - greater than or equal to 9.5% and less than 14.5%
- 3 points - greater than or equal to 14.5%

*Calculation of Amounts of Pool Payments for Hospitals* -- These points will then be used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate included all inpatient costs (operating, capital, direct education) but excluded add-ons (indirect education, MDSA, return on equity). The GHR for Safety Net Hospitals is $908.52. The GHR for Other Essential Access Hospitals is $674.11. The points for each qualifying hospital will be summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each of the 4 pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initially calculated amount will then be adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. For example, if the sum of the initial calculated amounts for the pediatric group is $9 million and the total pool for children's hospitals is $5 million, each hospital's initial calculated amount will be multiplied by $5 million / $9 million.

*Pool Payments* -- Hospitals will be paid on a quarterly basis following the end of each quarter. The initial payment will include all quarters that have ended at the time that the payment is made. All subsequent quarterly payments will be made

following the end of the quarter. In order to receive a payment for the quarter, all hospitals, with the exception of the free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, with at least one Managed Care Organization, and must have contracted with TennCare Select for the entire quarter that the payment represents. In order for a free standing psychiatric hospital to receive a payment for the quarter, it must be a contracted provider with at least one of the Managed Care Organizations.

*Additional Payment*. For the 12 month period beginning on April 1, 2014, and ending on March 31, 2015, an additional $81.3 million may be allocated to hospitals meeting the qualifications listed in this subparagraph. Payments to individual hospitals will be calculated according to the stated methodology. TennCare will have the flexibility to distribute these payments on a quarterly or multi-quarterly basis, as long as the total expenditure under this authority does not exceed $80 million.

f. **Critical Access Hospital (CAH) Pool.** Actual cash disbursements, of up to $10 million per demonstration year, paid from a supplemental pool to pay for the uncompensated costs of the designated CAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and the appropriate charity care patients in accordance with the pool distribution methodology that has been given CMS prior approval. CAHs are designated by the Tennessee Department of Health, and they are typically small, rural hospitals that are part of a rural health network. CAHs allow communities to maintain access to primary care and emergency care when the maintenance of a full-service acute care hospital is no longer feasible. The purpose of this pool is to address the uncompensated care situation of CAHs in serving a disproportionate number of low-income patients in rural areas who have special needs. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

*CAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Critical Access Hospitals.

*Qualifications* -- To qualify for payment as a Critical Access Hospital, a hospital must meet the following criteria:

- The hospital is an acute care hospital located and licensed in the state of Tennessee;
- The hospital has been designated a Critical Access Hospital by the Tennessee Department of Health; and
- The hospital contracts with a managed care organization participating in TennCare.

*Reimbursement* -- TennCare will provide reimbursement to Critical Access Hospitals under the following terms. Reimbursement to hospitals will be

limited to specific annual legislative appropriation. In any state fiscal year that reimbursable TennCare costs incurred by Critical Access Hospitals exceed annual appropriations, equitable adjustments will be made to the rates described below, in order to cap reimbursement at the annual appropriation.

***Inpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare inpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly with interim per diem rates and will be cost-settled at year-end. Using the Joint Annual Reports filed for the most recent year available, interim per diem rates for TennCare inpatient services will be determined with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs. Inpatient Critical Access Hospital services will not include more than 15 acute inpatient beds. An exception to the 15 bed requirement is made for swing bed hospitals. Critical Access Hospitals are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that not more than 15 beds are used at any one time for acute care.

***Outpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare outpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly based on a percentage of charges with year-end cost settlements. Using the Joint Annual Reports filed for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges, with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs.

**Cost Settlements** -- Cost settlements are determined from provider submitted Medicare cost reports that include the title XIX schedules based on 100 percent (100%) of TennCare reasonable costs. The term “reasonable costs” is defined for this purpose as total reimbursable costs under Medicare principles of cost reimbursement for Critical Access Hospitals.

*New Designations of Critical Access Hospitals* -- For new hospitals that qualify after July 1, 2002, the state will begin reimbursement at the rates established by this part on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its Critical Access Hospital designation. At that time, interim rates will be established according to this part and the designation will be confirmed with the Tennessee Department of Health.

*Audit Trail and Audit Requirements* -- Each CAH is required to maintain adequate financial and statistical records which are accurate and in sufficient

detail to substantiate the cost data reported. These records must be retained for a period of not less than 5 years from the date of the submission of the Joint Annual Report, and the provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint Annual Reports are subject to audit at any time by Federal and state auditors, including the Comptroller of the Treasury and the Bureau of TennCare, or their designated representative.

g. **Meharry Medical College (Meharry) Pool.** Actual cash disbursements paid from a $10 million supplemental pool per demonstration year to pay for the uncompensated costs of the two Medicaid clinics operated by the Meharry Medical College for TennCare covered services provided to TennCare enrollees and the appropriate charity care patients. The Meharry Pool payments will be limited to the uncompensated costs of the care as determined by an independent audit each year and subject to the review and approval by the CMS staff. Before paying the annual pool amount to the providers, the state will provide CMS with a copy of the annual independent audit report. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

h. **Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (CPE).** Actual costs incurred by government operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients are eligible as CPE. The state must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital from the following sources: the MCOs; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds). With regard only to hospital CPE, the state will report actual CPE within 12 months after the end of each fiscal year. At that time, the state will revise its FFP claim to reconcile actual CPEs with the CPE estimates used during the preceding fiscal year (FY).

**State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the state of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

**CPE Methodology and Protocol.** The state must follow the CPE protocol, as contained in Attachment F of these STCs, which was approved by CMS for use beginning July 1, 2008.

i. **Disproportionate Share Hospital (DSH) Payments.** The Tax Relief and Health Care Act of 2006 (TRHCA 2006) established a DSH allotment for Tennessee for

FFY 2007, as described at Section 1923(f)(6) of the Act. The relationship between DSH payments made by Tennessee under TRHCA 2006 and payments from the EAH Pool is further specified in the second paragraph of subparagraph (e) above. If Congress should establish a DSH allotment for Tennessee for any subsequent Federal fiscal year, the state may make DSH payments to hospitals on the basis of a state plan amendment approved by CMS. Depending on the specifics of the legislation establishing the DSH allotment, modifications to the budget neutrality expenditure limit may be required, in the manner specified in paragraph 4.a. (*Impact on Demonstration of Changes in Federal Law, Regulation, and Policy)*. Unless otherwise specified by law, DSH payments shall be considered payments made under the demonstration and subject to the budget neutrality expenditure limit and the limit described in subparagraph (j) below. When determining hospital-specific DSH limits and DSH payments, the state must take into account all Medicaid payments under the Medicaid state plan and demonstration projects including amounts paid to hospitals through the GME, EAH, Meharry Medical College, UHC, PHSP, and CAH Pools, as well as any payments by or on behalf of individuals with no source of third party coverage. The state must make these payments directly to the providers of the services as specified at Section 1923(i) of the Social Security Act.

j. Beginning in DY 6 (state fiscal year 2008), the combined total of the payments to hospitals listed in i. below shall not exceed annual limits described in iv. Beginning in DY 11 (state fiscal year 2013), the combined total of the payments to the hospitals listed in iii. below shall not exceed annual limits described in iv. Any unused amount from the annual cap for one DY may not be rolled over and added to the annual cap for any subsequent DY.

i. The following payments are subject to the limit in DY 6 through 9:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of DSH payments (see 55.i. subject to the allotment for the FFY ending during the DY);
- Three-quarters of DSH payments (see 55.i. subject to the allotment for the FFY beginning during the DY);
- Hospital CPE (see-55.h.).

ii. The following payments are subject to the limit in DY 10:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of the DSH payments (see 55.i., subject to the allotment for the FFY 2011);
- Additional DSH payments equal to the DSH allotment for the first quarter of FFY 2012;
- Hospital CPE (see 55.h.)

iii. The following payments are subject to the limit in DYs 11-14:

- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- Hospital CPE (see 55.h.).

iv. The annual limit for DY 6 – DY 14 shall be $540 million (total computable).

k. **Unreimbursed Hospital Cost (UHC) Pool.** Actual costs incurred by eligible Tennessee hospitals that are unreimbursed by TennCare. The total amount of funds to be distributed to hospitals each DY from the pool will be determined annually, in a manner defined by the Tennessee General Assembly's Annual Coverage Assessment Act and this subparagraph, but in no event may exceed the limit defined below. For any demonstration year in which it elects to make payments under the UHC Pool authority described in this paragraph, the state may not implement a reduction in benefits or elimination of coverage for any of the following services: physical therapy, occupational therapy, speech therapy, inpatient hospital, lab and x-ray, non-emergency outpatient hospital, physician, podiatrist, certified nurse practitioner, or physician assistant services; or implement any co-payment for non-emergency medical transportation. (Nothing in this paragraph is intended to limit the state's ability to manage utilization of these services through changes to prior authorization requirements or other managed care practices.)

***Eligible Hospitals.*** Hospitals eligible to receive a pool payment include all hospitals licensed to operate in the State of Tennessee, except the following groups:

- Critical Access Hospitals;
- Public hospitals eligible to certify public expenditures, including state mental health institutes;
- Rehabilitation and long term care hospitals; and
- Pediatric research hospitals that limit patients to those that meet research protocols.

Any hospitals that have closed between 2008 and the time that the amounts of the payments are calculated are not eligible to receive payments.

***Minimum Qualifications.*** In order to receive a payment, the hospital must be contracted with at least one TennCare MCO and must have unreimbursed TennCare costs, unless the hospital is capitated and accepts the capitation from TennCare as full reimbursement for services to TennCare patients.

***Data Source.*** The Joint Annual Report (JAR) of Hospitals, which is a report containing data that each licensed hospital in the state is required to file annually in accordance with T.C.A. 68-11-310. This law says:

> All hospitals that submit a joint annual report to the department of health as designated in this section shall also submit to the department, at the same time they send the signed paper copy of the report, a notarized statement from their chief financial officer stating that the financial data reported on the joint annual report is consistent with the audited financials for the hospitals for that reporting year. The notarized statement shall also be attested to by the chief executive officer of the hospital.

Reports are submitted to the Tennessee Department of Health (DOH), edited by DOH, corrected by the hospital and placed in a final data file for that year by DOH. The instructions for completing the form require the hospitals to use the same accounting method required for the Medicare cost reports.

Payment amounts for each DY will be based on the final JAR from 3 years prior to the DY.

***Calculation.*** TennCare costs shall be determined by multiplying TennCare charges for hospital inpatient and outpatient services reported by the hospital by the ratio of reported total expenses to reported total charges (cost to charge ratio). Unreimbursed TennCare Costs are calculated as the difference between the calculated TennCare costs and the TennCare revenue as reported on the JAR.

Each hospital shall receive an annual payment each DY equal to a percentage of its Unreimbursed TennCare Costs, using the same percentage to calculate each hospital's payment.

***Funding.*** TennCare shall adjust payments if necessary to ensure no hospital receives supplemental payments in excess of unreimbursed TennCare costs. Payments may be prorated subject to available appropriations.

***Payments.*** The annual payment to each hospital shall be made in four equal quarterly payments.

***Annual Limit:*** The total amount of UHC Pool payments made each DY may not exceed $500 million total computable.

l. **Public Hospital Supplemental Payment (PHSP) Pool.** Actual cash disbursements paid from a $100 million (total computable) supplemental pool per demonstration year to selected public hospitals. The amount paid each DY to each hospital must not exceed the hospital's uncompensated cost of TennCare covered services provided to TennCare enrollees and uninsured patients. The state must make these payments directly to the providers of the services as

specified in 42 CFR § 447.10. Beginning April 1, 2014 Erlanger Medical Center in Chattanooga is added to the PHSP Pool. PHSP Pool payments may be made to the following hospitals:

- Regional Medical Center at Memphis,
- Nashville General Hospital at Meharry, and
- Erlanger Medical Center at Chattanooga.

**56. Medicare Part D Drugs.** No FFP is available under this demonstration for Medicare Part D drugs.

**57. Sources of Non-Federal Share.** The state certifies that the matching non-Federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-Federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding.

c. Under all circumstances, health care providers must retain 100 percent of the TennCare II reimbursement amounts claimed by the state as a demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

**58. Monitoring the Demonstration.** The state shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

## XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

**59**. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of Federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, with an aggregate adjustment for projected disproportionate share hospital payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section X, paragraph 51 *(Reporting Expenditures in the Demonstration).*

**60.** **Risk.** Tennessee shall be at risk for the per capita cost (as determined by the method described below in this Section) for Type 1 and Type 2 TennCare enrollees in the eligibility groups (EGs) described in paragraph 61 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)* under this budget neutrality agreement, but not for the number of demonstration eligibles in each of the groups. By providing FFP for all Type 1 and Type 2 TennCare enrollees in the specified EGs, Tennessee shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Tennessee at risk for the per capita costs for TennCare enrollees in each of the EGs under this agreement, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration. Tennessee will be at risk for both per capita costs and enrollment for Type 3 TennCare eligibles.

**61.** **Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement.** Individuals who are eligible under TennCare and whose expenditures are funded at title XIX matching rates will be one of three types:

a. Type 1 - are currently eligible under Tennessee's Medicaid state plan (Title XIX state plan mandatory or optional eligible population) - counted in the "with" and "without" waiver calculations;

b. Type 2 - could be eligible under Tennessee's Medicaid state plan if Tennessee amended its state plan or could be eligible for a Section 1915(c) waiver for aged and disabled adults pursuant to 42 C.F.R. § 435.217 (Title XIX demonstration-eligible hypothetical population) or is eligible under the At Risk Demonstration Group for the Interim CHOICES 3 program - counted in the "with" and "without" waiver calculations (the state cannot generate savings from these populations); and

c. Type 3 – are only eligible with Section 1115 demonstration authority (Title XIX demonstration-eligible expansion population) - counted only in the "with" waiver calculations.

**62. Budget Neutrality Ceiling.** The following describes the method for calculating the budget neutrality expenditure limit:

a. For each DY of the budget neutrality agreement, an annual target is calculated as the sum of two components:

   i. The sum of six sub-components calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the state in accordance with paragraph 52 *Reporting Member Months*) for Type 1 and Type 2 eligibles claimed under title XIX for the following six EGs: EG1 Disabled, EG2 Over 65, EG3 Children, EG4 Adults, EG5 Duals, and EG8 Med Exp Child (when title XXI allotment is exhausted); and

   ii. A Disproportionate Share Hospital (DSH) adjustment for the year described in d. below.

b. Member months for the following populations are not used for calculation of the budget neutrality expenditure limit:

   i. EG6E Expan Adult, EG7E Expan Child, and EG12E Carryover Type 3 eligibles

   ii. Med Exp Child: Medicaid Expansion children funded at the title XXI enhanced FMAP.

c. The following tables give the projected PMPM costs for the calculation described in paragraph 62.a. by DY. The PMPM costs for DY 8 and earlier are calculated following Attachment B of the November 14, 2006 Special Terms and Conditions and paragraph 64.c. of the July 22, 2009 STCs.

**Table 8**
**Projected PMPM Costs After CHOICES Implementation**

| | Trend | DY 12 | DY 13 | DY 14 |
|---|---|---|---|---|
| **EG1 Disabled*** | 5.1% | $1,561.46 | $1,641.09 | $1,724.79 |
| **EG2 Over 65**** | 4.6% | $1,022.17 | $1,069.19 | $1,118.37 |
| **EG3 Children** | 3.4% | $468.46 | $484.39 | $500.86 |
| **EG4 Adults** | 4.9% | $917.79 | $962.76 | $1,009.94 |
| **EG5 Duals** | 4.6% | $652.99 | $683.02 | $714.44 |
| **EG8 Med Exp Child***** | 3.4% | $468.46 | $484.39 | $500.86 |

* Includes EG 9 H-Disabled
** Includes EG10 H-Over 65
***Optional Targeted Low Income Children funded using title XIX

d. The DSH adjustment is based upon Tennessee's DSH allotment for 1992 and calculated in accordance with current law.

i. For the purpose of this subparagraph, the Average FMAP (AFMAP) for each DY is defined as 0.25 times the FMAP applicable to DSH expenditures for the Federal fiscal year that ends during that DY, plus 0.75 times the FMAP applicable to DSH expenditures for the Federal fiscal year that begins during that DY.

ii. A DSH allotment has been established for Tennessee under provisions of TRHCA 2006 (and extended through subsequent legislation). Beginning with DY 5, the DSH adjustment will be based on the DSH allotments established for Tennessee, following Section 1923(f)(6)(A)(i) of the Act, which are published in the *Federal Register*. The Federal share of the DSH adjustment for each DY will be equal to one quarter of the DSH allotment for the FFY ending during the DY, plus three quarters of the DSH allotment for the FFY beginning during the DY. A total computable equivalent for each DSH adjustment can be calculated as the DSH adjustment divided by the AFMAP for that DY. For DY 5, the figure

$305,541,928 will be used to compute the Federal share of the DSH adjustment in place of the FFY 2006 DSH allotment.

iii. The calculation of the DSH adjustment will be appropriately altered if legislation is enacted that impacts the calculation of DSH allotments, including any law that would affect the calculation of the DSH allotment for Tennessee.

iv. Table 9 gives the DSH adjustments for DY 1 through DY 14, and shows both total computable and Federal share. These totals reflect changes to the calculation of DSH allotments resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the temporary increase in DSH allotments provided under Section 5002 of the American Recovery and Reinvestment Act of 2009. Some of the figures are labeled "preliminary" because the final DSH allotments needed to calculate them have not yet been published in the *Federal Register*, and are best estimates based on current law.

**Table 9**
**DSH Adjustments for DY 1 Through DY 14**

| | **DSH Adjustment (total computable)** | **DSH Adjustment (Federal share)** |
|---|---|---|
| **DY 1** | $413,700,907 | $268,409,148 |
| **DY 2** | $479,893,052 | $310,106,890 |
| **DY 3** | $479,893,052 | $310,538,794 |
| **DY 4** | $479,893,052 | $308,091,339 |
| **DY 5** | $479,356,649 | $305,451,928 |
| **DY 6** | $479,657,638 | $305,451,928 |
| **DY 7** | $485,299,094 | $311,270,839 |
| **DY 8** | $488,969,517 | $319,052,610 |
| **DY 9** | $470,369,327 | $309,408,043 |
| **DY 10** | $463,996,853 | $305,451,928 |
| **DY 11** | $463,996,853 | $305,451,928 |
| **DY 12 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 13 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 14 (preliminary)** | $463,996,853 | $305,451,928 |

e. The budget neutrality expenditure limit is the Federal share of the annual PMPM limits for the demonstration period, plus DSH adjustments, for DY 1 through 14, and represents the maximum amount of FFP that the state may receive for title XIX expenditures during the demonstration period, as described in paragraph 51.g. *(Reporting Expenditures in the Demonstration: Title XIX Expenditures*

*Subject to the Budget Neutrality Expenditure Limit).* The budget neutrality expenditure limit is equal to (1) the sum of all of the subcomponents described in a.i. above for all DYs, times the Composite Federal Share (defined in f. below), plus (2) the sum of the Federal shares to the DSH adjustments for all DYs, as defined in d. above.

f. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional demonstration expenditures or offsets such as, but not limited to, premium collections and administrative costs subject to budget neutrality under paragraph 51.h. *(Reporting Expenditures in the Demonstration: Administrative Costs)* by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for DSH payments made under the Medicaid state plan must be subtracted from the numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

**63. Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under TennCare II. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of Section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

**64. Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

| DY | Cumulative Target Definition | Percentage |
|---|---|---|
| Years 1 through 6 | Cumulative budget neutrality cap plus: | 0.5 percent |
| Years 1 through 7 | Cumulative budget neutrality cap plus: | 0.25 percent |
| Years 1 through 14 | Cumulative budget neutrality cap plus: | 0 percent |

**65. Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end of this demonstration period, the excess Federal funds shall be returned to CMS. If the demonstration is terminated prior to the end of the budget

neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

## XII. EVALUATION OF THE DEMONSTRATION

**66. Submission of a Draft Evaluation Plan.** The state shall submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after CMS approval of the demonstration extension. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

**67. Inclusion of CHOICES Special Study Components.** Suggested special study topics from which the state may choose for its Evaluation Plan include, but are not limited to, the following:

a. The rebalancing of the long-term care system including impacts on outcomes, utilization and cost;

b. Implementation lessons, successes and evolution of the Single Point of Entry and streamlined eligibility processes;

c. The expansion and development of a more robust HCBS infrastructure under managed care;

d. Implementation of Consumer Directed options under manage care;

e. Enrollee satisfaction, based on surveys that include feedback on assessment and care planning processes, quality of care coordination, actual service delivery, and (when relevant) the appeals process; and

f. Provider satisfaction from surveys.

When developing its research approach, CMS encourages Tennessee to consider adapting research questions and methodologies from the CMS sponsored Evaluation of the Money Follows the Person (MFP) Grant Program. MFP and CHOICES share many of the same goals, and by using a common study approach, the Tennessee's planned reforms can be viewed within a national context. CMS staff will be available to provide technical assistance in this regard.

**68. Evaluation of Eligibility and Enrollment Systems.** The state shall propose data collection and reporting measures designed to assess the ongoing need for retroactive

Medicaid eligibility after changes specified in the Affordable Care Act are effectuated. The interim evaluation report required in paragraph 8 *(Extension of the Demonstration)* and paragraph 70 *(Interim Evaluation Reports)* should contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid and the Exchange. CMS may issue further guidance to the state on the specific performance measures. The state may include the following areas of interest in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other relevant data.

a. Evaluation of eligibility determinations by type, e.g. application, redetermination, transfer to the Exchange.

b. Evaluation of Medicaid denial and termination reasons.

c. Evaluation of average application processing times and timeliness.

d. Evaluation of reasons for disenrollment and internal churn.

e. Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable.

**69. Evaluation of Uncompensated Care Costs for the Uninsured.** The state shall propose data collection and reporting measures designed to assess the ongoing need for payments to compensate hospitals for providing care to the uninsured after changes specified in the Affordable Care Act are effectuated. The state should provide documentation demonstrating cost expended for uncompensated care in relation to the number of uninsured individuals that receive care during the current approval period. CMS may issue further guidance to the state on specific data collection and tracking mechanisms. The state may include the following areas of interest in its interim evaluation report. This list is not all inclusive and the state may include any other relevant data.

a. Evaluation of uninsured patient cost and dates of service.

b. Evaluation of cost for medical services to charities and the indigent.

c. Evaluation of amounts expended for services to hospitals that serve a disproportionate number of low-income patients.

**70. Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request.

**71. Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation plan within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports. The state shall

submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

**72. Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

## XIII. TENNCARE ELIGIBILITY REDETERMINATION AND DISENROLLMENT AND RIGHTS; APPEALS PROCESS FOR CHANGES IN BENEFITS; AND ENROLLMENT IN STANDARD SPEND DOWN

The state will follow these procedures throughout the demonstration approval period unless modified through an approved demonstration amendment.

### PART I: MEDICALLY NEEDY AND TENNCARE STANDARD ELIGIBILITY REDETERMINATION AND DISENROLLMENT PROCESS

This Part summarizes the process Tennessee will use, in accordance with paragraph 21.a. *(Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category)*, of these STCs, to: (i) redetermine eligibility and terminate the adult (non-pregnant) Medically Needy; and (ii) disenroll adults who are TennCare/Medicare dual eligible, uninsured, and Medically Eligible. This process was approved as an amendment to the TennCare II demonstration on March 24, 2005. It is used for redetermining the eligibility of those enrollees whose eligibility is ending, including when their period of eligibility has ended or the category in which they have been enrolled is being closed. The state will continue to follow this process for all redeterminations and terminations of eligibility throughout the demonstration approval period unless modified through an approved demonstration amendment.

**I. Termination of Adult Non-Pregnant Medically Needy**

**1. Ex Parte Review**

A. The state will conduct a data match of the Social Security numbers of individuals classified as adult non-pregnant Medically Needy in its InterChange Information System (which contains information on TennCare enrollees) with Social Security Administration (SSA) data to determine whether the individual has lost supplemental security income (SSI) eligibility for reasons that would qualify them as Medicaid eligible.[2]

B. The state will conduct a data match of the Social Security numbers (SSNs) of individuals classified as adult non-pregnant Medically Needy in InterChange with individuals classified as participants in its Food Stamps or Families First (TANF) program in its ACCENT system (a database maintained by the Department of Human Services (DHS)). In all instances in which there is a match between an adult Medically Needy individual with an individual with an open Food Stamps or Families First record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

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[2] Such reasons include (i) they lost SSI eligibility because of Social Security cost of living adjustment(s) ("COLA(s)") but would be SSI eligible if the COLA(s) was/were disregarded ("Passalong" eligibles); or (ii) they lost SSI eligibility for some reason other than a Social Security COLA, but would be eligible for SSI if the COLA(s) received since their SSI termination was/were disregarded ("Pickle" eligibles).

## 2. Request for Information

A. At least 30 days prior to the end of the individual's current eligibility period, the state will send notification (Request for Information) to those adult non-pregnant Medically Needy enrollees who have not been identified through the ex parte review process as eligible for open categories of TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for Medicaid is ending, and that they will only remain eligible for TennCare Medicaid if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for a Medicaid category that is not ending (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for open Medicaid categories. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for Medicaid and the enrollee will receive an advance notice that will provide appeal rights.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be fair hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with Limited English Proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as Seriously and/or Persistently Mentally Ill (SPMI). Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package—i.e., elimination of pharmacy coverage for adult non-institutionalized non-pregnant Medically Needy) until

DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a "Verification Request." Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package). If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain TennCare Medicaid coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), enrollees will retain Medicaid coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. The state will make the determination that enrollees are not eligible for open TennCare Medicaid categories in the following two scenarios: (i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or (ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Expiration Notice**

A. Upon making a determination that enrollees are no longer eligible for TennCare Medicaid, the state will provide a notice (Expiration Notice) to enrollees at least 20 days in advance of the end date of the enrollees' eligibility period.

B. Expiration Notices will:

i. Inform enrollees that they will be terminated from Medicaid as of a date specified in the notice because their current eligibility period has ended, their category of TennCare Medicaid is closed and they have not proven their eligibility for other open categories of TennCare Medicaid.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Expiration Notice to request a hearing for factual disputes related to the termination and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing prior to the date of termination specified in the Notice, Medicaid benefits for non-pregnant Medically Needy (subject to changes in the benefit package) will continue until the appeal has been resolved.

C. If enrollees submit information to qualify for Medicaid prior to their termination, enrollees will continue to be eligible for TennCare Medicaid for non-pregnant Medically Needy (subject to changes in the TennCare Medicaid benefit package) pending the determination as to whether the individual is eligible for other open TennCare Medicaid categories.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Expiration Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the termination. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. Valid factual disputes include:

i. Enrollees received the Expiration Notice in error (i.e., they are currently enrolled in other categories of TennCare Medicaid including Medically Needy pregnant women or enrollees under 21 years of age);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Request for Information but failed to extend the time;

iv. Enrollees requested assistance because of a health, mental health, learning problem, or disability but the state failed to provide this assistance; or

v. The state sent the Expiration Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the request for a hearing is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of termination identified in the Expiration Notice, TennCare Medicaid benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute as described above, or the appeal is resolved.

E. If the enrollee does not request a hearing prior to the date of termination identified in the Expiration Notice, the enrollee will be disenrolled from TennCare Medicaid.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## II. Disenrollment of Adult Medicare/TennCare Dual Eligible, Uninsured, Medically Eligible

### 1. Ex Parte Review

A. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in InterChange (which contains information on TennCare enrollees) with SSA data to determine whether the individual has lost SSI eligibility for reasons that would qualify them as Medicaid eligible.[3]

B. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in Interchange with individuals classified as participants in the state's TANF program in DHS' ACCENT system. In all instances when there is a match between an adult member of these demonstration populations with an individual with an open TANF record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

### 2. Request for Information

[3] See footnote 1

A. At least 30 days prior to disenrollment, the state will send a Request for Information to all adult Medicare/TennCare Dual Eligible, Uninsured, and Medically Eligible enrollees not identified through the ex parte review process as eligible for TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for TennCare Standard is ending and that they will only maintain coverage if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for Medicaid (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for TennCare Medicaid. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for TennCare Medicaid and the enrollee will receive a Disenrollment Notice prior to disenrollment from TennCare Standard.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with limited English proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as SPMI. Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Standard until DHS determines that the individual does not qualify for open categories of Medicaid (and proper disenrollment and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a Verification Request. Verification Requests will inform enrollees that they must submit

the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid. If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper disenrollment and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), the enrollee will retain coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in an appropriate TennCare Medicaid category. The state will make the determination that enrollees are no longer eligible for TennCare in the following two scenarios:

   i. if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or

   ii. if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

**3. <u>Termination Notice</u>**

A. Upon determination or confirming that enrollees are not eligible for TennCare Medicaid, the state will provide a Termination Notice to enrollees 20 days in advance of the date upon which the coverage will be terminated.

B. Termination Notices will:

   i. Inform enrollees that they will be disenrolled from TennCare as of the date specified in the Notice (20 days after the date of the Notice) because their category of TennCare Standard is ending and they have not proven their eligibility for open TennCare Medicaid categories.

   ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the notice to appeal factual disputes related to the action of disenrollment and inform enrollees how they may request a hearing.

   iii. Inform enrollees that if prior to the date of disenrollment specified in the Termination Notice, an enrollee appeals the action of disenrollment, he or she will not lose eligibility for TennCare until the state determines that the enrollee has not raised a valid factual dispute or the appeal is resolved.

iv. Inform enrollees that they may submit new information to demonstrate Medicaid eligibility at any time before or after disenrollment. Such information will be treated as a new application for Medicaid. The enrollee will not continue benefits pending the state's review and processing of this information.

**4. <u>Appeals Process</u>**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:

i. Enrollee received the Termination Notice in error (e.g., he or she is currently enrolled in Medicaid or in a TennCare Standard category that is not ending);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Termination Notice but failed to extend the time;

iv. Enrollee requested assistance because of a health, mental health, learning problem, or disability, but the state failed to provide this assistance; or

v. The state sent the Termination Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the appeal is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of disenrollment as identified in the Termination Notice, TennCare Standard benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute, or the appeal is resolved.

E. If the enrollee does not appeal prior to the date of disenrollment as identified in the Termination Notice, the enrollee will be disenrolled from TennCare Standard.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## PART II: NOTICE AND APPEALS PROCESS FOR CHANGES IN COVERAGE OF TENNCARE BENEFITS

This Part summarizes the process Tennessee will use upon and after the implementation of changes in coverage of TennCare benefits. These procedures were approved as an amendment to the TennCare II demonstration on March 31, 2006. This detailed process is used by the state to implement benefit changes, specifically benefit limits. It is used daily with enrollees who are subject to pharmacy benefit limits when they reach their monthly maximum. With this process, Tennessee provides one notice per month when benefit limits have been reached. The state will continue to follow this process with enrollees who are subject to pharmacy or other benefit limits throughout the Demonstration approval period unless modified through an approved Demonstration amendment. To change benefits covered under the Demonstration, the state must submit a Demonstration amendment in accordance with paragraphs 6 and 7 regarding amendments of these STCs.

### I. Implementation of Changes in Coverage Policies

#### 1. Initial Notice

A. At least 30 days prior to the effective date of changes in coverage of TennCare benefits (e.g., implementation of pharmacy benefit limits and elimination of covered services), the state shall provide a notice (Benefit Notice) to enrollees who are impacted by such changes in coverage of TennCare benefits.

B. Benefit Notices will:

i. Inform enrollees of how changes in coverage of TennCare benefits will apply to enrollees.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Benefit Notice to request a hearing for valid factual disputes related to the changes in coverage and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing for a valid factual dispute prior to the effective date of the change in coverage of TennCare benefits, benefits will be continued at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the level for Non-Institutionalized Medicaid Adults (Default Level). The state will apply the Default Level of benefits until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary. (The resolution of an appeal, for purposes of this Part, is defined as when the appeal is dismissed or resolved prior to a hearing or when a decision is rendered at or after the hearing.)

## 2. Appeals Process

A. An enrollee will have the opportunity to request a state fair hearing for 40 days (inclusive of mail time) from the date of the Benefit Notice.

B. The state will grant state fair hearings only for those enrollees raising valid factual disputes related to the changes in coverage. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to a different level of TennCare benefits than that identified in the Benefit Notice. Valid factual disputes include when an enrollee claims to have received the Benefit Notice in error (e.g., he or she is already in a TennCare category that is not subject to the particular changes in coverage).

C. When an enrollee requests a hearing prior to the effective date of changes in coverage as identified in the Benefit Notice, the enrollee shall continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the Default Level. The state will apply the Default Level until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary.

D. If the enrollee appeals, the changes in coverage in dispute shall become effective upon resolution of the appeal.

E. If the enrollee does not appeal prior to the effective date of changes in coverage as identified in the Benefit Notice, such changes in benefits will become effective, as applied to the enrollee, upon this date.

F. If the enrollee appeals and:

(i) The appeal is dismissed because the enrollee has not asserted a valid factual dispute; or

(ii) The enrollee is granted a hearing and the hearing decision sustains the state's action.

The state reserves its right to recover from the enrollee the cost of services provided as a result of the appeal.

# II. Post-Implementation Appeals from Denials of Prior Authorization for Pharmacy Products

## 1. Prior Authorization Requirements

A. Any prescription of a branded drug may be subjected to a prior authorization requirement by the state; and prior authorization will be required as a condition of coverage for branded prescription drugs that are not included on the state's Preferred Drug List.

B. Physicians (or other providers with prescribing authority) participating in TennCare will be responsible for requesting prior authorization, according to procedures to be established by the state.

**2. <u>Notice of Prior Authorization Denial</u>**

A. Requests for prior authorization of covered outpatient drugs shall be transmitted to and acted upon by appropriate staff of the Pharmacy Benefit Manager (PBM) Clinical Call Center.

B. Written notice of denial of a request for prior authorization shall be mailed by the PBM on behalf of the state to the enrollee and transmitted by facsimile to the prescribing physician. Such Notice will inform the enrollee that the request for prior authorization of the prescribed drug has been denied and that TennCare does not cover the drug absent prior authorization, briefly state the reason or reasons for denial of the request, explain the procedures that are available to the enrollee to appeal from that decision, and inform the enrollee that TennCare will not cover the cost of the prescribed medication during the pendency of any appeal. The state's failure to act on a request for prior authorization within a 24-hour period after receiving a submission that complies with the state's requirements for a completed prior authorization request may be deemed a denial from which the enrollee can appeal.

**3. <u>Procedures for Filing and Pursuing an Appeal</u>**

A. Appeals of denials of requests for prior authorization may be initiated within 20 days of the Notice of denial of prior authorization, at the option of the enrollee, by the enrollee (or an individual appointed or otherwise authorized under state law to act as the enrollee's representative) submitting to the TennCare Solutions Unit via hand delivery, mail, or facsimile, a written statement of intent to appeal on a form prescribed by the state. Such form will be available on the PBM Web site, and the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's managed care organization (MCO), or from the TennCare Solutions Unit. Undue delay by the state in deciding a prior authorization request (i.e., delay in excess of the 24-hour period permitted for such decisions) will be considered a denial of prior authorization for purposes of appeal.

B. The state will dismiss any appeal that does not raise a valid factual dispute without a hearing, and will retain the authority to determine whether an appeal raises a valid factual dispute relating to denial of a prior authorization request or the state's failure to act on a request for prior authorization within a 24-hour period after such request. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the prescribed drug. A dispute concerning whether a particular

drug or dosage is medically necessary for the enrollee, will be considered a valid factual dispute.

C. An initial determination on appeals involving issues of medical necessity will be made by appropriately qualified medical professionals on the staff of the TennCare Solutions Unit as promptly as possible after the enrollee's submission of the appeal. After submission of the appeal, the TennCare Solutions Unit may seek additional information or documentation in support of the appeal, before any initial determination is made.

D. Upon initially deciding an appeal, the state shall send a letter communicating its decision to the enrollee and stating the reasons for that decision, and shall also communicate any decision granting prior authorization to the enrollee and/or the prescribing physician by the fastest means practicable. A letter initially denying an appeal shall also inform the enrollee of his or her opportunity to request a state fair hearing, and the procedures that must be followed to pursue such further appeal.

**4. <u>Benefits During the Pendency of an Appeal</u>**

A. During the pendency of any appeal from denial of a pharmacy service due to the lack of required prior authorization, the enrollee will continue to be eligible for pharmacy benefits within applicable pharmacy service limits, but will not have any right to receive on a covered basis the drug that is the subject of the appeal.

B. If the enrollee chooses to purchase the unauthorized, prescribed drug at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the drug upon prevailing in his or her appeal, but only to the extent that applicable, monthly pharmacy benefit limits would not thereby be exceeded.

## III. <u>Post Implementation Appeals of Application of Benefit Limits</u>

**1. <u>Initial Notice</u>**

A. Pharmacists will be required to verify TennCare coverage for all prescriptions presented by enrollees through an electronic database maintained by the PBM. If, through the database, the PBM denies coverage of a prescription because the enrollee has reached or exceeded the monthly pharmacy benefit limit ("the pharmacy limit"), the PBM on behalf of the state will mail a written notice of the denial to the enrollee (Service Notice). Service Notice shall be provided only upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five prescription limit, and/or upon the first denial in that month of a pharmacy service sought by the enrollee that exceeds the two prescriptions limit on branded drugs. (For purposes of this Part, "the pharmacy limit" is defined as a five prescription limit per month, of which no more than two prescriptions or refills could be for branded drugs and at least three out of any five prescriptions or refills in the same month must be for generic drugs.)

B. If a pharmacist fills a prescription in excess of the pharmacy limit and submits a claim for such service, the PBM will deny payment for the claim. Upon denial of payment for such claim, the PBM on behalf of the state will mail a written notice (Notice of Limit) to enrollees.

C. If a provider denies a non-pharmacy service or charges the enrollee for the service because the enrollee has reached or exceeded a benefit limit, the provider need not give specific notice of appeal rights to the enrollee but must direct the enrollee to the responsible arm of the managed care contractor (MCC).

D. If a provider renders a non-pharmacy service in excess of a non-pharmacy benefit limit and the provider or the enrollee submits a claim for such service, the MCC will deny payment for the claim. Upon denial of payment for such claims, the MCC, on behalf of the state, will mail a Notice of Limit to enrollees. A Notice of Limit shall be provided only upon the first denial of coverage of a non-pharmacy service sought by the enrollee that exceeds the applicable limit for the kind and number of services during a given time period specified in the state's program.

E. The Notice of Limit and Service Notice will:

i. Inform an enrollee that he or she has reached or exceeded the applicable benefit limit.

ii. Provide enrollees with at least 20 days from the Notice of Limit or Service Notice to request a hearing for valid factual disputes related to the benefit limit and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing, they will not receive continuation of benefits (i.e., services in excess of the applicable limit) during the pendency of their appeal.

iv. Remind enrollees of any exceptions to the limits and inform them how to obtain more information about such exceptions.

**2. <u>Appeals Process</u>**

A. Enrollees will have the opportunity to request a state fair hearing for at least 20 days from the date of the Notice of Limit or Service Notice.

B. The enrollee will be required to submit a designated form in order to request a state fair hearing. The form, which must be signed by the enrollee (or an individual appointed or otherwise authorized to act as the enrollee's representative under state law), would include the basis for the appeal and the enrollee must attest, under penalty of perjury, that his contention is true to the best of his knowledge and is made in good faith. Enrollees may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its

discretion of an exemption from a signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or by an individual authorized under state law to act as the enrollee's representative.

C. The state will grant a state fair hearing only for those enrollees raising valid factual disputes related to the benefit limit. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the service that was denied because the enrollee had reached or exceeded the applicable benefit limit. Valid factual disputes include:

   i. An administrative error was allegedly made and the enrollee has not yet reached the relevant benefit limit.

   ii. The enrollee alleges that his or her circumstances have changed and he or she has been re-classified in a TennCare eligibility category that is not subject to the benefit limit the state has applied. The state, however, shall not grant a hearing to individuals who allege solely that they are not subject to the benefit limit without further alleging a change of circumstances that has been reported to TennCare and has resulted in a change in their eligibility category. These enrollees will be granted a hearing because they did not have the opportunity to appeal the application of the benefit limit to them in connection with the Benefit Notice.

   iii. The enrollee alleges an administrative error in the processing of a request for a special exemption to the benefit limit (i.e., the enrollee's physician submitted the required attestation necessary to obtain a special exemption from the benefit limit and the prescribed drug is on the special exemption list but coverage for the drug was nonetheless denied).

D. The enrollee shall not receive continuation of benefits when appealing a denial of services based on the application of a benefit limit. This policy shall apply even for items or services that have been previously authorized as medically necessary to the extent that the denial of services is based on the application of a benefit limit.

E. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal with respect to those benefits.

F. If the enrollee does not request a hearing, the benefit limit deemed applicable by the state will continue to apply to the enrollee.

G. Providers will be permitted to bill enrollees for services that were provided in excess of the benefit limits.

## IV. Post Implementation Appeals of Elimination of Coverage for Certain Services

1. Neither the state nor the MCC will provide notification in addition to the Benefit Notice described above with respect to services that are eliminated from TennCare coverage as those services are no longer covered by TennCare.

2. Upon denial of non-covered services, TennCare enrollees will have the opportunity to request a state fair hearing. The enrollee will be required to submit a designated form in order to request a hearing. Such form would include a statement, which must be signed by the enrollee, or an individual appointed or otherwise authorized to act as the enrollee's representative under state law that sets out or describes the factual contention on which the appeal is based, and attests, under penalty of perjury, that the contention is true to the best of the signatory's knowledge and is made in good faith. Enrollees or their representatives may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its discretion of an exemption from the signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or his/her authorized representative.

3. The state will grant a state fair hearing only for those enrollees who raise valid factual disputes related to the elimination of coverage. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to coverage of the disputed service. In the context of excluded services, valid factual disputes are limited to when an enrollee claims that he or she is already in a TennCare category that is entitled to coverage of the particular service at issue. Appeals that do not raise a valid factual dispute will be dismissed without a hearing.

4. If the request for a hearing is granted, the enrollee will not receive continuation of the benefits in dispute pending the appeal.

5. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee may be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal.

## PART III: ENROLLMENT IN TENNCARE STANDARD SPEND DOWN

TennCare Standard Spend Down (SSD) is open to people who are not currently eligible for Medicaid and who meet the criteria for the SSD program. Financial eligibility criteria for SSD will be based on criteria that apply to medically needy pregnant women and children eligible under the state plan.

Applicants will be enrolled only through a single toll-free telephone point of entry (the Call-In Line) initiated in periods of open enrollment. In each open enrollment period, the state will determine a specified number of calls that it will accept through the Call-In Line based on the number of applications that the state estimates it can process within federal timeliness standards. The state will not accept or track calls received outside of open enrollment periods.

Once the state has reached its targeted enrollment of 100,000 persons, new open enrollment periods will be scheduled when enrollment in the SSD program drops to 90 percent of target enrollment. Any subsequent open enrollment periods will remain open until a pre-determined number of calls to the Call-In Line have been received. The number of calls to be received will be established based on the state's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the state estimates it can process in a timely manner in accordance with federal standards. The state's decision to open or close enrollment is a policy decision that is within the state's discretion and the state is not required to provide fair hearings for challenges to these decisions.

Callers to the Call-In Line will be asked for basic demographic information and will be assigned a unique identifier. After conducting a match to verify that callers are not already enrolled in TennCare Medicaid as state plan eligibles, the state will send each non-enrolled caller a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within 30 days. (Those callers who are already enrolled in TennCare Medicaid as state plan eligibles will be sent letters advising them that they currently have benefits and need not apply.)

Completed signed applications received by the state by the 30-day deadline established by the state will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will still be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the state. If the individual does not mail back an application by the deadline, the state will send the individual a letter advising him or her that since no application was received, the state will not make an eligibility determination for him or her, but the individual is free to apply for SSD during any subsequent open enrollment period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he or she did submit a signed, written application within the deadline. Since all SSD applications received during an open enrollment period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open enrollment period will be carried forward to future open enrollment periods. The state will determine SSD eligibility within the timeframes specified by Federal regulations at 42

CFR § 435.911; such timeframes will begin on the date a signed written application is received by the state.

The effective date of SSD eligibility for individuals whose enrollment is originally initiated through the Call-In Line and who submit a timely signed application will be the later of: 1) the date that their call was received by the Call-In Line; or 2) the date spend down is met (which must be no later than the end of the 1-month budget period -- in this case, the end of the month of the original call to the Call-In Line). The effective date provisions contained herein only apply to SSD eligibility and do not apply to other categories of TennCare eligibility. All enrollees in the SSD demonstration category will have an eligibility period of 12 months from the effective date of the determination. At the end of the 12-month period the enrollee will need to have his eligibility status redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for TennCare Medicaid.

## XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

| | | |
|---|---|---|
| **Monthly Deliverables** | | |
| Monthly | Monitoring Call | ~~44~~ |
| **Quarterly Deliverables** | | |
| 60 days after end of each quarter | Quarterly progress reports | 45 |
| Per Sections 2500 & 2115 of State Medicaid Manual, or upon request | Quarterly expenditure, budget neutrality, member month reports | 41,42 Sections X and XI |
| **Annual Deliverables** | | |
| 120 days after end of each demonstration year | Draft Annual Progress Report | 46 |
| Within 30 days of receipt of comments from CMS on the Draft Annual Progress Report | Final Annual Progress Report | 46 |
| Dec. 31st of each year | Annual CHIP Report entered into CHIP Annual Report Template System (SARTS) | 46 |
| Sept. of each demonstration year | Annual beneficiary survey report | 47 |
| **Other Deliverables** | | |
| 6 months before expiration of demonstration | Request for extension | 8 |
| 5 months prior to suspending or terminating the demonstration | Phase-out plan | 9 |
| 6 months before expiration of demonstration | Interim evaluation report. | 8, 70 |
| 120 days after expiration of demonstration | Draft Final Evaluation Report | 48, 71 |
| 60 days after receipt of CMS comments on Draft Final | Final Evaluation Report | 48, 71 |

| | | |
|---|---|---|
| Evaluation Report | | |
| Implementation of compliance plan by January 1, 2013. | Enrollee notification and implementation of the new cost-sharing requirements | 35 |
| At least annually | MEQC plan proposal and report on findings | 23 |
| Upon receipt by state | Financial audits and quality assessment reviews of participating health plans, and other managed care and HCBS requirements | 40, 43 |
| Upon receipt by state | Fraud and abuse and program integrity reports related to 1115 Demonstration beneficiaries and providers | |
| As required by CMS | Corrective Action Plans and findings | |
| Upon submission to Regional Office | Courtesy copy of all state plan amendments to be sent to the CMS Project Officer | 7 |
| 60 days advance notice | Modification of CHOICES benefits defined in Attachment D | 7 |
| No later than 120 days prior to planned implementation and may not be implemented until approved | Demonstration amendments, including requests for services not defined in Attachment D | 6, 7 |
| 30 days advance notice | Notice on increases in CHOICES Enrollment Targets within allowable range | 32 |
| 3 months after each point in time. i.e. September 30 of each demonstration year | Submission of CHOICES data | 43.d. |
| Annually | Integrated Quality Improvement Strategy Update | 43.c. |
| Subject to CMS approval prior to implementation | Final MCO contracts developed for CMS approval | 40 |
| When issued or amended by state | Procedural manuals or operating protocols related to the 1115 Demonstration | |
| *All Reports Required by Sections 2500 and 2115 of the State Medicaid Manual* | | |

**ATTACHMENT A**
**QUARTERLY PROGRESS REPORT**

Under Section IX, paragraph 45 *(Quarterly Progress Reports)* of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

## NARRATIVE REPORT FORMAT:

**Title Line One –** TennCare II

**Title Line Two -** Section 1115 Quarterly Report

**Demonstration/Quarter Reporting Period:**
*Example: Demonstration Year: 6 (7/1/2007 – 6/30/2008)*
*Federal Fiscal Quarter: 1/2008 (10/07 - 12/07)*

**Footer:** Approval Period July 1, 2013 – June 30, 2016

## I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

## II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to TennCare eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.
    - Progress on implementing TennCare Standard Spend Down.
    - Progress on phasing out closed eligibility categories.
    - Other

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

**Enrollment Counts for Quarter**

Note: Enrollment counts should be person counts, not member months

| Demonstration Populations | Total No. TennCare Enrollees in current Quarter |
|---|---|
| **EG1 Disabled, Type 1 state plan eligibles** | |
| **EG 9 H-Disabled, Type 2 demonstration population** | |
| **EG2 Over 65, Type 1 state plan eligibles** | |
| **EG10 H-Over 65, Type 2 demonstration population** | |
| **EG3 Children, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 2 demonstration population** | |
| **EG5 Duals, Type 1 state plan eligibles and EG-11 H-Duals 65, Type 2 demonstration population** | |
| **EG6E Expan Adult, Type 3 demonstration population** | |
| **EG7E Expan Child, Type 3 demonstration population** | |
| **EG8, Med Exp Child, Type 2 demonstration population, Optional Targeted Low Income Children funded by Title XIX** | |
| **Med Exp Child, Title XXI demonstration population** | |
| **EG12E Carryover, Type 3, demonstration population** | |

**III. Outreach/Innovative Activities to Assure Access**

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for TennCare enrollees or potential eligibles.

**IV. Collection and Verification of Encounter Data and Enrollment Data**

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

**V. Operational/Policy/Systems/Fiscal Developments/Issues**

Identify all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

**VI. Action Plans for Addressing Any Issues Identified**

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration.

**VII. Financial/Budget Neutrality Development/Issues**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

## VIII. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

### A. For Use in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| ***Medicaid eligibles (Type 1)*** | | | | |
| **EG1 Disabled, Type 1 state plan eligibles (paragraph 53.a.i.)** | | | | |
| **EG2 Over 65, Type 1 state plan eligibles (paragraph 53.a.ii.)** | | | | |
| **EG3 Children, Type 1 state plan eligibles (paragraph 53.a.iii.)** | | | | |
| **EG4 Adults, Type 1 state plan eligibles (paragraph 53.a.iv.)** | | | | |
| **EG5 Duals, Type 1 state plan eligibles (paragraph 53.a.v.)** | | | | |
| ***Demonstration eligibles (Type 2)*** | | | | |
| **EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX (paragraph 53.b.iii.)** | | | | |
| **EG9 H-Disabled, Type 2 Demonstration Population (paragraph 53.b.iv.)** | | | | |
| **EG10 H-Over 65, Type 2 Demonstration Population (paragraph 53.b.v.)** | | | | |
| **EG11 H-Duals, Type 2 Demonstration Population (paragraph 53.b.vi.)** | | | | |

### B. Not Used in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **EG6E Expan Adult, Type 3, Demonstration Population (paragraph 53.b.i.)** | | | | |
| **EG7E Expan Child, Type 3, Demonstration Population (paragraph 53.b.ii.)** | | | | |
| **Med Exp Child, Title XXI Demonstration Population (paragraph 53.c.)** | | | | |
| **EG12E Carryover, Type 3, Demonstration Population (paragraph 53.b.vii.)** | | | | |

## IX. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

## X. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

## XI. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

## XII. Essential Access Hospital Pool

List the Essential Access Hospitals and specify their type from the following:
Essential Service Safety Net
Children's Safety Net
Free Standing Psychiatric Hospitals
Other Essential Acute Care

## XIII. Graduate Medical Education (GME) Hospitals

List the GME hospitals and their affiliated teaching universities.

## XIV. Critical Access Hospitals

List the Critical Access Hospitals.

## Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

## State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

## Date Submitted to CMS

## ATTACHMENT B
## LIMITATIONS ON HOME HEALTH SERVICES

Home health services are delivered in accordance with 42 CFR § 440.70. Prior authorization may be required. Definitions and coverage limitations used by the state are as follows:

1. Home health services shall include any of the following services ordered by a treating physician and provided by a licensed home health agency pursuant to a plan of care at an enrollee's place of residence.

   a. Part-time or intermittent nursing services.

      (1) To be considered "part-time and intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, AND no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide care combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. The above limits may be exceeded when medically necessary for children under the age of 21.

      (2) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on an as needed basis. Part-time or skilled nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.

   b. Home health aide services.

      (1) Home health aide care must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

      (2) The above limits may be exceeded when medically necessary for children under the age of 21.

   c. Physical therapy, occupational therapy, speech pathology and audiology services.

d. Medical supplies, equipment, and appliances ordered by a treating physician and suitable for use at an enrollee's place of residence.

2. Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, or preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:

   a. The child is non-ambulatory; and

   b. The child has no or extremely limited ability to interact with caregivers; and

   c. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and

   d. No other children shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult.

## ATTACHMENT C
## LIMITATIONS ON PRIVATE DUTY NURSING SERVICES

Private duty nursing services are delivered in accordance with 42 CFR § 440.80. Prior approval may be required. Definitions and coverage limitations used by the state are as follows:

PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period. A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members.

1. If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home that determines whether the nursing services are continuous or intermittent.

2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:

    a. Have a demonstrated understanding, ability, and commitment to the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration, and feeding, as applicable; and

    b. Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and

    c. Are willing and available as needed to meet the recipient's non-nursing support needs.

3. Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:

    a. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

    b. Has a functioning tracheostomy

        (1) Requiring suctioning, AND

(2) Oxygen supplementation, AND

(3) Receiving nebulizer treatments or requiring the use of Cough Assist/inexsufflator devices.

(4) In addition, for persons with a functioning tracheostomy, at least one from each of the following (I and II) must be met:

(I) Medication

(a) Receiving medication via a gastrostomy tube (G-tube), OR

(b) Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port. AND

(II) Nutrition

(a) Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube), OR

(b) Receiving total parenteral nutrition.

4. Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.

5. A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period, or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of this Attachment may receive medically necessary nursing care as an intermittent service under home health.

6. General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have other non-medical caregiving needs which must be met, to the extent that private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

a. The child is non-ambulatory; and

b. The child has no or extremely limited ability to interact with caregivers; and

c. The child would not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse would be present in the home without the presence of another responsible adult; and

d. No other children will be present in the home during the time the private duty nurse would be present in the home without the presence of another responsible adult.

## ATTACHMENT D
## GLOSSARY OF TERMS FOR TENNCARE CHOICES

**Adult care homes.** A state-licensed community-based residential alternative which offers 24-hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet nursing facility level of care, but who would prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-basis is living in the home with the individuals for whom they are providing care. Coverage shall not include the costs of room and board.

**Adult day care.** Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day provided pursuant to an individualized plan of care by a licensed provider not related to the participating adult.

**Assisted care living facility services**. Community-based residential alternative to nursing facility care in a licensed Assisted Care Living Facility that provides and/or arranges for daily meals, personal care, homemaker and other supportive services or health care including medication oversight (to the extent permitted under state law), in a home-like environment to persons who need assistance with activities of daily living. Coverage shall not include the costs of room and board.

**Assistive technology.** Assistive device, adaptive aids, controls or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive or control their environment. Examples include, but are not limited to, 'grabbers' to pick objects off the floor, strobe lights to signify the smoke alarm has been activated, etc.

**At-Risk.** As it relates to the CHOICES program, SSI eligible adults age 65+ or age 21+ with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined by the state in administrative rule, such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As is relates to Interim CHOICES 3, open for enrollment starting on July 1, 2012 and closed to enrollment on June 30, 2015, "at risk" is defined as adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meeting nursing facility financial eligibility criteria, and also meet the nursing facility level of care in effect on June 30, 2012.

**Attendant care.** Hands-on assistance, safety monitoring and supervision for an enrollee who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visits (more than four (4) hours per visit or visits at intervals of less than four (4) hours between visits). This may include assistance

with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, attendant care may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home, or continuous monitoring and supervision because there is no household member, relative, caregiver, or volunteer to meet the specified need. Attendant care shall not be provided for enrollees who do not require hands-on assistance with ADLs.

Attendant care does not include:

1) Care or assistance including meal preparation or household tasks for other residents of the same household;
2) Yard work; or
3) Care of non-service related pets and animals.

Only for persons who require homemaker services in addition to hands-on assistance with ADLs, the annual benefit shall be up to 1400 hours per full calendar year.

**Community-based residential alternatives to institutional care (Community-based residential alternatives).** Residential services which offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, assisted care living facilities, adult care homes, and companion care.

**Companion care.** A consumer-directed residential model in which a CHOICES member may choose to select, employ, supervise and pay, utilizing the services of a fiscal intermediary, on a daily, weekly, or monthly basis, as applicable, a live-in companion who will be present in the member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration. Such model will be available only for a CHOICES member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with activities of daily living or supervision and monitoring for extended periods of time that cannot be met more cost-effectively with other non-residential services. A CHOICES member who requires assistance in order to direct his or her companion care may designate a representative to assume consumer direction of companion care services on his/her behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.

**Consumer direction of eligible CHOICES HCBS.** The opportunity for a member assessed to need specified types of HCBS including attendant care, personal care visits, homemaker services (provided only as part of attendant care or personal care visits), in-home respite care, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such

services—primarily, the hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed service(s).

**Electronic visit verification (EVV) system**. An electronic system in which caregivers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of HCBS and which may also be utilized for submission of claims.

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

**Homemaker services.** Effective July 1, 2012, homemaker services are only available as part of attendant care or personal care visits for individuals who need hands-on assistance with ADLs. Services covered include general household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the member, changing the member's linens, making the member's bed, washing the member's dishes, doing the member's personal laundry, ironing, or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the member, assistance with maintenance of safe environment, and errands such as grocery shopping and having the member's prescriptions filled. Homemaker services are to be provided only for the member (and not for other household members) and only when the member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the member.

**In-home respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in the individual's place of residence, because of the absence or need for relief of those persons normally providing the care.

**In-patient respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in a licensed nursing facility or licensed community-based residential alternative, because of the absence or need for relief of those persons normally providing the care.

**Minor home modifications.** Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered

improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

**Nursing facility care.** See Social Security Act, Section 1919(a).

**Personal care visits.** Intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance to an enrollee who, due to age and/or physical disability, needs help with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, personal care visits may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need.

Personal care visits do not include:

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

**Personal emergency response system (PERS).** An electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. The individual may also wear a portable 'help' button to allow for mobility. The system is programmed to signal a response center once the 'help' button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed.

PERS services are limited to those individuals who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time, such that the individual's safety would be compromised without access to a PERS.

**Pest control.** The use of sprays, poisons and traps, as appropriate, in the enrollee's residence (excluding NF, ACLF) to regulate or eliminate the intrusion of roaches, wasps,

mice, rats and other species of pests into the household environment thereby removing an environmental issue that could be detrimental to a frail elderly or disabled enrollee's health and physical well-being.

**Reserve capacity.** The state's right to maintain some capacity within an established enrollment target to enroll individuals into HCBS under certain circumstances. These circumstances could include, but are not limited to: discharge from a nursing facility; discharge from an acute care setting where institutional placement is otherwise imminent, or other circumstances which the state may establish from time to time in accord with these STCs.

**Room and board.** Refers to lodging, meals, and utilities. The kinds of items that are considered "room and board" and are therefore not reimbursable by Medicaid include:

- Rent, or, if the individual owns his home, mortgage payments, depreciation, or mortgage interest
- Property taxes
- Insurance (title, mortgage, property and casualty)
- Building and/or grounds maintenance costs
- Resident "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included)
- Household supplies necessary for the room and board of the individual
- Furnishings used by the resident
- Utilities (electricity, water and sewer, gas)
- Resident telephone
- Resident cable television

**Short Term Nursing Facility Care.** The provision of nursing facility care for no more than 90 days to a CHOICES 2 or CHOICES 3 participant who was receiving home and community based services upon admission and who requires temporary placement in a nursing facility—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 90 days. Such CHOICES 2 or CHOICES 3 member must meet the nursing facility level of care upon admission (which for CHOICES 3 participants is anticipated to be due to a short-term condition), and in such case, while receiving short-term nursing facility care may continue enrollment in CHOICES 2 or CHOICES 3, as applicable, pending discharge from the nursing facility within no more than 90 days or until such time it is determined that discharge within 90 days from admission is not likely to occur, at which time the person shall be transitioned to CHOICES 1, as appropriate. The community personal needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

**Transition Allowance.** A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of a managed care organization, be

provided as a cost-effective alternative to continued institutional care for a CHOICES member in order to facilitate transition from a nursing facility to the community when such member will, upon transition, receive more cost-effective non-residential home and community based services or companion care. Items which may be purchased or reimbursed are only those items that the member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

## ATTACHMENT E
## BEST PRACTICES GUIDANCE REGARDING
## CONSUMER DIRECTION OF HOME AND COMMUNITY BASED SERVICES

The state will define services that eligible members may elect to direct. Members determined, as a part of the needs assessment and plan of care processes, to require such services will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e. consumer direction of HCBS).

All eligible members requiring these services will be offered the option to participate in consumer direction of HCBS.

i. Upon enrollment in HCBS and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.

ii. Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at anytime, service by service, without affecting their enrollment in HCBS. Only the state can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare.

iii. A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or be a member's paid worker.

iv. The state will utilize a fiscal employer agency (FEA) to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services rendered; and withholding, filing and paying applicable Federal, state and local income and employment taxes for workers) and to provide supports broker assistance.

v. The plan of care process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports, contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.

vi. Members will have the flexibility to hire persons close to them, including family members but excluding spouses, to serve as their workers. All workers must meet the state specified qualifications for providers of comparable non-consumer directed services and must sign a service agreement.

vii. Members will have flexibility in establishing payment rates that do not exceed the state specified ceiling for each service.

viii. Members and/or representatives must receive training prior to participating in consumer direction of HCBS and re-enrolling in consumer direction of HCBS. Ongoing training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.

ix. Workers must receive training, as a condition for hire, certain aspects of which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.

x. A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care, and the adequacy of payment rates.

**ATTACHMENT F**
**CERTIFIED PUBLIC EXPENDITURES PROTOCOL**

**Preamble**

This protocol governs the use of certified public expenditures to furnish the non-Federal share of expenditures claimed for Federal participation under the Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (paragraph 55.h.). The protocol is based on the following elements:

1) Units of government, including governmentally operated health care providers, may certify that costs have been incurred for providing services to TennCare and uninsured individuals. The CPE process contained in this attachment is in accordance with Federal regulations and CMS guidance or policy.

   i. Units of government have been determined by the state as eligible to certify public expenditures.

   ii. Certification must be supported by cost documentation, which represents both the Federal and non-Federal share of funds (i.e., total computable expenditures) under the Demonstration. Federal matching funds are available as a percentage of such eligible costs.

2) To the extent the state continues to utilize certified public expenditures (CPEs) as the funding mechanism for title XIX and XXI (or under Section 1115 authority) payments beyond the date defined in this section, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs as eligible under title XIX or XXI (or under Section 1115 authority) for purposes of certifying public expenditures.

3) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the state the amount of such tax revenue (state or local) appropriated to the non-governmental provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the state's claim for Federal match. Federal matching funds will be available as a percentage of such eligible costs.

## I. Cost Computation

### A. TN CPE 1115 – Medicaid Fee-For-Service

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552)

covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from MMIS for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the

cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

## B. TN CPE 1115 – Medicaid Managed Care

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not

be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

## C. TN CPE 1115 – Hospital Uninsured Care

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently as-filed Medicare cost report (CMS 2552), as-filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the as-filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospital's audited financial statements and other auditable documentation. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of Uninsured care usable organs to total usable organs. This is determined by dividing the number of Uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible Uninsured care costs are determined by adding the Uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual Uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

## II. Payments and Recoveries

All payments and recoveries, from MCO's; BHO's; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds) including any related patient co-payments, or payments from other non-state payers will be offset against the costs computed in Section I above. Payments to the hospital from uninsured individuals for their care for the fiscal year are identified from the hospital's records. Such uninsured data must be supported by auditable documentation.

## III. Interim Reconciliation

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3

Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5

Actual Medicaid paid days and charges from MMIS paid claims data for services furnished during the payment year are used.

Step 6

Organ acquisition costs and total usable organs from the as-filed CMS 2552 cost report for the payment year are used.

## IV. Final Reconciliation

Upon finalization of the CMS-2552 by the Medicare fiscal intermediary, the methodologies as prescribed above will be used to determine final Medicaid FFS cost, Medicaid managed care cost, and uninsured cost. The routine per diems and ancillary cost-to-charge ratios will be determined using cost, day and charge data from the finalized cost report. The Medicaid FFS, Medicaid managed care, and uninsured days, charges, and payment offsets will be updated with the latest MMIS reports and other auditable financial records.

Cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include:

1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS data to the per diem amount;

2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and

3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly excepted for Medicaid.

If, at the end of the reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Recoveries are updated and offset to cost as calculated per Steps above.

For hospitals whose cost report year is different from the state's fiscal year, the state will proportionally allocate to the state plan rate year the costs of two cost report periods encompassing the state Plan payment year. To do so, the state will obtain the actual Medicaid FFS, Medicaid managed care, and uninsured days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS, Medicaid managed care, and uninsured costs for the reporting periods; these costs will then be proportionally allocated to the state plan rate year. All allocations will be made based upon number of months. (For example, a hospital's cost reporting period ending 12/31/07 encompasses three-fourths of the state plan rate year ending 9/30/2007, and one-fourth of the state plan rate year ending 9/30/2008. To fulfill reconciliation requirements for state plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2006, to the state plan rate year.) The state will ensure that the total costs claimed in a state plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**7500 Security Boulevard, Mail Stop: S2-01-16**
**Baltimore, Maryland 21244-1850**

December 26, 2013

Mr. Darin Gordon
Director
Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to amend the TennCare II section 1115 of the Social Security Act (the Act) demonstration (Project No. 11-W-00151/4). This amendment is effective as of January 1, 2014.

This award is a partial response to Tennessee's request in which several changes to the TennCare II demonstration were requested. At this time, CMS is approving the request to extend the enrollment period for the Interim CHOICES 3 group. We look forward to discussing the other components of Tennessee's request with your staff in the coming weeks.

The demonstration expenditure authorities and Special Terms and Conditions (STCs) have been changed to reflect that Interim CHOICES 3 group that provides home and community based services (HCBS) to individuals at risk for institutionalization will remain open until June 30, 2015. This will allow the state to continue to enroll and provide HCBS to the Interim CHOICES 3 population.

The approval for extending enrollment for the Interim CHOICES 3 group is conditioned upon compliance with the enclosed STCs and is subject to our receiving your acknowledgement of the award and the acceptance of the STCs within 30 days of the date of this letter.

Your acceptance and any questions regarding the TennCare II program may be directed to your project officer, Jessica Woodard. Ms. Woodard can be reached at (410) 786-9249 or Jessica.Woodard@cms.hhs.gov. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Ms. Woodard at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services

Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communications regarding program matters should be sent simultaneously to Ms. Woodard and to Ms. Jackie Glaze, Associate Regional Administrator, in our Atlanta Regional Office. Ms. Glaze's contact information is as follows:

Centers for Medicare & Medicaid Services
Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909
Telephone: (404) 562-7359
E-mail: Jackie.Glaze@cms.hhs.gov

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

Cc: Jackie Glaze, Associate Regional Administrator, CMS Atlanta
Kenni Howard, CMS Atlanta

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**WAIVER LIST**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or specified as not applicable in the following list, shall apply to all TennCare II populations identified in paragraph 17 *(Eligibility)* of the Special Terms and Conditions.

The TennCare II Demonstration will operate under these waiver authorities and those provisions specified as "not applicable." The waiver authorities and the provisions specified as "not applicable" will continue through June 30, 2016, unless otherwise stated.

The following waivers shall enable Tennessee to implement the TennCare II Medicaid Section 1115 demonstration.

**WAIVERS OF TITLE XIX REQUIREMENTS FOR TENNCARE MEDICAID TITLE XIX STATE PLAN GROUPS**

**1. Statewideness/Uniformity** **Section 1902(a)(1)**
**42 CFR § 431.50**

To the extent necessary to enable the state to provide managed care plans or certain types of managed care plans only in certain geographical areas of the state. Certain managed care plans or certain types of managed care plans (e.g., risk-based plans) are only available in certain areas of the state.

**2. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR § 438.52**

To the extent necessary to permit the state to have only one pharmacy benefits manager and one dental benefits manager to provide services in a region of the state or statewide.

**3. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR § 435.831**

To the extent necessary to enable Tennessee to use streamlined eligibility procedures that provide for coverage of optional Medically Needy children and pregnant women and the Standard Spend Down demonstration population for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. In accordance with the Code of Federal Regulations, the "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

**4. Reasonable Promptness** **Section 1902(a)(8)**

To the extent necessary to enable the state to limit enrollment in CHOICES 2 and 3 to the enrollment target(s) established by the state, as authorized under 32.d. (*Enrollment Targets for TennCare CHOICES)* of the Special Terms and Conditions, and to allow the state to require applicants for long-term services and supports to complete a person-centered assessment and options counseling process.

**5. Access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Benefits** **Section 1902(a)(10) 42 CFR §§ 440.210 and 440.220**

To the extent necessary to enable the state to permit managed care contractors to limit coverage of FQHC and RHC services, so long as access to care is assured from other providers.

**6. Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B) 42 CFR 440 Subpart B**

To the extent necessary to enable the state to offer a reduced benefit package, a different benefit package, or cost-effective alternative benefit packages to different populations under the demonstration (except for individuals specified in Section 1902(l)(4) of the Act), to the extent authorized under Section V of the Special Terms and Conditions.

**7. Comparability and Amount Duration and Scope** **Sections 1902(a)(17) and 1902(a)(10)(B)**

Should the state change the level of care criteria for admission to nursing facilities, to the extent necessary to enable the state to determine whether an individual has a continuing need for nursing facility services, PACE services, or home and community-based services for the elderly and disabled, based on the criteria in use when the individual first was determined to need the service.

**8. Freedom of Choice** **Section 1902(a)(23)(A) 42 CFR § 431.51**

To enable the state to restrict freedom of choice of provider, through the use of mandatory enrollment in managed care plans or TennCare Select for the receipt of TennCare II and TennCare CHOICES covered services, including for individuals specified at Section 1932(a)(2) of the Social Security Act (the Act). No waiver of freedom of choice is authorized for family planning providers.

**9. Retroactive Eligibility** **Section 1902(a)(34) 42 CFR § 435.914**

To enable the state not to extend eligibility prior to the date that an application for assistance is made. This waiver authority will expire at the end of the extension period of the demonstration, June 30, 2016, unless otherwise approved based on the requirements of paragraph 8 (*Extension of the Demonstration*) of the STCs.

**10. Payment for Outpatient Drugs** **Section 1902(a)(54)**

**42 CFR §§ 440.120,**
**447.331-447.334,**
**and 456 Subpart K**

To the extent necessary to enable the state to establish a drug formulary that does not comply with the requirements of Section 1927(d)(4) of the Act.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under Section 1903, shall, for the period of this demonstration extension, be regarded as expenditures under the state's Medicaid title XIX state plan.

The following expenditure authorities shall enable Tennessee to implement the Medicaid Section 1115 demonstration (TennCare II).

**1. Expenditures Related to MCO Enrollment and Disenrollment.**
Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the Act specified below. Tennessee managed care plans will be required to meet all requirements of Section 1903(m) except the following:

- Section 1903(m)(2)(A)(vi) of the Act, Federal regulations at 42 CFR § 438.56, to the extent that the rules in Section 1932(a)(4) are inconsistent with the enrollment and disenrollment rules contained in paragraph 39 *(Plan Enrollment and Disenrollment)* of the demonstration's Special Terms and Conditions (STCs), such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 45 days of enrollment in an MCO. After 45 days, enrollees may disenroll from an MCO with cause at any time.

**2. Expenditures Related to Expansion of Existing Eligibility Groups.**
To enable Tennessee to use streamlined eligibility procedures and include eligibility standards and requirements that differ from those required by law.

a. Expenditures for Medical Assistance furnished to state plan optional Medically Needy children and pregnant women for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. The "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

b. Expenditures for Medical Assistance furnished to mandatory state plan Transitional Medical Assistance beneficiaries, who are eligible in accordance with section 1931(c)(1) of the Act, for the remainder of a 12-month eligibility period after the 4-month period specified in the statute.

**3. Expenditures for Expanded Benefits and Coverage of Cost-Effective Alternative Services.**

a. Expenditures for TennCare Medicaid and TennCare Standard child enrollees for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*. and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

b. Expenditures for TennCare Medicaid and TennCare Standard adult enrollees for optional services not covered under Tennessee's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*., paragraph 28 *(TennCare Benefits)*, and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

**4. Expenditures for Pool Payments.**
Expenditures for Graduate Medical Education, Essential Access Hospital, Critical Access Hospital, Meharry Medical College, Unreimbursed Public Hospital Costs for Certified Public Expenditures, Unreimbursed Hospital Cost, and Public Hospital Supplemental Payment pool payments to the extent specified in paragraph 55.d. through h. and j. through l. *(Extent of Federal Financial Participation for the Demonstration)* of the demonstration's STCs. This expenditure authority will expire December 31, 2015, unless otherwise approved based on the requirements of paragraph 8 *(Extension of the Demonstration)* of these STCs.

**5. Indirect Payment of Graduate Medical Education.**
Expenditures, up to $50 million in total computable expenditures for each demonstration year, for payments to universities that operate graduate physician medical education programs, which are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics.

**6. Payments for Non-Risk Contractor.**
Payments to the TennCare Select prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor more than what Medical Assistance would have paid fee-for-service under the state plan in accordance with the upper limits at 42 CFR § 447.362.

**7. Expenditures Related to Eligibility Expansion.**
Expenditures to provide Medical Assistance coverage to the following demonstration populations that are not covered under the Medicaid state plan and are enrolled in TennCare Standard :

a. **Medically Eligible Demonstration Population Children, Not CHIP Eligible.**
Uninsured children under age 19 who lose eligibility in TennCare Medicaid, have been determined to be "medically eligible" (uninsurable), have family income at

or above 200 percent of the Federal poverty level (FPL), and do not meet the definition of an optional targeted low-income child.

b. **Adult Demonstration Population Eligibles-Standard Spend Down (SSD):** Non-pregnant, non-postpartum adults aged 21 or older who have been determined to meet criteria patterned after the state plan Medically Needy requirements (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category* of the STCs), comprising:
   - Aged, blind, or disabled individuals; or
   - Caretaker relatives.

**8. CHIP-Related Medicaid Expansion Demonstration Population Children.**
Expenditures to provide Medical Assistance coverage to uninsured children who lose eligibility under TennCare, who meet the definition of optional targeted low-income child, and who have family income up to 200 percent of the FPL.

**9. The CHOICES 217-Like HCBS Group.**
Expenditures for TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with Section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under TennCare CHOICES were provided under an HCBS waiver granted to the state under Section 1915(c) of the Act, as of the initial approval date of the TennCare CHOICES component of this demonstration. This includes the application of the spousal impoverishment eligibility rules. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the STCs;

b. Home and community-based waiver-like services as specified in Table 2b, subject to the definitions in Attachment D of the STCs, net of beneficiary regular and spousal impoverishment post-eligibility responsibility for the cost of care, and with post-eligibility treatment of income for individuals receiving short-term nursing facility care calculated as if they were receiving HCBS in the community.

**10. HCBS Services for SSI-Eligibles.**
Expenditures for the provision of home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs that are not described in Section 1905(a) of the Act and not otherwise available under the approved state plan but could be provided under the authority of Section 1915(c) waivers, that are furnished to TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities with income at 100 percent of the Supplemental Security Income/Federal Benefit Rate and resources at or below $2,000 who either:

a. Meet the nursing facility institutional level of care; or

b. Do not meet the nursing facility institutional level of care but who, in the absence of TennCare CHOICES services, are "at risk" of institutionalization.

**11. The At Risk Demonstration Group.**

Elderly adults and adults age 21 and older with physical disabilities who have not been otherwise determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012. The At Risk Demonstration Group is open to new enrollment until June 30, 2015.

Expenditures allowable under this demonstration for these individuals are for the following benefits:

a. Services as presented in Table 2a of the STCs.

b. Home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs, net of beneficiary post-eligibility responsibility for the cost of care (including application of spousal impoverishment rules), as set forth in the STCs.

**12. Continuing Receipt of Nursing Facility Care.**

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**13. Continuing Receipt of Home and Community-Based Services.**

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**14. Continuing Receipt of Program of All-Inclusive Care for the Elderly (PACE) Services.**

Expenditures for PACE-enrolled individuals, who upon redetermination do not meet the current nursing facility level of care criteria, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the PACE Carryover Group.

**15. LTC Partnership.**

Expenditures for individuals in CHOICES 2 to participate in the Long Term Care Partnership Program.

**REQUIREMENTS NOT APPLICABLE TO TENNCARE STANDARD TITLE XIX DEMONSTRATION ELIGIBLE GROUPS**

All Title XIX requirements that are waived for the TennCare Medicaid Groups are also not applicable to the TennCare Standard Title XIX Demonstration Eligible Groups. In addition, the following is not applicable to the Title XIX Demonstration Eligible Groups.

| | |
|---|---|
| **Cost Sharing** | **Section 1902(a)(14) and Section 1916**<br>**42 CFR §§ 447.51 – 447.56** |

To enable the state to charge cost sharing beyond applicable Medicaid limits to TennCare Standard demonstration populations, with cost-sharing subject to a quarterly aggregate cap of 5 percent of family income for children.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS (STCs)**

**NUMBER:** **11-W-00151/4 (Title XIX)**

**TITLE:** **TennCare II**

**AWARDEE:** **Tennessee Department of Finance and Administration**

**DEMONSTRATION EXTENSION PERIOD:** **July 1, 2013 through June 30, 2016**

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**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS**

**NUMBER:** **Title XIX No. 11-W-00151/4**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for Tennessee's TennCare II Section 1115(f) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to this agreement are the Tennessee Department of Finance and Administration, Bureau of TennCare ("state") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the demonstration project. The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the approval letter's date, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This demonstration extension is approved through June 30, 2016.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits; CHOICES Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality for the Demonstration; Evaluation of the Demonstration; TennCare Eligibility Redetermination and Disenrollment and Rights; Appeals Process for Changes in Benefits; Enrollment in Standard Spend Down; and the Schedule of State Deliverables During the Demonstration Extension.

## II. PROGRAM DESCRIPTION AND OBJECTIVES

TennCare II is a continuation of the state's demonstration, funded through titles XIX and XXI of the Social Security Act (the Act). TennCare began as an 1115(a) demonstration project in January 1994. A 3-year extension was approved for 1999-2001, and a 1-year extension was approved early in 2002. A new TennCare II 1115(a) demonstration was approved by CMS on May 30, 2002, and initiated on July 1, 2002, for a 5-year period. On October 5, 2007, an extension was granted under Section 1115(a) through June 30, 2010, with revised waiver and expenditure authorities and STCs. (Note: Temporary extensions under the existing TennCare II STCs were granted for the July 1 through October 5, 2007 period, in order to provide additional time to conclude discussions on a longer extension.) The most recent extension, granted in December 2009 under the authority of Section 1115(e) of the Act, was in effect from July 1, 2010 through June 30, 2013. The current extension is granted under the authority of Section 1115(f) of the Act and is in effect from July 1, 2013 through June 30, 2016.

As of October 2012, the TennCare II program had 1.213 million enrollees, about half of whom were children. All mandatory and optional populations eligible under Tennessee's state plan are enrolled in TennCare II, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only").

There are three components to the TennCare II demonstration program. **TennCare Medicaid** is the component that serves enrollees who are Medicaid-eligible under Tennessee's title XIX state plan. **TennCare Standard** is the component that serves title XIX Medicaid enrollees who are eligible only through the demonstration's expenditure authorities**.** Title XXI Medicaid expansion children are also served under TennCare Standard, with a more extensive benefits package and a different service delivery system than the children served under the title XXI stand-alone Children's Health Insurance Program (CHIP). Both TennCare Medicaid and TennCare Standard deliver all Medicaid services, except for services specified at paragraphs 28 *(TennCare Benefits)* and 30 *(Medicaid Benefits Carved Out of TennCare II Demonstration)* as excluded from the TennCare benefits package for specified populations.

The **CHOICES** Program is the newest component. CHOICES utilizes the existing for-risk, Medicaid managed care organizations to provide eligible individuals with nursing facility services or home and community based services. With the implementation of the CHOICES program in 2010, home and community based services and nursing facility services were added to the existing TennCare II benefit package of primary, acute, and behavioral health services for qualifying state plan and demonstration eligible individuals. This provides participating individuals with an integrated package of acute and long-term services and supports, through a managed care delivery system.

The goals of TennCare are the following:

- Use a managed care approach to provide services to Medicaid state plan and demonstration enrollees at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.

- Assure appropriate access to care for enrollees.
- Provide quality care to enrollees.
- Assure enrollees' satisfaction with services.
- Improve health care for program enrollees.
- Assure that participating health plans maintain stability and viability, while meeting all contract and program requirements.
- Provide appropriate, and cost-effective home and community based services that will improve the quality of life for persons who qualify for nursing facility care, as well as for persons who do not qualify for nursing facility care but who are "at risk" of institutional placement and that will help to rebalance long-term services and supports expenditures.

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with Section 1115 of the Act. The state must

not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 *(Amendment Process)* below.

**7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following

a. An explanation of the public process used by the state, consistent with the requirements of paragraph 15 *(Public Notice and Consultation with Interested Parties)*, to reach a decision regarding the requested amendment;

b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

Changes to TennCare II benefits described in the state plan shall be made by state plan amendment. Changes to TennCare II benefits not described in the state plan shall be made by amendment to the demonstration. Changes in benefits shall be implemented in accordance with the process set forth in Section XIII of these STCs.

Additions or Changes to CHOICES Benefits. All requests for changes in coverage of CHOICES benefits are subject to CMS approval. Changes in benefits defined in Attachment D must be submitted to CMS for approval at least 60 days in advance of the state's desired implementation date. Requests for services that are not defined in Attachment D must be submitted by the state to CMS as a request to amend the demonstration.

The state must send a courtesy copy of all Medicaid state plan amendment requests to the Project Officer. This requirement is in addition to the submissions that the state must make as part of the usual state plan amendment process, and is not meant to substitute for or supplant that process in any way.

**8. Extension of the Demonstration.**

a. Should the state intend to request an extension of the demonstration, the state must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9 *(Demonstration Phase-Out).*

b. Compliance with Transparency Requirements 42 CFR § 431.412. Effective April 27, 2012, as part of demonstration extension requests the state must provide documentation of compliance with the transparency requirements of 42 CFR § 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15 *(Public Notice and Consultation with Interested Parties).*

**9. Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, only consistent with the following requirements:

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of the phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §§ 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §§ 431.220 and 431.221. If a demonstration participant requests a hearing

before the date of action, the state must maintain benefits as required in 42 CFR § 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010 State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

**10.** **Post Award Forum**. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this paragraph. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 45 *(Quarterly Progress Reports)* associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 46 *(Annual Report).*

**11.** **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

**12.** **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

**13.** **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

**14.** **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

**15.** **Public Notice and Consultation with Interested Parties.** The state must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6 *(Changes Subject to the Amendment Process)*, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR § 431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 CFR § 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR § 447.205 for changes in statewide methods and standards for setting payment rates.

**16.** **FFP.** No Federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

## IV. ELIGIBILITY

**17. Eligibility.** Tennessee includes in the TennCare II demonstration all of the mandatory and optional populations eligible under the Tennessee Medicaid state plan, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only"). Also included in TennCare II are several title XIX demonstration-only eligible populations and one title XXI Medicaid Expansion demonstration population. Medicaid state plan-eligible individuals are served in the component of the program called TennCare Medicaid. Other demonstration-only eligible populations are served in the component called TennCare Standard.

The mandatory and optional Medicaid state plan populations described below derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the demonstration to generate savings for covering the Expansion populations, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.

The title XXI Medicaid Expansion demonstration population is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as otherwise listed as not applicable.

Under the TennCare II demonstration, Tennessee is not required to extend eligibility for medical assistance prior to the date that an application for assistance is made; however, the state may provide retroactive coverage for up to 3 months for class members in *Daniels, et al. v. Tenn. Dept. of Health and Env't., et al.*, (1) who have been terminated from TennCare on or before March 31, 2010, for failure to respond to a Request for Information and Expiration Notice in accordance with the process approved in the Federal court order dated January 8, 2009; (2) who subsequently complete a Request for Information within 60 days of termination; and (3) who are determined to have been eligible at the time of termination. The state must notify the Project Officer by letter if it intends to extend retroactive eligibility to Daniels class members as described above.

Any changes to eligibility must be submitted to CMS as an amendment request, subject to the process set forth in paragraphs 6 (*Changes Subject to the Amendment Process)* and 7 *(Amendment Process)* of these STCs.

The criteria for TennCare eligibility groups are as follows (Table 1a).

**Table 1a**
**TennCare Eligibility Groups**

Note: This table does not change the state plan requirements.

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **Title XIX State Plan Mandatory Groups – TennCare Medicaid** | | |
| 1931 recipients including:<br>• Children younger than 18/19<br>• Caretaker relatives<br>• Pregnant women with no other eligible children (coverage for third trimester) | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Transitional Medical Assistance – Medicaid Extension for families who lose TANF benefits due to:<br>• income from employment or work hours or loss of "income disregard"<br>• increased child or spousal support collections | 6 initial months + 6 months continued coverage<br>4 months continued coverage *and expenditure authority for 8 additional months* | 1, 2, 5, 6, 8, 9, 10 |
| Individuals who are ineligible for AFDC benefits solely due to requirements that are prohibited under Medicaid, including AFDC time limits | Income up to and including 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Poverty level pregnant & postpartum women | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level newborns under age 1 | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 1-5 | Income up to and including 133% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 6-18 | Income up to and including 100% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Deemed categorically eligible newborns: born to & living with a woman who was eligible and received Medicaid on the date of the child's birth | Eligible for 1 year as long as mother is eligible or would be if pregnant | 1, 2, 5, 8, 10 |
| Pregnant woman who would otherwise lose eligibility because of an increase in income remains eligible through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Woman who was eligible while pregnant continues eligibility through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Title IV-E eligible children in adoption subsidy or foster care | AFDC income standard | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash recipients: aged, blind or disabled (may or may not be receiving CHOICES benefits) | | 1, 2, 4, 5, 6, 7, 8, 9, 10, |
| Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87 | | 1, 2, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| "DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash ineligible for reasons prohibited by Title XIX. | | 1, 2, 5, 6, 8, 9, 10 |
| "Pickle" SSA Beneficiaries who lost SSI cash benefits due to cost of living adjustment (COLA) increase in Title II OASDI benefits | | 1, 2, 5, 6, 8, 9, 10 |
| "DWB" Disabled widow/widower who lost SSI or state supplement due to early receipt of OASDI benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| **Title XIX State Plan Optional Groups – TennCare Medicaid** | | |
| Presumptively eligible pregnant & postpartum women | Income up to 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Children under 21 who meet AFDC income & resource criteria—children in state custody, foster care, subsidized adoptions, institutionalized | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Persons who would be eligible for AFDC or SSI cash assistance except for their institutional status | | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Special income level group: individuals who are in a medical institution at least 30 consecutive days with income that does not exceed 300% of SSI income standard under 1902(a)(10)(ii)(V) of the Act. | Income no more than 300% of SSI rate; resources $2000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Categorically needy individuals under the state plan who are receiving home and community based services in accordance with 42 CFR § 435.217. (This group consists solely of enrollees in the ID waivers.) | | 1, 2, 5, 6, 8, 9, 10 |
| Non-IV-E children with special medical needs who receive a state adoption subsidy payment | | 1, 2, 5, 6, 8, 9, 10 |
| Women under 65 who need treatment for breast or cervical cancer, and are not otherwise eligible for Medicaid. State utilizes presumptive eligibility for this population. | | 1, 2, 5, 6, 8, 9, 10 |
| Medically needy children under 21 *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| Medically needy pregnant or postpartum women *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |
| **Title XIX Demonstration Eligible Groups– Carryover** | | |
| **CHOICES 1 and 2 Carryover Group:** Individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **PACE Carryover Group:** Individuals who were enrolled in a PACE program as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | As required under the state plan. | |
| **Title XIX Demonstration Eligible Groups – TennCare Standard** | | |
| **Medically Eligible Children:** uninsured children under 19 who have been determined to be "medically eligible" (uninsurable) (category is currently closed to new enrollment except for Medicaid rollovers *[*as defined in paragraph 20, *Rollover Definition]* who are not otherwise eligible for TennCare. See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*. | Income 200% FPL or higher without limit; no resource test | 1, 2, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Standard Spend Down (SSD):** non-pregnant/postpartum adults 21 or older who have been determined to meet criteria patterned after the medically needy requirements *(enrollment target: 100,000)*<br>• aged, blind, or disabled<br>• caretaker relatives<br>CMS approved an amendment to add this expansion population in Nov. 2006.<br>(Expenditure authority for 12-month coverage based on 1-month budget period.)<br>See paragraph 21.a. *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*. | Medically needy spend-down level ($241 for 1, etc.); resources $2000 | 1, 2,, 3, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Title XIX Demonstration Eligible Groups – CHOICES** | | |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **CHOICES 217-Like HCBS Group:** Aged and / or disabled categorically needy adults who meet the CHOICES NF level of care requirement, are receiving home and community based services and who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236, and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915 (c) waiver. This group is subject to the enrollment target for CHOICES 2 in paragraph 32.d *(Enrollment Targets for TennCare CHOICES)*. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **At Risk Demonstration Group:** Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of the TennCare Interim Choices 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open to enrollment starting July 1, 2012, and closed to new enrollment on June 30, 2015. [1] | Income no more than 300% SSI/FBR; resources $2,000 | 1,2,4,5,6,7,8,9,10 |
| **Title XXI Medicaid Expansion Demonstration Eligible Group – TennCare Standard** | | |
| Optional Targeted Low-Income Children: uninsured children under 19 who:<br>• have lost Medicaid eligibility under the approved Medicaid state plan and who do not have access to insurance or<br>• were uninsured and enrolled in this category in the original TennCare demonstration as of 12/31/01, even if they had access to insurance, and have been continuously enrolled in this category since 12/31/01<br>See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*.. | Income up to 200% FPL | 1, 2, 5, 6, 8, 9, 10, and cost sharing "not applicable" |

## 18. TennCare CHOICES Eligibility Groups.

As further set forth in paragraph 32 *(Operations of the TennCare CHOICES Program)*, eligibility for enrollment in TennCare CHOICES depends on (a) the individual's

[1] Although the state is approved to determine CHOICES eligibility using a more restrictive nursing facility level of care standard beginning July 1, 2012, the state has not yet instituted the more restrictive nursing facility level of care. Individuals enrolled in Interim CHOICES 3 until June 30, 2015 meet the nursing facility level of care in place on June 30, 2012

TennCare Eligibility Group, (b) the nursing facility (NF) (or "At Risk," as applicable) level-of-care (LOC) criteria as established by the state, and (c) the type of long-term services and supports (LTSS) to be provided.

There are three principal eligibility groups for TennCare CHOICES. CHOICES 1 is for individuals receiving NF services. CHOICES 2 is for individuals who meet the NF LOC that are receiving HCBS as an alternative to NF care. CHOICES 3 is for individuals who do not meet the NF LOC, but are at risk of NF placement and are receiving HCBS to delay or prevent NF placement.

Effective July 1, 2012, the state elected to change the level of care that is medically necessary for admission to a NF. CHOICES 3 serves SSI eligibles enrolled after the implementation of the LOC change who do not meet the new LOC standard but who are "at risk" of institutionalization. Individuals in CHOICES 1 and CHOICES 2 who continue to meet the standard in place at the time of the individual's enrollment will continue to qualify for those services.

Between July 1, 2012, and December 31, 2013, the state opened Interim CHOICES 3 to serve SSI eligibles and other adults who meet the LOC standard and financial eligibility requirements in place prior to the change, allowing the state to abide by the "Maintenance of Effort" (MOE) requirements as specified by the Affordable Care Act, Section 2001. The Interim CHOICES 3 group has since been extended through June 30, 2015.

Table 1b summarizes the CHOICES Eligibility Groups and addresses how a change in LOC criteria is taken into account in determining eligibility for each group.

**Table 1b**
**TennCare + CHOICES Eligibility Groups**

Note: This table does not change the state plan requirements. CHOICES 1, CHOICES 2, CHOICES 3, and Interim CHOICES 3 are defined in paragraph 32 *(Operations of the TennCare CHOICES Program)*. The CHOICES 1 and 2 Carryover Group and the PACE Carryover Group are defined in Table 1a of paragraph 17 *(Eligibility)*. With respect to benefits, cost-sharing, and similar issues, persons in the CHOICES 1 Carryover Group are treated as though they were in CHOICES 1; persons in the CHOICES 2 Carryover Group are treated as though they were in CHOICES 2; and persons in the PACE Carryover Group are treated as though they were in PACE.

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 1 | • Nursing facility residents who meet the NF LOC in place at the time of enrollment* | Yes | Yes, CHOICES 1 and 2 Carryover Group |

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 2 | • Meet NF LOC in place at the time of HCBS<br>• Receive HCBS as alternative to NF care<br>• Age 65+ or 21+ and disabled | Yes, SSI only | Yes, CHOICES 217-Like HCBS Group and CHOICES 1 and 2 Carryover Group |
| CHOICES 3 | • "At risk" for institutionalization (as defined in Attachment D)<br>• Age 65+ or age 21+ and disabled | Yes, SSI only | No |
| INTERIM CHOICES 3 (open to enrollment starting July 1, 2012 and closed to new enrollment on June 30, 2015) | • Same as CHOICES 3, but not limited to SSI recipients<br>• Must meet nursing facility financial eligibility criteria | Yes, SSI only | Yes, At Risk Demonstration Group |

***** The state may grant an exception for persons in the community seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

**19. Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed.** The state has closed enrollment into the following demonstration categories, except for "rollovers" (as defined in paragraph 20, *Rollover Definition*). Therefore, children are only eligible for a non-state plan demonstration population as a "rollover." If children lose Medicaid state plan eligibility, they may qualify for one of these demonstration-only groups rather than for the stand-alone title XXI CHIP program.

- Title XIX Medically Eligible Children: Individuals who are under age 19, are uninsured, have income that is 200 percent of the FPL or higher without limit, are not otherwise eligible for TennCare, and meet the state-defined criteria of "medically eligible" as having medical conditions that make them uninsurable. (There is no income or resource limit for this group.)

- Title XXI Medicaid Expansion Children: Individuals under age 19 who are uninsured, have family income less than 200 percent of the FPL, and meet the definition of an optional targeted low-income child. (There is no resource limit for this group.)

Individuals under age 19 who lose eligibility for a Medicaid category may roll over into a TennCare Standard category if they meet the criteria for the category.

**20. Rollover Definition.** For the purpose of this demonstration, a "rollover" eligible is an individual who qualifies for continued coverage through a TennCare Standard demonstration category upon losing Medicaid eligibility under any category included in Tennessee's title XIX state plan.

**21. Adult Non-State Plan Demonstration Population Categories.**

a. **Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category.** The SSD eligibility category is open to non-pregnant/postpartum adults ages 21 or older who are Caretaker Relatives or Aged, Blind, or Disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the state plan. The SSD demonstration eligibility group has an enrollment cap of 105,000, with a target enrollment of 100,000. The state shall establish eligibility and enroll individuals into the SSD group in accordance with the process set forth in Section XIII of these STCs.

b. **CHOICES 217-Like HCBS Group**. This group consists of persons aged 65 and older or persons aged 21+ and who are disabled who: (1) meet the CHOICES NF level of care requirement; (2) are receiving home and community-based services; and (3) would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal Regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915(c) waiver. Paragraph 18 *(TennCare CHOICES Eligibility Groups)* and paragraph 32.b. *(Eligibility for TennCare CHOICES Benefits)* describe how the NF LOC requirements shall be determined for individuals in this group. The state retains the discretion to apply an enrollment target as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES).*

c. **At Risk Demonstration Group.** As of July 1, 2012, this group consists of elderly adults and adults age 21 and older with physical disabilities who (1) meet nursing facility financial eligibility; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization.

d. **CHOICES 1 and 2 Carryover Group.** This group consists of individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who no longer qualify for CHOICES enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in CHOICES 1 or CHOICES 2 if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, (2) meet all the eligibility requirements for a CHOICES program; and (3) remain continuously enrolled in CHOICES 1 and/or 2, as specified below:

i. Persons enrolled in CHOICES 1 can continue in CHOICES 1 or transition to CHOICES 2, and persons enrolled in CHOICES 2 can continue in CHOICES 2; and

ii. The state may grant an exception to i. for persons in CHOICES 2 seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

e. **PACE Carryover Group.** This group consists of individuals who were enrolled in PACE as of June 30, 2012, but who no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in PACE if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, and (2) meet all other eligibility requirements for PACE in the Medicaid state plan. PACE remains under the Medicaid state plan.

**22. Medically Needy Eligibility Period.** Financial eligibility for state plan medically needy pregnant women and children and for Standard Spend Down adults is based on a 1-month budget period described in the state plan. Those determined eligible remain eligible for up to 1 year from the effective date of eligibility.

**23. Quality Review of Eligibility**. At least annually, the state shall submit a plan for a Medicaid Eligibility Quality Control (MEQC) pilot project to the CMS Regional Office for approval. When each pilot is complete, the state shall send a report to the CMS Regional Office for approval, and shall submit a plan for the next pilot project. The MEQC pilots must be conducted in accordance with Federal law, regulations, and policy.

**24. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.**

a. Except as specified in paragraph 24.b. below, in determining eligibility for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in Section 1924 of the Act and 42 CFR § 435.725 of the Federal regulations.

b. For an individual in CHOICES 2 or CHOICES 3 who is admitted for short-term nursing facility care (as defined in Attachment D), in order to ensure that the individual can maintain a community residence for transition back to the community, the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. After 90 days, or as soon as it appears that the inpatient stay will not be short-term, whichever comes first, the person will be transitioned to CHOICES 1 and the institutional post-eligibility calculation shall apply.

25. **Eligibility/Post-Eligibility Treatment of Income and Resources for the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group.** For individuals receiving 1915(c) like services in CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, or the PACE Carryover Group, the state must use institutional eligibility and post-eligibility rules for individuals who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a Section 1915(c) waiver.

26. **Post-Eligibility and Patient Liability for the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group.** The state assures that, for individuals receiving 1915(c) like services, under the post-eligibility process, the state must have a method to carve out / identify the cost of the 1915(c) like services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of the 1915(c) like services.

27. **Non-Payment of Patient Liability.** A provider (including an MCO) may decline to continue to provide services to an individual who fails to pay his or her patient liability. If an enrollee who has failed to pay patient liability is unable to find another provider or MCO who is willing to provide LTSS, then the individual may be disenrolled from the CHOICES program. If the beneficiary's eligibility for TennCare is dependent on the receipt of long-term institutional care or HCBS through TennCare CHOICES, as would be the case if an enrollee is a member of the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group, such individual may be disenrolled from TennCare if he or she is no longer able to receive such services, unless he/she qualifies in another Medicaid category. The consequences for failing to pay patient liability must be clearly explained to members upon enrollment in CHOICES. Nothing herein shall prejudice any individual from fully exercising his or her rights to reapply for Medicaid coverage.

## V. BENEFITS

**28. TennCare Benefits.** With the implementation of the CHOICES program, TennCare covers physical, behavioral, and long-term care benefits provided through managed care delivery systems.

a. All mandatory and optional Medicaid state plan eligible adults aged 21 or older, are enrolled in TennCare Medicaid, and receive all services covered under Tennessee's state plan according to the limitations specified in the state plan, including the services identified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration)* as appropriate. Additional TennCare benefits are provided as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)*.

b. Members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group or the CHOICES 1 and 2 Carryover Group, all of which are demonstration-only groups, are enrolled in TennCare Standard, but receive all benefits described in a. above. In addition, individuals in the CHOICES 217-Like HCBS Group are members of CHOICES 2 and members of the At Risk Demonstration Group are members of Interim CHOICES 3.

c. Demonstration-only eligible adults who are members of the Standard Spend Down population (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*) are enrolled in TennCare Standard and receive all state plan services, plus additional TennCare benefits as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)* as appropriate, except that they do not have access to the services discussed in Table 2b or Table 3. Medicare Parts A and B premiums and Medicare co-payments and deductibles are covered in accordance with paragraphs 30.b. and c.

d. All mandatory and optional Medicaid state plan eligible children younger than 21 years old enrolled in TennCare Medicaid receive all state plan and EPSDT covered services.

e. The demonstration-only eligible children enrolled in TennCare Standard receive the same benefits as the state plan eligible children enrolled in TennCare Medicaid, except as specified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration)*.

f. The Medicaid state plan mandatory and optional eligibility categories for poverty level pregnant or postpartum women receive all TennCare Medicaid benefits, because the state considers that all of these services are pregnancy-related services.

g. The following table (Table 2a) lists benefits for TennCare Medicaid and TennCare Standard adults aged 21 and older that are different from those

identified in the state plan. All benefits are limited by medical necessity as defined by the state. "State Plan Coverage for Adults" is provided for informational purposes only, and does not supersede the approved Medicaid state plan. CMS will issue an updated version of Table 2a in the event that future SPAs cause the Medicaid state plan to be in conflict with what appears in Table 2a.

**Table 2a**
**TennCare Medicaid and TennCare Standard Benefits for Adults Aged 21 and Older That Are Different Than State Plan Covered Services and Limitations**

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Diagnostic services not included in other service categories | Covered as medically necessary. | Not covered. |
| Home health | Covered as medically necessary, and in accordance with the definitions and limitations included in Attachment B. | Coverage limited to 60 visits per enrollee per state fiscal year. |
| Hospice care | Covered as medically necessary. | Coverage limited to 210 days per enrollee per state fiscal year. |
| Inpatient and outpatient substance abuse services | Covered as medically necessary | Not covered. |
| Inpatient hospital services | Covered as medically necessary. | Coverage limited to 43 days for heart transplants, 67 days for liver transplants, and 40 days for bone marrow transplants, per enrollee, per state fiscal year. |
| Lab and X-ray services | Covered as medically necessary. | Coverage limited to 30 occasions per enrollee per state fiscal year. |
| Medicare premiums and cost-sharing | Covered for state plan eligibles, SSD enrollees, members of the CHOICES 217-Like HCBS Group, and members of the At Risk Demonstration Group, in accordance with paragraphs 30.b. and c. | Covered for Medicare beneficiaries who are dually eligible for Medicaid according to their classification under the state plan (QMB, SLMB, Other Medicaid/Medicare Duals, etc.) |
| Mental health case management services | Covered as medically necessary. | Coverage limited to Targeted Case Management for persons who are Severely and/or Persistently Mentally Ill. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Occupational therapy | Covered as medically necessary. | Not covered. |
| Organ and tissue transplants | Covered as medically necessary, except that experimental or investigational transplants are not covered. | Coverage limited to renal, heart, liver, corneal, and bone marrow transplants. |
| Outpatient hospital services | Covered as medically necessary. | Coverage limited to 30 visits per enrollee per fiscal year. |
| Outpatient rehabilitation services | Covered as medically necessary. | Coverage limited to mental health services provided by Community Mental Health Agencies. |
| Pharmacy services | • Not covered for dually eligible adults.<br>• Covered for non-dual state plan eligibles in accordance with the state plan.<br>• Covered for non-dual SSD eligibles and non-dual At Risk Demonstration Group members, with the co-payments specified in Table 6 of paragraph 34.b. *(Co-Pays on Pharmacy).*<br>• Covered for non-dual CHOICES 217-Like HCBS Group enrollees, CHOICES 1 and 2 Carryover Group enrollees, and PACE Carryover enrollees in accordance with the state plan for Medicaid enrollees. | Coverage as specified in state plan. |
| Physical therapy services | Covered as medically necessary. | Not covered. |
| Physicians' services (including medical and surgical services furnished by a dentist) | Outpatient services: Covered as medically necessary.<br><br>Inpatient services: Covered as medically necessary. | Outpatient services: Coverage limited to 24 outpatient office visits per year, which includes 2 office visits for podiatrists and 4 office visits for optometrists.<br><br>Inpatient services: Coverage limited to 20 visits per enrollee per state fiscal year for services other than heart, liver, and bone marrow transplants, which are limited to 43, 67, and 40 days, respectively. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Preventive services | Covered as medically necessary. | Not covered. |
| Private duty nursing services | Covered when medically necessary to support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Definitions and limitations applicable to this service are contained in Attachment C. | Not covered. |
| Psychiatric residential treatment services (outside of an IMD) | Covered as medically necessary. | Not covered. |
| Screening services | Covered as medically necessary. | Not covered. |
| Speech, hearing, and language services | Covered as medically necessary. | Not covered. |
| Vision services | Covered for the first pair of cataract glasses following cataract surgery. | Not covered. |

h. The following table (Table 2b) lists HCBS benefits for TennCare Medicaid enrollees and CHOICES demonstration eligibles who are enrolled in the designated CHOICES groups (specified in paragraph 32.a., *Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition, the following rules apply to the CHOICES benefit.

i. The cost of medical assistance provided to an eligible participant in CHOICES 2 is limited to the amount calculated in the individual cost-neutrality test used in Section 1915(c) waivers as set forth in Section 1915(c)(4)(A). The state may delegate implementation of the cost neutrality test to the MCOs.

ii. For purposes of determining capitation rates, the cost of room and board, as defined in Attachment D, is not included in non-institutional care costs.

iii. For persons in CHOICES 3 or Interim CHOICES 3, in addition to the service limits stated in Table 2b, the total cost of the HCBS identified in

Table 2b shall not exceed $15,000 per calendar year, excluding the cost of minor home modifications.

iv. Definitions for CHOICES benefits are provided in Attachment D of these STCs.

**Table 2b**
**Benefits for Persons Enrolled in the CHOICES Program**

| **Benefit** (Definitions provided in Attachment D) | **CHOICES 1** | **CHOICES 2** | **CHOICES 3*** |
|---|---|---|---|
| Nursing facility care | X | Short-term only | Short-term only |
| Community-based residential alternatives | | X | |
| Personal care visits (up to 2 visits per day) | | X | X |
| Attendant care (up to 1080 hours per calendar year); up to 1400 hours per calendar year ONLY when Homemaker services are needed in addition to hands-on care | | X | X |
| Home-delivered meals (up to 1 meal per day) | | X | X |
| Personal Emergency Response Systems | | X | X |
| Adult day care (up to 2080 hours per calendar year) | | X | X |
| In-home respite care (up to 216 hours per calendar year) | | X | X |
| In-patient respite care (up to 9 days per calendar year) | | X | X |
| Assistive technology (up to $900 per calendar year) | | X | X |
| Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) | | X | X |
| Pest control (up to 9 units per calendar year) | | X | X |

*Subject to the limitations in 28.h.iii.

**29. Cost-Effective Alternatives.** TennCare MCOs and TennCare Select may provide services not listed in, or exceeding the individual service limits in, the Medicaid state plan or paragraph 28 (*TennCare Benefits*) of these STCs as allowed under their contracts with the TennCare program. Provision of these services is at the sole discretion of the MCO and TennCare Select. Capitation for the MCOs must be certified as actuarially sound (in accord with 42 CFR § 438.6), and comply with the Federal managed care regulations at 42 CFR §§ 438 et seq. TennCare Select must demonstrate to the state that a service not listed as covered in the Medicaid state plan or in paragraph 28 (TennCare Benefits) is a cost-effective alternative, in order for the state to reimburse TennCare Select for the service. The state must demonstrate to CMS annually as part of the annual report described in paragraph 46 (*Annual Report*) that utilization of these services by the MCOs and TennCare Select is cost-effective and is reimbursed in compliance with the Federal managed care regulations at 42 CFR §§ 438 et seq. Under the CHOICES program, cost-effective alternatives may include a Transition Allowance, as defined in Attachment D.

**30. Medicaid Benefits Carved Out of the TennCare II Demonstration.**

a. **"Base" Medicaid State plan services.** Base services are services carved out of TennCare II, and are provided, in accordance with the provisions of the Medicaid state plan, only to the mandatory and optional state plan eligibles and members of the PACE Carryover Group (in the case of PACE services only). The other TennCare II demonstration-only populations, which are eligible through the demonstration's expenditure authorities and enrolled in TennCare Standard, are not eligible for any of the services listed in Table 3. Expenditures for these "Base" services are not demonstration expenditures (see paragraph 51.a., *Tracking Expenditures*), are not included in the demonstration's budget neutrality, and should, therefore, be reported on the "Base" reporting schedules of the Form CMS-64 reports (or in the case of 1915(c) waiver services, the appropriate 1915(c) waiver schedule). Some carved out services were carved in as of the initial implementation of CHOICES (i.e., March 1, 2010), however, as indicated in Table 3, and must from that point forward be reported as TennCare II demonstration expenditures.

**Table 3**
**Base Services**

| **Services Carved Out of TennCare II** | |
|---|---|
| Nursing facility services | Services moved from the base to the demonstration as of March 1, 2010 (in Middle Tennessee) and August 1, 2010 (in East and West Tennessee) |
| Services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) | Base |
| State Plan targeted case management services | Base |
| Program of All Inclusive Care for the Elderly (PACE) | Base |
| Services covered by the home and community-based services waiver for individuals with intellectual disabilities under 1915(c) of the Social Security Act. | Base |
| Services covered through the state's agreement under Title V of the Social Security Act | Base |

b. **Medicare Parts A and B Buy-In Premiums.** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the Standard Spend Down group, the CHOICES 1 and 2 Carryover Group

and the PACE Carryover Group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare Buy-In premiums are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles as permitted in Section 1902(a)(10)(E) of the Act and 42 CFR § 431.625,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals),

(C) Dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the Standard Spend Down group (QMBs/SLMBs and Demo Duals), and

(E) Dually eligible members of the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group (QMBs, SLMBs, and Demo Duals).

ii. Medicare premiums paid on behalf of Demo Duals are demonstration expenditures, and must be reported on an appropriate Form CMS-64.9 or 9p Waiver, as described in paragraph 51.e. *(Use of Forms).*

iii. Medicare premium payments for other beneficiaries are excluded from TennCare II and must be reported as "Base" Medicaid expenditures on the CMS-64 reports.

iv. Records in CMS's Master Billing Record for Demo Duals and all buy-in transactions for Demo Duals must be identified using a specific Buy-In Eligibility Code (BIEC) value as agreed upon between the state and the Project Officer.

c. **Medicare Co-payments and Deductibles (i.e., Medicare crossover claims).** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, At Risk Demonstration Group, CHOICES 1 and 2 Carryover Group, the PACE Carryover Group or the Standard Spend Down group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare crossover claims are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs, and Demo Duals),

(C) Dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the CHOICES 1 and 2 Carryover Group and PACE Carryover Group, and

(E) Standard Spend Down enrollees (QMBs/SLMBs and Demo Duals).

The SSD population, the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group are the only demonstration populations for whom the state pays Medicare cost-sharing.

ii. For TennCare Medicaid enrollees, members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals), members of the At Risk Demonstration Group (QMBs, SLMBs, and Demo Duals), members of the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group (QMBs/SLMBs and Demo Duals), these expenditures are not demonstration expenditures and are not included in the budget neutrality calculations, so report these as "Base" Medicaid expenditures on the CMS-64 reports.

iii. For dually eligible SSD enrollees (QMBs/SLMBs and Demo Duals), these expenditures are included as demonstration expenditures that are subject to budget neutrality, so report these demonstration expenditures as "EG6E Expan Adult" on the CMS-64 reports. Medicare cost-sharing for SSD dual eligibles is covered in the same manner as Medicare cost-sharing would be covered for Medically Needy aged, blind, or disabled individuals and caretaker relatives, had these groups been included in the Medicaid state plan.

**31. Additional Provisions Related to Institutions for Mental Diseases (IMDs).** Expenditures for services rendered to TennCare II enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.

## VI. CHOICES ENROLLMENT

### 32. Operations of the TennCare CHOICES Program.

a. **Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group.** The CHOICES Program provides long-term services and supports (LTSS) as identified in Table 2b to four groups of people, as defined below:

i. **CHOICES 1.** This group consists of persons who are receiving Medicaid-reimbursed care in a nursing facility (NF).

ii. **CHOICES 2.** Persons age 65 and older and adults age 21 and older with physical disabilities who meet the NF level of care (LOC), who qualify either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to NF care. The demonstration population includes persons who could have been eligible under 42 CFR § 435.217 had the state continued its 1915(c) HCBS waiver for persons who are elderly and/or physically disabled.

iii. **CHOICES 3.** Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles, who do not meet the NF LOC, but who, in the absence of HCBS, are "at risk" for institutionalization, as defined by the state. The state must notify CMS when it determines that it will institute the more restrictive nursing facility level of care standards approved on July 1, 2012 and open CHOICES 3 for enrollment prior to implementation.

iv. **Interim CHOICES 3.** Elderly adults and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of the At Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. This group will close to new enrollment on June 30, 2015.

b. **Eligibility for TennCare CHOICES Benefits.** Individuals can be eligible for one of the four TennCare CHOICES groups defined in a. above depending upon their medical and / or functional needs, their TennCare eligibility group, and the ability of the state to provide them with safe, appropriate, and cost-effective LTSS.

i. Medical and / or functional needs are assessed according to LOC criteria published by the state in state rules.

(A) There will be one set of LOC criteria for NF care, which will be used in assessing eligibility for CHOICES 1 and CHOICES 2.

(B) On July 1, 2012, the state opened enrollment in CHOICES 3, which is subject to a separate set of criteria to determine the "At-Risk" population.

(C) For the purposes of redetermining whether a recipient of NF services (CHOICES 1) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial LOC determination for that individual at the time of enrollment into CHOICES 1.

(D) For the purposes of determining whether a recipient of HCBS for elderly and disabled (CHOICES 2) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial level of care determination for that individual at the time of HCBS enrollment, or for persons transitioning from a NF, at the time of enrollment into CHOICES 1.

(E) For purposes of enrollment into CHOICES 1, the state may grant an exception for persons in the community who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely be met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of initial enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

ii. Financial eligibility:

(A) Financial eligibility for CHOICES 1 is established according to the Medicaid state plan.

(B) In order to be financially eligible for CHOICES 2, an individual must be eligible for TennCare as an SSI recipient or meet the criteria for the CHOICES 217-Like HCBS Group, individuals who qualify under institutional income and resource rules, and who are receiving home and community-based services and would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.726, and 435.236 of the Federal regulations and Section 1924 of the Act, if the home and community based services were provided under a 1915(c) waiver.

(C) In order to be financially eligible for CHOICES 3, an individual must be eligible for TennCare as an SSI recipient.

(D) In order to be financially eligible for Interim CHOICES 3, an individual must be eligible for TennCare as an SSI recipient or as a member of the At Risk Demonstration Group. Members of the At Risk Demonstration Group must meet institutional income and resource criteria.

iii. The state's ability to provide applicants with appropriate home and community based services is determined by the availability of slots under an established enrollment target (see paragraph 32.d., *Enrollment Targets for TennCare CHOICES*) and, for persons in CHOICES 2, the determination by the MCO that the individual can be served appropriately at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i), and for persons in CHOICES 3 and Interim CHOICES 3, the determination by the MCO that the cost of HCBS will not exceed the limit in paragraph 28.h.iii. There is no enrollment target for Interim CHOICES 3.

c. **Enrollment in TennCare CHOICES.** The effective date of enrollment in TennCare CHOICES must be established by the state based on a determination that an applicant is eligible for and must begin receiving LTSS. Enrollment procedures differ depending upon whether or not the person is already enrolled in TennCare Medicaid.

i. **Persons Not Already Enrolled in TennCare.** Persons not already enrolled in TennCare who wish to enroll in TennCare CHOICES must enroll through the State's Single Point of Entry (SPOE). The SPOE must provide counseling and assistance in evaluating LTSS options, screening and intake for LTSS programs offered by the state (TennCare CHOICES as well as other programs), assistance in evaluating the individual's functional LOC for LTSS, and facilitation of Medicaid eligibility determination by the state.

(A) Individuals who are determined to be both medically and financially eligible for NF placement will always be allowed to receive TennCare CHOICES services in a NF as members of CHOICES 1, if they choose.

(B) Those individuals who meet the criteria for CHOICES 2 subject to the limitations set out in these STCs, will be allowed to choose HCBS as an alternative to NF placement if the determination is made that the individual can be served appropriately in CHOICES 2 at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i).

ii. **Persons Already Enrolled in TennCare.**

(A) **Nursing Facility Residents.** MCOs will conduct an assessment of NF residents who wish to move to HCBS to determine if they can be served appropriately in the community at a cost that does not exceed the cost neutrality test set forth in Section 1915(c)(4)(A), as individually applied. Even if an enrollment target has been reached for CHOICES 2, an MCO may transition persons from CHOICES 1 to CHOICES 2 in accord with subparagraph 32.d.iii.(C) *(Transition from CHOICES 1 to CHOICES 2)*.

(B) TennCare enrollees who are not already participating in CHOICES may request enrollment in CHOICES through their MCOs, or they may be identified through other mechanisms that would trigger an assessment of their need for LTSS by the MCO. The MCO will provide counseling and assistance in evaluating LTSS options, and assistance in evaluating the individual's functional LOC eligibility for LTSS. The functional LOC determination for LTSS will be made by the Bureau of TennCare, using criteria published in state rules. Once individuals have established LOC and financial eligibility for LTSS, they can be enrolled in CHOICES in accordance with paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*).

d. **Enrollment Targets for TennCare CHOICES.** The state may establish enrollment targets for CHOICES 2 and CHOICES 3. (There will be no enrollment target for CHOICES 1 or Interim CHOICES 3.) The purpose of the targets is to permit the CHOICES program to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available state and Federal resources. Information on CHOICES Groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Progress Report as set forth in paragraphs 45 *(Quarterly Progress Reports)*, 49 *(Enrollment Reporting)* and Attachment A.

i. The state may establish an enrollment target for CHOICES 2, consistent with the upper and lower limits shown in the table below; with the actual target number to be published in state rules. The state may adjust the target as appropriate from time to time upon notification to CMS at least 30 days prior to the desired effective date of the change. Except as set forth in paragraph 32.d.iii., an increase in the enrollment target above the upper limit appropriate to the DY or a decrease below the lower limit will require an approved waiver amendment prior to implementation.

**Table 4**
**Enrollment Targets for Demonstration Years 12 Through 14**

| Demonstration Year | Lower Limit | Upper Limit |
|---|---|---|
| DY 12 | 12,000 | 16,000 |

| | | |
|---|---|---|
| DY 13 | 13,500 | 17,500 |
| DY 14 | 15,000 | 18,500 |

ii. The state may also establish an enrollment target for CHOICES 3, if this group is established after a change in the level of care criteria. At a minimum, this target will be set at 10% of the enrollment target for CHOICES 2. There will be no enrollment target for Interim CHOICES 3.

iii. If the enrollment target established by the state for CHOICES 2 or CHOICES 3 is reached or exceeded, the state shall not enroll additional persons in CHOICES 2 or CHOICES 3, except as indicated below. The state may also establish a waiting list for CHOICES, subject to the following:

(A) **Reserve Capacity.** The state may reserve slots in CHOICES 2 for individuals being discharged from a NF and for individuals being discharged from an acute care setting who are in imminent risk of being placed in a nursing facility setting absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved must be included as an attachment to the Annual Report (see paragraph 46). The state may establish additional criteria or modify procedures for allocating reserve slots upon 30 day advance written notification to CMS; the operational procedure documents included as attachments to subsequent Annual Reports must reflect any such changes. In each Quarterly Progress Report, the state must provide an accounting of their management of the reserve capacity, including a summary (as of the last day of the quarter) that states the total enrollment targets for CHOICES 2 and 3, the number enrolled in each CHOICES group, and the numbers of slots being held in reserve for various purposes.

(B) **HCBS as a Cost-Effective Alternative.** An MCO with a TennCare enrollee who meets the criteria for CHOICES 2, but which cannot enroll the individual in CHOICES 2 because the enrollment target for CHOICES 2 has been met, has the option, at its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care, in accordance with paragraph 29 *(Cost-Effective Alternatives).* (Consistent with paragraph 32.d.iii.(C), this person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.) The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. The state may require the MCO to provide documentation of its cost-effective alternative determination and assurance of

provider capacity to meet the member's needs prior to enrollment in CHOICES.

(C) **Transition from CHOICES 1 to CHOICES 2.** An enrollee being served in CHOICES 1 who meets the requirements to enroll in CHOICES 2 can enroll in CHOICES 2 at any time such a transition can be accomplished, even if an enrollment target for CHOICES 2 has been reached. This person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.

e. **Waiting Lists for TennCare CHOICES.** The use of enrollment targets as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*) may mean that there will be waiting lists for CHOICES 2 and/or 3. (There will be no enrollment target or waiting list for CHOICES 1 or the Interim CHOICES 3 Group.) These lists must be managed on a statewide basis using a standardized assessment tool and in accord with criteria to be established by the state. Waiting list policies must be based on objective criteria and applied consistently in all geographic areas served. The state may use separate criteria for prioritization of services under CHOICES 2 and CHOICES 3, and may revise these upon notification to CMS.

f. **Consumer Direction.** CHOICES members who have been determined by a care coordinator, as a part of the needs assessment and plan of care processes, to require attendant care, personal care, in-home respite services, companion care or other services specified by the state as eligible for consumer direction, will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e., consumer direction of HCBS). The state will notify CMS in advance of any changes to the list of services eligible for consumer direction. All CHOICES members requiring these services will be offered the option to participate in consumer direction of HCBS. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E.

g. **Miscellaneous Provisions Related to CHOICES Enrollment and Implementation**

i. The state will maintain an electronic visit verification system (as defined in Attachment D) as part of the CHOICES quality program.

ii. The state must ensure that the Care Plan is considered part of the medical record of a CHOICES participant, subject to all associated requirements and protections, and available for review by the state upon request.

## VII. COST SHARING

### 33. Cost Sharing.

a. TennCare Medicaid enrollees under the state plan are subject to cost sharing for pharmacy services (see Table 6 below).

b. Demonstration-only eligible adults enrolled in the SSD category or the At Risk Demonstration Group are subject to cost sharing for pharmacy services (see Table 6 below).

c. TennCare Standard children are subject to cost sharing for both non-pharmacy services and pharmacy services (see Table 5 and Table 6).

d. Individuals participating in CHOICES 1 or CHOICES 2 are exempt from all cost sharing.

e. Individuals participating in CHOICES 3 or Interim CHOICES 3 are subject to cost sharing for pharmacy services (see Table 6 below), similar to other Medicaid state plan adult enrollees.

**34. Co-Payments.** For demonstration-only eligible children in TennCare Standard (title XXI Medicaid Expansion children and medically eligible title XIX children), co-payments are collected by the provider when services are rendered. The requirements at Section 1916A of the Act and at 42 CFR §§ 447.50, 57, 58, and 62 through 82 will apply to cost sharing for this group.

a. **Non-Pharmacy Co-pays.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), the non-pharmacy co-pay amounts are presented in Table 5 (*TennCare Non-Pharmacy Co-Pays).*

**Table 5**
**TennCare Non-Pharmacy Co-pays**

| Poverty Level | Co-payment Amounts |
|---|---|
| 0%-99% | $0.00 |

| Poverty Level | Co-payment Amounts |
|---|---|
| 100% - 199% | $10.00 Non-emergency Hospital Emergency Room (waived if admitted)<br><br>$5.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$5.00 Physician Specialists (including Psychiatrists and Dentists)<br><br>$5.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |
| 200% and above | $50.00 Non-emergency Hospital Emergency Room (waived if admitted)<br><br>$15.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$20.00 Physician Specialists (including Psychiatrists and Dentists)<br><br>$100.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |

b. **Co-Pays on Pharmacy.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), and adults in the Standard Spend Down Demonstration Group, and persons in the At Risk Demonstration Group, co-pays on outpatient pharmacy services are presented in Table 6 (*Co-Pays on Pharmacy)*.

**Table 6**
**Co-Pays on Pharmacy**

| Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| TennCare Medicaid adults who are not exempt from cost-sharing under 42 CFR § 447.53 | $3.00 | $1.50 |
| TennCare Standard under age 21 with incomes below 100% FPL | $0 | $0 |
| TennCare Standard under age 21 with incomes at or above 100% FPL | $3.00 | $1.50 |
| TennCare Standard aged 21 and older -- SSD | $3.00 | $1.50 |

| Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| enrollees | | |
| CHOICES 1 and CHOICES 2 | $0 | $0 |
| Interim CHOICES 3 | $3.00 | $1.50 |
| CHOICES 3 | $3.00 | $1.50 |

**35. Compliance of TennCare Standard Cost Sharing With Federal Regulations.** The state submitted a plan for ensuring that cost sharing for TennCare Standard complies with the statutory and regulatory requirements, including the implementation of an aggregate cost sharing cap as described in 42 CFR § 447.78. The state implemented its plan on January 1, 2013.

## VIII. DELIVERY SYSTEMS

**36. Managed Care Entities.** TennCare II operates totally in a managed care environment and uses various types of managed care entities for delivering covered services to TennCare enrollees. The types of managed care entities used are listed in Table 7 below, with the reimbursement and rate-setting methodologies for each one. Title XXI Medicaid Expansion demonstration population children use the same delivery systems as other enrollees.

**Table 7– Types of Managed Care Entities**

| Type of Entity | BBA Definition | Description of Services Covered | Reimbursement and Rate-Setting Methodology |
|---|---|---|---|
| Managed Care Organizations (MCOs)—at full risk | MCO | All TennCare physical health, behavioral health, and LTSS* | MCO rates are actuarially certified by an independent third party actuary |
| TennCare Select—non-risk or partial risk | Prepaid Inpatient Health Plan (PIHP) | All TennCare physical health, behavioral health, and LTSS* for enrollees selected for participation in TennCare Select rather than enrolled in MCOs (see paragraph 38, *TennCare Select*) | Provider payment rates are negotiated between the PIHP and providers; an administrative fee is approved by CMS and paid to the PIHP |
| Dental Benefits Manager (DBM)—non-risk (may be renegotiated as at risk) | Prepaid Ambulatory Health Plan (PAHP) | Dental benefits for all TennCare enrollees with this coverage | Provider payment rates are established within DBM contract as approved by CMS; an administrative fee, approved by CMS, is paid to the DBM |
| Pharmacy Benefits Manager (PBM)—non-risk (may be renegotiated as at risk) | PAHP | Pharmacy benefits for all TennCare enrollees with this coverage. | Provider payment rates are established in accordance with the state plan; an administrative fee, approved by CMS, is paid to the PBM |

***LTSS refers to services for persons who are elderly or who have physical disabilities.

**37. Enrollment in Managed Care Organizations (MCOs).** With the exception of individuals enrolled in TennCare Select, all individuals eligible for TennCare (TennCare Medicaid or TennCare Standard), including those dually eligible for Medicare, shall be enrolled in a managed care organization providing the benefits described in paragraphs 28 *(TennCare Benefits)* and 29 *(Cost-Effective Alternatives)* of these STCs. In addition to the managed care organization, enrollees are enrolled with a Pharmacy Benefits Manager for covered pharmacy services and a Dental Benefits Manager for covered dental services. The Pharmacy Benefits Manager administers the pharmacy benefits program, using a preferred drug list that is established by the state (in consultation with a Pharmacy

Advisory Committee), taking into account the cost, therapeutic equivalency, and clinical efficacy in accordance with waiver authority.

**38. TennCare Select.** TennCare Select is a prepaid inpatient health plan (PIHP) (as defined in 42 CFR § 438.2) which operates in all areas of the state and covers the same services as the MCOs. The state's TennCare Select contractor is reimbursed on a non-risk, non-capitated basis or a partial risk basis for services rendered to covered populations, and in addition receives fees from the state to offset administrative costs.

a. The TennCare Medicaid and TennCare Standard populations included in the TennCare Select delivery system and the services provided to these populations by the TennCare Select contractor are as follows:

i. Children who are eligible for Supplemental Security Income. TennCare Select provides medical case management and all MCO covered services.

ii. Children in state custody and children leaving state custody for 6 months post-custody as long as the child remains eligible. TennCare Select provides medical case management, all MCO covered services, and coordination with the Department of Children's Services (DCS) around medical and behavioral services.

iii. Children who are receiving care in a nursing facility or an intermediate care facility for individuals with intellectual disabilities. For children and adults in a Home and Community Based Services 1915(c) waiver for individuals with intellectual disabilities, current enrollees may opt-in to receive services through TennCare Select, and new participants may opt-out of TennCare Select in order to receive services through another MCO. TennCare Select provides medical case management and all MCO covered services.

iv . Enrollees living in areas where there is insufficient capacity to serve them. TennCare Select provides medical case management and all MCO covered services.

After being assigned to TennCare Select, persons in categories i. and iii. above may choose to disenroll from TennCare Select and enroll in an MCO if one is available. Persons in categories ii. and iv. must remain in TennCare Select. The state must request a demonstration amendment (as described in paragraphs 6 and 7 regarding amendments) in order to change the list of populations included in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

b. TennCare Select also provides the following functions:

i. It is the back-up plan should one of the MCOs have to leave the TennCare program unexpectedly. For TennCare enrollees previously enrolled with

the MCO, TennCare Select provides medical case management and all MCO covered services.

ii. It is the only entity responsible for payment of the services described in 42 CFR § 431.52 (regarding services provided to residents temporarily absent from the state), and provides all MCO covered services (primarily emergency services).

iii. It is also the only entity responsible for payment of the services described in 42 CFR § 440.255 (regarding emergency services for aliens), and is responsible for payment of emergency medical services only. TennCare Select is paid an administrative fee for processing these claims.

**39. Plan Enrollment and Disenrollment.** The state maintains a managed care enrollment and disenrollment process that must comply with 42 CFR Part 438, except that, in accordance with waiver authority, TennCare participants have 45 days in which to disenroll from an MCO without cause. After 45 days, a participant may disenroll from an MCO only for cause, as set forth in 42 CFR § 438.56(d)(2). The "other reasons" that will be considered cause under 42 CFR § 438.56(d)(2)(iv) do not include the following:

- The enrollee is unhappy with the current plan or primary care provider (PCP), but there is no hardship medical situation (as defined by the state);
- The enrollee claims lack of access to services but the plan meets the state's access standards;
- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- The enrollee is concerned that a current provider might drop out of the plan in the future;
- The enrollee is a Medicare recipient who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation; and
- The enrollee's Primary Care Provider (PCP) is no longer in the MCO's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO.

In the event that a CHOICES member is determined, based on an assessment of needs, to require long term services and supports that are not currently available under the MCO in which he is currently enrolled, but that are available through another MCO, the state shall work with the current MCO to arrange for the provision of the required services, which may involve providing such services out-of-network. It shall be considered to be cause for disenrollment only if the current MCO, after working with the state, is unable to provide the required services. In such cases, the MCO that is unable to provide the required services after working with the state may be subject to sanctions.

**40. Contracts.** The following subparagraphs provide additional requirements pertaining to contracts awarded by the state for the provision of health care services under TennCare II.

a. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation.

b. Payments under contracts with public agencies that are not competitively bid in a process involving multiple bidders shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

c. With respect to CHOICES, the state established minimum guidelines regarding the person-centered service plan, the processes for the development of the plan, and the monitoring of its implementation. These expectations were submitted to CMS and are reflected in the MCO contract. Any changes in the contract requirements related to the subjects enumerated below will be submitted to CMS for review prior to executing a contract amendment with an MCO. CMS will respond within 15 working days of receipt of the draft. The required subject areas are as follows:

   i. The individuals who develop the person-centered service plan (and their requisite qualifications);

   ii. The individuals who are expected to participate in the plan development process;

   iii. Timing of the plan, how and when it is updated, including mechanisms to address changing circumstances and needs (and expectations regarding scheduling and location of meetings to accommodate individuals receiving services);

   iv. Types of assessments that are conducted as a part of the service plan development process;

   v. How participants are informed of the services available to them;

   vi. How the process ensures that the service plan addresses the participants' desired outcomes, needs and preferences; and

   vii. The plans' responsibilities for implementing and monitoring the plan of care.

d. The state will require the MCOs to develop and maintain emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. These contingency plans will be available for inspection by state officials upon request.

e. The state will monitor loss ratios of the managed care plans.

## IX. GENERAL REPORTING REQUIREMENTS

**41. General Financial Requirements.** The state shall comply with all general financial requirements under title XIX and title XXI set forth in these STCs.

**42. Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request.

**43. Additional Reporting Requirements.**

a. **Compliance with Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR §§ 438 *et seq.*

b. **Compliance with Specified HCBS Requirements.** The following regulations, which govern the provision of HCBS under Section 1915(c) waivers, shall apply to the HCBS program authorized under Section 1115 and provided through CHOICES:

- 42 CFR § 440.180(a);
- 42 CFR § 441.302;
  (a),
  (c) (insofar as it relates to NF level of care, and applying only to CHOICES 2),
  (d) (consistent with a waiver of Section 1902(a)(23) of the Act),
  (g) (applies only to CHOICES 2), and
  (j);
- 42 CFR § 441.303
  (a),
  (c) (except that the requirements following the semi-colon in (c)(2) do not apply to CHOICES 3 or Interim CHOICES 3),
  (d) (consistent with Table 2b, paragraph 28), and
  (e); and
- 42 CFR § 441.310.

Any conflict between the regulations listed in this subparagraph and these STCs shall be resolved in favor of the STCs. The state shall include a description of the steps taken to ensure compliance with these regulations as part of the Annual Report discussed in paragraph 46 *(Annual Report)*.

c. **Quality Improvement Strategy for the CHOICES Program.** The state must submit to CMS an integrated quality improvement (QI) strategy which builds on existing managed care quality requirements as defined in 42 CFR § 438, Subpart E, and incorporates applicable 1915(c) Home and Community-Based Services

waiver regulatory assurances as discussed in paragraph 43.b.

The state must identify: 1) measures of process, health outcomes, functional status, quality of life, member choice, autonomy, satisfaction, and TennCare and CHOICES system performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

The MCOs must be required to establish methods for discovery, remediation and systems improvement and, per state prescribed timeframes, regularly report on outcomes associated with continuous quality improvements.

The state must clearly demonstrate its oversight of the process.

The QI strategy must be submitted to CMS for approval prior to implementation.

No less frequently than annually, the state must provide to CMS information regarding QI activities which must include evidence regarding system performance based on identified objectives and measures, and which demonstrates efficacy in implementing the quality strategy, including but not limited to external quality review, discovery, remediation and systems improvement activities.

d. **CHOICES Data.**

i. **CHOICES Data Plan.** The state will collect and submit data to CMS, including the following data elements:

(A) Numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services at a point in time,

(B) Unduplicated numbers of persons receiving HCBS and unduplicated numbers of persons receiving NF services during a 12 month period,

(C) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period,

(D) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period as a percentage of total long-term services and supports expenditures (excluding expenditures on the population of persons with intellectual disabilities),

(E) Average per person HCBS expenditures and NF expenditures on the elderly and disabled populations during a 12 month period,

(F) Average length of stay in HCBS during a 12 month period,

(G) Percent of new LTSS recipients admitted to NFs during a 12 month period,

(H) Average length of stay in NFs during a 12 month period,

(I) Number of persons transitioned from NFs to HCBS during a 12 month period.

"Point in time" refers to June 30 of each year.

ii. **Electronic Collection of Choices Data.** The systems must be in place to record the requisite data elements for the CHOICES Program.

iii. **CHOICES Data Reporting.** The state must report to CMS, in the Quarterly and Annual Progress Reports, on data and trends of the designated CHOICES data elements. An electronic copy of the actual data addressing the required data elements must be submitted to CMS within 3 months following each point in time (e.g., by September 30 of each DY).

e. **Requirements Related to the Affordable Care Act.** Subparagraphs i. and ii. below describe elements that must be included in an extension proposal or phase-out plan, as discussed in paragraph 8 *(Extension of the Demonstration)* and paragraph 9 *(Demonstration Phase-Out)*.

i. **Affordable Care Act Transition Plan for Extension.** The extension proposal submitted to CMS in June 2012 included a Transition Plan. This plan will be updated consistent with the provisions of the Affordable Care Act and CMS regulations for any individuals enrolled in Demonstration Eligible Groups (as defined in paragraph 17, Table 1a) who will be eligible for coverage under the state plan as of January 1, 2014, including under the new Medicaid eligibility group identified in Section 1902(a)(10)(A)(i)(VIII) of the Act, or who elect to move to an Exchange plan. Persons who are demonstration eligibles at the time of transition will continue to receive demonstration benefits as long as they are enrolled in a Medicaid category and they continue to meet the criteria for their particular demonstration program. The updated Transition Plan will include procedures for ensuring that these individuals transition to their new eligibility status without interruption in coverage to the maximum extent possible.

ii. **Demonstration Phase-Out and Affordable Care Act Transition.** As part of a phase-out plan submitted under paragraph 9, the state must include a plan for using information already in its possession on members of demonstration Eligible Groups to make advance determinations of

eligibility for TennCare under its Medicaid state plan on January 1, 2014, consistent with guidance to be issued by CMS.

**44.** **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the state's progress on enrolling individuals into the TennCare Standard Spend Down Demonstration Group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

**45.** **Quarterly Progress Reports.** The state must submit progress reports containing the items listed below (see also Attachment A for format), no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. An updated CHIP allotment neutrality monitoring spreadsheet, if necessary;

c. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the TennCare Standard Spend Down Demonstration Group; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the demonstration; pertinent legislative or litigation activity; and other operational issues;

d. Action plans for addressing any policy, administrative, or budget issues identified;

e. Quarterly enrollment reports for demonstration eligibles that include the member months for each demonstration population;

f. Quarterly enrollment reports for individuals who would otherwise be eligible for Interim CHOICES 3 but who meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual;

g. Evaluation activities and interim findings; and

h. Other reports as indicated in these STCs.

**46. Annual Report.** The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The state shall also submit the title XXI annual state report for its Medicaid Expansion children in the demonstration, by December 31 of each year.

**47. Beneficiary Survey.** The state shall conduct a beneficiary survey each demonstration year for a statistically valid sample of all TennCare enrollees. The survey shall measure satisfaction, enrollee efforts to secure out-of-network care, average waiting time for physician office visits, and enrollee efforts to change plans, along with reasons for requesting plan changes. Results of the survey must be provided to CMS by September after the end of in each demonstration year (e.g. survey results for demonstration year 12 are due no later than September 30, 2014).

**48. Final Evaluation Report.** The state shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act and as specified in Section XII of these STCs.

**49. Enrollment Reporting.**

a. Each quarter the state will provide CMS with an enrollment report for the title XXI Medicaid Expansion demonstration population and for title XIX Medicaid children, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the state into the Statistical Enrollment Data System (SEDS) within 30 days after the end of each quarter. SEDS reporting is required for any title XXI-funded population, including Medicaid Expansions, and is also required for title XIX Medicaid child enrollment.

b. Enrollment reporting in the Quarterly and Annual Reports (see paragraphs 45 *Quarterly Progress Reports* and 46 *Annual Report*) is required by Eligibility Group (EG) and Type for the TennCare title XIX and XXI state plan and demonstration populations.

## X. GENERAL FINANCIAL REQUIREMENTS

**50. Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under Section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period and pool payments and certified public expenditures made for the demonstration period. CMS shall provide Federal financial participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X of these Terms and Conditions.

**51. Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Tennessee must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which capitation payments were made. For this purpose, demonstration year 1 (DY 1) is defined as the year beginning July 1, 2002, and ending June 30, 2003. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures should be reported on Forms CMS-64.9 Base/64.9P Base.

Expenditures for Medicaid Expansion children claimed under the authority of title XXI of the Act shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

b. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by demonstration year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the eligibility groups (EGs) from which collections were made (see paragraph 53, *Assignment of Expenditures and Member Months to EGs*). In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations shall be offset

against expenditures. These Section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver or 64.9P Waiver schedules, and allocated to forms named for the different EGs described in e.i. through e.xii. below as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to demonstration populations shall be offset against expenditures.

e. **Use of Forms**. The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration and title XIX expenditures made in other payment categories as follows. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system. The terms "EG1" through "EG12" refer to the demonstration Eligibility Groups defined in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)* of these STCs.

i. "EG1 Disabled" expenditures (see paragraph 53.a.i.)

ii. "EG2 Over 65" expenditures (see paragraph 53.a.ii.)

iii. "EG3 Children" expenditures (see paragraph 53.a.iii.)

iv. "EG4 Adults" expenditures (see paragraph 53.a.iv.)

v. "EG5 Duals" expenditures (see paragraph 53.a.v.)

vi. "EG6E Expan Adult" expenditures (see paragraph-53.b.i.)

vii. "EG7E Expan Child" expenditures (see paragraph 53.b.ii.)

viii. "EG8 Med Exp Child" expenditures (see paragraph 53.b.iii.)

ix. "EG9 H-Disabled" expenditures (see paragraph 53.b.iv.)

x. "EG10 H-Over 65" expenditures (see paragraph 53.b.v.)

xi. "EG11 H-Duals" expenditures (see paragraph 53.b.vi.)

xii. "EG12E Carryover" expenditures (see paragraph 53.b.vii.)

xiii. "GME" (Graduate Medical Education) (see paragraph 55.d.)

xiv. "EAH Pool" (Essential Access Hospital Pool) (see paragraph 55.e.)

xv. "CAH Pool" (Critical Access Hospital Pool) (see paragraph 55.f.)

xvi. "Meharry Pool" (see paragraph 55.g.)

xvii. "CPE" (Certified Public Expenditures) for Unreimbursed Public Hospital Costs Pool (see paragraph 55.h.)

xviii. "DSH" (Disproportionate Share Hospital Payments) (see paragraph 55.i.)

xix. "UHC Pool" (Unreimbursed Hospital Cost Pool) (see paragraph 55.k.)

xx. "PHSP Pool" (Public Hospital Supplemental Payment Pool) (see 55.l.)

f. **Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population.**

i. **Expenditures Subject to the Allotment Neutrality Limit.** The state will be subject to a limit on the amount of Federal title XXI funding that the state may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including available reallocated funds published in the *Federal Register*. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of demonstration until the next allotment becomes available.

ii. The state is eligible to receive title XXI funds for expenditures for TennCare Medicaid Expansion children described on the last row of Table 1a in Section IV, paragraph 17 *(Eligibility)*, up to the amount of its title XXI allotment. Waiver expenditures for these children under title XXI must be reported as a Medicaid expansion population on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver, in accordance with the instructions in Section 2115 of the State Medicaid Manual, under waiver name "Med Exp Child," identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which

capitation payments were made. They are reported in Column C for the enhanced match under title XXI.

iii. If the state exhausts its title XXI allotment, title XIX funds are available for title XXI children in this demonstration. To access this funding, the state must submit for approval a written request to CMS, referencing this STC, to access title XIX funds for the title XXI Medicaid Expansion Demonstration Group. This request must be submitted at least 90 days prior to the date on which the state anticipates its title XXI allotment will be exhausted, and must include:

(A) An updated budget neutrality assessment that adds Medicaid Expansion children to budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that removes Medicaid Expansion children.

iv. Once the title XXI allotment is again available, the state will claim title XXI funding for the title XXI children in this demonstration. To access this funding, the state shall submit for approval a written request to CMS, referencing this STC, to access title XXI funds for the title XXI Medicaid Expansion Demonstration Group, which includes a request to update the STCs related to claiming. This formal request must be submitted prior to the change in funding source and include:

(A) An updated budget neutrality assessment that removes Medicaid Expansion children from budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that adds Medicaid Expansion children.

v. During periods in which the state is claiming title XIX funds for Title XXI Medicaid Expansion demonstration population children, the member months attributable to this demonstration population will count toward calculation of the budget neutrality expenditure limit, using the per member per month (PMPM) amounts for "EG8 Med Exp Child." The expenditures will be considered expenditures subject to the budget neutrality expenditure limit, so that the state is not fully at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

g. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to:

i. All TennCare title XIX expenditures on behalf of individuals who are enrolled in this demonstration (excluding the services specified in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*), including all service expenditures and applicable administrative costs (see subparagraph h. below) net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse), and

ii. All expenditures described in paragraph 55.d. through i. *(Extent of Federal Financial Participation for the Demonstration).*

All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver, with the exception of those described in h. below.

h. **Administrative Costs.** In general, administrative costs are not included in the budget neutrality expenditure limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. Administrative costs subject to budget neutrality (see below) must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, according to the EGs for which the expenditure was made (following the list in e.i. through e.xii. above). Other administrative costs not subject to budget neutrality will not be broken out by EG, and will be reported under waiver name "TennCare II."

In accordance with Federal regulations at 42 CFR § 438.812(b)(2), during the periods that services are provided in accordance with MCO, pharmacy benefit manager, or dental benefit manager non-risk contracts, the portion of the state's payments that is for reimbursement of the non-risk contractors' administrative services can only be claimed by the state as an administration cost at the Federal matching rates available for the costs of administration of the Medicaid program. The administrative services portion of the amounts paid by the state to compensate any non-risk contractors for their administration costs incurred in accordance with non-risk contracts are costs of the demonstration waiver that are subject to the budget neutrality expenditure limit explained in Section XI of these STCs.

i. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the Section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.

**52. Reporting Member Months.** The following describes the reporting of member months for TennCare Medicaid and TennCare Standard enrollees:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 45 *(Quarterly Progress Reports)* of these STCs, the actual number of eligible member months for all TennCare Medicaid and TennCare Standard Eligibility Groups (EGs) defined in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)*. The state must submit a statement accompanying the quarterly report, which recognizes the accuracy of this information. Member months should be reported only for individuals who are included in TennCare, as defined in paragraph 17 *(Eligibility)*. Persons for whom Medicaid only pays for services carved out of TennCare (as described in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*) are not enrolled in TennCare (e.g., QMBs, SLMBs).

b. A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for Type 1 and Type 2 eligibles (as defined in paragraph 61, *Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement*) are reported in Section VIIIA of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for Type 3 demonstration expansion populations and for title XXI Medicaid Expansion demonstration eligibles are reported in Section VIIIB of the template, and are not used to calculate the budget neutrality expenditure limit. Detailed instructions for

assigning member months to Types and to EGs are provided in paragraphs 53 *(Assignment of Expenditures and Member Months to EGs)* and 61 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)*.

c. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the state must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

d. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

e. The state will ensure that eligible member month totals reported to CMS for the TennCare II demonstration from July 1, 2002, forward conform to the EG definitions contained in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)*.

**53. Assignment of Expenditures and Member Months to EGs:** The following rules govern the:

- Reporting of expenditures subject to the budget neutrality expenditure limit on separate waiver forms by EG, as described in paragraph 51.e. *(Use of Forms)* above, for the period beginning July 1, 2007, through the end of the TennCare II demonstration, and
- Reporting of eligible member months for the TennCare II demonstration from July 1, 2002, forward.

Beginning July 1, 2007, and as subsequently modified, the quarterly progress report template in Attachment A, Part VIII should be used to report separate member month totals for Type 1, Type 2, and Type 3 eligibles, and for other subgroups as specified below.

a. **<u>Title XIX State Plan Mandatory or Optional Groups (Type 1 Eligibles)– TennCare Medicaid:</u>**

i. For Medicaid eligibles of any age who have qualified for Medicaid on the basis of disability but who are not eligible for Medicare, report under **EG1 Disabled, Type 1.** This includes non-dual SSI eligibles in CHOICES 1, 2, and 3, the CHOICES 1 and 2 Carryover Group, or the PACE Carryover Group.

ii. For Medicaid eligibles who have not qualified for Medicaid on the basis of

disability, who are not eligible for Medicare, and who are 65 years of age or older, report under **EG2 Over 65, Type 1.**

iii. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are age 18 or younger, report under **EG3 Children, Type 1.**

iv. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are between the ages of 19 and 64, report under **EG4 Adults, Type 1.**

v, For Medicaid eligibles of any age who are also eligible for Medicare, report under **EG5 Duals, Type 1.** This category includes dually eligible Medicaid/Medicare individuals who have been classified as "disabled." It does not include any dually eligible members of demonstration populations such as the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group.

b. **Title XIX Demonstration Eligible Groups (Type 2 or 3 Eligibles) – TennCare Standard**

i. For demonstration eligibles who are enrolled in the Standard Spend Down category, report under **EG6E Expan Adult, Type 3.** This category includes SSD enrollees who have Medicare or who have been classified as "disabled."

ii. For demonstration eligible children under age 19 who have been determined to be "Medically Eligible" and who have incomes at or above 200 percent of poverty, report under **EG7E Expan Child, Type 3.**

iii. For demonstration eligible children under age 19 who have been determined to be uninsured and who have incomes below 200 percent of poverty, report under **EG8 Med Expan Child, Type 2, only when Title XIX funds are being used.** This is the Title XXI population. This EG is in effect only when the state is using Title XIX funds for this population. In periods when the state is using Title XXI funds, these children would not be included in any EG but would be reported as indicated in c. below.

iv. For persons in the CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are under age 65, report under **EG9 H-Disabled, Type 2.** This category should also be used for members of any age in the At Risk Demonstration Group who are not eligible for Medicare.

v. For persons in the CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are age 65 or older, report under **EG10 H-Over 65,**

**Type 2.**

vi. For persons in the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group who are also eligible for Medicare, report under **EG11 H-Duals, Type 2.**

vii. For demonstration eligible (non-SSI) persons in the CHOICES 1 and 2 Carryover Group or the PACE Carryover Group, report under **EG12E Carryover, Type 3.** This category should be used for both duals and non-duals in the Carryover Groups.

c. Expenditures for title XXI Medicaid Expansion children matched at the title XXI enhanced FMAP should be reported on Forms 64.21U Waiver/64.21UP Waiver, using waiver name "Med Exp Child." Report member months for quarterly reporting using Attachment A, Part VIII. For periods in which the state claims title XIX FMAP for this population (paragraph 51.f. *Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population*), follow the instructions in b.iii. above.

d. Type 2 eligibles can be identified as disabled for reporting purposes (see b.iv. above) if information exists in their enrollment record that would result in a capitation rate for disabled populations being paid on their behalf.

**54. Standard Funding Process.**

a. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

b. **Standard CHIP Funding Process.** The standard CHIP funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the allotment neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by

CMS. Within 30 days after the end of each quarter, the state must submit quarterly CHIP expenditure reports as described in paragraph 51.f. *(Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population)*, showing CHIP expenditures made in the quarter just ended. CMS shall reconcile expenditures with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

**55. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding (see Section X, paragraph 57, *Sources of Non-Federal Share*), CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section XI of these STCs.

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

d. **Graduate Medical Education (GME) Pool.** Actual cash disbursements, up to $50 million in total computable expenditures for each demonstration year, paid by the state from a supplemental pool to pay for GME costs in accordance with the pool distribution methodology described below. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology, authorized by the demonstration's expenditure authorities. Should CMS promulgate new regulations, the TennCare GME program must come into compliance in accordance with the effective date of the new regulations.

*GME Pool Methodology*: GME Pool payments will be made to the following medical universities that operate graduate physician medical education programs. These payments are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics: East Tennessee State University, Meharry Medical College, University of Tennessee at Memphis, and Vanderbilt University. The annual GME Pool funds will be allocated based on the annual ratio derived by dividing each hospital's average of its Primary Care Position Allocation and its Total Filled Positions Allocation by the aggregate of the medical hospitals' averages. The Primary Care Position Allocation is computed by taking each hospital's total number of primary care residents in years 1 through 4 of residency and dividing it by the total of all primary care residents in the medical hospitals in years 1 through 4 of residency.

The Total Filled Positions Allocation is computed by taking each hospital's total number of residents in years 1 through 4 of residency and dividing it by the total of the medical hospitals' number of residents in years 1 through 4 of residency. This annual ratio is applied to the total GME Pool funding to be allocated. The annual GME Pool funds will be disbursed quarterly. The state must make these payments directly to the universities, and not through any third party or intermediary.

e. **Essential Access Hospital (EAH) Pool.** Actual cash disbursements paid each quarter from a $25 million quarterly supplemental pool to pay for the uncompensated costs of the designated EAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and appropriate charity care patients in accordance with the pool distribution methodology described below. The purpose of this pool is to address the uncompensated care situation of high volume and charity hospitals that serve a disproportionate number of low-income patients with special needs. Hospitals designated as Critical Access Hospitals (CAHs) or as state mental health institutes do not participate in this pool. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

For FFYs 2008 and beyond, EAH Pool payments will be assumed to pertain to the FFY during which the payments were made. To the extent required by Federal law, EAH Pool payments made during a given FFY shall be reduced on a dollar for dollar basis by the amount of DSH payments made under the DSH allotment for that FFY.

*EAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Essential Access Hospitals.

*Qualifications* -- Hospitals eligible to receive EAH Pool payments include all hospitals licensed to operate in the State of Tennessee excluding the four (4) state mental health institutes and the CAHs. The four regional mental health institutes are Memphis Mental Health Institute, Moccasin Bend Mental Health Institute, Western Mental Health Institute, and Middle Tennessee Mental Health Institute. The CAHs receive cost-based reimbursement from the TennCare program subject to limitations outlined in subsection f. of this paragraph.

- All hospitals, with the exception of free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program.
- The free standing psychiatric hospitals must be a contracted provider with at least one of the Managed Care Organizations in the TennCare program and at least 30% of their total adjusted days must be covered by TennCare.

- All acute care hospitals must have either of the following: (i) at least 13.5% or more of their total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days.
- All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare cost.

*Allocation of the EAH Pool to Segments of Hospitals* -- The $25 million Pool should be segmented into 4 distinct parts as follows:

- Essential Service Safety Net – $12.5 Million -- These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved.
- Children's Safety Net – $1.25 Million -- These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children under the age of 21 in Tennessee.
- Free Standing Psychiatric Hospitals - $0.5 Million -- These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health for the provision of psychiatric hospital services in Tennessee, excluding the state mental health institutes.
- Other Essential Acute Care – $10.75 Million -- These hospitals include all other hospitals licensed by the Tennessee Department of Health to provide services in Tennessee, excluding the Critical Access Hospitals.

*Quarterly Reports* – The state must include in its Quarterly Progress Reports a list of the current hospitals in each of the above categories (see Attachment A).

*Data* -- Calculation of the quarterly payment amounts will be based on the most recently completed Joint Annual Report of Hospitals at the time of the first quarterly payment for a given fiscal year.

*Allocation will be based on an assignment of points for*:
- TennCare adjusted days expressed as a percent of total adjusted patient days; and
- Charity, medically indigent care, and bad debt expressed as a percent of total expenses.

*Calculation of Points*
**(1)** TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:

- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the critical access, pediatric and safety net providers;
- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 34.5%;
- 3 points – greater that 34.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

**(2)** Bad Debt, Charity and Medically Indigent – BDCHMI costs as a percent of total expenses

- 0 points - less than 4.5%
- 1 point - greater than or equal to 4.5% and less than 9.5%
- 2 points - greater than or equal to 9.5% and less than 14.5%
- 3 points - greater than or equal to 14.5%

*Calculation of Amounts of Pool Payments for Hospitals* -- These points will then be used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate included all inpatient costs (operating, capital, direct education) but excluded add-ons (indirect education, MDSA, return on equity). The GHR for Safety Net Hospitals is $908.52. The GHR for Other Essential Access Hospitals is $674.11. The points for each qualifying hospital will be summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each of the 4 pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initially calculated amount will then be adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. For example, if the sum of the initial calculated amounts for the pediatric group is $9 million and the total pool for children's hospitals is $5 million, each hospital's initial calculated amount will be multiplied by $5 million / $9 million.

*Pool Payments* -- Hospitals will be paid on a quarterly basis following the end of each quarter. The initial payment will include all quarters that have ended at the time that the payment is made. All subsequent quarterly payments will be made

following the end of the quarter. In order to receive a payment for the quarter, all hospitals, with the exception of the free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, with at least one Managed Care Organization, and must have contracted with TennCare Select for the entire quarter that the payment represents. In order for a free standing psychiatric hospital to receive a payment for the quarter, it must be a contracted provider with at least one of the Managed Care Organizations.

f. **Critical Access Hospital (CAH) Pool.** Actual cash disbursements, of up to $10 million per demonstration year, paid from a supplemental pool to pay for the uncompensated costs of the designated CAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and the appropriate charity care patients in accordance with the pool distribution methodology that has been given CMS prior approval. CAHs are designated by the Tennessee Department of Health, and they are typically small, rural hospitals that are part of a rural health network. CAHs allow communities to maintain access to primary care and emergency care when the maintenance of a full-service acute care hospital is no longer feasible. The purpose of this pool is to address the uncompensated care situation of CAHs in serving a disproportionate number of low-income patients in rural areas who have special needs. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

*CAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Critical Access Hospitals.

*Qualifications* -- To qualify for payment as a Critical Access Hospital, a hospital must meet the following criteria:

- The hospital is an acute care hospital located and licensed in the state of Tennessee;
- The hospital has been designated a Critical Access Hospital by the Tennessee Department of Health; and
- The hospital contracts with a managed care organization participating in TennCare.

*Reimbursement* -- TennCare will provide reimbursement to Critical Access Hospitals under the following terms. Reimbursement to hospitals will be limited to specific annual legislative appropriation. In any state fiscal year that reimbursable TennCare costs incurred by Critical Access Hospitals exceed annual appropriations, equitable adjustments will be made to the rates described below, in order to cap reimbursement at the annual appropriation.

***Inpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare inpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly with interim per diem rates and will be cost-

settled at year-end. Using the Joint Annual Reports filed for the most recent year available, interim per diem rates for TennCare inpatient services will be determined with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs. Inpatient Critical Access Hospital services will not include more than 15 acute inpatient beds. An exception to the 15 bed requirement is made for swing bed hospitals. Critical Access Hospitals are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that not more than 15 beds are used at any one time for acute care.

***Outpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare outpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly based on a percentage of charges with year-end cost settlements. Using the Joint Annual Reports filed for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges, with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs.

**Cost Settlements** -- Cost settlements are determined from provider submitted Medicare cost reports that include the title XIX schedules based on 100 percent (100%) of TennCare reasonable costs. The term “reasonable costs” is defined for this purpose as total reimbursable costs under Medicare principles of cost reimbursement for Critical Access Hospitals.

*New Designations of Critical Access Hospitals* -- For new hospitals that qualify after July 1, 2002, the state will begin reimbursement at the rates established by this part on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its Critical Access Hospital designation. At that time, interim rates will be established according to this part and the designation will be confirmed with the Tennessee Department of Health.

*Audit Trail and Audit Requirements* -- Each CAH is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than 5 years from the date of the submission of the Joint Annual Report, and the provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint Annual Reports are subject to audit at any time by Federal and state auditors, including the Comptroller of the Treasury and the Bureau of TennCare, or their designated representative.

g. **Meharry Medical College (Meharry) Pool.** Actual cash disbursements paid from a $10 million supplemental pool per demonstration year to pay for the uncompensated costs of the two Medicaid clinics operated by the Meharry Medical College for TennCare covered services provided to TennCare enrollees and the appropriate charity care patients. The Meharry Pool payments will be limited to the uncompensated costs of the care as determined by an independent audit each year and subject to the review and approval by the CMS staff. Before paying the annual pool amount to the providers, the state will provide CMS with a copy of the annual independent audit report. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

h. **Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (CPE).** Actual costs incurred by government operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients are eligible as CPE. The state must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital from the following sources: the MCOs; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds). With regard only to hospital CPE, the state will report actual CPE within 12 months after the end of each fiscal year. At that time, the state will revise its FFP claim to reconcile actual CPEs with the CPE estimates used during the preceding fiscal year (FY).

**State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the state of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

**CPE Methodology and Protocol.** The state must follow the CPE protocol, as contained in Attachment F of these STCs, which was approved by CMS for use beginning July 1, 2008.

i. **Disproportionate Share Hospital (DSH) Payments.** The Tax Relief and Health Care Act of 2006 (TRHCA 2006) established a DSH allotment for Tennessee for FFY 2007, as described at Section 1923(f)(6) of the Act. The relationship between DSH payments made by Tennessee under TRHCA 2006 and payments from the EAH Pool is further specified in the second paragraph of subparagraph (e) above. If Congress should establish a DSH allotment for Tennessee for any subsequent Federal fiscal year, the state may make DSH payments to hospitals on the basis of a state plan amendment approved by CMS. Depending on the specifics of the legislation establishing the DSH allotment, modifications to the budget neutrality expenditure limit may be required, in the manner specified in

paragraph 4.a. (*Impact on Demonstration of Changes in Federal Law, Regulation, and Policy).* Unless otherwise specified by law, DSH payments shall be considered payments made under the demonstration and subject to the budget neutrality expenditure limit and the limit described in subparagraph (j) below. When determining hospital-specific DSH limits and DSH payments, the state must take into account all Medicaid payments under the Medicaid state plan and demonstration projects including amounts paid to hospitals through the GME, EAH, Meharry Medical College, UHC, PHSP, and CAH Pools, as well as any payments by or on behalf of individuals with no source of third party coverage. The state must make these payments directly to the providers of the services as specified at Section 1923(i) of the Social Security Act.

j. Beginning in DY 6 (state fiscal year 2008), the combined total of the payments to hospitals listed in i. below shall not exceed annual limits described in iv. Beginning in DY 11 (state fiscal year 2013), the combined total of the payments to the hospitals listed in iii. below shall not exceed annual limits described in iv. Any unused amount from the annual cap for one DY may not be rolled over and added to the annual cap for any subsequent DY.

i. The following payments are subject to the limit in DY 6 through 9:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of DSH payments (see 55.i. subject to the allotment for the FFY ending during the DY);
- Three-quarters of DSH payments (see 55.i. subject to the allotment for the FFY beginning during the DY);
- Hospital CPE (see-55.h.).

ii. The following payments are subject to the limit in DY 10:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of the DSH payments (see 55.i., subject to the allotment for the FFY 2011);
- Additional DSH payments equal to the DSH allotment for the first quarter of FFY 2012;
- Hospital CPE (see 55.h.)

iii. The following payments are subject to the limit in DYs 11-14:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- Hospital CPE (see 55.h.).

iv. The annual limit for DY 6 – DY 14 shall be $540 million (total computable).

k. **Unreimbursed Hospital Cost (UHC) Pool.** Actual costs incurred by eligible Tennessee hospitals that are unreimbursed by TennCare. The total amount of funds to be distributed to hospitals each DY from the pool will be determined annually, in a manner defined by the Tennessee General Assembly's Annual Coverage Assessment Act and this subparagraph, but in no event may exceed the limit defined below. For any demonstration year in which it elects to make payments under the UHC Pool authority described in this paragraph, the state may not implement a reduction in benefits or elimination of coverage for any of the following services: physical therapy, occupational therapy, speech therapy, inpatient hospital, lab and x-ray, non-emergency outpatient hospital, physician, podiatrist, certified nurse practitioner, or physician assistant services; or implement any co-payment for non-emergency medical transportation. (Nothing in this paragraph is intended to limit the state's ability to manage utilization of these services through changes to prior authorization requirements or other managed care practices.)

***Eligible Hospitals.*** Hospitals eligible to receive a pool payment include all hospitals licensed to operate in the State of Tennessee, except the following groups:

- Critical Access Hospitals;
- Public hospitals eligible to certify public expenditures, including state mental health institutes;
- Rehabilitation and long term care hospitals; and
- Pediatric research hospitals that limit patients to those that meet research protocols.

Any hospitals that have closed between 2008 and the time that the amounts of the payments are calculated are not eligible to receive payments.

***Minimum Qualifications.*** In order to receive a payment, the hospital must be contracted with at least one TennCare MCO and must have unreimbursed TennCare costs, unless the hospital is capitated and accepts the capitation from TennCare as full reimbursement for services to TennCare patients.

***Data Source.*** The Joint Annual Report (JAR) of Hospitals, which is a report containing data that each licensed hospital in the state is required to file annually in accordance with T.C.A. 68-11-310. This law says:

> All hospitals that submit a joint annual report to the department of health as designated in this section shall also submit to the department, at the same time they send the signed paper copy of the report, a notarized statement from their chief financial officer stating that the financial data reported on the joint annual report is consistent with the audited financials

for the hospitals for that reporting year. The notarized statement shall also be attested to by the chief executive officer of the hospital.

Reports are submitted to the Tennessee Department of Health (DOH), edited by DOH, corrected by the hospital and placed in a final data file for that year by DOH. The instructions for completing the form require the hospitals to use the same accounting method required for the Medicare cost reports.

Payment amounts for each DY will be based on the final JAR from 3 years prior to the DY.

***Calculation.*** TennCare costs shall be determined by multiplying TennCare charges for hospital inpatient and outpatient services reported by the hospital by the ratio of reported total expenses to reported total charges (cost to charge ratio). Unreimbursed TennCare Costs are calculated as the difference between the calculated TennCare costs and the TennCare revenue as reported on the JAR.

Each hospital shall receive an annual payment each DY equal to a percentage of its Unreimbursed TennCare Costs, using the same percentage to calculate each hospital's payment.

***Funding.*** TennCare shall adjust payments if necessary to ensure no hospital receives supplemental payments in excess of unreimbursed TennCare costs. Payments may be prorated subject to available appropriations.

***Payments.*** The annual payment to each hospital shall be made in four equal quarterly payments.

***Annual Limit:*** The total amount of UHC Pool payments made each DY may not exceed $500 million total computable.

l. **Public Hospital Supplemental Payment (PHSP) Pool.** Actual cash disbursements paid from a $70 million (total computable) supplemental pool per demonstration year to selected public hospitals. The amount paid each DY to each hospital must not exceed the hospital's uncompensated cost of TennCare covered services provided to TennCare enrollees and uninsured patients. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10. PHSP Pool payments may be made to the following hospitals:

- Regional Medical Center at Memphis, and
- Nashville General Hospital at Meharry.

**56. Medicare Part D Drugs.** No FFP is available under this demonstration for Medicare Part D drugs.

**57. Sources of Non-Federal Share.** The state certifies that the matching non-Federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-Federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding.

c. Under all circumstances, health care providers must retain 100 percent of the TennCare II reimbursement amounts claimed by the state as a demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

**58. Monitoring the Demonstration.** The state shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

## XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

**59**. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of Federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, with an aggregate adjustment for projected disproportionate share hospital payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section X, paragraph 51 *(Reporting Expenditures in the Demonstration).*

**60.** **Risk.** Tennessee shall be at risk for the per capita cost (as determined by the method described below in this Section) for Type 1 and Type 2 TennCare enrollees in the eligibility groups (EGs) described in paragraph 61 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)* under this budget neutrality agreement, but not for the number of demonstration eligibles in each of the groups. By providing FFP for all Type 1 and Type 2 TennCare enrollees in the specified EGs, Tennessee shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Tennessee at risk for the per capita costs for TennCare enrollees in each of the EGs under this agreement, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration. Tennessee will be at risk for both per capita costs and enrollment for Type 3 TennCare eligibles.

**61.** **Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement.** Individuals who are eligible under TennCare and whose expenditures are funded at title XIX matching rates will be one of three types:

a. Type 1 - are currently eligible under Tennessee's Medicaid state plan (Title XIX state plan mandatory or optional eligible population) - counted in the "with" and "without" waiver calculations;

b. Type 2 - could be eligible under Tennessee's Medicaid state plan if Tennessee amended its state plan or could be eligible for a Section 1915(c) waiver for aged and disabled adults pursuant to 42 C.F.R. § 435.217 (Title XIX demonstration-eligible hypothetical population) or is eligible under the At Risk Demonstration Group for the Interim CHOICES 3 program - counted in the "with" and "without" waiver calculations (the state cannot generate savings from these populations); and

c. Type 3 – are only eligible with Section 1115 demonstration authority (Title XIX demonstration-eligible expansion population) - counted only in the "with" waiver calculations.

**62. Budget Neutrality Ceiling.** The following describes the method for calculating the budget neutrality expenditure limit:

a. For each DY of the budget neutrality agreement, an annual target is calculated as the sum of two components:

i. The sum of six sub-components calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the state in accordance with paragraph 52 *Reporting Member Months*) for Type 1 and Type 2 eligibles claimed under title XIX for the following six EGs: EG1 Disabled, EG2 Over 65, EG3 Children, EG4 Adults, EG5 Duals, and EG8 Med Exp Child (when title XXI allotment is exhausted); and

ii. A Disproportionate Share Hospital (DSH) adjustment for the year described in d. below.

b. Member months for the following populations are not used for calculation of the budget neutrality expenditure limit:

i. EG6E Expan Adult, EG7E Expan Child, and EG12E Carryover Type 3 eligibles

ii. Med Exp Child: Medicaid Expansion children funded at the title XXI enhanced FMAP.

c. The following tables give the projected PMPM costs for the calculation described in paragraph 62.a. by DY. The PMPM costs for DY 8 and earlier are calculated following Attachment B of the November 14, 2006 Special Terms and Conditions and paragraph 64.c. of the July 22, 2009 STCs.

**Table 8**
**Projected PMPM Costs After CHOICES Implementation**

| | Trend | DY 12 | DY 13 | DY 14 |
|---|---|---|---|---|
| **EG1 Disabled*** | 5.1% | $1,561.46 | $1,641.09 | $1,724.79 |
| **EG2 Over 65**** | 4.6% | $1,022.17 | $1,069.19 | $1,118.37 |
| **EG3 Children** | 3.4% | $468.46 | $484.39 | $500.86 |
| **EG4 Adults** | 4.9% | $917.79 | $962.76 | $1,009.94 |
| **EG5 Duals** | 4.6% | $652.99 | $683.02 | $714.44 |
| **EG8 Med Exp Child***** | 3.4% | $468.46 | $484.39 | $500.86 |

* Includes EG 9 H-Disabled
** Includes EG10 H-Over 65
***Optional Targeted Low Income Children funded using title XIX

d. The DSH adjustment is based upon Tennessee's DSH allotment for 1992 and calculated in accordance with current law.

i. For the purpose of this subparagraph, the Average FMAP (AFMAP) for each DY is defined as 0.25 times the FMAP applicable to DSH expenditures for the Federal fiscal year that ends during that DY, plus 0.75 times the FMAP applicable to DSH expenditures for the Federal fiscal year that begins during that DY.

ii. A DSH allotment has been established for Tennessee under provisions of TRHCA 2006 (and extended through subsequent legislation). Beginning with DY 5, the DSH adjustment will be based on the DSH allotments established for Tennessee, following Section 1923(f)(6)(A)(i) of the Act, which are published in the *Federal Register*. The Federal share of the DSH adjustment for each DY will be equal to one quarter of the DSH allotment for the FFY ending during the DY, plus three quarters of the DSH allotment for the FFY beginning during the DY. A total computable equivalent for each DSH adjustment can be calculated as the DSH adjustment divided by the AFMAP for that DY. For DY 5, the figure

$305,541,928 will be used to compute the Federal share of the DSH adjustment in place of the FFY 2006 DSH allotment.

iii. The calculation of the DSH adjustment will be appropriately altered if legislation is enacted that impacts the calculation of DSH allotments, including any law that would affect the calculation of the DSH allotment for Tennessee.

iv. Table 9 gives the DSH adjustments for DY 1 through DY 14, and shows both total computable and Federal share. These totals reflect changes to the calculation of DSH allotments resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the temporary increase in DSH allotments provided under Section 5002 of the American Recovery and Reinvestment Act of 2009. Some of the figures are labeled "preliminary" because the final DSH allotments needed to calculate them have not yet been published in the *Federal Register*, and are best estimates based on current law.

**Table 9**
**DSH Adjustments for DY 1 Through DY 14**

| | **DSH Adjustment (total computable)** | **DSH Adjustment (Federal share)** |
|---|---|---|
| **DY 1** | $413,700,907 | $268,409,148 |
| **DY 2** | $479,893,052 | $310,106,890 |
| **DY 3** | $479,893,052 | $310,538,794 |
| **DY 4** | $479,893,052 | $308,091,339 |
| **DY 5** | $479,356,649 | $305,451,928 |
| **DY 6** | $479,657,638 | $305,451,928 |
| **DY 7** | $485,299,094 | $311,270,839 |
| **DY 8** | $488,969,517 | $319,052,610 |
| **DY 9** | $470,369,327 | $309,408,043 |
| **DY 10** | $463,996,853 | $305,451,928 |
| **DY 11** | $463,996,853 | $305,451,928 |
| **DY 12 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 13 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 14 (preliminary)** | $463,996,853 | $305,451,928 |

e. The budget neutrality expenditure limit is the Federal share of the annual PMPM limits for the demonstration period, plus DSH adjustments, for DY 1 through 14, and represents the maximum amount of FFP that the state may receive for title XIX expenditures during the demonstration period, as described in paragraph 51.g. *(Reporting Expenditures in the Demonstration: Title XIX Expenditures*

*Subject to the Budget Neutrality Expenditure Limit).* The budget neutrality expenditure limit is equal to (1) the sum of all of the subcomponents described in a.i. above for all DYs, times the Composite Federal Share (defined in f. below), plus (2) the sum of the Federal shares to the DSH adjustments for all DYs, as defined in d. above.

f. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional demonstration expenditures or offsets such as, but not limited to, premium collections and administrative costs subject to budget neutrality under paragraph 51.h. *(Reporting Expenditures in the Demonstration: Administrative Costs)* by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for DSH payments made under the Medicaid state plan must be subtracted from the numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

**63. Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under TennCare II. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of Section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

**64. Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

| DY | Cumulative Target Definition | Percentage |
|---|---|---|
| Years 1 through 6 | Cumulative budget neutrality cap plus: | 0.5 percent |
| Years 1 through 7 | Cumulative budget neutrality cap plus: | 0.25 percent |
| Years 1 through 14 | Cumulative budget neutrality cap plus: | 0 percent |

**65. Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end of this demonstration period, the excess Federal funds shall be returned to CMS. If the demonstration is terminated prior to the end of the budget

neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

## XII. EVALUATION OF THE DEMONSTRATION

**66. Submission of a Draft Evaluation Plan.** The state shall submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after CMS approval of the demonstration extension. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

**67. Inclusion of CHOICES Special Study Components.** Suggested special study topics from which the state may choose for its Evaluation Plan include, but are not limited to, the following:

a. The rebalancing of the long-term care system including impacts on outcomes, utilization and cost;

b. Implementation lessons, successes and evolution of the Single Point of Entry and streamlined eligibility processes;

c. The expansion and development of a more robust HCBS infrastructure under managed care;

d. Implementation of Consumer Directed options under manage care;

e. Enrollee satisfaction, based on surveys that include feedback on assessment and care planning processes, quality of care coordination, actual service delivery, and (when relevant) the appeals process; and

f. Provider satisfaction from surveys.

When developing its research approach, CMS encourages Tennessee to consider adapting research questions and methodologies from the CMS sponsored Evaluation of the Money Follows the Person (MFP) Grant Program. MFP and CHOICES share many of the same goals, and by using a common study approach, the Tennessee's planned reforms can be viewed within a national context. CMS staff will be available to provide technical assistance in this regard.

**68. Evaluation of Eligibility and Enrollment Systems.** The state shall propose data collection and reporting measures designed to assess the ongoing need for retroactive

Medicaid eligibility after changes specified in the Affordable Care Act are effectuated. The interim evaluation report required in paragraph 8 *(Extension of the Demonstration)* and paragraph 70 *(Interim Evaluation Reports)* should contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid and the Exchange. CMS may issue further guidance to the state on the specific performance measures. The state may include the following areas of interest in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other relevant data.

a. Evaluation of eligibility determinations by type, e.g. application, redetermination, transfer to the Exchange.

b. Evaluation of Medicaid denial and termination reasons.

c. Evaluation of average application processing times and timeliness.

d. Evaluation of reasons for disenrollment and internal churn.

e. Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable.

**69. Evaluation of Uncompensated Care Costs for the Uninsured.** The state shall propose data collection and reporting measures designed to assess the ongoing need for payments to compensate hospitals for providing care to the uninsured after changes specified in the Affordable Care Act are effectuated. The state should provide documentation demonstrating cost expended for uncompensated care in relation to the number of uninsured individuals that receive care during the current approval period. CMS may issue further guidance to the state on specific data collection and tracking mechanisms. The state may include the following areas of interest in its interim evaluation report. This list is not all inclusive and the state may include any other relevant data.

a. Evaluation of uninsured patient cost and dates of service.

b. Evaluation of cost for medical services to charities and the indigent.

c. Evaluation of amounts expended for services to hospitals that serve a disproportionate number of low-income patients.

**70. Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request.

**71. Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation plan within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports. The state shall

submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

**72. Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

## XIII. TENNCARE ELIGIBILITY REDETERMINATION AND DISENROLLMENT AND RIGHTS; APPEALS PROCESS FOR CHANGES IN BENEFITS; AND ENROLLMENT IN STANDARD SPEND DOWN

The state will follow these procedures throughout the demonstration approval period unless modified through an approved demonstration amendment.

### PART I: MEDICALLY NEEDY AND TENNCARE STANDARD ELIGIBILITY REDETERMINATION AND DISENROLLMENT PROCESS

This Part summarizes the process Tennessee will use, in accordance with paragraph 21.a. *(Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category)*, of these STCs, to: (i) redetermine eligibility and terminate the adult (non-pregnant) Medically Needy; and (ii) disenroll adults who are TennCare/Medicare dual eligible, uninsured, and Medically Eligible. This process was approved as an amendment to the TennCare II demonstration on March 24, 2005. It is used for redetermining the eligibility of those enrollees whose eligibility is ending, including when their period of eligibility has ended or the category in which they have been enrolled is being closed. The state will continue to follow this process for all redeterminations and terminations of eligibility throughout the demonstration approval period unless modified through an approved demonstration amendment.

**I. Termination of Adult Non-Pregnant Medically Needy**

**1. Ex Parte Review**

A. The state will conduct a data match of the Social Security numbers of individuals classified as adult non-pregnant Medically Needy in its InterChange Information System (which contains information on TennCare enrollees) with Social Security Administration (SSA) data to determine whether the individual has lost supplemental security income (SSI) eligibility for reasons that would qualify them as Medicaid eligible.[2]

B. The state will conduct a data match of the Social Security numbers (SSNs) of individuals classified as adult non-pregnant Medically Needy in InterChange with individuals classified as participants in its Food Stamps or Families First (TANF) program in its ACCENT system (a database maintained by the Department of Human Services (DHS)). In all instances in which there is a match between an adult Medically Needy individual with an individual with an open Food Stamps or Families First record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

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[2] Such reasons include (i) they lost SSI eligibility because of Social Security cost of living adjustment(s) ("COLA(s)") but would be SSI eligible if the COLA(s) was/were disregarded ("Passalong" eligibles); or (ii) they lost SSI eligibility for some reason other than a Social Security COLA, but would be eligible for SSI if the COLA(s) received since their SSI termination was/were disregarded ("Pickle" eligibles).

## 2. Request for Information

A. At least 30 days prior to the end of the individual's current eligibility period, the state will send notification (Request for Information) to those adult non-pregnant Medically Needy enrollees who have not been identified through the ex parte review process as eligible for open categories of TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for Medicaid is ending, and that they will only remain eligible for TennCare Medicaid if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for a Medicaid category that is not ending (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for open Medicaid categories. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for Medicaid and the enrollee will receive an advance notice that will provide appeal rights.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be fair hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with Limited English Proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as Seriously and/or Persistently Mentally Ill (SPMI). Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package—i.e., elimination of pharmacy coverage for adult non-institutionalized non-pregnant Medically Needy) until

DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a "Verification Request." Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package). If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain TennCare Medicaid coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), enrollees will retain Medicaid coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. The state will make the determination that enrollees are not eligible for open TennCare Medicaid categories in the following two scenarios: (i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or (ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Expiration Notice**

A. Upon making a determination that enrollees are no longer eligible for TennCare Medicaid, the state will provide a notice (Expiration Notice) to enrollees at least 20 days in advance of the end date of the enrollees' eligibility period.

B. Expiration Notices will:

i. Inform enrollees that they will be terminated from Medicaid as of a date specified in the notice because their current eligibility period has ended, their category of TennCare Medicaid is closed and they have not proven their eligibility for other open categories of TennCare Medicaid.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Expiration Notice to request a hearing for factual disputes related to the termination and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing prior to the date of termination specified in the Notice, Medicaid benefits for non-pregnant Medically Needy (subject to changes in the benefit package) will continue until the appeal has been resolved.

C. If enrollees submit information to qualify for Medicaid prior to their termination, enrollees will continue to be eligible for TennCare Medicaid for non-pregnant Medically Needy (subject to changes in the TennCare Medicaid benefit package) pending the determination as to whether the individual is eligible for other open TennCare Medicaid categories.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Expiration Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the termination. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. Valid factual disputes include:

i. Enrollees received the Expiration Notice in error (i.e., they are currently enrolled in other categories of TennCare Medicaid including Medically Needy pregnant women or enrollees under 21 years of age);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Request for Information but failed to extend the time;

iv. Enrollees requested assistance because of a health, mental health, learning problem, or disability but the state failed to provide this assistance; or

v. The state sent the Expiration Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the request for a hearing is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of termination identified in the Expiration Notice, TennCare Medicaid benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute as described above, or the appeal is resolved.

E. If the enrollee does not request a hearing prior to the date of termination identified in the Expiration Notice, the enrollee will be disenrolled from TennCare Medicaid.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## II. Disenrollment of Adult Medicare/TennCare Dual Eligible, Uninsured, Medically Eligible

### 1. Ex Parte Review

A. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in InterChange (which contains information on TennCare enrollees) with SSA data to determine whether the individual has lost SSI eligibility for reasons that would qualify them as Medicaid eligible.[3]

B. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in Interchange with individuals classified as participants in the state's TANF program in DHS' ACCENT system. In all instances when there is a match between an adult member of these demonstration populations with an individual with an open TANF record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

### 2. Request for Information

[3] See footnote 1

A. At least 30 days prior to disenrollment, the state will send a Request for Information to all adult Medicare/TennCare Dual Eligible, Uninsured, and Medically Eligible enrollees not identified through the ex parte review process as eligible for TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for TennCare Standard is ending and that they will only maintain coverage if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for Medicaid (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for TennCare Medicaid. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for TennCare Medicaid and the enrollee will receive a Disenrollment Notice prior to disenrollment from TennCare Standard.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with limited English proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as SPMI. Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Standard until DHS determines that the individual does not qualify for open categories of Medicaid (and proper disenrollment and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a Verification Request. Verification Requests will inform enrollees that they must submit

the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid. If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper disenrollment and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), the enrollee will retain coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in an appropriate TennCare Medicaid category. The state will make the determination that enrollees are no longer eligible for TennCare in the following two scenarios:

   i. if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or

   ii. if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

**3. <u>Termination Notice</u>**

A. Upon determination or confirming that enrollees are not eligible for TennCare Medicaid, the state will provide a Termination Notice to enrollees 20 days in advance of the date upon which the coverage will be terminated.

B. Termination Notices will:

   i. Inform enrollees that they will be disenrolled from TennCare as of the date specified in the Notice (20 days after the date of the Notice) because their category of TennCare Standard is ending and they have not proven their eligibility for open TennCare Medicaid categories.

   ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the notice to appeal factual disputes related to the action of disenrollment and inform enrollees how they may request a hearing.

   iii. Inform enrollees that if prior to the date of disenrollment specified in the Termination Notice, an enrollee appeals the action of disenrollment, he or she will not lose eligibility for TennCare until the state determines that the enrollee has not raised a valid factual dispute or the appeal is resolved.

iv. Inform enrollees that they may submit new information to demonstrate Medicaid eligibility at any time before or after disenrollment. Such information will be treated as a new application for Medicaid. The enrollee will not continue benefits pending the state's review and processing of this information.

**4. <u>Appeals Process</u>**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:

i. Enrollee received the Termination Notice in error (e.g., he or she is currently enrolled in Medicaid or in a TennCare Standard category that is not ending);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Termination Notice but failed to extend the time;

iv. Enrollee requested assistance because of a health, mental health, learning problem, or disability, but the state failed to provide this assistance; or

v. The state sent the Termination Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the appeal is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of disenrollment as identified in the Termination Notice, TennCare Standard benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute, or the appeal is resolved.

E. If the enrollee does not appeal prior to the date of disenrollment as identified in the Termination Notice, the enrollee will be disenrolled from TennCare Standard.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## PART II: NOTICE AND APPEALS PROCESS FOR CHANGES IN COVERAGE OF TENNCARE BENEFITS

This Part summarizes the process Tennessee will use upon and after the implementation of changes in coverage of TennCare benefits. These procedures were approved as an amendment to the TennCare II demonstration on March 31, 2006. This detailed process is used by the state to implement benefit changes, specifically benefit limits. It is used daily with enrollees who are subject to pharmacy benefit limits when they reach their monthly maximum. With this process, Tennessee provides one notice per month when benefit limits have been reached. The state will continue to follow this process with enrollees who are subject to pharmacy or other benefit limits throughout the Demonstration approval period unless modified through an approved Demonstration amendment. To change benefits covered under the Demonstration, the state must submit a Demonstration amendment in accordance with paragraphs 6 and 7 regarding amendments of these STCs.

### I. Implementation of Changes in Coverage Policies

#### 1. Initial Notice

A. At least 30 days prior to the effective date of changes in coverage of TennCare benefits (e.g., implementation of pharmacy benefit limits and elimination of covered services), the state shall provide a notice (Benefit Notice) to enrollees who are impacted by such changes in coverage of TennCare benefits.

B. Benefit Notices will:

i. Inform enrollees of how changes in coverage of TennCare benefits will apply to enrollees.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Benefit Notice to request a hearing for valid factual disputes related to the changes in coverage and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing for a valid factual dispute prior to the effective date of the change in coverage of TennCare benefits, benefits will be continued at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the level for Non-Institutionalized Medicaid Adults (Default Level). The state will apply the Default Level of benefits until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary. (The resolution of an appeal, for purposes of this Part, is defined as when the appeal is dismissed or resolved prior to a hearing or when a decision is rendered at or after the hearing.)

## 2. Appeals Process

A. An enrollee will have the opportunity to request a state fair hearing for 40 days (inclusive of mail time) from the date of the Benefit Notice.

B. The state will grant state fair hearings only for those enrollees raising valid factual disputes related to the changes in coverage. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to a different level of TennCare benefits than that identified in the Benefit Notice. Valid factual disputes include when an enrollee claims to have received the Benefit Notice in error (e.g., he or she is already in a TennCare category that is not subject to the particular changes in coverage).

C. When an enrollee requests a hearing prior to the effective date of changes in coverage as identified in the Benefit Notice, the enrollee shall continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the Default Level. The state will apply the Default Level until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary.

D. If the enrollee appeals, the changes in coverage in dispute shall become effective upon resolution of the appeal.

E. If the enrollee does not appeal prior to the effective date of changes in coverage as identified in the Benefit Notice, such changes in benefits will become effective, as applied to the enrollee, upon this date.

F. If the enrollee appeals and:

(i) The appeal is dismissed because the enrollee has not asserted a valid factual dispute; or

(ii) The enrollee is granted a hearing and the hearing decision sustains the state's action.

The state reserves its right to recover from the enrollee the cost of services provided as a result of the appeal.

# II. Post-Implementation Appeals from Denials of Prior Authorization for Pharmacy Products

## 1. Prior Authorization Requirements

A. Any prescription of a branded drug may be subjected to a prior authorization requirement by the state; and prior authorization will be required as a condition of coverage for branded prescription drugs that are not included on the state's Preferred Drug List.

B. Physicians (or other providers with prescribing authority) participating in TennCare will be responsible for requesting prior authorization, according to procedures to be established by the state.

**2. <u>Notice of Prior Authorization Denial</u>**

A. Requests for prior authorization of covered outpatient drugs shall be transmitted to and acted upon by appropriate staff of the Pharmacy Benefit Manager (PBM) Clinical Call Center.

B. Written notice of denial of a request for prior authorization shall be mailed by the PBM on behalf of the state to the enrollee and transmitted by facsimile to the prescribing physician. Such Notice will inform the enrollee that the request for prior authorization of the prescribed drug has been denied and that TennCare does not cover the drug absent prior authorization, briefly state the reason or reasons for denial of the request, explain the procedures that are available to the enrollee to appeal from that decision, and inform the enrollee that TennCare will not cover the cost of the prescribed medication during the pendency of any appeal. The state's failure to act on a request for prior authorization within a 24-hour period after receiving a submission that complies with the state's requirements for a completed prior authorization request may be deemed a denial from which the enrollee can appeal.

**3. <u>Procedures for Filing and Pursuing an Appeal</u>**

A. Appeals of denials of requests for prior authorization may be initiated within 20 days of the Notice of denial of prior authorization, at the option of the enrollee, by the enrollee (or an individual appointed or otherwise authorized under state law to act as the enrollee's representative) submitting to the TennCare Solutions Unit via hand delivery, mail, or facsimile, a written statement of intent to appeal on a form prescribed by the state. Such form will be available on the PBM Web site, and the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's managed care organization (MCO), or from the TennCare Solutions Unit. Undue delay by the state in deciding a prior authorization request (i.e., delay in excess of the 24-hour period permitted for such decisions) will be considered a denial of prior authorization for purposes of appeal.

B. The state will dismiss any appeal that does not raise a valid factual dispute without a hearing, and will retain the authority to determine whether an appeal raises a valid factual dispute relating to denial of a prior authorization request or the state's failure to act on a request for prior authorization within a 24-hour period after such request. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the prescribed drug. A dispute concerning whether a particular

drug or dosage is medically necessary for the enrollee, will be considered a valid factual dispute.

C. An initial determination on appeals involving issues of medical necessity will be made by appropriately qualified medical professionals on the staff of the TennCare Solutions Unit as promptly as possible after the enrollee's submission of the appeal. After submission of the appeal, the TennCare Solutions Unit may seek additional information or documentation in support of the appeal, before any initial determination is made.

D. Upon initially deciding an appeal, the state shall send a letter communicating its decision to the enrollee and stating the reasons for that decision, and shall also communicate any decision granting prior authorization to the enrollee and/or the prescribing physician by the fastest means practicable. A letter initially denying an appeal shall also inform the enrollee of his or her opportunity to request a state fair hearing, and the procedures that must be followed to pursue such further appeal.

**4. <u>Benefits During the Pendency of an Appeal</u>**

A. During the pendency of any appeal from denial of a pharmacy service due to the lack of required prior authorization, the enrollee will continue to be eligible for pharmacy benefits within applicable pharmacy service limits, but will not have any right to receive on a covered basis the drug that is the subject of the appeal.

B. If the enrollee chooses to purchase the unauthorized, prescribed drug at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the drug upon prevailing in his or her appeal, but only to the extent that applicable, monthly pharmacy benefit limits would not thereby be exceeded.

## III. <u>Post Implementation Appeals of Application of Benefit Limits</u>

**1. <u>Initial Notice</u>**

A. Pharmacists will be required to verify TennCare coverage for all prescriptions presented by enrollees through an electronic database maintained by the PBM. If, through the database, the PBM denies coverage of a prescription because the enrollee has reached or exceeded the monthly pharmacy benefit limit ("the pharmacy limit"), the PBM on behalf of the state will mail a written notice of the denial to the enrollee (Service Notice). Service Notice shall be provided only upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five prescription limit, and/or upon the first denial in that month of a pharmacy service sought by the enrollee that exceeds the two prescriptions limit on branded drugs. (For purposes of this Part, "the pharmacy limit" is defined as a five prescription limit per month, of which no more than two prescriptions or refills could be for branded drugs and at least three out of any five prescriptions or refills in the same month must be for generic drugs.)

B. If a pharmacist fills a prescription in excess of the pharmacy limit and submits a claim for such service, the PBM will deny payment for the claim. Upon denial of payment for such claim, the PBM on behalf of the state will mail a written notice (Notice of Limit) to enrollees.

C. If a provider denies a non-pharmacy service or charges the enrollee for the service because the enrollee has reached or exceeded a benefit limit, the provider need not give specific notice of appeal rights to the enrollee but must direct the enrollee to the responsible arm of the managed care contractor (MCC).

D. If a provider renders a non-pharmacy service in excess of a non-pharmacy benefit limit and the provider or the enrollee submits a claim for such service, the MCC will deny payment for the claim. Upon denial of payment for such claims, the MCC, on behalf of the state, will mail a Notice of Limit to enrollees. A Notice of Limit shall be provided only upon the first denial of coverage of a non-pharmacy service sought by the enrollee that exceeds the applicable limit for the kind and number of services during a given time period specified in the state's program.

E. The Notice of Limit and Service Notice will:

i. Inform an enrollee that he or she has reached or exceeded the applicable benefit limit.

ii. Provide enrollees with at least 20 days from the Notice of Limit or Service Notice to request a hearing for valid factual disputes related to the benefit limit and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing, they will not receive continuation of benefits (i.e., services in excess of the applicable limit) during the pendency of their appeal.

iv. Remind enrollees of any exceptions to the limits and inform them how to obtain more information about such exceptions.

**2. <u>Appeals Process</u>**

A. Enrollees will have the opportunity to request a state fair hearing for at least 20 days from the date of the Notice of Limit or Service Notice.

B. The enrollee will be required to submit a designated form in order to request a state fair hearing. The form, which must be signed by the enrollee (or an individual appointed or otherwise authorized to act as the enrollee's representative under state law), would include the basis for the appeal and the enrollee must attest, under penalty of perjury, that his contention is true to the best of his knowledge and is made in good faith. Enrollees may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its

discretion of an exemption from a signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or by an individual authorized under state law to act as the enrollee's representative.

C. The state will grant a state fair hearing only for those enrollees raising valid factual disputes related to the benefit limit. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the service that was denied because the enrollee had reached or exceeded the applicable benefit limit. Valid factual disputes include:

   i. An administrative error was allegedly made and the enrollee has not yet reached the relevant benefit limit.

   ii. The enrollee alleges that his or her circumstances have changed and he or she has been re-classified in a TennCare eligibility category that is not subject to the benefit limit the state has applied. The state, however, shall not grant a hearing to individuals who allege solely that they are not subject to the benefit limit without further alleging a change of circumstances that has been reported to TennCare and has resulted in a change in their eligibility category. These enrollees will be granted a hearing because they did not have the opportunity to appeal the application of the benefit limit to them in connection with the Benefit Notice.

   iii. The enrollee alleges an administrative error in the processing of a request for a special exemption to the benefit limit (i.e., the enrollee's physician submitted the required attestation necessary to obtain a special exemption from the benefit limit and the prescribed drug is on the special exemption list but coverage for the drug was nonetheless denied).

D. The enrollee shall not receive continuation of benefits when appealing a denial of services based on the application of a benefit limit. This policy shall apply even for items or services that have been previously authorized as medically necessary to the extent that the denial of services is based on the application of a benefit limit.

E. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal with respect to those benefits.

F. If the enrollee does not request a hearing, the benefit limit deemed applicable by the state will continue to apply to the enrollee.

G. Providers will be permitted to bill enrollees for services that were provided in excess of the benefit limits.

## IV. Post Implementation Appeals of Elimination of Coverage for Certain Services

1. Neither the state nor the MCC will provide notification in addition to the Benefit Notice described above with respect to services that are eliminated from TennCare coverage as those services are no longer covered by TennCare.

2. Upon denial of non-covered services, TennCare enrollees will have the opportunity to request a state fair hearing. The enrollee will be required to submit a designated form in order to request a hearing. Such form would include a statement, which must be signed by the enrollee, or an individual appointed or otherwise authorized to act as the enrollee's representative under state law that sets out or describes the factual contention on which the appeal is based, and attests, under penalty of perjury, that the contention is true to the best of the signatory's knowledge and is made in good faith. Enrollees or their representatives may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its discretion of an exemption from the signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or his/her authorized representative.

3. The state will grant a state fair hearing only for those enrollees who raise valid factual disputes related to the elimination of coverage. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to coverage of the disputed service. In the context of excluded services, valid factual disputes are limited to when an enrollee claims that he or she is already in a TennCare category that is entitled to coverage of the particular service at issue. Appeals that do not raise a valid factual dispute will be dismissed without a hearing.

4. If the request for a hearing is granted, the enrollee will not receive continuation of the benefits in dispute pending the appeal.

5. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee may be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal.

## PART III: ENROLLMENT IN TENNCARE STANDARD SPEND DOWN

TennCare Standard Spend Down (SSD) is open to people who are not currently eligible for Medicaid and who meet the criteria for the SSD program. Financial eligibility criteria for SSD will be based on criteria that apply to medically needy pregnant women and children eligible under the state plan.

Applicants will be enrolled only through a single toll-free telephone point of entry (the Call-In Line) initiated in periods of open enrollment. In each open enrollment period, the state will determine a specified number of calls that it will accept through the Call-In Line based on the number of applications that the state estimates it can process within federal timeliness standards. The state will not accept or track calls received outside of open enrollment periods.

Once the state has reached its targeted enrollment of 100,000 persons, new open enrollment periods will be scheduled when enrollment in the SSD program drops to 90 percent of target enrollment. Any subsequent open enrollment periods will remain open until a pre-determined number of calls to the Call-In Line have been received. The number of calls to be received will be established based on the state's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the state estimates it can process in a timely manner in accordance with federal standards. The state's decision to open or close enrollment is a policy decision that is within the state's discretion and the state is not required to provide fair hearings for challenges to these decisions.

Callers to the Call-In Line will be asked for basic demographic information and will be assigned a unique identifier. After conducting a match to verify that callers are not already enrolled in TennCare Medicaid as state plan eligibles, the state will send each non-enrolled caller a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within 30 days. (Those callers who are already enrolled in TennCare Medicaid as state plan eligibles will be sent letters advising them that they currently have benefits and need not apply.)

Completed signed applications received by the state by the 30-day deadline established by the state will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will still be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the state. If the individual does not mail back an application by the deadline, the state will send the individual a letter advising him or her that since no application was received, the state will not make an eligibility determination for him or her, but the individual is free to apply for SSD during any subsequent open enrollment period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he or she did submit a signed, written application within the deadline. Since all SSD applications received during an open enrollment period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open enrollment period will be carried forward to future open enrollment periods. The state will determine SSD eligibility within the timeframes specified by Federal regulations at 42

CFR § 435.911; such timeframes will begin on the date a signed written application is received by the state.

The effective date of SSD eligibility for individuals whose enrollment is originally initiated through the Call-In Line and who submit a timely signed application will be the later of: 1) the date that their call was received by the Call-In Line; or 2) the date spend down is met (which must be no later than the end of the 1-month budget period -- in this case, the end of the month of the original call to the Call-In Line). The effective date provisions contained herein only apply to SSD eligibility and do not apply to other categories of TennCare eligibility. All enrollees in the SSD demonstration category will have an eligibility period of 12 months from the effective date of the determination. At the end of the 12-month period the enrollee will need to have his eligibility status redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for TennCare Medicaid.

## XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

| | | |
|---|---|---|
| **Monthly Deliverables** | | |
| Monthly | Monitoring Call | ~~44~~ |
| **Quarterly Deliverables** | | |
| 60 days after end of each quarter | Quarterly progress reports | 45 |
| Per Sections 2500 & 2115 of State Medicaid Manual, or upon request | Quarterly expenditure, budget neutrality, member month reports | 41,42 Sections X and XI |
| **Annual Deliverables** | | |
| 120 days after end of each demonstration year | Draft Annual Progress Report | 46 |
| Within 30 days of receipt of comments from CMS on the Draft Annual Progress Report | Final Annual Progress Report | 46 |
| Dec. 31st of each year | Annual CHIP Report entered into CHIP Annual Report Template System (SARTS) | 46 |
| Sept. of each demonstration year | Annual beneficiary survey report | 47 |
| **Other Deliverables** | | |
| 6 months before expiration of demonstration | Request for extension | 8 |
| 5 months prior to suspending or terminating the demonstration | Phase-out plan | 9 |
| 6 months before expiration of demonstration | Interim evaluation report. | 8, 70 |
| 120 days after expiration of demonstration | Draft Final Evaluation Report | 48, 71 |
| 60 days after receipt of CMS comments on Draft Final | Final Evaluation Report | 48, 71 |

| | | |
|---|---|---|
| Evaluation Report | | |
| Implementation of compliance plan by January 1, 2013. | Enrollee notification and implementation of the new cost-sharing requirements | 35 |
| At least annually | MEQC plan proposal and report on findings | 23 |
| Upon receipt by state | Financial audits and quality assessment reviews of participating health plans, and other managed care and HCBS requirements | 40, 43 |
| Upon receipt by state | Fraud and abuse and program integrity reports related to 1115 Demonstration beneficiaries and providers | |
| As required by CMS | Corrective Action Plans and findings | |
| Upon submission to Regional Office | Courtesy copy of all state plan amendments to be sent to the CMS Project Officer | 7 |
| 60 days advance notice | Modification of CHOICES benefits defined in Attachment D | 7 |
| No later than 120 days prior to planned implementation and may not be implemented until approved | Demonstration amendments, including requests for services not defined in Attachment D | 6, 7 |
| 30 days advance notice | Notice on increases in CHOICES Enrollment Targets within allowable range | 32 |
| 3 months after each point in time. i.e. September 30 of each demonstration year | Submission of CHOICES data | 43.d. |
| Annually | Integrated Quality Improvement Strategy Update | 43.c. |
| Subject to CMS approval prior to implementation | Final MCO contracts developed for CMS approval | 40 |
| When issued or amended by state | Procedural manuals or operating protocols related to the 1115 Demonstration | |
| *All Reports Required by Sections 2500 and 2115 of the State Medicaid Manual* | | |

**ATTACHMENT A**
**QUARTERLY PROGRESS REPORT**

Under Section IX, paragraph 45 *(Quarterly Progress Reports)* of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

## NARRATIVE REPORT FORMAT:

**Title Line One –** TennCare II

**Title Line Two -** Section 1115 Quarterly Report

**Demonstration/Quarter Reporting Period:**
*Example: Demonstration Year: 6 (7/1/2007 – 6/30/2008)*
*Federal Fiscal Quarter: 1/2008 (10/07 - 12/07)*

**Footer:** Approval Period July 1, 2013 – June 30, 2016

## I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

## II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to TennCare eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.
    - Progress on implementing TennCare Standard Spend Down.
    - Progress on phasing out closed eligibility categories.
    - Other

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

**Enrollment Counts for Quarter**

Note: Enrollment counts should be person counts, not member months

| Demonstration Populations | Total No. TennCare Enrollees in current Quarter |
|---|---|
| **EG1 Disabled, Type 1 state plan eligibles** | |
| **EG 9 H-Disabled, Type 2 demonstration population** | |
| **EG2 Over 65, Type 1 state plan eligibles** | |
| **EG10 H-Over 65, Type 2 demonstration population** | |
| **EG3 Children, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 2 demonstration population** | |
| **EG5 Duals, Type 1 state plan eligibles and EG-11 H-Duals 65, Type 2 demonstration population** | |
| **EG6E Expan Adult, Type 3 demonstration population** | |
| **EG7E Expan Child, Type 3 demonstration population** | |
| **EG8, Med Exp Child, Type 2 demonstration population, Optional Targeted Low Income Children funded by Title XIX** | |
| **Med Exp Child, Title XXI demonstration population** | |
| **EG12E Carryover, Type 3, demonstration population** | |

## III. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for TennCare enrollees or potential eligibles.

## IV. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

## V. Operational/Policy/Systems/Fiscal Developments/Issues

Identify all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

## VI. Action Plans for Addressing Any Issues Identified

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration.

## VII. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

## VIII. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

### A. For Use in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| ***Medicaid eligibles (Type 1)*** | | | | |
| **EG1 Disabled, Type 1 state plan eligibles (paragraph 53.a.i.)** | | | | |
| **EG2 Over 65, Type 1 state plan eligibles (paragraph 53.a.ii.)** | | | | |
| **EG3 Children, Type 1 state plan eligibles (paragraph 53.a.iii.)** | | | | |
| **EG4 Adults, Type 1 state plan eligibles (paragraph 53.a.iv.)** | | | | |
| **EG5 Duals, Type 1 state plan eligibles (paragraph 53.a.v.)** | | | | |
| ***Demonstration eligibles (Type 2)*** | | | | |
| **EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX (paragraph 53.b.iii.)** | | | | |
| **EG9 H-Disabled, Type 2 Demonstration Population (paragraph 53.b.iv.)** | | | | |
| **EG10 H-Over 65, Type 2 Demonstration Population (paragraph 53.b.v.)** | | | | |
| **EG11 H-Duals, Type 2 Demonstration Population (paragraph 53.b.vi.)** | | | | |

### B. Not Used in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **EG6E Expan Adult, Type 3, Demonstration Population (paragraph 53.b.i.)** | | | | |
| **EG7E Expan Child, Type 3, Demonstration Population (paragraph 53.b.ii.)** | | | | |
| **Med Exp Child, Title XXI Demonstration Population (paragraph 53.c.)** | | | | |
| **EG12E Carryover, Type 3, Demonstration Population (paragraph 53.b.vii.)** | | | | |

## IX. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

## X. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

## XI. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

## XII. Essential Access Hospital Pool

List the Essential Access Hospitals and specify their type from the following:
Essential Service Safety Net
Children's Safety Net
Free Standing Psychiatric Hospitals
Other Essential Acute Care

## XIII. Graduate Medical Education (GME) Hospitals

List the GME hospitals and their affiliated teaching universities.

## XIV. Critical Access Hospitals

List the Critical Access Hospitals.

## Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

## State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

## Date Submitted to CMS

## ATTACHMENT B
## LIMITATIONS ON HOME HEALTH SERVICES

Home health services are delivered in accordance with 42 CFR § 440.70. Prior authorization may be required. Definitions and coverage limitations used by the state are as follows:

1. Home health services shall include any of the following services ordered by a treating physician and provided by a licensed home health agency pursuant to a plan of care at an enrollee's place of residence.

   a. Part-time or intermittent nursing services.

      (1) To be considered "part-time and intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, AND no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide care combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. The above limits may be exceeded when medically necessary for children under the age of 21.

      (2) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on an as needed basis. Part-time or skilled nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.

   b. Home health aide services.

      (1) Home health aide care must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

      (2) The above limits may be exceeded when medically necessary for children under the age of 21.

   c. Physical therapy, occupational therapy, speech pathology and audiology services.

d. Medical supplies, equipment, and appliances ordered by a treating physician and suitable for use at an enrollee's place of residence.

2. Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, or preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:

   a. The child is non-ambulatory; and

   b. The child has no or extremely limited ability to interact with caregivers; and

   c. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and

   d. No other children shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult.

## ATTACHMENT C
## LIMITATIONS ON PRIVATE DUTY NURSING SERVICES

Private duty nursing services are delivered in accordance with 42 CFR § 440.80. Prior approval may be required. Definitions and coverage limitations used by the state are as follows:

PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period. A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members.

1. If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home that determines whether the nursing services are continuous or intermittent.

2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:

    a. Have a demonstrated understanding, ability, and commitment to the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration, and feeding, as applicable; and

    b. Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and

    c. Are willing and available as needed to meet the recipient's non-nursing support needs.

3. Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:

    a. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

    b. Has a functioning tracheostomy

        (1) Requiring suctioning, AND

(2) Oxygen supplementation, AND

(3) Receiving nebulizer treatments or requiring the use of Cough Assist/inexsufflator devices.

(4) In addition, for persons with a functioning tracheostomy, at least one from each of the following (I and II) must be met:

(I) Medication

(a) Receiving medication via a gastrostomy tube (G-tube), OR

(b) Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port. AND

(II) Nutrition

(a) Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube), OR

(b) Receiving total parenteral nutrition.

4. Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.

5. A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period, or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of this Attachment may receive medically necessary nursing care as an intermittent service under home health.

6. General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have other non-medical caregiving needs which must be met, to the extent that private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

a. The child is non-ambulatory; and

b. The child has no or extremely limited ability to interact with caregivers; and

c. The child would not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse would be present in the home without the presence of another responsible adult; and

d. No other children will be present in the home during the time the private duty nurse would be present in the home without the presence of another responsible adult.

## ATTACHMENT D
## GLOSSARY OF TERMS FOR TENNCARE CHOICES

**Adult care homes.** A state-licensed community-based residential alternative which offers 24-hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet nursing facility level of care, but who would prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-basis is living in the home with the individuals for whom they are providing care. Coverage shall not include the costs of room and board.

**Adult day care.** Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day provided pursuant to an individualized plan of care by a licensed provider not related to the participating adult.

**Assisted care living facility services**. Community-based residential alternative to nursing facility care in a licensed Assisted Care Living Facility that provides and/or arranges for daily meals, personal care, homemaker and other supportive services or health care including medication oversight (to the extent permitted under state law), in a home-like environment to persons who need assistance with activities of daily living. Coverage shall not include the costs of room and board.

**Assistive technology.** Assistive device, adaptive aids, controls or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive or control their environment. Examples include, but are not limited to, 'grabbers' to pick objects off the floor, strobe lights to signify the smoke alarm has been activated, etc.

**At-Risk.** As it relates to the CHOICES program, SSI eligible adults age 65+ or age 21+ with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined by the state in administrative rule, such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As is relates to Interim CHOICES 3, open for enrollment starting on July 1, 2012 and closed to enrollment on June 30, 2015, "at risk" is defined as adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meeting nursing facility financial eligibility criteria, and also meet the nursing facility level of care in effect on June 30, 2012.

**Attendant care.** Hands-on assistance, safety monitoring and supervision for an enrollee who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visits (more than four (4) hours per visit or visits at intervals of less than four (4) hours between visits). This may include assistance

with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, attendant care may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home, or continuous monitoring and supervision because there is no household member, relative, caregiver, or volunteer to meet the specified need. Attendant care shall not be provided for enrollees who do not require hands-on assistance with ADLs.

Attendant care does not include:

1) Care or assistance including meal preparation or household tasks for other residents of the same household;
2) Yard work; or
3) Care of non-service related pets and animals.

Only for persons who require homemaker services in addition to hands-on assistance with ADLs, the annual benefit shall be up to 1400 hours per full calendar year.

**Community-based residential alternatives to institutional care (Community-based residential alternatives).** Residential services which offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, assisted care living facilities, adult care homes, and companion care.

**Companion care.** A consumer-directed residential model in which a CHOICES member may choose to select, employ, supervise and pay, utilizing the services of a fiscal intermediary, on a daily, weekly, or monthly basis, as applicable, a live-in companion who will be present in the member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration. Such model will be available only for a CHOICES member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with activities of daily living or supervision and monitoring for extended periods of time that cannot be met more cost-effectively with other non-residential services. A CHOICES member who requires assistance in order to direct his or her companion care may designate a representative to assume consumer direction of companion care services on his/her behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.

**Consumer direction of eligible CHOICES HCBS.** The opportunity for a member assessed to need specified types of HCBS including attendant care, personal care visits, homemaker services (provided only as part of attendant care or personal care visits), in-home respite care, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such

services—primarily, the hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed service(s).

**Electronic visit verification (EVV) system**. An electronic system in which caregivers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of HCBS and which may also be utilized for submission of claims.

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

**Homemaker services.** Effective July 1, 2012, homemaker services are only available as part of attendant care or personal care visits for individuals who need hands-on assistance with ADLs. Services covered include general household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the member, changing the member's linens, making the member's bed, washing the member's dishes, doing the member's personal laundry, ironing, or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the member, assistance with maintenance of safe environment, and errands such as grocery shopping and having the member's prescriptions filled. Homemaker services are to be provided only for the member (and not for other household members) and only when the member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the member.

**In-home respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in the individual's place of residence, because of the absence or need for relief of those persons normally providing the care.

**In-patient respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in a licensed nursing facility or licensed community-based residential alternative, because of the absence or need for relief of those persons normally providing the care.

**Minor home modifications.** Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered

improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

**Nursing facility care.** See Social Security Act, Section 1919(a).

**Personal care visits.** Intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance to an enrollee who, due to age and/or physical disability, needs help with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, personal care visits may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need.

Personal care visits do not include:

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

**Personal emergency response system (PERS).** An electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. The individual may also wear a portable 'help' button to allow for mobility. The system is programmed to signal a response center once the 'help' button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed.

PERS services are limited to those individuals who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time, such that the individual's safety would be compromised without access to a PERS.

**Pest control.** The use of sprays, poisons and traps, as appropriate, in the enrollee's residence (excluding NF, ACLF) to regulate or eliminate the intrusion of roaches, wasps,

mice, rats and other species of pests into the household environment thereby removing an environmental issue that could be detrimental to a frail elderly or disabled enrollee's health and physical well-being.

**Reserve capacity.** The state's right to maintain some capacity within an established enrollment target to enroll individuals into HCBS under certain circumstances. These circumstances could include, but are not limited to: discharge from a nursing facility; discharge from an acute care setting where institutional placement is otherwise imminent, or other circumstances which the state may establish from time to time in accord with these STCs.

**Room and board.** Refers to lodging, meals, and utilities. The kinds of items that are considered "room and board" and are therefore not reimbursable by Medicaid include:

- Rent, or, if the individual owns his home, mortgage payments, depreciation, or mortgage interest
- Property taxes
- Insurance (title, mortgage, property and casualty)
- Building and/or grounds maintenance costs
- Resident "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included)
- Household supplies necessary for the room and board of the individual
- Furnishings used by the resident
- Utilities (electricity, water and sewer, gas)
- Resident telephone
- Resident cable television

**Short Term Nursing Facility Care.** The provision of nursing facility care for no more than 90 days to a CHOICES 2 or CHOICES 3 participant who was receiving home and community based services upon admission and who requires temporary placement in a nursing facility—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 90 days. Such CHOICES 2 or CHOICES 3 member must meet the nursing facility level of care upon admission (which for CHOICES 3 participants is anticipated to be due to a short-term condition), and in such case, while receiving short-term nursing facility care may continue enrollment in CHOICES 2 or CHOICES 3, as applicable, pending discharge from the nursing facility within no more than 90 days or until such time it is determined that discharge within 90 days from admission is not likely to occur, at which time the person shall be transitioned to CHOICES 1, as appropriate. The community personal needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

**Transition Allowance.** A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of a managed care organization, be

provided as a cost-effective alternative to continued institutional care for a CHOICES member in order to facilitate transition from a nursing facility to the community when such member will, upon transition, receive more cost-effective non-residential home and community based services or companion care. Items which may be purchased or reimbursed are only those items that the member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

## ATTACHMENT E
## BEST PRACTICES GUIDANCE REGARDING
## CONSUMER DIRECTION OF HOME AND COMMUNITY BASED SERVICES

The state will define services that eligible members may elect to direct. Members determined, as a part of the needs assessment and plan of care processes, to require such services will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e. consumer direction of HCBS).

All eligible members requiring these services will be offered the option to participate in consumer direction of HCBS.

i. Upon enrollment in HCBS and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.

ii. Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at anytime, service by service, without affecting their enrollment in HCBS. Only the state can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare.

iii. A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or be a member's paid worker.

iv. The state will utilize a fiscal employer agency (FEA) to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services rendered; and withholding, filing and paying applicable Federal, state and local income and employment taxes for workers) and to provide supports broker assistance.

v. The plan of care process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports, contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.

vi. Members will have the flexibility to hire persons close to them, including family members but excluding spouses, to serve as their workers. All workers must meet the state specified qualifications for providers of comparable non-consumer directed services and must sign a service agreement.

vii. Members will have flexibility in establishing payment rates that do not exceed the state specified ceiling for each service.

viii. Members and/or representatives must receive training prior to participating in consumer direction of HCBS and re-enrolling in consumer direction of HCBS. Ongoing training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.

ix. Workers must receive training, as a condition for hire, certain aspects of which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.

x. A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care, and the adequacy of payment rates.

**ATTACHMENT F**
**CERTIFIED PUBLIC EXPENDITURES PROTOCOL**

**Preamble**

This protocol governs the use of certified public expenditures to furnish the non-Federal share of expenditures claimed for Federal participation under the Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (paragraph 55.h.). The protocol is based on the following elements:

1) Units of government, including governmentally operated health care providers, may certify that costs have been incurred for providing services to TennCare and uninsured individuals. The CPE process contained in this attachment is in accordance with Federal regulations and CMS guidance or policy.

   i. Units of government have been determined by the state as eligible to certify public expenditures.

   ii. Certification must be supported by cost documentation, which represents both the Federal and non-Federal share of funds (i.e., total computable expenditures) under the Demonstration. Federal matching funds are available as a percentage of such eligible costs.

2) To the extent the state continues to utilize certified public expenditures (CPEs) as the funding mechanism for title XIX and XXI (or under Section 1115 authority) payments beyond the date defined in this section, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs as eligible under title XIX or XXI (or under Section 1115 authority) for purposes of certifying public expenditures.

3) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the state the amount of such tax revenue (state or local) appropriated to the non-governmental provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the state's claim for Federal match. Federal matching funds will be available as a percentage of such eligible costs.

## I. Cost Computation

### A. TN CPE 1115 – Medicaid Fee-For-Service

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552)

covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from MMIS for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the

cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

## B. TN CPE 1115 – Medicaid Managed Care

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not

be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

## C. TN CPE 1115 – Hospital Uninsured Care

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently as-filed Medicare cost report (CMS 2552), as-filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the as-filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospital's audited financial statements and other auditable documentation. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of Uninsured care usable organs to total usable organs. This is determined by dividing the number of Uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible Uninsured care costs are determined by adding the Uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual Uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

## II. Payments and Recoveries

All payments and recoveries, from MCO's; BHO's; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds) including any related patient co-payments, or payments from other non-state payers will be offset against the costs computed in Section I above. Payments to the hospital from uninsured individuals for their care for the fiscal year are identified from the hospital's records. Such uninsured data must be supported by auditable documentation.

## III. Interim Reconciliation

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3

Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5

Actual Medicaid paid days and charges from MMIS paid claims data for services furnished during the payment year are used.

Step 6

Organ acquisition costs and total usable organs from the as-filed CMS 2552 cost report for the payment year are used.

## IV. Final Reconciliation

Upon finalization of the CMS-2552 by the Medicare fiscal intermediary, the methodologies as prescribed above will be used to determine final Medicaid FFS cost, Medicaid managed care cost, and uninsured cost. The routine per diems and ancillary cost-to-charge ratios will be determined using cost, day and charge data from the finalized cost report. The Medicaid FFS, Medicaid managed care, and uninsured days, charges, and payment offsets will be updated with the latest MMIS reports and other auditable financial records.

Cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include:

1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS data to the per diem amount;

2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and

3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly excepted for Medicaid.

If, at the end of the reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Recoveries are updated and offset to cost as calculated per Steps above.

For hospitals whose cost report year is different from the state's fiscal year, the state will proportionally allocate to the state plan rate year the costs of two cost report periods encompassing the state Plan payment year. To do so, the state will obtain the actual Medicaid FFS, Medicaid managed care, and uninsured days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS, Medicaid managed care, and uninsured costs for the reporting periods; these costs will then be proportionally allocated to the state plan rate year. All allocations will be made based upon number of months. (For example, a hospital's cost reporting period ending 12/31/07 encompasses three-fourths of the state plan rate year ending 9/30/2007, and one-fourth of the state plan rate year ending 9/30/2008. To fulfill reconciliation requirements for state plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2006, to the state plan rate year.) The state will ensure that the total costs claimed in a state plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

**July 16, 2013**

Mr. Darin Gordon
Director
Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to amend the TennCare II section 1115 of the Social Security Act (the Act) demonstration (Project No. 11-W-00151/4). This amendment is effective as of October 1, 2013.

The Special Terms and Conditions (STCs) have been changed to reflect that the following groups under the demonstration will be subject to a $1.50 co-pay for generic outpatient prescriptions:

- TennCare Medicaid adults who are not exempt from cost sharing under 42 CFR 447.53
- TennCare Standard individuals under age 21 with incomes at or above 100 percent of the federal poverty level (FPL)
- TennCare Standard individuals aged 21 and older under the Standard Spend Down program
- CHOICES 3 and Interim CHOICES 3 enrollees that are at risk-for institutionalization

The approval is conditioned upon compliance with the enclosed STCs and is subject to our receiving your acknowledgement of the award and the acceptance of the STCs within 30 days of the date of this letter.

Your acceptance and any questions regarding the TennCare II program may be directed to your project officer, Jessica Woodard. Ms. Woodard can be reached at (410) 786-9249 or Jessica.Woodard@cms.hhs.gov.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

Cc: Jennifer Ryan, Acting Director, Children and Adults Health Programs Group
Diane T. Gerrits, Director, Division of State Demonstrations and Waivers
Jackie Glaze, Associate Regional Administrator, CMS Atlanta
Kenni Howard, CMS Atlanta
Jessica Woodard, CMCS

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**WAIVER LIST**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or specified as not applicable in the following list, shall apply to all TennCare II populations identified in paragraph 17 *(Eligibility)* of the Special Terms and Conditions.

The TennCare II Demonstration will operate under these waiver authorities and those provisions specified as "not applicable." The waiver authorities and the provisions specified as "not applicable" will continue through June 30, 2016, unless otherwise stated.

The following waivers shall enable Tennessee to implement the TennCare II Medicaid Section 1115 demonstration.

**WAIVERS OF TITLE XIX REQUIREMENTS FOR TENNCARE MEDICAID TITLE XIX STATE PLAN GROUPS**

**1. Statewideness/Uniformity** **Section 1902(a)(1)**
**42 CFR § 431.50**

To the extent necessary to enable the state to provide managed care plans or certain types of managed care plans only in certain geographical areas of the state. Certain managed care plans or certain types of managed care plans (e.g., risk-based plans) are only available in certain areas of the state.

**2. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR § 438.52**

To the extent necessary to permit the state to have only one pharmacy benefits manager and one dental benefits manager to provide services in a region of the state or statewide.

**3. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR § 435.831**

To the extent necessary to enable Tennessee to use streamlined eligibility procedures that provide for coverage of optional Medically Needy children and pregnant women and the Standard Spend Down demonstration population for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. In accordance with the Code of Federal Regulations, the "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

**4. Reasonable Promptness** **Section 1902(a)(8)**

To the extent necessary to enable the state to limit enrollment in CHOICES 2 and 3 to the enrollment target(s) established by the state, as authorized under 32.d. (*Enrollment Targets for TennCare CHOICES)* of the Special Terms and Conditions, and to allow the state to require applicants for long-term services and supports to complete a person-centered assessment and options counseling process.

**5. Access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Benefits** **Section 1902(a)(10) 42 CFR §§ 440.210 and 440.220**

To the extent necessary to enable the state to permit managed care contractors to limit coverage of FQHC and RHC services, so long as access to care is assured from other providers.

**6. Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B) 42 CFR 440 Subpart B**

To the extent necessary to enable the state to offer a reduced benefit package, a different benefit package, or cost-effective alternative benefit packages to different populations under the demonstration (except for individuals specified in Section 1902(l)(4) of the Act), to the extent authorized under Section V of the Special Terms and Conditions.

**7. Comparability and Amount Duration and Scope** **Sections 1902(a)(17) and 1902(a)(10)(B)**

Should the state change the level of care criteria for admission to nursing facilities, to the extent necessary to enable the state to determine whether an individual has a continuing need for nursing facility services, PACE services, or home and community-based services for the elderly and disabled, based on the criteria in use when the individual first was determined to need the service.

**8. Freedom of Choice** **Section 1902(a)(23)(A) 42 CFR § 431.51**

To enable the state to restrict freedom of choice of provider, through the use of mandatory enrollment in managed care plans or TennCare Select for the receipt of TennCare II and TennCare CHOICES covered services, including for individuals specified at Section 1932(a)(2) of the Social Security Act (the Act). No waiver of freedom of choice is authorized for family planning providers.

**9. Retroactive Eligibility** **Section 1902(a)(34) 42 CFR § 435.914**

To enable the state not to extend eligibility prior to the date that an application for assistance is made. This waiver authority will expire at the end of the extension period of the demonstration, June 30, 2016, unless otherwise approved based on the requirements of paragraph 8 (*Extension of the Demonstration*) of the STCs.

**10. Payment for Outpatient Drugs** **Section 1902(a)(54)**

**42 CFR §§ 440.120,**
**447.331-447.334,**
**and 456 Subpart K**

To the extent necessary to enable the state to establish a drug formulary that does not comply with the requirements of Section 1927(d)(4) of the Act.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under Section 1903, shall, for the period of this demonstration extension, be regarded as expenditures under the state's Medicaid title XIX state plan.

The following expenditure authorities shall enable Tennessee to implement the Medicaid Section 1115 demonstration (TennCare II).

**1. Expenditures Related to MCO Enrollment and Disenrollment.**
Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the Act specified below. Tennessee managed care plans will be required to meet all requirements of Section 1903(m) except the following:

- Section 1903(m)(2)(A)(vi) of the Act, Federal regulations at 42 CFR § 438.56, to the extent that the rules in Section 1932(a)(4) are inconsistent with the enrollment and disenrollment rules contained in paragraph 39 *(Plan Enrollment and Disenrollment)* of the demonstration's Special Terms and Conditions (STCs), such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 45 days of enrollment in an MCO. After 45 days, enrollees may disenroll from an MCO with cause at any time.

**2. Expenditures Related to Expansion of Existing Eligibility Groups.**
To enable Tennessee to use streamlined eligibility procedures and include eligibility standards and requirements that differ from those required by law.

a. Expenditures for Medical Assistance furnished to state plan optional Medically Needy children and pregnant women for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. The "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

b. Expenditures for Medical Assistance furnished to mandatory state plan Transitional Medical Assistance beneficiaries, who are eligible in accordance with section 1931(c)(1) of the Act, for the remainder of a 12-month eligibility period after the 4-month period specified in the statute.

**3. Expenditures for Expanded Benefits and Coverage of Cost-Effective Alternative Services.**

a. Expenditures for TennCare Medicaid and TennCare Standard child enrollees for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*. and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

b. Expenditures for TennCare Medicaid and TennCare Standard adult enrollees for optional services not covered under Tennessee's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*., paragraph 28 *(TennCare Benefits)*, and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

**4. Expenditures for Pool Payments.**
Expenditures for Graduate Medical Education, Essential Access Hospital, Critical Access Hospital, Meharry Medical College, Unreimbursed Public Hospital Costs for Certified Public Expenditures, Unreimbursed Hospital Cost, and Public Hospital Supplemental Payment pool payments to the extent specified in paragraph 55.d. through h. and j. through l. *(Extent of Federal Financial Participation for the Demonstration)* of the demonstration's STCs. This expenditure authority will expire December 31, 2015, unless otherwise approved based on the requirements of paragraph 8 *(Extension of the Demonstration)* of these STCs.

**5. Indirect Payment of Graduate Medical Education.**
Expenditures, up to $50 million in total computable expenditures for each demonstration year, for payments to universities that operate graduate physician medical education programs, which are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics.

**6. Payments for Non-Risk Contractor.**
Payments to the TennCare Select prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor more than what Medical Assistance would have paid fee-for-service under the state plan in accordance with the upper limits at 42 CFR § 447.362.

**7. Expenditures Related to Eligibility Expansion.**
Expenditures to provide Medical Assistance coverage to the following demonstration populations that are not covered under the Medicaid state plan and are enrolled in TennCare Standard :

a. **Medically Eligible Demonstration Population Children, Not CHIP Eligible.**
Uninsured children under age 19 who lose eligibility in TennCare Medicaid, have been determined to be "medically eligible" (uninsurable), have family income at

or above 200 percent of the Federal poverty level (FPL), and do not meet the definition of an optional targeted low-income child.

b. **Adult Demonstration Population Eligibles-Standard Spend Down (SSD):** Non-pregnant, non-postpartum adults aged 21 or older who have been determined to meet criteria patterned after the state plan Medically Needy requirements (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category* of the STCs), comprising:
   - Aged, blind, or disabled individuals; or
   - Caretaker relatives.

**8. CHIP-Related Medicaid Expansion Demonstration Population Children.**
Expenditures to provide Medical Assistance coverage to uninsured children who lose eligibility under TennCare, who meet the definition of optional targeted low-income child, and who have family income up to 200 percent of the FPL.

**9. The CHOICES 217-Like HCBS Group.**
Expenditures for TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with Section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under TennCare CHOICES were provided under an HCBS waiver granted to the state under Section 1915(c) of the Act, as of the initial approval date of the TennCare CHOICES component of this demonstration. This includes the application of the spousal impoverishment eligibility rules. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the STCs;

b. Home and community-based waiver-like services as specified in Table 2b, subject to the definitions in Attachment D of the STCs, net of beneficiary regular and spousal impoverishment post-eligibility responsibility for the cost of care, and with post-eligibility treatment of income for individuals receiving short-term nursing facility care calculated as if they were receiving HCBS in the community.

**10. HCBS Services for SSI-Eligibles.**
Expenditures for the provision of home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs that are not described in Section 1905(a) of the Act and not otherwise available under the approved state plan but could be provided under the authority of Section 1915(c) waivers, that are furnished to TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities with income at 100 percent of the Supplemental Security Income/Federal Benefit Rate and resources at or below $2,000 who either:

a. Meet the nursing facility institutional level of care; or

b. Do not meet the nursing facility institutional level of care but who, in the absence of TennCare CHOICES services, are "at risk" of institutionalization.

**11. The At Risk Demonstration Group.**

Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open new to enrollment until December 31, 2013. Persons enrolled in the At Risk Demonstration Group as of December 31, 2013, may continue to qualify in the group as long as they continue to meet nursing facility financial eligibility standards and the nursing facility level of care criteria in place on June 30, 2012, and remain continuously eligible and enrolled in the At Risk Demonstration Group.

Expenditures for these individuals are:

a. Services as presented in Table 2a of the STCs.

b. Home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs, net of beneficiary post-eligibility responsibility for the cost of care (including application of spousal impoverishment rules), and with post-eligibility treatment of income for individuals receiving short-term nursing facility care calculated as if they were receiving HCBS in the community.

**12. Continuing Receipt of Nursing Facility Care.**

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**13. Continuing Receipt of Home and Community-Based Services.**

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**14. Continuing Receipt of Program of All-Inclusive Care for the Elderly (PACE) Services.**

Expenditures for PACE-enrolled individuals, who upon redetermination do not meet the current nursing facility level of care criteria, but who continue to meet the level of care

criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the PACE Carryover Group.

**15. LTC Partnership.**
Expenditures for individuals in CHOICES 2 to participate in the Long Term Care Partnership Program.

## REQUIREMENTS NOT APPLICABLE TO TENNCARE STANDARD TITLE XIX DEMONSTRATION ELIGIBLE GROUPS

All Title XIX requirements that are waived for the TennCare Medicaid Groups are also not applicable to the TennCare Standard Title XIX Demonstration Eligible Groups. In addition, the following is not applicable to the Title XIX Demonstration Eligible Groups.

| | |
|---|---|
| **Cost Sharing** | **Section 1902(a)(14) and Section 1916**<br>**42 CFR §§ 447.51 – 447.56** |

To enable the state to charge cost sharing beyond applicable Medicaid limits to TennCare Standard demonstration populations, with cost-sharing subject to a quarterly aggregate cap of 5 percent of family income for children.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS (STCs)**

**NUMBER:** **11-W-00151/4 (Title XIX)**

**TITLE:** **TennCare II**

**AWARDEE:** **Tennessee Department of Finance and Administration**

**DEMONSTRATION EXTENSION PERIOD:** **July 1, 2013 through June 30, 2016**

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**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS**

**NUMBER:** **Title XIX No. 11-W-00151/4**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for Tennessee's TennCare II Section 1115(f) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to this agreement are the Tennessee Department of Finance and Administration, Bureau of TennCare ("state") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the demonstration project. The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the approval letter's date, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This demonstration extension is approved through June 30, 2016.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits; CHOICES Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality for the Demonstration; Evaluation of the Demonstration; TennCare Eligibility Redetermination and Disenrollment and Rights; Appeals Process for Changes in Benefits; Enrollment in Standard Spend Down; and the Schedule of State Deliverables During the Demonstration Extension.

## II. PROGRAM DESCRIPTION AND OBJECTIVES

TennCare II is a continuation of the state's demonstration, funded through titles XIX and XXI of the Social Security Act (the Act). TennCare began as an 1115(a) demonstration project in January 1994. A 3-year extension was approved for 1999-2001, and a 1-year extension was approved early in 2002. A new TennCare II 1115(a) demonstration was approved by CMS on May 30, 2002, and initiated on July 1, 2002, for a 5-year period. On October 5, 2007, an extension was granted under Section 1115(a) through June 30, 2010, with revised waiver and expenditure authorities and STCs. (Note: Temporary extensions under the existing TennCare II STCs were granted for the July 1 through October 5, 2007 period, in order to provide additional time to conclude discussions on a longer extension.) The most recent extension, granted in December 2009 under the authority of Section 1115(e) of the Act, was in effect from July 1, 2010 through June 30, 2013. The current extension is granted under the authority of Section 1115(f) of the Act and is in effect from July 1, 2013 through June 30, 2016.

As of October 2012, the TennCare II program had 1.213 million enrollees, about half of whom were children. All mandatory and optional populations eligible under Tennessee's state plan are enrolled in TennCare II, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only").

There are three components to the TennCare II demonstration program. **TennCare Medicaid** is the component that serves enrollees who are Medicaid-eligible under Tennessee's title XIX state plan. **TennCare Standard** is the component that serves title XIX Medicaid enrollees who are eligible only through the demonstration's expenditure authorities**.** Title XXI Medicaid expansion children are also served under TennCare Standard, with a more extensive benefits package and a different service delivery system than the children served under the title XXI stand-alone Children's Health Insurance Program (CHIP). Both TennCare Medicaid and TennCare Standard deliver all Medicaid services, except for services specified at paragraphs 28 *(TennCare Benefits)* and 30 *(Medicaid Benefits Carved Out of TennCare II Demonstration)* as excluded from the TennCare benefits package for specified populations.

The **CHOICES** Program is the newest component. CHOICES utilizes the existing for-risk, Medicaid managed care organizations to provide eligible individuals with nursing facility services or home and community based services. With the implementation of the CHOICES program in 2010, home and community based services and nursing facility services were added to the existing TennCare II benefit package of primary, acute, and behavioral health services for qualifying state plan and demonstration eligible individuals. This provides participating individuals with an integrated package of acute and long-term services and supports, through a managed care delivery system.

The goals of TennCare are the following:

- Use a managed care approach to provide services to Medicaid state plan and demonstration enrollees at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.

- Assure appropriate access to care for enrollees.
- Provide quality care to enrollees.
- Assure enrollees' satisfaction with services.
- Improve health care for program enrollees.
- Assure that participating health plans maintain stability and viability, while meeting all contract and program requirements.
- Provide appropriate, and cost-effective home and community based services that will improve the quality of life for persons who qualify for nursing facility care, as well as for persons who do not qualify for nursing facility care but who are "at risk" of institutional placement and that will help to rebalance long-term services and supports expenditures.

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with Section 1115 of the Act. The state must

not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 *(Amendment Process)* below.

**7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following

a. An explanation of the public process used by the state, consistent with the requirements of paragraph 15 *(Public Notice and Consultation with Interested Parties)*, to reach a decision regarding the requested amendment;

b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

Changes to TennCare II benefits described in the state plan shall be made by state plan amendment. Changes to TennCare II benefits not described in the state plan shall be made by amendment to the demonstration. Changes in benefits shall be implemented in accordance with the process set forth in Section XIII of these STCs.

Additions or Changes to CHOICES Benefits. All requests for changes in coverage of CHOICES benefits are subject to CMS approval. Changes in benefits defined in Attachment D must be submitted to CMS for approval at least 60 days in advance of the state's desired implementation date. Requests for services that are not defined in Attachment D must be submitted by the state to CMS as a request to amend the demonstration.

The state must send a courtesy copy of all Medicaid state plan amendment requests to the Project Officer. This requirement is in addition to the submissions that the state must make as part of the usual state plan amendment process, and is not meant to substitute for or supplant that process in any way.

**8. Extension of the Demonstration.**

a. Should the state intend to request an extension of the demonstration, the state must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9 *(Demonstration Phase-Out).*

b. Compliance with Transparency Requirements 42 CFR § 431.412. Effective April 27, 2012, as part of demonstration extension requests the state must provide documentation of compliance with the transparency requirements of 42 CFR § 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15 *(Public Notice and Consultation with Interested Parties).*

**9. Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, only consistent with the following requirements:

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of the phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §§ 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §§ 431.220 and 431.221. If a demonstration participant requests a hearing

before the date of action, the state must maintain benefits as required in 42 CFR § 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010 State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

**10.** **Post Award Forum**. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this paragraph. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 45 *(Quarterly Progress Reports)* associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 46 *(Annual Report).*

**11.** **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

**12.** **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

**13.** **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

**14.** **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

**15.** **Public Notice and Consultation with Interested Parties.** The state must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6 *(Changes Subject to the Amendment Process)*, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR § 431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 CFR § 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR § 447.205 for changes in statewide methods and standards for setting payment rates.

**16.** **FFP.** No Federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

## IV. ELIGIBILITY

**17. Eligibility.** Tennessee includes in the TennCare II demonstration all of the mandatory and optional populations eligible under the Tennessee Medicaid state plan, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only"). Also included in TennCare II are several title XIX demonstration-only eligible populations and one title XXI Medicaid Expansion demonstration population. Medicaid state plan-eligible individuals are served in the component of the program called TennCare Medicaid. Other demonstration-only eligible populations are served in the component called TennCare Standard.

The mandatory and optional Medicaid state plan populations described below derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the demonstration to generate savings for covering the Expansion populations, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.

The title XXI Medicaid Expansion demonstration population is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as otherwise listed as not applicable.

Under the TennCare II demonstration, Tennessee is not required to extend eligibility for medical assistance prior to the date that an application for assistance is made; however, the state may provide retroactive coverage for up to 3 months for class members in *Daniels, et al. v. Tenn. Dept. of Health and Env't., et al.*, (1) who have been terminated from TennCare on or before March 31, 2010, for failure to respond to a Request for Information and Expiration Notice in accordance with the process approved in the Federal court order dated January 8, 2009; (2) who subsequently complete a Request for Information within 60 days of termination; and (3) who are determined to have been eligible at the time of termination. The state must notify the Project Officer by letter if it intends to extend retroactive eligibility to Daniels class members as described above.

Any changes to eligibility must be submitted to CMS as an amendment request, subject to the process set forth in paragraphs 6 (*Changes Subject to the Amendment Process)* and 7 *(Amendment Process)* of these STCs.

The criteria for TennCare eligibility groups are as follows (Table 1a).

**Table 1a**
**TennCare Eligibility Groups**

Note: This table does not change the state plan requirements.

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **Title XIX State Plan Mandatory Groups – TennCare Medicaid** | | |
| 1931 recipients including:<br>• Children younger than 18/19<br>• Caretaker relatives<br>• Pregnant women with no other eligible children (coverage for third trimester) | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Transitional Medical Assistance – Medicaid Extension for families who lose TANF benefits due to:<br>• income from employment or work hours or loss of "income disregard"<br>• increased child or spousal support collections | 6 initial months + 6 months continued coverage<br>4 months continued coverage *and expenditure authority for 8 additional months* | 1, 2, 5, 6, 8, 9, 10 |
| Individuals who are ineligible for AFDC benefits solely due to requirements that are prohibited under Medicaid, including AFDC time limits | Income up to and including 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Poverty level pregnant & postpartum women | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level newborns under age 1 | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 1-5 | Income up to and including 133% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 6-18 | Income up to and including 100% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Deemed categorically eligible newborns: born to & living with a woman who was eligible and received Medicaid on the date of the child's birth | Eligible for 1 year as long as mother is eligible or would be if pregnant | 1, 2, 5, 8, 10 |
| Pregnant woman who would otherwise lose eligibility because of an increase in income remains eligible through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Woman who was eligible while pregnant continues eligibility through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Title IV-E eligible children in adoption subsidy or foster care | AFDC income standard | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash recipients: aged, blind or disabled (may or may not be receiving CHOICES benefits) | | 1, 2, 4, 5, 6, 7, 8, 9, 10, |
| Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87 | | 1, 2, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| "DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash ineligible for reasons prohibited by Title XIX. | | 1, 2, 5, 6, 8, 9, 10 |
| "Pickle" SSA Beneficiaries who lost SSI cash benefits due to cost of living adjustment (COLA) increase in Title II OASDI benefits | | 1, 2, 5, 6, 8, 9, 10 |
| "DWB" Disabled widow/widower who lost SSI or state supplement due to early receipt of OASDI benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| **Title XIX State Plan Optional Groups – TennCare Medicaid** | | |
| Presumptively eligible pregnant & postpartum women | Income up to 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Children under 21 who meet AFDC income & resource criteria—children in state custody, foster care, subsidized adoptions, institutionalized | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Persons who would be eligible for AFDC or SSI cash assistance except for their institutional status | | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Special income level group: individuals who are in a medical institution at least 30 consecutive days with income that does not exceed 300% of SSI income standard under 1902(a)(10)(ii)(V) of the Act. | Income no more than 300% of SSI rate; resources $2000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Categorically needy individuals under the state plan who are receiving home and community based services in accordance with 42 CFR § 435.217. (This group consists solely of enrollees in the ID waivers.) | | 1, 2, 5, 6, 8, 9, 10 |
| Non-IV-E children with special medical needs who receive a state adoption subsidy payment | | 1, 2, 5, 6, 8, 9, 10 |
| Women under 65 who need treatment for breast or cervical cancer, and are not otherwise eligible for Medicaid. State utilizes presumptive eligibility for this population. | | 1, 2, 5, 6, 8, 9, 10 |
| Medically needy children under 21 *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| Medically needy pregnant or postpartum women *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |
| **Title XIX Demonstration Eligible Groups– Carryover** | | |
| **CHOICES 1 and 2 Carryover Group:** Individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **PACE Carryover Group:** Individuals who were enrolled in a PACE program as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | As required under the state plan. | |
| **Title XIX Demonstration Eligible Groups – TennCare Standard** | | |
| **Medically Eligible Children:** uninsured children under 19 who have been determined to be "medically eligible" (uninsurable) (category is currently closed to new enrollment except for Medicaid rollovers *[*as defined in paragraph 20, *Rollover Definition]* who are not otherwise eligible for TennCare. See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*. | Income 200% FPL or higher without limit; no resource test | 1, 2, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Standard Spend Down (SSD):** non-pregnant/postpartum adults 21 or older who have been determined to meet criteria patterned after the medically needy requirements *(enrollment target: 100,000)*<br>• aged, blind, or disabled<br>• caretaker relatives<br>CMS approved an amendment to add this expansion population in Nov. 2006.<br>(Expenditure authority for 12-month coverage based on 1-month budget period.)<br>See paragraph 21.a. *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*. | Medically needy spend-down level ($241 for 1, etc.); resources $2000 | 1, 2,, 3, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Title XIX Demonstration Eligible Groups – CHOICES** | | |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **CHOICES 217-Like HCBS Group:** Aged and / or disabled categorically needy adults who meet the CHOICES NF level of care requirement, are receiving home and community based services and who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236, and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915 (c) waiver. This group is subject to the enrollment target for CHOICES 2 in paragraph 32.d *(Enrollment Targets for TennCare CHOICES)*. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **At Risk Demonstration Group:** Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of the TennCare Interim Choices 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open to enrollment starting July 1, 2012, and closed to new enrollment on December 31, 2013. | Income no more than 300% SSI/FBR; resources $2,000 | 1,2,4,5,6,7,8,9,10 |
| **Title XXI Medicaid Expansion Demonstration Eligible Group – TennCare Standard** | | |
| Optional Targeted Low-Income Children: uninsured children under 19 who:<br>• have lost Medicaid eligibility under the approved Medicaid state plan and who do not have access to insurance or<br>• were uninsured and enrolled in this category in the original TennCare demonstration as of 12/31/01, even if they had access to insurance, and have been continuously enrolled in this category since 12/31/01<br>See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*.. | Income up to 200% FPL | 1, 2, 5, 6, 8, 9, 10, and cost sharing "not applicable" |

## 18. TennCare CHOICES Eligibility Groups.

As further set forth in paragraph 32 *(Operations of the TennCare CHOICES Program)*, eligibility for enrollment in TennCare CHOICES depends on (a) the individual's TennCare Eligibility Group, (b) the nursing facility (NF) (or "At Risk," as applicable) level-of-care (LOC) criteria as established by the state, and (c) the type of long-term services and supports (LTSS) to be provided.

There are three principal eligibility groups for TennCare CHOICES. CHOICES 1 is for individuals receiving NF services. CHOICES 2 is for individuals who meet the NF LOC that are receiving HCBS as an alternative to NF care. CHOICES 3 is for individuals who do not meet the NF LOC, but are at risk of NF placement and are receiving HCBS to delay or prevent NF placement.

Effective July 1, 2012, the state elected to change the level of care that is medically necessary for admission to a NF. CHOICES 3 serves SSI eligibles enrolled after the implementation of the LOC change who do not meet the new LOC standard but who are "at risk" of institutionalization. Individuals in CHOICES 1 and CHOICES 2 who continue to meet the standard in place at the time of the individual's enrollment will continue to qualify for those services.

Between July 1, 2012, and December 31, 2013, the state opened Interim CHOICES 3 to serve SSI eligibles and other adults who meet the LOC standard and financial eligibility requirements in place prior to the change, allowing the state to abide by the "Maintenance of Effort" (MOE) requirements as specified by the Affordable Care Act, Section 2001.

Table 1b summarizes the CHOICES Eligibility Groups and addresses how a change in LOC criteria is taken into account in determining eligibility for each group.

**Table 1b**
**TennCare + CHOICES Eligibility Groups**

Note: This table does not change the state plan requirements. CHOICES 1, CHOICES 2, CHOICES 3, and Interim CHOICES 3 are defined in paragraph 32 *(Operations of the TennCare CHOICES Program).* The CHOICES 1 and 2 Carryover Group and the PACE Carryover Group are defined in Table 1a of paragraph 17 *(Eligibility).* With respect to benefits, cost-sharing, and similar issues, persons in the CHOICES 1 Carryover Group are treated as though they were in CHOICES 1; persons in the CHOICES 2 Carryover Group are treated as though they were in CHOICES 2; and persons in the PACE Carryover Group are treated as though they were in PACE.

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 1 | • Nursing facility residents who meet the NF LOC in place at the time of enrollment* | Yes | Yes, CHOICES 1 and 2 Carryover Group |
| CHOICES 2 | • Meet NF LOC in place at the time of HCBS<br>• Receive HCBS as alternative to NF care<br>• Age 65+ or 21+ and disabled | Yes, SSI only | Yes, CHOICES 217-Like HCBS Group and CHOICES 1 and 2 Carryover Group |
| CHOICES 3 | • "At risk" for institutionalization (as defined in Attachment D)<br>• Age 65+ or age 21+ and disabled | Yes, SSI only | No |
| INTERIM | • Same as CHOICES 3, but not limited | Yes, SSI only | Yes, At Risk |

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 3 (open to enrollment starting July 1, 2012 and closed to new enrollment on December 31, 2013) | to SSI recipients<br>• Must meet nursing facility financial eligibility criteria | | Demonstration Group |

***** The state may grant an exception for persons in the community seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

**19. Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed.** The state has closed enrollment into the following demonstration categories, except for "rollovers" (as defined in paragraph 20, *Rollover Definition*). Therefore, children are only eligible for a non-state plan demonstration population as a "rollover." If children lose Medicaid state plan eligibility, they may qualify for one of these demonstration-only groups rather than for the stand-alone title XXI CHIP program.

- Title XIX Medically Eligible Children: Individuals who are under age 19, are uninsured, have income that is 200 percent of the FPL or higher without limit, are not otherwise eligible for TennCare, and meet the state-defined criteria of "medically eligible" as having medical conditions that make them uninsurable. (There is no income or resource limit for this group.)

- Title XXI Medicaid Expansion Children: Individuals under age 19 who are uninsured, have family income less than 200 percent of the FPL, and meet the definition of an optional targeted low-income child. (There is no resource limit for this group.)

Individuals under age 19 who lose eligibility for a Medicaid category may roll over into a TennCare Standard category if they meet the criteria for the category.

**20. Rollover Definition.** For the purpose of this demonstration, a "rollover" eligible is an individual who qualifies for continued coverage through a TennCare Standard demonstration category upon losing Medicaid eligibility under any category included in Tennessee's title XIX state plan.

**21. Adult Non-State Plan Demonstration Population Categories.**

a. **Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category.** The SSD eligibility category is open to non-pregnant/postpartum adults ages 21 or older who are Caretaker Relatives or Aged, Blind, or Disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the state plan. The

SSD demonstration eligibility group has an enrollment cap of 105,000, with a target enrollment of 100,000. The state shall establish eligibility and enroll individuals into the SSD group in accordance with the process set forth in Section XIII of these STCs.

b. **CHOICES 217-Like HCBS Group**. This group consists of persons aged 65 and older or persons aged 21+ and who are disabled who: (1) meet the CHOICES NF level of care requirement; (2) are receiving home and community-based services; and (3) would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal Regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915(c) waiver. Paragraph 18 *(TennCare CHOICES Eligibility Groups)* and paragraph 32.b. *(Eligibility for TennCare CHOICES Benefits)* describe how the NF LOC requirements shall be determined for individuals in this group. The state retains the discretion to apply an enrollment target as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES)*.

c. **At Risk Demonstration Group.** As of July 1, 2012, this group consists of elderly adults and adults age 21 and older with physical disabilities who (1) meet nursing facility financial eligibility; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization.

d. **CHOICES 1 and 2 Carryover Group.** This group consists of individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who no longer qualify for CHOICES enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in CHOICES 1 or CHOICES 2 if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, (2) meet all the eligibility requirements for a CHOICES program; and (3) remain continuously enrolled in CHOICES 1 and/or 2, as specified below:

i. Persons enrolled in CHOICES 1 can continue in CHOICES 1 or transition to CHOICES 2, and persons enrolled in CHOICES 2 can continue in CHOICES 2; and

ii. The state may grant an exception to i. for persons in CHOICES 2 seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

e. **PACE Carryover Group.** This group consists of individuals who were enrolled in PACE as of June 30, 2012, but who no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in PACE if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, and (2) meet all other eligibility requirements for PACE in the Medicaid state plan. PACE remains under the Medicaid state plan.

**22. Medically Needy Eligibility Period.** Financial eligibility for state plan medically needy pregnant women and children and for Standard Spend Down adults is based on a 1-month budget period described in the state plan. Those determined eligible remain eligible for up to 1 year from the effective date of eligibility.

**23. Quality Review of Eligibility**. At least annually, the state shall submit a plan for a Medicaid Eligibility Quality Control (MEQC) pilot project to the CMS Regional Office for approval. When each pilot is complete, the state shall send a report to the CMS Regional Office for approval, and shall submit a plan for the next pilot project. The MEQC pilots must be conducted in accordance with Federal law, regulations, and policy.

**24. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.**

a. Except as specified in paragraph 24.b. below, in determining eligibility for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in Section 1924 of the Act and 42 CFR § 435.725 of the Federal regulations.

b. For an individual in CHOICES 2 or CHOICES 3 who is admitted for short-term nursing facility care (as defined in Attachment D), in order to ensure that the individual can maintain a community residence for transition back to the community, the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. After 90 days, or as soon as it appears that the inpatient stay will not be short-term, whichever comes first, the person will be transitioned to CHOICES 1 and the institutional post-eligibility calculation shall apply.

**25. Eligibility/Post-Eligibility Treatment of Income and Resources for the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group.** For individuals receiving 1915(c) like services in CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, or the PACE Carryover Group, the state must use institutional eligibility and post-eligibility rules for individuals who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a Section 1915(c) waiver.

26. **Post-Eligibility and Patient Liability for the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group.** The state assures that, for individuals receiving 1915(c) like services, under the post-eligibility process, the state must have a method to carve out / identify the cost of the 1915(c) like services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of the 1915(c) like services.

27. **Non-Payment of Patient Liability.** A provider (including an MCO) may decline to continue to provide services to an individual who fails to pay his or her patient liability. If an enrollee who has failed to pay patient liability is unable to find another provider or MCO who is willing to provide LTSS, then the individual may be disenrolled from the CHOICES program. If the beneficiary's eligibility for TennCare is dependent on the receipt of long-term institutional care or HCBS through TennCare CHOICES, as would be the case if an enrollee is a member of the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group, such individual may be disenrolled from TennCare if he or she is no longer able to receive such services, unless he/she qualifies in another Medicaid category. The consequences for failing to pay patient liability must be clearly explained to members upon enrollment in CHOICES. Nothing herein shall prejudice any individual from fully exercising his or her rights to reapply for Medicaid coverage.

## V. BENEFITS

**28. TennCare Benefits.** With the implementation of the CHOICES program, TennCare covers physical, behavioral, and long-term care benefits provided through managed care delivery systems.

a. All mandatory and optional Medicaid state plan eligible adults aged 21 or older, are enrolled in TennCare Medicaid, and receive all services covered under Tennessee's state plan according to the limitations specified in the state plan, including the services identified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration)* as appropriate. Additional TennCare benefits are provided as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)*.

b. Members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group or the CHOICES 1 and 2 Carryover Group, all of which are demonstration-only groups, are enrolled in TennCare Standard, but receive all benefits described in a. above. In addition, individuals in the CHOICES 217-Like HCBS Group are members of CHOICES 2 and members of the At Risk Demonstration Group are members of Interim CHOICES 3.

c. Demonstration-only eligible adults who are members of the Standard Spend Down population (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*) are enrolled in TennCare Standard and receive all state plan services, plus additional TennCare benefits as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)* as appropriate, except that they do not have access to the services discussed in Table 2b or Table 3. Medicare Parts A and B premiums and Medicare co-payments and deductibles are covered in accordance with paragraphs 30.b. and c.

d. All mandatory and optional Medicaid state plan eligible children younger than 21 years old enrolled in TennCare Medicaid receive all state plan and EPSDT covered services.

e. The demonstration-only eligible children enrolled in TennCare Standard receive the same benefits as the state plan eligible children enrolled in TennCare Medicaid, except as specified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration)*.

f. The Medicaid state plan mandatory and optional eligibility categories for poverty level pregnant or postpartum women receive all TennCare Medicaid benefits, because the state considers that all of these services are pregnancy-related services.

g. The following table (Table 2a) lists benefits for TennCare Medicaid and TennCare Standard adults aged 21 and older that are different from those

identified in the state plan. All benefits are limited by medical necessity as defined by the state. "State Plan Coverage for Adults" is provided for informational purposes only, and does not supersede the approved Medicaid state plan. CMS will issue an updated version of Table 2a in the event that future SPAs cause the Medicaid state plan to be in conflict with what appears in Table 2a.

**Table 2a**
**TennCare Medicaid and TennCare Standard Benefits for Adults Aged 21 and Older That Are Different Than State Plan Covered Services and Limitations**

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Diagnostic services not included in other service categories | Covered as medically necessary. | Not covered. |
| Home health | Covered as medically necessary, and in accordance with the definitions and limitations included in Attachment B. | Coverage limited to 60 visits per enrollee per state fiscal year. |
| Hospice care | Covered as medically necessary. | Coverage limited to 210 days per enrollee per state fiscal year. |
| Inpatient and outpatient substance abuse services | Covered as medically necessary | Not covered. |
| Inpatient hospital services | Covered as medically necessary. | Coverage limited to 43 days for heart transplants, 67 days for liver transplants, and 40 days for bone marrow transplants, per enrollee, per state fiscal year. |
| Lab and X-ray services | Covered as medically necessary. | Coverage limited to 30 occasions per enrollee per state fiscal year. |
| Medicare premiums and cost-sharing | Covered for state plan eligibles, SSD enrollees, members of the CHOICES 217-Like HCBS Group, and members of the At Risk Demonstration Group, in accordance with paragraphs 30.b. and c. | Covered for Medicare beneficiaries who are dually eligible for Medicaid according to their classification under the state plan (QMB, SLMB, Other Medicaid/Medicare Duals, etc.) |
| Mental health case management services | Covered as medically necessary. | Coverage limited to Targeted Case Management for persons who are Severely and/or Persistently Mentally Ill. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Occupational therapy | Covered as medically necessary. | Not covered. |
| Organ and tissue transplants | Covered as medically necessary, except that experimental or investigational transplants are not covered. | Coverage limited to renal, heart, liver, corneal, and bone marrow transplants. |
| Outpatient hospital services | Covered as medically necessary. | Coverage limited to 30 visits per enrollee per fiscal year. |
| Outpatient rehabilitation services | Covered as medically necessary. | Coverage limited to mental health services provided by Community Mental Health Agencies. |
| Pharmacy services | • Not covered for dually eligible adults.<br>• Covered for non-dual state plan eligibles in accordance with the state plan.<br>• Covered for non-dual SSD eligibles and non-dual At Risk Demonstration Group members, with the co-payments specified in Table 6 of paragraph 34.b. *(Co-Pays on Pharmacy).*<br>• Covered for non-dual CHOICES 217-Like HCBS Group enrollees, CHOICES 1 and 2 Carryover Group enrollees, and PACE Carryover enrollees in accordance with the state plan for Medicaid enrollees. | Coverage as specified in state plan. |
| Physical therapy services | Covered as medically necessary. | Not covered. |
| Physicians' services (including medical and surgical services furnished by a dentist) | Outpatient services: Covered as medically necessary.<br><br>Inpatient services: Covered as medically necessary. | Outpatient services: Coverage limited to 24 outpatient office visits per year, which includes 2 office visits for podiatrists and 4 office visits for optometrists.<br><br>Inpatient services: Coverage limited to 20 visits per enrollee per state fiscal year for services other than heart, liver, and bone marrow transplants, which are limited to 43, 67, and 40 days, respectively. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Preventive services | Covered as medically necessary. | Not covered. |
| Private duty nursing services | Covered when medically necessary to support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Definitions and limitations applicable to this service are contained in Attachment C. | Not covered. |
| Psychiatric residential treatment services (outside of an IMD) | Covered as medically necessary. | Not covered. |
| Screening services | Covered as medically necessary. | Not covered. |
| Speech, hearing, and language services | Covered as medically necessary. | Not covered. |
| Vision services | Covered for the first pair of cataract glasses following cataract surgery. | Not covered. |

h. The following table (Table 2b) lists HCBS benefits for TennCare Medicaid enrollees and CHOICES demonstration eligibles who are enrolled in the designated CHOICES groups (specified in paragraph 32.a., *Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition, the following rules apply to the CHOICES benefit.

i. The cost of medical assistance provided to an eligible participant in CHOICES 2 is limited to the amount calculated in the individual cost-neutrality test used in Section 1915(c) waivers as set forth in Section 1915(c)(4)(A). The state may delegate implementation of the cost neutrality test to the MCOs.

ii. For purposes of determining capitation rates, the cost of room and board, as defined in Attachment D, is not included in non-institutional care costs.

iii. For persons in CHOICES 3 or Interim CHOICES 3, in addition to the service limits stated in Table 2b, the total cost of the HCBS identified in

Table 2b shall not exceed $15,000 per calendar year, excluding the cost of minor home modifications.

iv. Definitions for CHOICES benefits are provided in Attachment D of these STCs.

**Table 2b**
**Benefits for Persons Enrolled in the CHOICES Program**

| **Benefit** (Definitions provided in Attachment D) | **CHOICES 1** | **CHOICES 2** | **CHOICES 3*** |
|---|---|---|---|
| Nursing facility care | X | Short-term only | Short-term only |
| Community-based residential alternatives | | X | |
| Personal care visits (up to 2 visits per day) | | X | X |
| Attendant care (up to 1080 hours per calendar year); up to 1400 hours per calendar year ONLY when Homemaker services are needed in addition to hands-on care | | X | X |
| Home-delivered meals (up to 1 meal per day) | | X | X |
| Personal Emergency Response Systems | | X | X |
| Adult day care (up to 2080 hours per calendar year) | | X | X |
| In-home respite care (up to 216 hours per calendar year) | | X | X |
| In-patient respite care (up to 9 days per calendar year) | | X | X |
| Assistive technology (up to $900 per calendar year) | | X | X |
| Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) | | X | X |
| Pest control (up to 9 units per calendar year) | | X | X |

*Subject to the limitations in 28.h.iii.

**29. Cost-Effective Alternatives.** TennCare MCOs and TennCare Select may provide services not listed in, or exceeding the individual service limits in, the Medicaid state plan or paragraph 28 (*TennCare Benefits*) of these STCs as allowed under their contracts with the TennCare program. Provision of these services is at the sole discretion of the MCO and TennCare Select. Capitation for the MCOs must be certified as actuarially sound (in accord with 42 CFR § 438.6), and comply with the Federal managed care regulations at 42 CFR §§ 438 et seq. TennCare Select must demonstrate to the state that a service not listed as covered in the Medicaid state plan or in paragraph 28 (TennCare Benefits) is a cost-effective alternative, in order for the state to reimburse TennCare Select for the service. The state must demonstrate to CMS annually as part of the annual report described in paragraph 46 (*Annual Report*) that utilization of these services by the MCOs and TennCare Select is cost-effective and is reimbursed in compliance with the Federal managed care regulations at 42 CFR §§ 438 et seq. Under the CHOICES program, cost-effective alternatives may include a Transition Allowance, as defined in Attachment D.

**30. Medicaid Benefits Carved Out of the TennCare II Demonstration.**

a. **"Base" Medicaid State plan services.** Base services are services carved out of TennCare II, and are provided, in accordance with the provisions of the Medicaid state plan, only to the mandatory and optional state plan eligibles and members of the PACE Carryover Group (in the case of PACE services only). The other TennCare II demonstration-only populations, which are eligible through the demonstration's expenditure authorities and enrolled in TennCare Standard, are not eligible for any of the services listed in Table 3. Expenditures for these "Base" services are not demonstration expenditures (see paragraph 51.a., *Tracking Expenditures*), are not included in the demonstration's budget neutrality, and should, therefore, be reported on the "Base" reporting schedules of the Form CMS-64 reports (or in the case of 1915(c) waiver services, the appropriate 1915(c) waiver schedule). Some carved out services were carved in as of the initial implementation of CHOICES (i.e., March 1, 2010), however, as indicated in Table 3, and must from that point forward be reported as TennCare II demonstration expenditures.

**Table 3**
**Base Services**

| **Services Carved Out of TennCare II** | |
|---|---|
| Nursing facility services | Services moved from the base to the demonstration as of March 1, 2010 (in Middle Tennessee) and August 1, 2010 (in East and West Tennessee) |
| Services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) | Base |
| State Plan targeted case management services | Base |
| Program of All Inclusive Care for the Elderly (PACE) | Base |
| Services covered by the home and community-based services waiver for individuals with intellectual disabilities under 1915(c) of the Social Security Act. | Base |
| Services covered through the state's agreement under Title V of the Social Security Act | Base |

b. **Medicare Parts A and B Buy-In Premiums.** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the Standard Spend Down group, the CHOICES 1 and 2 Carryover Group

and the PACE Carryover Group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare Buy-In premiums are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles as permitted in Section 1902(a)(10)(E) of the Act and 42 CFR § 431.625,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals),

(C) Dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the Standard Spend Down group (QMBs/SLMBs and Demo Duals), and

(E) Dually eligible members of the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group (QMBs, SLMBs, and Demo Duals).

ii. Medicare premiums paid on behalf of Demo Duals are demonstration expenditures, and must be reported on an appropriate Form CMS-64.9 or 9p Waiver, as described in paragraph 51.e. *(Use of Forms).*

iii. Medicare premium payments for other beneficiaries are excluded from TennCare II and must be reported as "Base" Medicaid expenditures on the CMS-64 reports.

iv. Records in CMS's Master Billing Record for Demo Duals and all buy-in transactions for Demo Duals must be identified using a specific Buy-In Eligibility Code (BIEC) value as agreed upon between the state and the Project Officer.

c. **Medicare Co-payments and Deductibles (i.e., Medicare crossover claims).** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, At Risk Demonstration Group, CHOICES 1 and 2 Carryover Group, the PACE Carryover Group or the Standard Spend Down group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare crossover claims are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs, and Demo Duals),

(C) Dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the CHOICES 1 and 2 Carryover Group and PACE Carryover Group, and

(E) Standard Spend Down enrollees (QMBs/SLMBs and Demo Duals).

The SSD population, the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group are the only demonstration populations for whom the state pays Medicare cost-sharing.

ii. For TennCare Medicaid enrollees, members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals), members of the At Risk Demonstration Group (QMBs, SLMBs, and Demo Duals), members of the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group (QMBs/SLMBs and Demo Duals), these expenditures are not demonstration expenditures and are not included in the budget neutrality calculations, so report these as "Base" Medicaid expenditures on the CMS-64 reports.

iii. For dually eligible SSD enrollees (QMBs/SLMBs and Demo Duals), these expenditures are included as demonstration expenditures that are subject to budget neutrality, so report these demonstration expenditures as "EG6E Expan Adult" on the CMS-64 reports. Medicare cost-sharing for SSD dual eligibles is covered in the same manner as Medicare cost-sharing would be covered for Medically Needy aged, blind, or disabled individuals and caretaker relatives, had these groups been included in the Medicaid state plan.

**31. Additional Provisions Related to Institutions for Mental Diseases (IMDs).** Expenditures for services rendered to TennCare II enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.

## VI. CHOICES ENROLLMENT

### 32. Operations of the TennCare CHOICES Program.

a. **Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group.** The CHOICES Program provides long-term services and supports (LTSS) as identified in Table 2b to four groups of people, as defined below:

i. **CHOICES 1.** This group consists of persons who are receiving Medicaid-reimbursed care in a nursing facility (NF).

ii. **CHOICES 2.** Persons age 65 and older and adults age 21 and older with physical disabilities who meet the NF level of care (LOC), who qualify either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to NF care. The demonstration population includes persons who could have been eligible under 42 CFR § 435.217 had the state continued its 1915(c) HCBS waiver for persons who are elderly and/or physically disabled.

iii. **CHOICES 3.** Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles, who do not meet the NF LOC, but who, in the absence of HCBS, are "at risk" for institutionalization, as defined by the state.

iv. **Interim CHOICES 3.** Elderly adults and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of the At Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. This group will close to new enrollment on December 31, 2013.

b. **Eligibility for TennCare CHOICES Benefits.** Individuals can be eligible for one of the four TennCare CHOICES groups defined in a. above depending upon their medical and / or functional needs, their TennCare eligibility group, and the ability of the state to provide them with safe, appropriate, and cost-effective LTSS.

i. Medical and / or functional needs are assessed according to LOC criteria published by the state in state rules.

(A) There will be one set of LOC criteria for NF care, which will be used in assessing eligibility for CHOICES 1 and CHOICES 2.

(B) On July 1, 2012, the state opened enrollment in CHOICES 3, which is subject to a separate set of criteria to determine the "At-Risk" population.

(C) For the purposes of redetermining whether a recipient of NF services (CHOICES 1) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial LOC determination for that individual at the time of enrollment into CHOICES 1.

(D) For the purposes of determining whether a recipient of HCBS for elderly and disabled (CHOICES 2) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial level of care determination for that individual at the time of HCBS enrollment, or for persons transitioning from a NF, at the time of enrollment into CHOICES 1.

(E) For purposes of enrollment into CHOICES 1, the state may grant an exception for persons in the community who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely be met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of initial enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

ii. Financial eligibility:

(A) Financial eligibility for CHOICES 1 is established according to the Medicaid state plan.

(B) In order to be financially eligible for CHOICES 2, an individual must be eligible for TennCare as an SSI recipient or meet the criteria for the CHOICES 217-Like HCBS Group, individuals who qualify under institutional income and resource rules, and who are receiving home and community-based services and would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.726, and 435.236 of the Federal regulations and Section 1924 of the Act, if the home and community based services were provided under a 1915(c) waiver.

(C) In order to be financially eligible for CHOICES 3, an individual must be eligible for TennCare as an SSI recipient.

(D) In order to be financially eligible for Interim CHOICES 3, an individual must be eligible for TennCare as an SSI recipient or as a member of the At Risk Demonstration Group. Members of the At Risk Demonstration Group must meet institutional income and resource criteria.

iii. The state's ability to provide applicants with appropriate home and community based services is determined by the availability of slots under an established enrollment target (see paragraph 32.d., *Enrollment Targets for TennCare CHOICES*) and, for persons in CHOICES 2, the determination by the MCO that the individual can be served appropriately at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i), and for persons in CHOICES 3 and Interim CHOICES 3, the determination by the MCO that the cost of HCBS will not exceed the limit in paragraph 28.h.iii. There is no enrollment target for Interim CHOICES 3.

c. **Enrollment in TennCare CHOICES.** The effective date of enrollment in TennCare CHOICES must be established by the state based on a determination that an applicant is eligible for and must begin receiving LTSS. Enrollment procedures differ depending upon whether or not the person is already enrolled in TennCare Medicaid.

i. **Persons Not Already Enrolled in TennCare.** Persons not already enrolled in TennCare who wish to enroll in TennCare CHOICES must enroll through the State's Single Point of Entry (SPOE). The SPOE must provide counseling and assistance in evaluating LTSS options, screening and intake for LTSS programs offered by the state (TennCare CHOICES as well as other programs), assistance in evaluating the individual's functional LOC for LTSS, and facilitation of Medicaid eligibility determination by the state.

(A) Individuals who are determined to be both medically and financially eligible for NF placement will always be allowed to receive TennCare CHOICES services in a NF as members of CHOICES 1, if they choose.

(B) Those individuals who meet the criteria for CHOICES 2 subject to the limitations set out in these STCs, will be allowed to choose HCBS as an alternative to NF placement if the determination is made that the individual can be served appropriately in CHOICES 2 at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i).

ii. **Persons Already Enrolled in TennCare.**

(A) **Nursing Facility Residents.** MCOs will conduct an assessment of NF residents who wish to move to HCBS to determine if they can be served appropriately in the community at a cost that does not exceed the cost neutrality test set forth in Section 1915(c)(4)(A), as individually applied. Even if an enrollment target has been reached for CHOICES 2, an MCO may transition persons from

CHOICES 1 to CHOICES 2 in accord with subparagraph 32.d.iii.(C) *(Transition from CHOICES 1 to CHOICES 2)*.

(B) TennCare enrollees who are not already participating in CHOICES may request enrollment in CHOICES through their MCOs, or they may be identified through other mechanisms that would trigger an assessment of their need for LTSS by the MCO. The MCO will provide counseling and assistance in evaluating LTSS options, and assistance in evaluating the individual's functional LOC eligibility for LTSS. The functional LOC determination for LTSS will be made by the Bureau of TennCare, using criteria published in state rules. Once individuals have established LOC and financial eligibility for LTSS, they can be enrolled in CHOICES in accordance with paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*).

d. **Enrollment Targets for TennCare CHOICES.** The state may establish enrollment targets for CHOICES 2 and CHOICES 3. (There will be no enrollment target for CHOICES 1 or Interim CHOICES 3.) The purpose of the targets is to permit the CHOICES program to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available state and Federal resources. Information on CHOICES Groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Progress Report as set forth in paragraphs 45 *(Quarterly Progress Reports)*, 49 *(Enrollment Reporting)* and Attachment A.

i. The state may establish an enrollment target for CHOICES 2, consistent with the upper and lower limits shown in the table below; with the actual target number to be published in state rules. The state may adjust the target as appropriate from time to time upon notification to CMS at least 30 days prior to the desired effective date of the change. Except as set forth in paragraph 32.d.iii., an increase in the enrollment target above the upper limit appropriate to the DY or a decrease below the lower limit will require an approved waiver amendment prior to implementation.

**Table 4**
**Enrollment Targets for Demonstration Years 12 Through 14**

| Demonstration Year | Lower Limit | Upper Limit |
|---|---|---|
| DY 12 | 12,000 | 16,000 |
| DY 13 | 13,500 | 17,500 |
| DY 14 | 15,000 | 18,500 |

ii. The state may also establish an enrollment target for CHOICES 3, if this group is established after a change in the level of care criteria. At a

minimum, this target will be set at 10% of the enrollment target for CHOICES 2. There will be no enrollment target for Interim CHOICES 3.

iii. If the enrollment target established by the state for CHOICES 2 or CHOICES 3 is reached or exceeded, the state shall not enroll additional persons in CHOICES 2 or CHOICES 3, except as indicated below. The state may also establish a waiting list for CHOICES, subject to the following:

(A) **Reserve Capacity.** The state may reserve slots in CHOICES 2 for individuals being discharged from a NF and for individuals being discharged from an acute care setting who are in imminent risk of being placed in a nursing facility setting absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved must be included as an attachment to the Annual Report (see paragraph 46). The state may establish additional criteria or modify procedures for allocating reserve slots upon 30 day advance written notification to CMS; the operational procedure documents included as attachments to subsequent Annual Reports must reflect any such changes. In each Quarterly Progress Report, the state must provide an accounting of their management of the reserve capacity, including a summary (as of the last day of the quarter) that states the total enrollment targets for CHOICES 2 and 3, the number enrolled in each CHOICES group, and the numbers of slots being held in reserve for various purposes.

(B) **HCBS as a Cost-Effective Alternative.** An MCO with a TennCare enrollee who meets the criteria for CHOICES 2, but which cannot enroll the individual in CHOICES 2 because the enrollment target for CHOICES 2 has been met, has the option, at its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care, in accordance with paragraph 29 *(Cost-Effective Alternatives).* (Consistent with paragraph 32.d.iii.(C), this person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.) The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. The state may require the MCO to provide documentation of its cost-effective alternative determination and assurance of provider capacity to meet the member's needs prior to enrollment in CHOICES.

(C) **Transition from CHOICES 1 to CHOICES 2.** An enrollee being served in CHOICES 1 who meets the requirements to enroll

in CHOICES 2 can enroll in CHOICES 2 at any time such a transition can be accomplished, even if an enrollment target for CHOICES 2 has been reached. This person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.

e. **Waiting Lists for TennCare CHOICES.** The use of enrollment targets as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*) may mean that there will be waiting lists for CHOICES 2 and/or 3. (There will be no enrollment target or waiting list for CHOICES 1 or the Interim CHOICES 3 Group.) These lists must be managed on a statewide basis using a standardized assessment tool and in accord with criteria to be established by the state. Waiting list policies must be based on objective criteria and applied consistently in all geographic areas served. The state may use separate criteria for prioritization of services under CHOICES 2 and CHOICES 3, and may revise these upon notification to CMS.

f. **Consumer Direction.** CHOICES members who have been determined by a care coordinator, as a part of the needs assessment and plan of care processes, to require attendant care, personal care, in-home respite services, companion care or other services specified by the state as eligible for consumer direction, will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e., consumer direction of HCBS). The state will notify CMS in advance of any changes to the list of services eligible for consumer direction. All CHOICES members requiring these services will be offered the option to participate in consumer direction of HCBS. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E.

g. **Miscellaneous Provisions Related to CHOICES Enrollment and Implementation**

i. The state will maintain an electronic visit verification system (as defined in Attachment D) as part of the CHOICES quality program.

ii. The state must ensure that the Care Plan is considered part of the medical record of a CHOICES participant, subject to all associated requirements and protections, and available for review by the state upon request.

## VII. COST SHARING

### 33. Cost Sharing.

a. TennCare Medicaid enrollees under the state plan are subject to cost sharing for pharmacy services (see Table 6 below).

b. Demonstration-only eligible adults enrolled in the SSD category or the At Risk Demonstration Group are subject to cost sharing for pharmacy services (see Table 6 below).

c. TennCare Standard children are subject to cost sharing for both non-pharmacy services and pharmacy services (see Table 5 and Table 6).

d. Individuals participating in CHOICES 1 or CHOICES 2 are exempt from all cost sharing.

e. Individuals participating in CHOICES 3 or Interim CHOICES 3 are subject to cost sharing for pharmacy services (see Table 6 below), similar to other Medicaid state plan adult enrollees.

**34. Co-Payments.** For demonstration-only eligible children in TennCare Standard (title XXI Medicaid Expansion children and medically eligible title XIX children), co-payments are collected by the provider when services are rendered. The requirements at Section 1916A of the Act and at 42 CFR §§ 447.50, 57, 58, and 62 through 82 will apply to cost sharing for this group.

a. **Non-Pharmacy Co-pays.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), the non-pharmacy co-pay amounts are presented in Table 5 (*TennCare Non-Pharmacy Co-Pays).*

**Table 5**
**TennCare Non-Pharmacy Co-pays**

| Poverty Level | Co-payment Amounts |
|---|---|
| 0%-99% | $0.00 |

| Poverty Level | Co-payment Amounts |
|---|---|
| 100% - 199% | $10.00 Non-emergency Hospital Emergency Room (waived if admitted)<br><br>$5.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$5.00 Physician Specialists (including Psychiatrists and Dentists)<br><br>$5.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |
| 200% and above | $50.00 Non-emergency Hospital Emergency Room (waived if admitted)<br><br>$15.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$20.00 Physician Specialists (including Psychiatrists and Dentists)<br><br>$100.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |

b. **Co-Pays on Pharmacy.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), and adults in the Standard Spend Down Demonstration Group, and persons in the At Risk Demonstration Group, co-pays on outpatient pharmacy services are presented in Table 6 (*Co-Pays on Pharmacy)*.

**Table 6**
**Co-Pays on Pharmacy**

| Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| TennCare Medicaid adults who are not exempt from cost-sharing under 42 CFR § 447.53 | $3.00 | $1.50 |
| TennCare Standard under age 21 with incomes below 100% FPL | $0 | $0 |
| TennCare Standard under age 21 with incomes at or above 100% FPL | $3.00 | $1.50 |
| TennCare Standard aged 21 and older -- SSD | $3.00 | $1.50 |

| Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| enrollees | | |
| CHOICES 1 and CHOICES 2 | $0 | $0 |
| Interim CHOICES 3 | $3.00 | $1.50 |
| CHOICES 3 | $3.00 | $1.50 |

**35. Compliance of TennCare Standard Cost Sharing With Federal Regulations.** The state submitted a plan for ensuring that cost sharing for TennCare Standard complies with the statutory and regulatory requirements, including the implementation of an aggregate cost sharing cap as described in 42 CFR § 447.78. The state implemented its plan on January 1, 2013.

## VIII. DELIVERY SYSTEMS

**36. Managed Care Entities.** TennCare II operates totally in a managed care environment and uses various types of managed care entities for delivering covered services to TennCare enrollees. The types of managed care entities used are listed in Table 7 below, with the reimbursement and rate-setting methodologies for each one. Title XXI Medicaid Expansion demonstration population children use the same delivery systems as other enrollees.

**Table 7– Types of Managed Care Entities**

| Type of Entity | BBA Definition | Description of Services Covered | Reimbursement and Rate-Setting Methodology |
|---|---|---|---|
| Managed Care Organizations (MCOs)—at full risk | MCO | All TennCare physical health, behavioral health, and LTSS* | MCO rates are actuarially certified by an independent third party actuary |
| TennCare Select—non-risk or partial risk | Prepaid Inpatient Health Plan (PIHP) | All TennCare physical health, behavioral health, and LTSS* for enrollees selected for participation in TennCare Select rather than enrolled in MCOs (see paragraph 38, *TennCare Select*) | Provider payment rates are negotiated between the PIHP and providers; an administrative fee is approved by CMS and paid to the PIHP |
| Dental Benefits Manager (DBM)—non-risk (may be renegotiated as at risk) | Prepaid Ambulatory Health Plan (PAHP) | Dental benefits for all TennCare enrollees with this coverage | Provider payment rates are established within DBM contract as approved by CMS; an administrative fee, approved by CMS, is paid to the DBM |
| Pharmacy Benefits Manager (PBM)—non-risk (may be renegotiated as at risk) | PAHP | Pharmacy benefits for all TennCare enrollees with this coverage. | Provider payment rates are established in accordance with the state plan; an administrative fee, approved by CMS, is paid to the PBM |

***LTSS refers to services for persons who are elderly or who have physical disabilities.

**37. Enrollment in Managed Care Organizations (MCOs).** With the exception of individuals enrolled in TennCare Select, all individuals eligible for TennCare (TennCare Medicaid or TennCare Standard), including those dually eligible for Medicare, shall be enrolled in a managed care organization providing the benefits described in paragraphs 28 *(TennCare Benefits)* and 29 *(Cost-Effective Alternatives)* of these STCs. In addition to the managed care organization, enrollees are enrolled with a Pharmacy Benefits Manager for covered pharmacy services and a Dental Benefits Manager for covered dental services. The Pharmacy Benefits Manager administers the pharmacy benefits program, using a preferred drug list that is established by the state (in consultation with a Pharmacy

Advisory Committee), taking into account the cost, therapeutic equivalency, and clinical efficacy in accordance with waiver authority.

**38. TennCare Select.** TennCare Select is a prepaid inpatient health plan (PIHP) (as defined in 42 CFR § 438.2) which operates in all areas of the state and covers the same services as the MCOs. The state's TennCare Select contractor is reimbursed on a non-risk, non-capitated basis or a partial risk basis for services rendered to covered populations, and in addition receives fees from the state to offset administrative costs.

a. The TennCare Medicaid and TennCare Standard populations included in the TennCare Select delivery system and the services provided to these populations by the TennCare Select contractor are as follows:

i. Children who are eligible for Supplemental Security Income. TennCare Select provides medical case management and all MCO covered services.

ii. Children in state custody and children leaving state custody for 6 months post-custody as long as the child remains eligible. TennCare Select provides medical case management, all MCO covered services, and coordination with the Department of Children's Services (DCS) around medical and behavioral services.

iii. Children who are receiving care in a nursing facility or an intermediate care facility for individuals with intellectual disabilities. For children and adults in a Home and Community Based Services 1915(c) waiver for individuals with intellectual disabilities, current enrollees may opt-in to receive services through TennCare Select, and new participants may opt-out of TennCare Select in order to receive services through another MCO. TennCare Select provides medical case management and all MCO covered services.

iv . Enrollees living in areas where there is insufficient capacity to serve them. TennCare Select provides medical case management and all MCO covered services.

After being assigned to TennCare Select, persons in categories i. and iii. above may choose to disenroll from TennCare Select and enroll in an MCO if one is available. Persons in categories ii. and iv. must remain in TennCare Select. The state must request a demonstration amendment (as described in paragraphs 6 and 7 regarding amendments) in order to change the list of populations included in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

b. TennCare Select also provides the following functions:

i. It is the back-up plan should one of the MCOs have to leave the TennCare program unexpectedly. For TennCare enrollees previously enrolled with

the MCO, TennCare Select provides medical case management and all MCO covered services.

ii. It is the only entity responsible for payment of the services described in 42 CFR § 431.52 (regarding services provided to residents temporarily absent from the state), and provides all MCO covered services (primarily emergency services).

iii. It is also the only entity responsible for payment of the services described in 42 CFR § 440.255 (regarding emergency services for aliens), and is responsible for payment of emergency medical services only. TennCare Select is paid an administrative fee for processing these claims.

**39. Plan Enrollment and Disenrollment.** The state maintains a managed care enrollment and disenrollment process that must comply with 42 CFR Part 438, except that, in accordance with waiver authority, TennCare participants have 45 days in which to disenroll from an MCO without cause. After 45 days, a participant may disenroll from an MCO only for cause, as set forth in 42 CFR § 438.56(d)(2). The "other reasons" that will be considered cause under 42 CFR § 438.56(d)(2)(iv) do not include the following:

- The enrollee is unhappy with the current plan or primary care provider (PCP), but there is no hardship medical situation (as defined by the state);
- The enrollee claims lack of access to services but the plan meets the state's access standards;
- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- The enrollee is concerned that a current provider might drop out of the plan in the future;
- The enrollee is a Medicare recipient who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation; and
- The enrollee's Primary Care Provider (PCP) is no longer in the MCO's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO.

In the event that a CHOICES member is determined, based on an assessment of needs, to require long term services and supports that are not currently available under the MCO in which he is currently enrolled, but that are available through another MCO, the state shall work with the current MCO to arrange for the provision of the required services, which may involve providing such services out-of-network. It shall be considered to be cause for disenrollment only if the current MCO, after working with the state, is unable to provide the required services. In such cases, the MCO that is unable to provide the required services after working with the state may be subject to sanctions.

**40. Contracts.** The following subparagraphs provide additional requirements pertaining to contracts awarded by the state for the provision of health care services under TennCare II.

a. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation.

b. Payments under contracts with public agencies that are not competitively bid in a process involving multiple bidders shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

c. With respect to CHOICES, the state established minimum guidelines regarding the person-centered service plan, the processes for the development of the plan, and the monitoring of its implementation. These expectations were submitted to CMS and are reflected in the MCO contract. Any changes in the contract requirements related to the subjects enumerated below will be submitted to CMS for review prior to executing a contract amendment with an MCO. CMS will respond within 15 working days of receipt of the draft. The required subject areas are as follows:

   i. The individuals who develop the person-centered service plan (and their requisite qualifications);

   ii. The individuals who are expected to participate in the plan development process;

   iii. Timing of the plan, how and when it is updated, including mechanisms to address changing circumstances and needs (and expectations regarding scheduling and location of meetings to accommodate individuals receiving services);

   iv. Types of assessments that are conducted as a part of the service plan development process;

   v. How participants are informed of the services available to them;

   vi. How the process ensures that the service plan addresses the participants' desired outcomes, needs and preferences; and

   vii. The plans' responsibilities for implementing and monitoring the plan of care.

d. The state will require the MCOs to develop and maintain emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. These contingency plans will be available for inspection by state officials upon request.

e. The state will monitor loss ratios of the managed care plans.

## IX. GENERAL REPORTING REQUIREMENTS

**41. General Financial Requirements.** The state shall comply with all general financial requirements under title XIX and title XXI set forth in these STCs.

**42. Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request.

**43. Additional Reporting Requirements.**

a. **Compliance with Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR §§ 438 *et seq.*

b. **Compliance with Specified HCBS Requirements.** The following regulations, which govern the provision of HCBS under Section 1915(c) waivers, shall apply to the HCBS program authorized under Section 1115 and provided through CHOICES:

- 42 CFR § 440.180(a);
- 42 CFR § 441.302;
  (a),
  (c) (insofar as it relates to NF level of care, and applying only to CHOICES 2),
  (d) (consistent with a waiver of Section 1902(a)(23) of the Act),
  (g) (applies only to CHOICES 2), and
  (j);
- 42 CFR § 441.303
  (a),
  (c) (except that the requirements following the semi-colon in (c)(2) do not apply to CHOICES 3 or Interim CHOICES 3),
  (d) (consistent with Table 2b, paragraph 28), and
  (e); and
- 42 CFR § 441.310.

Any conflict between the regulations listed in this subparagraph and these STCs shall be resolved in favor of the STCs. The state shall include a description of the steps taken to ensure compliance with these regulations as part of the Annual Report discussed in paragraph 46 *(Annual Report)*.

c. **Quality Improvement Strategy for the CHOICES Program.** The state must submit to CMS an integrated quality improvement (QI) strategy which builds on existing managed care quality requirements as defined in 42 CFR § 438, Subpart E, and incorporates applicable 1915(c) Home and Community-Based Services

waiver regulatory assurances as discussed in paragraph 43.b.

The state must identify: 1) measures of process, health outcomes, functional status, quality of life, member choice, autonomy, satisfaction, and TennCare and CHOICES system performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

The MCOs must be required to establish methods for discovery, remediation and systems improvement and, per state prescribed timeframes, regularly report on outcomes associated with continuous quality improvements.

The state must clearly demonstrate its oversight of the process.

The QI strategy must be submitted to CMS for approval prior to implementation.

No less frequently than annually, the state must provide to CMS information regarding QI activities which must include evidence regarding system performance based on identified objectives and measures, and which demonstrates efficacy in implementing the quality strategy, including but not limited to external quality review, discovery, remediation and systems improvement activities.

d. **CHOICES Data.**

i. **CHOICES Data Plan.** The state will collect and submit data to CMS, including the following data elements:

(A) Numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services at a point in time,

(B) Unduplicated numbers of persons receiving HCBS and unduplicated numbers of persons receiving NF services during a 12 month period,

(C) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period,

(D) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period as a percentage of total long-term services and supports expenditures (excluding expenditures on the population of persons with intellectual disabilities),

(E) Average per person HCBS expenditures and NF expenditures on the elderly and disabled populations during a 12 month period,

(F) Average length of stay in HCBS during a 12 month period,

(G) Percent of new LTSS recipients admitted to NFs during a 12 month period,

(H) Average length of stay in NFs during a 12 month period,

(I) Number of persons transitioned from NFs to HCBS during a 12 month period.

"Point in time" refers to June 30 of each year.

ii. **Electronic Collection of Choices Data.** The systems must be in place to record the requisite data elements for the CHOICES Program.

iii. **CHOICES Data Reporting.** The state must report to CMS, in the Quarterly and Annual Progress Reports, on data and trends of the designated CHOICES data elements. An electronic copy of the actual data addressing the required data elements must be submitted to CMS within 3 months following each point in time (e.g., by September 30 of each DY).

e. **Requirements Related to the Affordable Care Act.** Subparagraphs i. and ii. below describe elements that must be included in an extension proposal or phase-out plan, as discussed in paragraph 8 *(Extension of the Demonstration)* and paragraph 9 *(Demonstration Phase-Out)*.

i. **Affordable Care Act Transition Plan for Extension.** The extension proposal submitted to CMS in June 2012 included a Transition Plan. This plan will be updated consistent with the provisions of the Affordable Care Act and CMS regulations for any individuals enrolled in Demonstration Eligible Groups (as defined in paragraph 17, Table 1a) who will be eligible for coverage under the state plan as of January 1, 2014, including under the new Medicaid eligibility group identified in Section 1902(a)(10)(A)(i)(VIII) of the Act, or who elect to move to an Exchange plan. Persons who are demonstration eligibles at the time of transition will continue to receive demonstration benefits as long as they are enrolled in a Medicaid category and they continue to meet the criteria for their particular demonstration program. The updated Transition Plan will include procedures for ensuring that these individuals transition to their new eligibility status without interruption in coverage to the maximum extent possible.

ii. **Demonstration Phase-Out and Affordable Care Act Transition.** As part of a phase-out plan submitted under paragraph 9, the state must include a plan for using information already in its possession on members of demonstration Eligible Groups to make advance determinations of

eligibility for TennCare under its Medicaid state plan on January 1, 2014, consistent with guidance to be issued by CMS.

**44.** **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the state's progress on enrolling individuals into the TennCare Standard Spend Down Demonstration Group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

**45.** **Quarterly Progress Reports.** The state must submit progress reports containing the items listed below (see also Attachment A for format), no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. An updated CHIP allotment neutrality monitoring spreadsheet, if necessary;

c. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the TennCare Standard Spend Down Demonstration Group; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the demonstration; pertinent legislative or litigation activity; and other operational issues;

d. Action plans for addressing any policy, administrative, or budget issues identified;

e. Quarterly enrollment reports for demonstration eligibles that include the member months for each demonstration population;

f. Quarterly enrollment reports for individuals who would otherwise be eligible for Interim CHOICES 3 but who meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual;

g. Evaluation activities and interim findings; and

h. Other reports as indicated in these STCs.

**46. Annual Report.** The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The state shall also submit the title XXI annual state report for its Medicaid Expansion children in the demonstration, by December 31 of each year.

**47. Beneficiary Survey.** The state shall conduct a beneficiary survey each demonstration year for a statistically valid sample of all TennCare enrollees. The survey shall measure satisfaction, enrollee efforts to secure out-of-network care, average waiting time for physician office visits, and enrollee efforts to change plans, along with reasons for requesting plan changes. Results of the survey must be provided to CMS by September after the end of in each demonstration year (e.g. survey results for demonstration year 12 are due no later than September 30, 2014).

**48. Final Evaluation Report.** The state shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act and as specified in Section XII of these STCs.

**49. Enrollment Reporting.**

a. Each quarter the state will provide CMS with an enrollment report for the title XXI Medicaid Expansion demonstration population and for title XIX Medicaid children, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the state into the Statistical Enrollment Data System (SEDS) within 30 days after the end of each quarter. SEDS reporting is required for any title XXI-funded population, including Medicaid Expansions, and is also required for title XIX Medicaid child enrollment.

b. Enrollment reporting in the Quarterly and Annual Reports (see paragraphs 45 *Quarterly Progress Reports* and 46 *Annual Report*) is required by Eligibility Group (EG) and Type for the TennCare title XIX and XXI state plan and demonstration populations.

## X. GENERAL FINANCIAL REQUIREMENTS

**50. Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under Section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period and pool payments and certified public expenditures made for the demonstration period. CMS shall provide Federal financial participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X of these Terms and Conditions.

**51. Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Tennessee must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which capitation payments were made. For this purpose, demonstration year 1 (DY 1) is defined as the year beginning July 1, 2002, and ending June 30, 2003. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures should be reported on Forms CMS-64.9 Base/64.9P Base.

Expenditures for Medicaid Expansion children claimed under the authority of title XXI of the Act shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

b. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by demonstration year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the eligibility groups (EGs) from which collections were made (see paragraph 53, *Assignment of Expenditures and Member Months to EGs*). In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations shall be offset

against expenditures. These Section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver or 64.9P Waiver schedules, and allocated to forms named for the different EGs described in e.i. through e.xii. below as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to demonstration populations shall be offset against expenditures.

e. **Use of Forms**. The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration and title XIX expenditures made in other payment categories as follows. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system. The terms "EG1" through "EG12" refer to the demonstration Eligibility Groups defined in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)* of these STCs.

i. "EG1 Disabled" expenditures (see paragraph 53.a.i.)

ii. "EG2 Over 65" expenditures (see paragraph 53.a.ii.)

iii. "EG3 Children" expenditures (see paragraph 53.a.iii.)

iv. "EG4 Adults" expenditures (see paragraph 53.a.iv.)

v. "EG5 Duals" expenditures (see paragraph 53.a.v.)

vi. "EG6E Expan Adult" expenditures (see paragraph-53.b.i.)

vii. "EG7E Expan Child" expenditures (see paragraph 53.b.ii.)

viii. "EG8 Med Exp Child" expenditures (see paragraph 53.b.iii.)

ix. "EG9 H-Disabled" expenditures (see paragraph 53.b.iv.)

x. "EG10 H-Over 65" expenditures (see paragraph 53.b.v.)

xi. "EG11 H-Duals" expenditures (see paragraph 53.b.vi.)

xii. "EG12E Carryover" expenditures (see paragraph 53.b.vii.)

xiii. "GME" (Graduate Medical Education) (see paragraph 55.d.)

xiv. "EAH Pool" (Essential Access Hospital Pool) (see paragraph 55.e.)

xv. "CAH Pool" (Critical Access Hospital Pool) (see paragraph 55.f.)

xvi. "Meharry Pool" (see paragraph 55.g.)

xvii. "CPE" (Certified Public Expenditures) for Unreimbursed Public Hospital Costs Pool (see paragraph 55.h.)

xviii. "DSH" (Disproportionate Share Hospital Payments) (see paragraph 55.i.)

xix. "UHC Pool" (Unreimbursed Hospital Cost Pool) (see paragraph 55.k.)

xx. "PHSP Pool" (Public Hospital Supplemental Payment Pool) (see 55.l.)

f. **Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population.**

i. **Expenditures Subject to the Allotment Neutrality Limit.** The state will be subject to a limit on the amount of Federal title XXI funding that the state may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including available reallocated funds published in the *Federal Register*. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of demonstration until the next allotment becomes available.

ii. The state is eligible to receive title XXI funds for expenditures for TennCare Medicaid Expansion children described on the last row of Table 1a in Section IV, paragraph 17 *(Eligibility)*, up to the amount of its title XXI allotment. Waiver expenditures for these children under title XXI must be reported as a Medicaid expansion population on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver, in accordance with the instructions in Section 2115 of the State Medicaid Manual, under waiver name "Med Exp Child," identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which

capitation payments were made. They are reported in Column C for the enhanced match under title XXI.

iii. If the state exhausts its title XXI allotment, title XIX funds are available for title XXI children in this demonstration. To access this funding, the state must submit for approval a written request to CMS, referencing this STC, to access title XIX funds for the title XXI Medicaid Expansion Demonstration Group. This request must be submitted at least 90 days prior to the date on which the state anticipates its title XXI allotment will be exhausted, and must include:

(A) An updated budget neutrality assessment that adds Medicaid Expansion children to budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that removes Medicaid Expansion children.

iv. Once the title XXI allotment is again available, the state will claim title XXI funding for the title XXI children in this demonstration. To access this funding, the state shall submit for approval a written request to CMS, referencing this STC, to access title XXI funds for the title XXI Medicaid Expansion Demonstration Group, which includes a request to update the STCs related to claiming. This formal request must be submitted prior to the change in funding source and include:

(A) An updated budget neutrality assessment that removes Medicaid Expansion children from budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that adds Medicaid Expansion children.

v. During periods in which the state is claiming title XIX funds for Title XXI Medicaid Expansion demonstration population children, the member months attributable to this demonstration population will count toward calculation of the budget neutrality expenditure limit, using the per member per month (PMPM) amounts for "EG8 Med Exp Child." The expenditures will be considered expenditures subject to the budget neutrality expenditure limit, so that the state is not fully at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

g. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to:

i. All TennCare title XIX expenditures on behalf of individuals who are enrolled in this demonstration (excluding the services specified in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*), including all service expenditures and applicable administrative costs (see subparagraph h. below) net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse), and

ii. All expenditures described in paragraph 55.d. through i. *(Extent of Federal Financial Participation for the Demonstration).*

All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver, with the exception of those described in h. below.

h. **Administrative Costs.** In general, administrative costs are not included in the budget neutrality expenditure limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. Administrative costs subject to budget neutrality (see below) must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, according to the EGs for which the expenditure was made (following the list in e.i. through e.xii. above). Other administrative costs not subject to budget neutrality will not be broken out by EG, and will be reported under waiver name "TennCare II."

In accordance with Federal regulations at 42 CFR § 438.812(b)(2), during the periods that services are provided in accordance with MCO, pharmacy benefit manager, or dental benefit manager non-risk contracts, the portion of the state's payments that is for reimbursement of the non-risk contractors' administrative services can only be claimed by the state as an administration cost at the Federal matching rates available for the costs of administration of the Medicaid program. The administrative services portion of the amounts paid by the state to compensate any non-risk contractors for their administration costs incurred in accordance with non-risk contracts are costs of the demonstration waiver that are subject to the budget neutrality expenditure limit explained in Section XI of these STCs.

i. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the Section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.

**52. Reporting Member Months.** The following describes the reporting of member months for TennCare Medicaid and TennCare Standard enrollees:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 45 *(Quarterly Progress Reports)* of these STCs, the actual number of eligible member months for all TennCare Medicaid and TennCare Standard Eligibility Groups (EGs) defined in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)*. The state must submit a statement accompanying the quarterly report, which recognizes the accuracy of this information. Member months should be reported only for individuals who are included in TennCare, as defined in paragraph 17 *(Eligibility)*. Persons for whom Medicaid only pays for services carved out of TennCare (as described in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*) are not enrolled in TennCare (e.g., QMBs, SLMBs).

b. A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for Type 1 and Type 2 eligibles (as defined in paragraph 61, *Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement*) are reported in Section VIIIA of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for Type 3 demonstration expansion populations and for title XXI Medicaid Expansion demonstration eligibles are reported in Section VIIIB of the template, and are not used to calculate the budget neutrality expenditure limit. Detailed instructions for

assigning member months to Types and to EGs are provided in paragraphs 53 *(Assignment of Expenditures and Member Months to EGs)* and 61 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)*.

c. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the state must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

d. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

e. The state will ensure that eligible member month totals reported to CMS for the TennCare II demonstration from July 1, 2002, forward conform to the EG definitions contained in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)*.

**53. Assignment of Expenditures and Member Months to EGs:** The following rules govern the:

- Reporting of expenditures subject to the budget neutrality expenditure limit on separate waiver forms by EG, as described in paragraph 51.e. *(Use of Forms)* above, for the period beginning July 1, 2007, through the end of the TennCare II demonstration, and
- Reporting of eligible member months for the TennCare II demonstration from July 1, 2002, forward.

Beginning July 1, 2007, and as subsequently modified, the quarterly progress report template in Attachment A, Part VIII should be used to report separate member month totals for Type 1, Type 2, and Type 3 eligibles, and for other subgroups as specified below.

a. **<u>Title XIX State Plan Mandatory or Optional Groups (Type 1 Eligibles)– TennCare Medicaid:</u>**

i. For Medicaid eligibles of any age who have qualified for Medicaid on the basis of disability but who are not eligible for Medicare, report under **EG1 Disabled, Type 1.** This includes non-dual SSI eligibles in CHOICES 1, 2, and 3, the CHOICES 1 and 2 Carryover Group, or the PACE Carryover Group.

ii. For Medicaid eligibles who have not qualified for Medicaid on the basis of

disability, who are not eligible for Medicare, and who are 65 years of age or older, report under **EG2 Over 65, Type 1.**

iii. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are age 18 or younger, report under **EG3 Children, Type 1.**

iv. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are between the ages of 19 and 64, report under **EG4 Adults, Type 1.**

v, For Medicaid eligibles of any age who are also eligible for Medicare, report under **EG5 Duals, Type 1.** This category includes dually eligible Medicaid/Medicare individuals who have been classified as "disabled." It does not include any dually eligible members of demonstration populations such as the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group.

b. **Title XIX Demonstration Eligible Groups (Type 2 or 3 Eligibles) – TennCare Standard**

i. For demonstration eligibles who are enrolled in the Standard Spend Down category, report under **EG6E Expan Adult, Type 3.** This category includes SSD enrollees who have Medicare or who have been classified as "disabled."

ii. For demonstration eligible children under age 19 who have been determined to be "Medically Eligible" and who have incomes at or above 200 percent of poverty, report under **EG7E Expan Child, Type 3.**

iii. For demonstration eligible children under age 19 who have been determined to be uninsured and who have incomes below 200 percent of poverty, report under **EG8 Med Expan Child, Type 2, only when Title XIX funds are being used.** This is the Title XXI population. This EG is in effect only when the state is using Title XIX funds for this population. In periods when the state is using Title XXI funds, these children would not be included in any EG but would be reported as indicated in c. below.

iv. For persons in the CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are under age 65, report under **EG9 H-Disabled, Type 2.** This category should also be used for members of any age in the At Risk Demonstration Group who are not eligible for Medicare.

v. For persons in the CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are age 65 or older, report under **EG10 H-Over 65,**

**Type 2.**

vi. For persons in the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group who are also eligible for Medicare, report under **EG11 H-Duals, Type 2.**

vii. For demonstration eligible (non-SSI) persons in the CHOICES 1 and 2 Carryover Group or the PACE Carryover Group, report under **EG12E Carryover, Type 3.** This category should be used for both duals and non-duals in the Carryover Groups.

c. Expenditures for title XXI Medicaid Expansion children matched at the title XXI enhanced FMAP should be reported on Forms 64.21U Waiver/64.21UP Waiver, using waiver name "Med Exp Child." Report member months for quarterly reporting using Attachment A, Part VIII. For periods in which the state claims title XIX FMAP for this population (paragraph 51.f. *Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population*), follow the instructions in b.iii. above.

d. Type 2 eligibles can be identified as disabled for reporting purposes (see b.iv. above) if information exists in their enrollment record that would result in a capitation rate for disabled populations being paid on their behalf.

**54. Standard Funding Process.**

a. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

b. **Standard CHIP Funding Process.** The standard CHIP funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the allotment neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by

CMS. Within 30 days after the end of each quarter, the state must submit quarterly CHIP expenditure reports as described in paragraph 51.f. *(Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population)*, showing CHIP expenditures made in the quarter just ended. CMS shall reconcile expenditures with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

**55. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding (see Section X, paragraph 57, *Sources of Non-Federal Share*), CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section XI of these STCs.

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

d. **Graduate Medical Education (GME) Pool.** Actual cash disbursements, up to $50 million in total computable expenditures for each demonstration year, paid by the state from a supplemental pool to pay for GME costs in accordance with the pool distribution methodology described below. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology, authorized by the demonstration's expenditure authorities. Should CMS promulgate new regulations, the TennCare GME program must come into compliance in accordance with the effective date of the new regulations.

*GME Pool Methodology*: GME Pool payments will be made to the following medical universities that operate graduate physician medical education programs. These payments are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics: East Tennessee State University, Meharry Medical College, University of Tennessee at Memphis, and Vanderbilt University. The annual GME Pool funds will be allocated based on the annual ratio derived by dividing each hospital's average of its Primary Care Position Allocation and its Total Filled Positions Allocation by the aggregate of the medical hospitals' averages. The Primary Care Position Allocation is computed by taking each hospital's total number of primary care residents in years 1 through 4 of residency and dividing it by the total of all primary care residents in the medical hospitals in years 1 through 4 of residency.

The Total Filled Positions Allocation is computed by taking each hospital's total number of residents in years 1 through 4 of residency and dividing it by the total of the medical hospitals' number of residents in years 1 through 4 of residency. This annual ratio is applied to the total GME Pool funding to be allocated. The annual GME Pool funds will be disbursed quarterly. The state must make these payments directly to the universities, and not through any third party or intermediary.

e. **Essential Access Hospital (EAH) Pool.** Actual cash disbursements paid each quarter from a $25 million quarterly supplemental pool to pay for the uncompensated costs of the designated EAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and appropriate charity care patients in accordance with the pool distribution methodology described below. The purpose of this pool is to address the uncompensated care situation of high volume and charity hospitals that serve a disproportionate number of low-income patients with special needs. Hospitals designated as Critical Access Hospitals (CAHs) or as state mental health institutes do not participate in this pool. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

For FFYs 2008 and beyond, EAH Pool payments will be assumed to pertain to the FFY during which the payments were made. To the extent required by Federal law, EAH Pool payments made during a given FFY shall be reduced on a dollar for dollar basis by the amount of DSH payments made under the DSH allotment for that FFY.

*EAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Essential Access Hospitals.

*Qualifications* -- Hospitals eligible to receive EAH Pool payments include all hospitals licensed to operate in the State of Tennessee excluding the four (4) state mental health institutes and the CAHs. The four regional mental health institutes are Memphis Mental Health Institute, Moccasin Bend Mental Health Institute, Western Mental Health Institute, and Middle Tennessee Mental Health Institute. The CAHs receive cost-based reimbursement from the TennCare program subject to limitations outlined in subsection f. of this paragraph.

- All hospitals, with the exception of free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program.
- The free standing psychiatric hospitals must be a contracted provider with at least one of the Managed Care Organizations in the TennCare program and at least 30% of their total adjusted days must be covered by TennCare.

- All acute care hospitals must have either of the following: (i) at least 13.5% or more of their total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days.
- All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare cost.

*Allocation of the EAH Pool to Segments of Hospitals* -- The $25 million Pool should be segmented into 4 distinct parts as follows:

- Essential Service Safety Net – $12.5 Million -- These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved.
- Children's Safety Net – $1.25 Million -- These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children under the age of 21 in Tennessee.
- Free Standing Psychiatric Hospitals - $0.5 Million -- These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health for the provision of psychiatric hospital services in Tennessee, excluding the state mental health institutes.
- Other Essential Acute Care – $10.75 Million -- These hospitals include all other hospitals licensed by the Tennessee Department of Health to provide services in Tennessee, excluding the Critical Access Hospitals.

*Quarterly Reports* – The state must include in its Quarterly Progress Reports a list of the current hospitals in each of the above categories (see Attachment A).

*Data* -- Calculation of the quarterly payment amounts will be based on the most recently completed Joint Annual Report of Hospitals at the time of the first quarterly payment for a given fiscal year.

*Allocation will be based on an assignment of points for*:
- TennCare adjusted days expressed as a percent of total adjusted patient days; and
- Charity, medically indigent care, and bad debt expressed as a percent of total expenses.

*Calculation of Points*
**(1)** TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:

- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the critical access, pediatric and safety net providers;
- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 34.5%;
- 3 points – greater that 34.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

**(2)** Bad Debt, Charity and Medically Indigent – BDCHMI costs as a percent of total expenses

- 0 points - less than 4.5%
- 1 point - greater than or equal to 4.5% and less than 9.5%
- 2 points - greater than or equal to 9.5% and less than 14.5%
- 3 points - greater than or equal to 14.5%

*Calculation of Amounts of Pool Payments for Hospitals* -- These points will then be used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate included all inpatient costs (operating, capital, direct education) but excluded add-ons (indirect education, MDSA, return on equity). The GHR for Safety Net Hospitals is $908.52. The GHR for Other Essential Access Hospitals is $674.11. The points for each qualifying hospital will be summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each of the 4 pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initially calculated amount will then be adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. For example, if the sum of the initial calculated amounts for the pediatric group is $9 million and the total pool for children's hospitals is $5 million, each hospital's initial calculated amount will be multiplied by $5 million / $9 million.

*Pool Payments* -- Hospitals will be paid on a quarterly basis following the end of each quarter. The initial payment will include all quarters that have ended at the time that the payment is made. All subsequent quarterly payments will be made

following the end of the quarter. In order to receive a payment for the quarter, all hospitals, with the exception of the free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, with at least one Managed Care Organization, and must have contracted with TennCare Select for the entire quarter that the payment represents. In order for a free standing psychiatric hospital to receive a payment for the quarter, it must be a contracted provider with at least one of the Managed Care Organizations.

f. **Critical Access Hospital (CAH) Pool.** Actual cash disbursements, of up to $10 million per demonstration year, paid from a supplemental pool to pay for the uncompensated costs of the designated CAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and the appropriate charity care patients in accordance with the pool distribution methodology that has been given CMS prior approval. CAHs are designated by the Tennessee Department of Health, and they are typically small, rural hospitals that are part of a rural health network. CAHs allow communities to maintain access to primary care and emergency care when the maintenance of a full-service acute care hospital is no longer feasible. The purpose of this pool is to address the uncompensated care situation of CAHs in serving a disproportionate number of low-income patients in rural areas who have special needs. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

*CAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Critical Access Hospitals.

*Qualifications* -- To qualify for payment as a Critical Access Hospital, a hospital must meet the following criteria:

- The hospital is an acute care hospital located and licensed in the state of Tennessee;
- The hospital has been designated a Critical Access Hospital by the Tennessee Department of Health; and
- The hospital contracts with a managed care organization participating in TennCare.

*Reimbursement* -- TennCare will provide reimbursement to Critical Access Hospitals under the following terms. Reimbursement to hospitals will be limited to specific annual legislative appropriation. In any state fiscal year that reimbursable TennCare costs incurred by Critical Access Hospitals exceed annual appropriations, equitable adjustments will be made to the rates described below, in order to cap reimbursement at the annual appropriation.

***Inpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare inpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly with interim per diem rates and will be cost-

settled at year-end. Using the Joint Annual Reports filed for the most recent year available, interim per diem rates for TennCare inpatient services will be determined with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs. Inpatient Critical Access Hospital services will not include more than 15 acute inpatient beds. An exception to the 15 bed requirement is made for swing bed hospitals. Critical Access Hospitals are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that not more than 15 beds are used at any one time for acute care.

***Outpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare outpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly based on a percentage of charges with year-end cost settlements. Using the Joint Annual Reports filed for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges, with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs.

**Cost Settlements** -- Cost settlements are determined from provider submitted Medicare cost reports that include the title XIX schedules based on 100 percent (100%) of TennCare reasonable costs. The term “reasonable costs” is defined for this purpose as total reimbursable costs under Medicare principles of cost reimbursement for Critical Access Hospitals.

*New Designations of Critical Access Hospitals* -- For new hospitals that qualify after July 1, 2002, the state will begin reimbursement at the rates established by this part on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its Critical Access Hospital designation. At that time, interim rates will be established according to this part and the designation will be confirmed with the Tennessee Department of Health.

*Audit Trail and Audit Requirements* -- Each CAH is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than 5 years from the date of the submission of the Joint Annual Report, and the provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint Annual Reports are subject to audit at any time by Federal and state auditors, including the Comptroller of the Treasury and the Bureau of TennCare, or their designated representative.

g. **Meharry Medical College (Meharry) Pool.** Actual cash disbursements paid from a $10 million supplemental pool per demonstration year to pay for the uncompensated costs of the two Medicaid clinics operated by the Meharry Medical College for TennCare covered services provided to TennCare enrollees and the appropriate charity care patients. The Meharry Pool payments will be limited to the uncompensated costs of the care as determined by an independent audit each year and subject to the review and approval by the CMS staff. Before paying the annual pool amount to the providers, the state will provide CMS with a copy of the annual independent audit report. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

h. **Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (CPE).** Actual costs incurred by government operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients are eligible as CPE. The state must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital from the following sources: the MCOs; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds). With regard only to hospital CPE, the state will report actual CPE within 12 months after the end of each fiscal year. At that time, the state will revise its FFP claim to reconcile actual CPEs with the CPE estimates used during the preceding fiscal year (FY).

**State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the state of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

**CPE Methodology and Protocol.** The state must follow the CPE protocol, as contained in Attachment F of these STCs, which was approved by CMS for use beginning July 1, 2008.

i. **Disproportionate Share Hospital (DSH) Payments.** The Tax Relief and Health Care Act of 2006 (TRHCA 2006) established a DSH allotment for Tennessee for FFY 2007, as described at Section 1923(f)(6) of the Act. The relationship between DSH payments made by Tennessee under TRHCA 2006 and payments from the EAH Pool is further specified in the second paragraph of subparagraph (e) above. If Congress should establish a DSH allotment for Tennessee for any subsequent Federal fiscal year, the state may make DSH payments to hospitals on the basis of a state plan amendment approved by CMS. Depending on the specifics of the legislation establishing the DSH allotment, modifications to the budget neutrality expenditure limit may be required, in the manner specified in

paragraph 4.a. (*Impact on Demonstration of Changes in Federal Law, Regulation, and Policy).* Unless otherwise specified by law, DSH payments shall be considered payments made under the demonstration and subject to the budget neutrality expenditure limit and the limit described in subparagraph (j) below. When determining hospital-specific DSH limits and DSH payments, the state must take into account all Medicaid payments under the Medicaid state plan and demonstration projects including amounts paid to hospitals through the GME, EAH, Meharry Medical College, UHC, PHSP, and CAH Pools, as well as any payments by or on behalf of individuals with no source of third party coverage. The state must make these payments directly to the providers of the services as specified at Section 1923(i) of the Social Security Act.

j. Beginning in DY 6 (state fiscal year 2008), the combined total of the payments to hospitals listed in i. below shall not exceed annual limits described in iv. Beginning in DY 11 (state fiscal year 2013), the combined total of the payments to the hospitals listed in iii. below shall not exceed annual limits described in iv. Any unused amount from the annual cap for one DY may not be rolled over and added to the annual cap for any subsequent DY.

i. The following payments are subject to the limit in DY 6 through 9:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of DSH payments (see 55.i. subject to the allotment for the FFY ending during the DY);
- Three-quarters of DSH payments (see 55.i. subject to the allotment for the FFY beginning during the DY);
- Hospital CPE (see-55.h.).

ii. The following payments are subject to the limit in DY 10:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of the DSH payments (see 55.i., subject to the allotment for the FFY 2011);
- Additional DSH payments equal to the DSH allotment for the first quarter of FFY 2012;
- Hospital CPE (see 55.h.)

iii. The following payments are subject to the limit in DYs 11-14:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- Hospital CPE (see 55.h.).

iv. The annual limit for DY 6 – DY 14 shall be $540 million (total computable).

k. **Unreimbursed Hospital Cost (UHC) Pool.** Actual costs incurred by eligible Tennessee hospitals that are unreimbursed by TennCare. The total amount of funds to be distributed to hospitals each DY from the pool will be determined annually, in a manner defined by the Tennessee General Assembly's Annual Coverage Assessment Act and this subparagraph, but in no event may exceed the limit defined below. For any demonstration year in which it elects to make payments under the UHC Pool authority described in this paragraph, the state may not implement a reduction in benefits or elimination of coverage for any of the following services: physical therapy, occupational therapy, speech therapy, inpatient hospital, lab and x-ray, non-emergency outpatient hospital, physician, podiatrist, certified nurse practitioner, or physician assistant services; or implement any co-payment for non-emergency medical transportation. (Nothing in this paragraph is intended to limit the state's ability to manage utilization of these services through changes to prior authorization requirements or other managed care practices.)

***Eligible Hospitals.*** Hospitals eligible to receive a pool payment include all hospitals licensed to operate in the State of Tennessee, except the following groups:

- Critical Access Hospitals;
- Public hospitals eligible to certify public expenditures, including state mental health institutes;
- Rehabilitation and long term care hospitals; and
- Pediatric research hospitals that limit patients to those that meet research protocols.

Any hospitals that have closed between 2008 and the time that the amounts of the payments are calculated are not eligible to receive payments.

***Minimum Qualifications.*** In order to receive a payment, the hospital must be contracted with at least one TennCare MCO and must have unreimbursed TennCare costs, unless the hospital is capitated and accepts the capitation from TennCare as full reimbursement for services to TennCare patients.

***Data Source.*** The Joint Annual Report (JAR) of Hospitals, which is a report containing data that each licensed hospital in the state is required to file annually in accordance with T.C.A. 68-11-310. This law says:

> All hospitals that submit a joint annual report to the department of health as designated in this section shall also submit to the department, at the same time they send the signed paper copy of the report, a notarized statement from their chief financial officer stating that the financial data reported on the joint annual report is consistent with the audited financials

for the hospitals for that reporting year. The notarized statement shall also be attested to by the chief executive officer of the hospital.

Reports are submitted to the Tennessee Department of Health (DOH), edited by DOH, corrected by the hospital and placed in a final data file for that year by DOH. The instructions for completing the form require the hospitals to use the same accounting method required for the Medicare cost reports.

Payment amounts for each DY will be based on the final JAR from 3 years prior to the DY.

***Calculation.*** TennCare costs shall be determined by multiplying TennCare charges for hospital inpatient and outpatient services reported by the hospital by the ratio of reported total expenses to reported total charges (cost to charge ratio). Unreimbursed TennCare Costs are calculated as the difference between the calculated TennCare costs and the TennCare revenue as reported on the JAR.

Each hospital shall receive an annual payment each DY equal to a percentage of its Unreimbursed TennCare Costs, using the same percentage to calculate each hospital's payment.

***Funding.*** TennCare shall adjust payments if necessary to ensure no hospital receives supplemental payments in excess of unreimbursed TennCare costs. Payments may be prorated subject to available appropriations.

***Payments.*** The annual payment to each hospital shall be made in four equal quarterly payments.

***Annual Limit:*** The total amount of UHC Pool payments made each DY may not exceed $500 million total computable.

l. **Public Hospital Supplemental Payment (PHSP) Pool.** Actual cash disbursements paid from a $70 million (total computable) supplemental pool per demonstration year to selected public hospitals. The amount paid each DY to each hospital must not exceed the hospital's uncompensated cost of TennCare covered services provided to TennCare enrollees and uninsured patients. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10. PHSP Pool payments may be made to the following hospitals:

- Regional Medical Center at Memphis, and
- Nashville General Hospital at Meharry.

**56. Medicare Part D Drugs.** No FFP is available under this demonstration for Medicare Part D drugs.

**57. Sources of Non-Federal Share.** The state certifies that the matching non-Federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-Federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding.

c. Under all circumstances, health care providers must retain 100 percent of the TennCare II reimbursement amounts claimed by the state as a demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

**58. Monitoring the Demonstration.** The state shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

## XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

**59**. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of Federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, with an aggregate adjustment for projected disproportionate share hospital payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section X, paragraph 51 *(Reporting Expenditures in the Demonstration).*

**60.** **Risk.** Tennessee shall be at risk for the per capita cost (as determined by the method described below in this Section) for Type 1 and Type 2 TennCare enrollees in the eligibility groups (EGs) described in paragraph 61 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)* under this budget neutrality agreement, but not for the number of demonstration eligibles in each of the groups. By providing FFP for all Type 1 and Type 2 TennCare enrollees in the specified EGs, Tennessee shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Tennessee at risk for the per capita costs for TennCare enrollees in each of the EGs under this agreement, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration. Tennessee will be at risk for both per capita costs and enrollment for Type 3 TennCare eligibles.

**61.** **Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement.** Individuals who are eligible under TennCare and whose expenditures are funded at title XIX matching rates will be one of three types:

a. Type 1 - are currently eligible under Tennessee's Medicaid state plan (Title XIX state plan mandatory or optional eligible population) - counted in the "with" and "without" waiver calculations;

b. Type 2 - could be eligible under Tennessee's Medicaid state plan if Tennessee amended its state plan or could be eligible for a Section 1915(c) waiver for aged and disabled adults pursuant to 42 C.F.R. § 435.217 (Title XIX demonstration-eligible hypothetical population) or is eligible under the At Risk Demonstration Group for the Interim CHOICES 3 program - counted in the "with" and "without" waiver calculations (the state cannot generate savings from these populations); and

c. Type 3 – are only eligible with Section 1115 demonstration authority (Title XIX demonstration-eligible expansion population) - counted only in the "with" waiver calculations.

**62. Budget Neutrality Ceiling.** The following describes the method for calculating the budget neutrality expenditure limit:

a. For each DY of the budget neutrality agreement, an annual target is calculated as the sum of two components:

i. The sum of six sub-components calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the state in accordance with paragraph 52 *Reporting Member Months*) for Type 1 and Type 2 eligibles claimed under title XIX for the following six EGs: EG1 Disabled, EG2 Over 65, EG3 Children, EG4 Adults, EG5 Duals, and EG8 Med Exp Child (when title XXI allotment is exhausted); and

ii. A Disproportionate Share Hospital (DSH) adjustment for the year described in d. below.

b. Member months for the following populations are not used for calculation of the budget neutrality expenditure limit:

i. EG6E Expan Adult, EG7E Expan Child, and EG12E Carryover Type 3 eligibles

ii. Med Exp Child: Medicaid Expansion children funded at the title XXI enhanced FMAP.

c. The following tables give the projected PMPM costs for the calculation described in paragraph 62.a. by DY. The PMPM costs for DY 8 and earlier are calculated following Attachment B of the November 14, 2006 Special Terms and Conditions and paragraph 64.c. of the July 22, 2009 STCs.

**Table 8**
**Projected PMPM Costs After CHOICES Implementation**

| | Trend | DY 12 | DY 13 | DY 14 |
|---|---|---|---|---|
| **EG1 Disabled*** | 5.1% | $1,561.46 | $1,641.09 | $1,724.79 |
| **EG2 Over 65**** | 4.6% | $1,022.17 | $1,069.19 | $1,118.37 |
| **EG3 Children** | 3.4% | $468.46 | $484.39 | $500.86 |
| **EG4 Adults** | 4.9% | $917.79 | $962.76 | $1,009.94 |
| **EG5 Duals** | 4.6% | $652.99 | $683.02 | $714.44 |
| **EG8 Med Exp Child***** | 3.4% | $468.46 | $484.39 | $500.86 |

* Includes EG 9 H-Disabled
** Includes EG10 H-Over 65
***Optional Targeted Low Income Children funded using title XIX

d. The DSH adjustment is based upon Tennessee's DSH allotment for 1992 and calculated in accordance with current law.

i. For the purpose of this subparagraph, the Average FMAP (AFMAP) for each DY is defined as 0.25 times the FMAP applicable to DSH expenditures for the Federal fiscal year that ends during that DY, plus 0.75 times the FMAP applicable to DSH expenditures for the Federal fiscal year that begins during that DY.

ii. A DSH allotment has been established for Tennessee under provisions of TRHCA 2006 (and extended through subsequent legislation). Beginning with DY 5, the DSH adjustment will be based on the DSH allotments established for Tennessee, following Section 1923(f)(6)(A)(i) of the Act, which are published in the *Federal Register*. The Federal share of the DSH adjustment for each DY will be equal to one quarter of the DSH allotment for the FFY ending during the DY, plus three quarters of the DSH allotment for the FFY beginning during the DY. A total computable equivalent for each DSH adjustment can be calculated as the DSH adjustment divided by the AFMAP for that DY. For DY 5, the figure

$305,541,928 will be used to compute the Federal share of the DSH adjustment in place of the FFY 2006 DSH allotment.

iii. The calculation of the DSH adjustment will be appropriately altered if legislation is enacted that impacts the calculation of DSH allotments, including any law that would affect the calculation of the DSH allotment for Tennessee.

iv. Table 9 gives the DSH adjustments for DY 1 through DY 14, and shows both total computable and Federal share. These totals reflect changes to the calculation of DSH allotments resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the temporary increase in DSH allotments provided under Section 5002 of the American Recovery and Reinvestment Act of 2009. Some of the figures are labeled "preliminary" because the final DSH allotments needed to calculate them have not yet been published in the *Federal Register*, and are best estimates based on current law.

**Table 9**
**DSH Adjustments for DY 1 Through DY 14**

| | **DSH Adjustment (total computable)** | **DSH Adjustment (Federal share)** |
|---|---|---|
| **DY 1** | $413,700,907 | $268,409,148 |
| **DY 2** | $479,893,052 | $310,106,890 |
| **DY 3** | $479,893,052 | $310,538,794 |
| **DY 4** | $479,893,052 | $308,091,339 |
| **DY 5** | $479,356,649 | $305,451,928 |
| **DY 6** | $479,657,638 | $305,451,928 |
| **DY 7** | $485,299,094 | $311,270,839 |
| **DY 8** | $488,969,517 | $319,052,610 |
| **DY 9** | $470,369,327 | $309,408,043 |
| **DY 10** | $463,996,853 | $305,451,928 |
| **DY 11** | $463,996,853 | $305,451,928 |
| **DY 12 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 13 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 14 (preliminary)** | $463,996,853 | $305,451,928 |

e. The budget neutrality expenditure limit is the Federal share of the annual PMPM limits for the demonstration period, plus DSH adjustments, for DY 1 through 14, and represents the maximum amount of FFP that the state may receive for title XIX expenditures during the demonstration period, as described in paragraph 51.g. *(Reporting Expenditures in the Demonstration: Title XIX Expenditures*

*Subject to the Budget Neutrality Expenditure Limit).* The budget neutrality expenditure limit is equal to (1) the sum of all of the subcomponents described in a.i. above for all DYs, times the Composite Federal Share (defined in f. below), plus (2) the sum of the Federal shares to the DSH adjustments for all DYs, as defined in d. above.

f. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional demonstration expenditures or offsets such as, but not limited to, premium collections and administrative costs subject to budget neutrality under paragraph 51.h. *(Reporting Expenditures in the Demonstration: Administrative Costs)* by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for DSH payments made under the Medicaid state plan must be subtracted from the numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

**63. Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under TennCare II. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of Section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

**64. Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

| DY | Cumulative Target Definition | Percentage |
|---|---|---|
| Years 1 through 6 | Cumulative budget neutrality cap plus: | 0.5 percent |
| Years 1 through 7 | Cumulative budget neutrality cap plus: | 0.25 percent |
| Years 1 through 14 | Cumulative budget neutrality cap plus: | 0 percent |

**65. Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end of this demonstration period, the excess Federal funds shall be returned to CMS. If the demonstration is terminated prior to the end of the budget

neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

## XII. EVALUATION OF THE DEMONSTRATION

**66. Submission of a Draft Evaluation Plan.** The state shall submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after CMS approval of the demonstration extension. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

**67. Inclusion of CHOICES Special Study Components.** Suggested special study topics from which the state may choose for its Evaluation Plan include, but are not limited to, the following:

a. The rebalancing of the long-term care system including impacts on outcomes, utilization and cost;

b. Implementation lessons, successes and evolution of the Single Point of Entry and streamlined eligibility processes;

c. The expansion and development of a more robust HCBS infrastructure under managed care;

d. Implementation of Consumer Directed options under manage care;

e. Enrollee satisfaction, based on surveys that include feedback on assessment and care planning processes, quality of care coordination, actual service delivery, and (when relevant) the appeals process; and

f. Provider satisfaction from surveys.

When developing its research approach, CMS encourages Tennessee to consider adapting research questions and methodologies from the CMS sponsored Evaluation of the Money Follows the Person (MFP) Grant Program. MFP and CHOICES share many of the same goals, and by using a common study approach, the Tennessee's planned reforms can be viewed within a national context. CMS staff will be available to provide technical assistance in this regard.

**68. Evaluation of Eligibility and Enrollment Systems.** The state shall propose data collection and reporting measures designed to assess the ongoing need for retroactive

Medicaid eligibility after changes specified in the Affordable Care Act are effectuated. The interim evaluation report required in paragraph 8 *(Extension of the Demonstration)* and paragraph 70 *(Interim Evaluation Reports)* should contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid and the Exchange. CMS may issue further guidance to the state on the specific performance measures. The state may include the following areas of interest in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other relevant data.

a. Evaluation of eligibility determinations by type, e.g. application, redetermination, transfer to the Exchange.

b. Evaluation of Medicaid denial and termination reasons.

c. Evaluation of average application processing times and timeliness.

d. Evaluation of reasons for disenrollment and internal churn.

e. Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable.

**69. Evaluation of Uncompensated Care Costs for the Uninsured.** The state shall propose data collection and reporting measures designed to assess the ongoing need for payments to compensate hospitals for providing care to the uninsured after changes specified in the Affordable Care Act are effectuated. The state should provide documentation demonstrating cost expended for uncompensated care in relation to the number of uninsured individuals that receive care during the current approval period. CMS may issue further guidance to the state on specific data collection and tracking mechanisms. The state may include the following areas of interest in its interim evaluation report. This list is not all inclusive and the state may include any other relevant data.

a. Evaluation of uninsured patient cost and dates of service.

b. Evaluation of cost for medical services to charities and the indigent.

c. Evaluation of amounts expended for services to hospitals that serve a disproportionate number of low-income patients.

**70. Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request.

**71. Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation plan within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports. The state shall

submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

**72. Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

## XIII. TENNCARE ELIGIBILITY REDETERMINATION AND DISENROLLMENT AND RIGHTS; APPEALS PROCESS FOR CHANGES IN BENEFITS; AND ENROLLMENT IN STANDARD SPEND DOWN

The state will follow these procedures throughout the demonstration approval period unless modified through an approved demonstration amendment.

### PART I: MEDICALLY NEEDY AND TENNCARE STANDARD ELIGIBILITY REDETERMINATION AND DISENROLLMENT PROCESS

This Part summarizes the process Tennessee will use, in accordance with paragraph 21.a. *(Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category)*, of these STCs, to: (i) redetermine eligibility and terminate the adult (non-pregnant) Medically Needy; and (ii) disenroll adults who are TennCare/Medicare dual eligible, uninsured, and Medically Eligible. This process was approved as an amendment to the TennCare II demonstration on March 24, 2005. It is used for redetermining the eligibility of those enrollees whose eligibility is ending, including when their period of eligibility has ended or the category in which they have been enrolled is being closed. The state will continue to follow this process for all redeterminations and terminations of eligibility throughout the demonstration approval period unless modified through an approved demonstration amendment.

**I. Termination of Adult Non-Pregnant Medically Needy**

**1. Ex Parte Review**

A. The state will conduct a data match of the Social Security numbers of individuals classified as adult non-pregnant Medically Needy in its InterChange Information System (which contains information on TennCare enrollees) with Social Security Administration (SSA) data to determine whether the individual has lost supplemental security income (SSI) eligibility for reasons that would qualify them as Medicaid eligible.[1]

B. The state will conduct a data match of the Social Security numbers (SSNs) of individuals classified as adult non-pregnant Medically Needy in InterChange with individuals classified as participants in its Food Stamps or Families First (TANF) program in its ACCENT system (a database maintained by the Department of Human Services (DHS)). In all instances in which there is a match between an adult Medically Needy individual with an individual with an open Food Stamps or Families First record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

[1] Such reasons include (i) they lost SSI eligibility because of Social Security cost of living adjustment(s) ("COLA(s)") but would be SSI eligible if the COLA(s) was/were disregarded ("Passalong" eligibles); or (ii) they lost SSI eligibility for some reason other than a Social Security COLA, but would be eligible for SSI if the COLA(s) received since their SSI termination was/were disregarded ("Pickle" eligibles).

## 2. Request for Information

A. At least 30 days prior to the end of the individual's current eligibility period, the state will send notification (Request for Information) to those adult non-pregnant Medically Needy enrollees who have not been identified through the ex parte review process as eligible for open categories of TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for Medicaid is ending, and that they will only remain eligible for TennCare Medicaid if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for a Medicaid category that is not ending (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for open Medicaid categories. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for Medicaid and the enrollee will receive an advance notice that will provide appeal rights.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be fair hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with Limited English Proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as Seriously and/or Persistently Mentally Ill (SPMI). Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package—i.e., elimination of pharmacy coverage for adult non-institutionalized non-pregnant Medically Needy) until

DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a "Verification Request." Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package). If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain TennCare Medicaid coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), enrollees will retain Medicaid coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. The state will make the determination that enrollees are not eligible for open TennCare Medicaid categories in the following two scenarios: (i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or (ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Expiration Notice**

A. Upon making a determination that enrollees are no longer eligible for TennCare Medicaid, the state will provide a notice (Expiration Notice) to enrollees at least 20 days in advance of the end date of the enrollees' eligibility period.

B. Expiration Notices will:

i. Inform enrollees that they will be terminated from Medicaid as of a date specified in the notice because their current eligibility period has ended, their category of TennCare Medicaid is closed and they have not proven their eligibility for other open categories of TennCare Medicaid.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Expiration Notice to request a hearing for factual disputes related to the termination and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing prior to the date of termination specified in the Notice, Medicaid benefits for non-pregnant Medically Needy (subject to changes in the benefit package) will continue until the appeal has been resolved.

C. If enrollees submit information to qualify for Medicaid prior to their termination, enrollees will continue to be eligible for TennCare Medicaid for non-pregnant Medically Needy (subject to changes in the TennCare Medicaid benefit package) pending the determination as to whether the individual is eligible for other open TennCare Medicaid categories.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Expiration Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the termination. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. Valid factual disputes include:

i. Enrollees received the Expiration Notice in error (i.e., they are currently enrolled in other categories of TennCare Medicaid including Medically Needy pregnant women or enrollees under 21 years of age);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Request for Information but failed to extend the time;

iv. Enrollees requested assistance because of a health, mental health, learning problem, or disability but the state failed to provide this assistance; or

v. The state sent the Expiration Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the request for a hearing is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of termination identified in the Expiration Notice, TennCare Medicaid benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute as described above, or the appeal is resolved.

E. If the enrollee does not request a hearing prior to the date of termination identified in the Expiration Notice, the enrollee will be disenrolled from TennCare Medicaid.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## II. Disenrollment of Adult Medicare/TennCare Dual Eligible, Uninsured, Medically Eligible

### 1. Ex Parte Review

A. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in InterChange (which contains information on TennCare enrollees) with SSA data to determine whether the individual has lost SSI eligibility for reasons that would qualify them as Medicaid eligible.[2]

B. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in Interchange with individuals classified as participants in the state's TANF program in DHS' ACCENT system. In all instances when there is a match between an adult member of these demonstration populations with an individual with an open TANF record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

### 2. Request for Information

[2] See footnote 1

A. At least 30 days prior to disenrollment, the state will send a Request for Information to all adult Medicare/TennCare Dual Eligible, Uninsured, and Medically Eligible enrollees not identified through the ex parte review process as eligible for TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for TennCare Standard is ending and that they will only maintain coverage if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for Medicaid (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for TennCare Medicaid. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for TennCare Medicaid and the enrollee will receive a Disenrollment Notice prior to disenrollment from TennCare Standard.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with limited English proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as SPMI. Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Standard until DHS determines that the individual does not qualify for open categories of Medicaid (and proper disenrollment and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a Verification Request. Verification Requests will inform enrollees that they must submit

the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid. If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper disenrollment and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), the enrollee will retain coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in an appropriate TennCare Medicaid category. The state will make the determination that enrollees are no longer eligible for TennCare in the following two scenarios:

   i. if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or

   ii. if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

**3. <u>Termination Notice</u>**

A. Upon determination or confirming that enrollees are not eligible for TennCare Medicaid, the state will provide a Termination Notice to enrollees 20 days in advance of the date upon which the coverage will be terminated.

B. Termination Notices will:

   i. Inform enrollees that they will be disenrolled from TennCare as of the date specified in the Notice (20 days after the date of the Notice) because their category of TennCare Standard is ending and they have not proven their eligibility for open TennCare Medicaid categories.

   ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the notice to appeal factual disputes related to the action of disenrollment and inform enrollees how they may request a hearing.

   iii. Inform enrollees that if prior to the date of disenrollment specified in the Termination Notice, an enrollee appeals the action of disenrollment, he or she will not lose eligibility for TennCare until the state determines that the enrollee has not raised a valid factual dispute or the appeal is resolved.

iv. Inform enrollees that they may submit new information to demonstrate Medicaid eligibility at any time before or after disenrollment. Such information will be treated as a new application for Medicaid. The enrollee will not continue benefits pending the state's review and processing of this information.

**4. <u>Appeals Process</u>**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:

i. Enrollee received the Termination Notice in error (e.g., he or she is currently enrolled in Medicaid or in a TennCare Standard category that is not ending);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Termination Notice but failed to extend the time;

iv. Enrollee requested assistance because of a health, mental health, learning problem, or disability, but the state failed to provide this assistance; or

v. The state sent the Termination Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the appeal is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of disenrollment as identified in the Termination Notice, TennCare Standard benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute, or the appeal is resolved.

E. If the enrollee does not appeal prior to the date of disenrollment as identified in the Termination Notice, the enrollee will be disenrolled from TennCare Standard.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## PART II: NOTICE AND APPEALS PROCESS FOR CHANGES IN COVERAGE OF TENNCARE BENEFITS

This Part summarizes the process Tennessee will use upon and after the implementation of changes in coverage of TennCare benefits. These procedures were approved as an amendment to the TennCare II demonstration on March 31, 2006. This detailed process is used by the state to implement benefit changes, specifically benefit limits. It is used daily with enrollees who are subject to pharmacy benefit limits when they reach their monthly maximum. With this process, Tennessee provides one notice per month when benefit limits have been reached. The state will continue to follow this process with enrollees who are subject to pharmacy or other benefit limits throughout the Demonstration approval period unless modified through an approved Demonstration amendment. To change benefits covered under the Demonstration, the state must submit a Demonstration amendment in accordance with paragraphs 6 and 7 regarding amendments of these STCs.

### I. Implementation of Changes in Coverage Policies

#### 1. Initial Notice

A. At least 30 days prior to the effective date of changes in coverage of TennCare benefits (e.g., implementation of pharmacy benefit limits and elimination of covered services), the state shall provide a notice (Benefit Notice) to enrollees who are impacted by such changes in coverage of TennCare benefits.

B. Benefit Notices will:

i. Inform enrollees of how changes in coverage of TennCare benefits will apply to enrollees.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Benefit Notice to request a hearing for valid factual disputes related to the changes in coverage and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing for a valid factual dispute prior to the effective date of the change in coverage of TennCare benefits, benefits will be continued at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the level for Non-Institutionalized Medicaid Adults (Default Level). The state will apply the Default Level of benefits until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary. (The resolution of an appeal, for purposes of this Part, is defined as when the appeal is dismissed or resolved prior to a hearing or when a decision is rendered at or after the hearing.)

## 2. Appeals Process

A. An enrollee will have the opportunity to request a state fair hearing for 40 days (inclusive of mail time) from the date of the Benefit Notice.

B. The state will grant state fair hearings only for those enrollees raising valid factual disputes related to the changes in coverage. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to a different level of TennCare benefits than that identified in the Benefit Notice. Valid factual disputes include when an enrollee claims to have received the Benefit Notice in error (e.g., he or she is already in a TennCare category that is not subject to the particular changes in coverage).

C. When an enrollee requests a hearing prior to the effective date of changes in coverage as identified in the Benefit Notice, the enrollee shall continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the Default Level. The state will apply the Default Level until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary.

D. If the enrollee appeals, the changes in coverage in dispute shall become effective upon resolution of the appeal.

E. If the enrollee does not appeal prior to the effective date of changes in coverage as identified in the Benefit Notice, such changes in benefits will become effective, as applied to the enrollee, upon this date.

F. If the enrollee appeals and:

(i) The appeal is dismissed because the enrollee has not asserted a valid factual dispute; or

(ii) The enrollee is granted a hearing and the hearing decision sustains the state's action.

The state reserves its right to recover from the enrollee the cost of services provided as a result of the appeal.

# II. Post-Implementation Appeals from Denials of Prior Authorization for Pharmacy Products

## 1. Prior Authorization Requirements

A. Any prescription of a branded drug may be subjected to a prior authorization requirement by the state; and prior authorization will be required as a condition of coverage for branded prescription drugs that are not included on the state's Preferred Drug List.

B. Physicians (or other providers with prescribing authority) participating in TennCare will be responsible for requesting prior authorization, according to procedures to be established by the state.

**2. <u>Notice of Prior Authorization Denial</u>**

A. Requests for prior authorization of covered outpatient drugs shall be transmitted to and acted upon by appropriate staff of the Pharmacy Benefit Manager (PBM) Clinical Call Center.

B. Written notice of denial of a request for prior authorization shall be mailed by the PBM on behalf of the state to the enrollee and transmitted by facsimile to the prescribing physician. Such Notice will inform the enrollee that the request for prior authorization of the prescribed drug has been denied and that TennCare does not cover the drug absent prior authorization, briefly state the reason or reasons for denial of the request, explain the procedures that are available to the enrollee to appeal from that decision, and inform the enrollee that TennCare will not cover the cost of the prescribed medication during the pendency of any appeal. The state's failure to act on a request for prior authorization within a 24-hour period after receiving a submission that complies with the state's requirements for a completed prior authorization request may be deemed a denial from which the enrollee can appeal.

**3. <u>Procedures for Filing and Pursuing an Appeal</u>**

A. Appeals of denials of requests for prior authorization may be initiated within 20 days of the Notice of denial of prior authorization, at the option of the enrollee, by the enrollee (or an individual appointed or otherwise authorized under state law to act as the enrollee's representative) submitting to the TennCare Solutions Unit via hand delivery, mail, or facsimile, a written statement of intent to appeal on a form prescribed by the state. Such form will be available on the PBM Web site, and the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's managed care organization (MCO), or from the TennCare Solutions Unit. Undue delay by the state in deciding a prior authorization request (i.e., delay in excess of the 24-hour period permitted for such decisions) will be considered a denial of prior authorization for purposes of appeal.

B. The state will dismiss any appeal that does not raise a valid factual dispute without a hearing, and will retain the authority to determine whether an appeal raises a valid factual dispute relating to denial of a prior authorization request or the state's failure to act on a request for prior authorization within a 24-hour period after such request. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the prescribed drug. A dispute concerning whether a particular

drug or dosage is medically necessary for the enrollee, will be considered a valid factual dispute.

C. An initial determination on appeals involving issues of medical necessity will be made by appropriately qualified medical professionals on the staff of the TennCare Solutions Unit as promptly as possible after the enrollee's submission of the appeal. After submission of the appeal, the TennCare Solutions Unit may seek additional information or documentation in support of the appeal, before any initial determination is made.

D. Upon initially deciding an appeal, the state shall send a letter communicating its decision to the enrollee and stating the reasons for that decision, and shall also communicate any decision granting prior authorization to the enrollee and/or the prescribing physician by the fastest means practicable. A letter initially denying an appeal shall also inform the enrollee of his or her opportunity to request a state fair hearing, and the procedures that must be followed to pursue such further appeal.

**4. <u>Benefits During the Pendency of an Appeal</u>**

A. During the pendency of any appeal from denial of a pharmacy service due to the lack of required prior authorization, the enrollee will continue to be eligible for pharmacy benefits within applicable pharmacy service limits, but will not have any right to receive on a covered basis the drug that is the subject of the appeal.

B. If the enrollee chooses to purchase the unauthorized, prescribed drug at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the drug upon prevailing in his or her appeal, but only to the extent that applicable, monthly pharmacy benefit limits would not thereby be exceeded.

## III. <u>Post Implementation Appeals of Application of Benefit Limits</u>

**1. <u>Initial Notice</u>**

A. Pharmacists will be required to verify TennCare coverage for all prescriptions presented by enrollees through an electronic database maintained by the PBM. If, through the database, the PBM denies coverage of a prescription because the enrollee has reached or exceeded the monthly pharmacy benefit limit ("the pharmacy limit"), the PBM on behalf of the state will mail a written notice of the denial to the enrollee (Service Notice). Service Notice shall be provided only upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five prescription limit, and/or upon the first denial in that month of a pharmacy service sought by the enrollee that exceeds the two prescriptions limit on branded drugs. (For purposes of this Part, "the pharmacy limit" is defined as a five prescription limit per month, of which no more than two prescriptions or refills could be for branded drugs and at least three out of any five prescriptions or refills in the same month must be for generic drugs.)

B. If a pharmacist fills a prescription in excess of the pharmacy limit and submits a claim for such service, the PBM will deny payment for the claim. Upon denial of payment for such claim, the PBM on behalf of the state will mail a written notice (Notice of Limit) to enrollees.

C. If a provider denies a non-pharmacy service or charges the enrollee for the service because the enrollee has reached or exceeded a benefit limit, the provider need not give specific notice of appeal rights to the enrollee but must direct the enrollee to the responsible arm of the managed care contractor (MCC).

D. If a provider renders a non-pharmacy service in excess of a non-pharmacy benefit limit and the provider or the enrollee submits a claim for such service, the MCC will deny payment for the claim. Upon denial of payment for such claims, the MCC, on behalf of the state, will mail a Notice of Limit to enrollees. A Notice of Limit shall be provided only upon the first denial of coverage of a non-pharmacy service sought by the enrollee that exceeds the applicable limit for the kind and number of services during a given time period specified in the state's program.

E. The Notice of Limit and Service Notice will:

i. Inform an enrollee that he or she has reached or exceeded the applicable benefit limit.

ii. Provide enrollees with at least 20 days from the Notice of Limit or Service Notice to request a hearing for valid factual disputes related to the benefit limit and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing, they will not receive continuation of benefits (i.e., services in excess of the applicable limit) during the pendency of their appeal.

iv. Remind enrollees of any exceptions to the limits and inform them how to obtain more information about such exceptions.

**2. <u>Appeals Process</u>**

A. Enrollees will have the opportunity to request a state fair hearing for at least 20 days from the date of the Notice of Limit or Service Notice.

B. The enrollee will be required to submit a designated form in order to request a state fair hearing. The form, which must be signed by the enrollee (or an individual appointed or otherwise authorized to act as the enrollee's representative under state law), would include the basis for the appeal and the enrollee must attest, under penalty of perjury, that his contention is true to the best of his knowledge and is made in good faith. Enrollees may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its

discretion of an exemption from a signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or by an individual authorized under state law to act as the enrollee's representative.

C. The state will grant a state fair hearing only for those enrollees raising valid factual disputes related to the benefit limit. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the service that was denied because the enrollee had reached or exceeded the applicable benefit limit. Valid factual disputes include:

   i. An administrative error was allegedly made and the enrollee has not yet reached the relevant benefit limit.

   ii. The enrollee alleges that his or her circumstances have changed and he or she has been re-classified in a TennCare eligibility category that is not subject to the benefit limit the state has applied. The state, however, shall not grant a hearing to individuals who allege solely that they are not subject to the benefit limit without further alleging a change of circumstances that has been reported to TennCare and has resulted in a change in their eligibility category. These enrollees will be granted a hearing because they did not have the opportunity to appeal the application of the benefit limit to them in connection with the Benefit Notice.

   iii. The enrollee alleges an administrative error in the processing of a request for a special exemption to the benefit limit (i.e., the enrollee's physician submitted the required attestation necessary to obtain a special exemption from the benefit limit and the prescribed drug is on the special exemption list but coverage for the drug was nonetheless denied).

D. The enrollee shall not receive continuation of benefits when appealing a denial of services based on the application of a benefit limit. This policy shall apply even for items or services that have been previously authorized as medically necessary to the extent that the denial of services is based on the application of a benefit limit.

E. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal with respect to those benefits.

F. If the enrollee does not request a hearing, the benefit limit deemed applicable by the state will continue to apply to the enrollee.

G. Providers will be permitted to bill enrollees for services that were provided in excess of the benefit limits.

## IV. Post Implementation Appeals of Elimination of Coverage for Certain Services

1. Neither the state nor the MCC will provide notification in addition to the Benefit Notice described above with respect to services that are eliminated from TennCare coverage as those services are no longer covered by TennCare.

2. Upon denial of non-covered services, TennCare enrollees will have the opportunity to request a state fair hearing. The enrollee will be required to submit a designated form in order to request a hearing. Such form would include a statement, which must be signed by the enrollee, or an individual appointed or otherwise authorized to act as the enrollee's representative under state law that sets out or describes the factual contention on which the appeal is based, and attests, under penalty of perjury, that the contention is true to the best of the signatory's knowledge and is made in good faith. Enrollees or their representatives may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its discretion of an exemption from the signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or his/her authorized representative.

3. The state will grant a state fair hearing only for those enrollees who raise valid factual disputes related to the elimination of coverage. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to coverage of the disputed service. In the context of excluded services, valid factual disputes are limited to when an enrollee claims that he or she is already in a TennCare category that is entitled to coverage of the particular service at issue. Appeals that do not raise a valid factual dispute will be dismissed without a hearing.

4. If the request for a hearing is granted, the enrollee will not receive continuation of the benefits in dispute pending the appeal.

5. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee may be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal.

## PART III: ENROLLMENT IN TENNCARE STANDARD SPEND DOWN

TennCare Standard Spend Down (SSD) is open to people who are not currently eligible for Medicaid and who meet the criteria for the SSD program. Financial eligibility criteria for SSD will be based on criteria that apply to medically needy pregnant women and children eligible under the state plan.

Applicants will be enrolled only through a single toll-free telephone point of entry (the Call-In Line) initiated in periods of open enrollment. In each open enrollment period, the state will determine a specified number of calls that it will accept through the Call-In Line based on the number of applications that the state estimates it can process within federal timeliness standards. The state will not accept or track calls received outside of open enrollment periods.

Once the state has reached its targeted enrollment of 100,000 persons, new open enrollment periods will be scheduled when enrollment in the SSD program drops to 90 percent of target enrollment. Any subsequent open enrollment periods will remain open until a pre-determined number of calls to the Call-In Line have been received. The number of calls to be received will be established based on the state's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the state estimates it can process in a timely manner in accordance with federal standards. The state's decision to open or close enrollment is a policy decision that is within the state's discretion and the state is not required to provide fair hearings for challenges to these decisions.

Callers to the Call-In Line will be asked for basic demographic information and will be assigned a unique identifier. After conducting a match to verify that callers are not already enrolled in TennCare Medicaid as state plan eligibles, the state will send each non-enrolled caller a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within 30 days. (Those callers who are already enrolled in TennCare Medicaid as state plan eligibles will be sent letters advising them that they currently have benefits and need not apply.)

Completed signed applications received by the state by the 30-day deadline established by the state will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will still be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the state. If the individual does not mail back an application by the deadline, the state will send the individual a letter advising him or her that since no application was received, the state will not make an eligibility determination for him or her, but the individual is free to apply for SSD during any subsequent open enrollment period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he or she did submit a signed, written application within the deadline. Since all SSD applications received during an open enrollment period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open enrollment period will be carried forward to future open enrollment periods. The state will determine SSD eligibility within the timeframes specified by Federal regulations at 42

CFR § 435.911; such timeframes will begin on the date a signed written application is received by the state.

The effective date of SSD eligibility for individuals whose enrollment is originally initiated through the Call-In Line and who submit a timely signed application will be the later of: 1) the date that their call was received by the Call-In Line; or 2) the date spend down is met (which must be no later than the end of the 1-month budget period -- in this case, the end of the month of the original call to the Call-In Line). The effective date provisions contained herein only apply to SSD eligibility and do not apply to other categories of TennCare eligibility. All enrollees in the SSD demonstration category will have an eligibility period of 12 months from the effective date of the determination. At the end of the 12-month period the enrollee will need to have his eligibility status redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for TennCare Medicaid.

## XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

| | | |
|---|---|---|
| **Monthly Deliverables** | | |
| Monthly | Monitoring Call | ~~44~~ |
| **Quarterly Deliverables** | | |
| 60 days after end of each quarter | Quarterly progress reports | 45 |
| Per Sections 2500 & 2115 of State Medicaid Manual, or upon request | Quarterly expenditure, budget neutrality, member month reports | 41,42 Sections X and XI |
| **Annual Deliverables** | | |
| 120 days after end of each demonstration year | Draft Annual Progress Report | 46 |
| Within 30 days of receipt of comments from CMS on the Draft Annual Progress Report | Final Annual Progress Report | 46 |
| Dec. 31st of each year | Annual CHIP Report entered into CHIP Annual Report Template System (SARTS) | 46 |
| Sept. of each demonstration year | Annual beneficiary survey report | 47 |
| **Other Deliverables** | | |
| 6 months before expiration of demonstration | Request for extension | 8 |
| 5 months prior to suspending or terminating the demonstration | Phase-out plan | 9 |
| 6 months before expiration of demonstration | Interim evaluation report. | 8, 70 |
| 120 days after expiration of demonstration | Draft Final Evaluation Report | 48, 71 |
| 60 days after receipt of CMS comments on Draft Final | Final Evaluation Report | 48, 71 |

| | | |
|---|---|---|
| Evaluation Report | | |
| Implementation of compliance plan by January 1, 2013. | Enrollee notification and implementation of the new cost-sharing requirements | 35 |
| At least annually | MEQC plan proposal and report on findings | 23 |
| Upon receipt by state | Financial audits and quality assessment reviews of participating health plans, and other managed care and HCBS requirements | 40, 43 |
| Upon receipt by state | Fraud and abuse and program integrity reports related to 1115 Demonstration beneficiaries and providers | |
| As required by CMS | Corrective Action Plans and findings | |
| Upon submission to Regional Office | Courtesy copy of all state plan amendments to be sent to the CMS Project Officer | 7 |
| 60 days advance notice | Modification of CHOICES benefits defined in Attachment D | 7 |
| No later than 120 days prior to planned implementation and may not be implemented until approved | Demonstration amendments, including requests for services not defined in Attachment D | 6, 7 |
| 30 days advance notice | Notice on increases in CHOICES Enrollment Targets within allowable range | 32 |
| 3 months after each point in time. i.e. September 30 of each demonstration year | Submission of CHOICES data | 43.d. |
| Annually | Integrated Quality Improvement Strategy Update | 43.c. |
| Subject to CMS approval prior to implementation | Final MCO contracts developed for CMS approval | 40 |
| When issued or amended by state | Procedural manuals or operating protocols related to the 1115 Demonstration | |
| *All Reports Required by Sections 2500 and 2115 of the State Medicaid Manual* | | |

**ATTACHMENT A**
**QUARTERLY PROGRESS REPORT**

Under Section IX, paragraph 45 *(Quarterly Progress Reports)* of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

## NARRATIVE REPORT FORMAT:

**Title Line One –** TennCare II

**Title Line Two -** Section 1115 Quarterly Report

**Demonstration/Quarter Reporting Period:**
*Example: Demonstration Year: 6 (7/1/2007 – 6/30/2008)*
*Federal Fiscal Quarter: 1/2008 (10/07 - 12/07)*

**Footer:** Approval Period July 1, 2013 – June 30, 2016

## I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

## II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to TennCare eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.
    - Progress on implementing TennCare Standard Spend Down.
    - Progress on phasing out closed eligibility categories.
    - Other

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

**Enrollment Counts for Quarter**

Note: Enrollment counts should be person counts, not member months

| Demonstration Populations | Total No. TennCare Enrollees in current Quarter |
|---|---|
| **EG1 Disabled, Type 1 state plan eligibles** | |
| **EG 9 H-Disabled, Type 2 demonstration population** | |
| **EG2 Over 65, Type 1 state plan eligibles** | |
| **EG10 H-Over 65, Type 2 demonstration population** | |
| **EG3 Children, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 2 demonstration population** | |
| **EG5 Duals, Type 1 state plan eligibles and EG-11 H-Duals 65, Type 2 demonstration population** | |
| **EG6E Expan Adult, Type 3 demonstration population** | |
| **EG7E Expan Child, Type 3 demonstration population** | |
| **EG8, Med Exp Child, Type 2 demonstration population, Optional Targeted Low Income Children funded by Title XIX** | |
| **Med Exp Child, Title XXI demonstration population** | |
| **EG12E Carryover, Type 3, demonstration population** | |

**III. Outreach/Innovative Activities to Assure Access**

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for TennCare enrollees or potential eligibles.

**IV. Collection and Verification of Encounter Data and Enrollment Data**

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

**V. Operational/Policy/Systems/Fiscal Developments/Issues**

Identify all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

**VI. Action Plans for Addressing Any Issues Identified**

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration.

**VII. Financial/Budget Neutrality Development/Issues**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

## VIII. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

### A. For Use in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| ***Medicaid eligibles (Type 1)*** | | | | |
| **EG1 Disabled, Type 1 state plan eligibles (paragraph 53.a.i.)** | | | | |
| **EG2 Over 65, Type 1 state plan eligibles (paragraph 53.a.ii.)** | | | | |
| **EG3 Children, Type 1 state plan eligibles (paragraph 53.a.iii.)** | | | | |
| **EG4 Adults, Type 1 state plan eligibles (paragraph 53.a.iv.)** | | | | |
| **EG5 Duals, Type 1 state plan eligibles (paragraph 53.a.v.)** | | | | |
| ***Demonstration eligibles (Type 2)*** | | | | |
| **EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX (paragraph 53.b.iii.)** | | | | |
| **EG9 H-Disabled, Type 2 Demonstration Population (paragraph 53.b.iv.)** | | | | |
| **EG10 H-Over 65, Type 2 Demonstration Population (paragraph 53.b.v.)** | | | | |
| **EG11 H-Duals, Type 2 Demonstration Population (paragraph 53.b.vi.)** | | | | |

### B. Not Used in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **EG6E Expan Adult, Type 3, Demonstration Population (paragraph 53.b.i.)** | | | | |
| **EG7E Expan Child, Type 3, Demonstration Population (paragraph 53.b.ii.)** | | | | |
| **Med Exp Child, Title XXI Demonstration Population (paragraph 53.c.)** | | | | |
| **EG12E Carryover, Type 3, Demonstration Population (paragraph 53.b.vii.)** | | | | |

## IX. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

## X. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

## XI. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

## XII. Essential Access Hospital Pool

List the Essential Access Hospitals and specify their type from the following:
Essential Service Safety Net
Children's Safety Net
Free Standing Psychiatric Hospitals
Other Essential Acute Care

## XIII. Graduate Medical Education (GME) Hospitals

List the GME hospitals and their affiliated teaching universities.

## XIV. Critical Access Hospitals

List the Critical Access Hospitals.

## Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

## State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

## Date Submitted to CMS

## ATTACHMENT B
## LIMITATIONS ON HOME HEALTH SERVICES

Home health services are delivered in accordance with 42 CFR § 440.70. Prior authorization may be required. Definitions and coverage limitations used by the state are as follows:

1. Home health services shall include any of the following services ordered by a treating physician and provided by a licensed home health agency pursuant to a plan of care at an enrollee's place of residence.

   a. Part-time or intermittent nursing services.

      (1) To be considered "part-time and intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, AND no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide care combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. The above limits may be exceeded when medically necessary for children under the age of 21.

      (2) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on an as needed basis. Part-time or skilled nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.

   b. Home health aide services.

      (1) Home health aide care must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

      (2) The above limits may be exceeded when medically necessary for children under the age of 21.

   c. Physical therapy, occupational therapy, speech pathology and audiology services.

d. Medical supplies, equipment, and appliances ordered by a treating physician and suitable for use at an enrollee's place of residence.

2. Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, or preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:

   a. The child is non-ambulatory; and

   b. The child has no or extremely limited ability to interact with caregivers; and

   c. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and

   d. No other children shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult.

## ATTACHMENT C
## LIMITATIONS ON PRIVATE DUTY NURSING SERVICES

Private duty nursing services are delivered in accordance with 42 CFR § 440.80. Prior approval may be required. Definitions and coverage limitations used by the state are as follows:

PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period. A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members.

1. If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home that determines whether the nursing services are continuous or intermittent.

2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:

    a. Have a demonstrated understanding, ability, and commitment to the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration, and feeding, as applicable; and

    b. Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and

    c. Are willing and available as needed to meet the recipient's non-nursing support needs.

3. Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:

    a. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

    b. Has a functioning tracheostomy

        (1) Requiring suctioning, AND

(2) Oxygen supplementation, AND

(3) Receiving nebulizer treatments or requiring the use of Cough Assist/inexsufflator devices.

(4) In addition, for persons with a functioning tracheostomy, at least one from each of the following (I and II) must be met:

(I) Medication

(a) Receiving medication via a gastrostomy tube (G-tube), OR

(b) Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port. AND

(II) Nutrition

(a) Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube), OR

(b) Receiving total parenteral nutrition.

4. Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.

5. A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period, or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of this Attachment may receive medically necessary nursing care as an intermittent service under home health.

6. General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have other non-medical caregiving needs which must be met, to the extent that private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

a. The child is non-ambulatory; and

b. The child has no or extremely limited ability to interact with caregivers; and

c. The child would not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse would be present in the home without the presence of another responsible adult; and

d. No other children will be present in the home during the time the private duty nurse would be present in the home without the presence of another responsible adult.

## ATTACHMENT D
## GLOSSARY OF TERMS FOR TENNCARE CHOICES

**Adult care homes.** A state-licensed community-based residential alternative which offers 24-hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet nursing facility level of care, but who would prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-basis is living in the home with the individuals for whom they are providing care. Coverage shall not include the costs of room and board.

**Adult day care.** Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day provided pursuant to an individualized plan of care by a licensed provider not related to the participating adult.

**Assisted care living facility services**. Community-based residential alternative to nursing facility care in a licensed Assisted Care Living Facility that provides and/or arranges for daily meals, personal care, homemaker and other supportive services or health care including medication oversight (to the extent permitted under state law), in a home-like environment to persons who need assistance with activities of daily living. Coverage shall not include the costs of room and board.

**Assistive technology.** Assistive device, adaptive aids, controls or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive or control their environment. Examples include, but are not limited to, 'grabbers' to pick objects off the floor, strobe lights to signify the smoke alarm has been activated, etc.

**At-Risk.** As it relates to the CHOICES program, SSI eligible adults age 65+ or age 21+ with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined by the state in administrative rule, such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As is relates to Interim CHOICES 3, open for enrollment starting on July 1, 2012 and closed to enrollment on December 31, 2013, "at risk" is defined as adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meeting nursing facility financial eligibility criteria, and also meet the nursing facility level of care in effect on June 30, 2012.

**Attendant care.** Hands-on assistance, safety monitoring and supervision for an enrollee who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visits (more than four (4) hours per visit or visits at intervals of less than four (4) hours between visits). This may include assistance

with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, attendant care may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home, or continuous monitoring and supervision because there is no household member, relative, caregiver, or volunteer to meet the specified need. Attendant care shall not be provided for enrollees who do not require hands-on assistance with ADLs.

Attendant care does not include:

1) Care or assistance including meal preparation or household tasks for other residents of the same household;
2) Yard work; or
3) Care of non-service related pets and animals.

Only for persons who require homemaker services in addition to hands-on assistance with ADLs, the annual benefit shall be up to 1400 hours per full calendar year.

**Community-based residential alternatives to institutional care (Community-based residential alternatives).** Residential services which offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, assisted care living facilities, adult care homes, and companion care.

**Companion care.** A consumer-directed residential model in which a CHOICES member may choose to select, employ, supervise and pay, utilizing the services of a fiscal intermediary, on a daily, weekly, or monthly basis, as applicable, a live-in companion who will be present in the member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration. Such model will be available only for a CHOICES member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with activities of daily living or supervision and monitoring for extended periods of time that cannot be met more cost-effectively with other non-residential services. A CHOICES member who requires assistance in order to direct his or her companion care may designate a representative to assume consumer direction of companion care services on his/her behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.

**Consumer direction of eligible CHOICES HCBS.** The opportunity for a member assessed to need specified types of HCBS including attendant care, personal care visits, homemaker services (provided only as part of attendant care or personal care visits), in-home respite care, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such

services—primarily, the hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed service(s).

**Electronic visit verification (EVV) system**. An electronic system in which caregivers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of HCBS and which may also be utilized for submission of claims.

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

**Homemaker services.** Effective July 1, 2012, homemaker services are only available as part of attendant care or personal care visits for individuals who need hands-on assistance with ADLs. Services covered include general household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the member, changing the member's linens, making the member's bed, washing the member's dishes, doing the member's personal laundry, ironing, or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the member, assistance with maintenance of safe environment, and errands such as grocery shopping and having the member's prescriptions filled. Homemaker services are to be provided only for the member (and not for other household members) and only when the member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the member.

**In-home respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in the individual's place of residence, because of the absence or need for relief of those persons normally providing the care.

**In-patient respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in a licensed nursing facility or licensed community-based residential alternative, because of the absence or need for relief of those persons normally providing the care.

**Minor home modifications.** Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered

improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

**Nursing facility care.** See Social Security Act, Section 1919(a).

**Personal care visits.** Intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance to an enrollee who, due to age and/or physical disability, needs help with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, personal care visits may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need.

Personal care visits do not include:

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

**Personal emergency response system (PERS).** An electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. The individual may also wear a portable 'help' button to allow for mobility. The system is programmed to signal a response center once the 'help' button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed.

PERS services are limited to those individuals who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time, such that the individual's safety would be compromised without access to a PERS.

**Pest control.** The use of sprays, poisons and traps, as appropriate, in the enrollee's residence (excluding NF, ACLF) to regulate or eliminate the intrusion of roaches, wasps,

mice, rats and other species of pests into the household environment thereby removing an environmental issue that could be detrimental to a frail elderly or disabled enrollee's health and physical well-being.

**Reserve capacity.** The state's right to maintain some capacity within an established enrollment target to enroll individuals into HCBS under certain circumstances. These circumstances could include, but are not limited to: discharge from a nursing facility; discharge from an acute care setting where institutional placement is otherwise imminent, or other circumstances which the state may establish from time to time in accord with these STCs.

**Room and board.** Refers to lodging, meals, and utilities. The kinds of items that are considered "room and board" and are therefore not reimbursable by Medicaid include:

- Rent, or, if the individual owns his home, mortgage payments, depreciation, or mortgage interest
- Property taxes
- Insurance (title, mortgage, property and casualty)
- Building and/or grounds maintenance costs
- Resident "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included)
- Household supplies necessary for the room and board of the individual
- Furnishings used by the resident
- Utilities (electricity, water and sewer, gas)
- Resident telephone
- Resident cable television

**Short Term Nursing Facility Care.** The provision of nursing facility care for no more than 90 days to a CHOICES 2 or CHOICES 3 participant who was receiving home and community based services upon admission and who requires temporary placement in a nursing facility—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 90 days. Such CHOICES 2 or CHOICES 3 member must meet the nursing facility level of care upon admission (which for CHOICES 3 participants is anticipated to be due to a short-term condition), and in such case, while receiving short-term nursing facility care may continue enrollment in CHOICES 2 or CHOICES 3, as applicable, pending discharge from the nursing facility within no more than 90 days or until such time it is determined that discharge within 90 days from admission is not likely to occur, at which time the person shall be transitioned to CHOICES 1, as appropriate. The community personal needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

**Transition Allowance.** A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of a managed care organization, be

provided as a cost-effective alternative to continued institutional care for a CHOICES member in order to facilitate transition from a nursing facility to the community when such member will, upon transition, receive more cost-effective non-residential home and community based services or companion care. Items which may be purchased or reimbursed are only those items that the member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

## ATTACHMENT E
## BEST PRACTICES GUIDANCE REGARDING
## CONSUMER DIRECTION OF HOME AND COMMUNITY BASED SERVICES

The state will define services that eligible members may elect to direct. Members determined, as a part of the needs assessment and plan of care processes, to require such services will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e. consumer direction of HCBS).

All eligible members requiring these services will be offered the option to participate in consumer direction of HCBS.

i. Upon enrollment in HCBS and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.

ii. Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at anytime, service by service, without affecting their enrollment in HCBS. Only the state can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare.

iii. A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or be a member's paid worker.

iv. The state will utilize a fiscal employer agency (FEA) to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services rendered; and withholding, filing and paying applicable Federal, state and local income and employment taxes for workers) and to provide supports broker assistance.

v. The plan of care process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports, contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.

vi. Members will have the flexibility to hire persons close to them, including family members but excluding spouses, to serve as their workers. All workers must meet the state specified qualifications for providers of comparable non-consumer directed services and must sign a service agreement.

vii. Members will have flexibility in establishing payment rates that do not exceed the state specified ceiling for each service.

viii. Members and/or representatives must receive training prior to participating in consumer direction of HCBS and re-enrolling in consumer direction of HCBS. Ongoing training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.

ix. Workers must receive training, as a condition for hire, certain aspects of which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.

x. A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care, and the adequacy of payment rates.

## ATTACHMENT F
## CERTIFIED PUBLIC EXPENDITURES PROTOCOL

**Preamble**

This protocol governs the use of certified public expenditures to furnish the non-Federal share of expenditures claimed for Federal participation under the Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (paragraph 55.h.). The protocol is based on the following elements:

1) Units of government, including governmentally operated health care providers, may certify that costs have been incurred for providing services to TennCare and uninsured individuals. The CPE process contained in this attachment is in accordance with Federal regulations and CMS guidance or policy.

   i. Units of government have been determined by the state as eligible to certify public expenditures.

   ii. Certification must be supported by cost documentation, which represents both the Federal and non-Federal share of funds (i.e., total computable expenditures) under the Demonstration. Federal matching funds are available as a percentage of such eligible costs.

2) To the extent the state continues to utilize certified public expenditures (CPEs) as the funding mechanism for title XIX and XXI (or under Section 1115 authority) payments beyond the date defined in this section, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs as eligible under title XIX or XXI (or under Section 1115 authority) for purposes of certifying public expenditures.

3) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the state the amount of such tax revenue (state or local) appropriated to the non-governmental provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the state's claim for Federal match. Federal matching funds will be available as a percentage of such eligible costs.

### I. Cost Computation

#### A. TN CPE 1115 – Medicaid Fee-For-Service

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552)

covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from MMIS for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the

cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

## B. TN CPE 1115 – Medicaid Managed Care

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not

be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

## C. TN CPE 1115 – Hospital Uninsured Care

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently as-filed Medicare cost report (CMS 2552), as-filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the as-filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospital's audited financial statements and other auditable documentation. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of Uninsured care usable organs to total usable organs. This is determined by dividing the number of Uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible Uninsured care costs are determined by adding the Uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual Uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

## II. Payments and Recoveries

All payments and recoveries, from MCO's; BHO's; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds) including any related patient co-payments, or payments from other non-state payers will be offset against the costs computed in Section I above. Payments to the hospital from uninsured individuals for their care for the fiscal year are identified from the hospital's records. Such uninsured data must be supported by auditable documentation.

## III. Interim Reconciliation

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3

Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5

Actual Medicaid paid days and charges from MMIS paid claims data for services furnished during the payment year are used.

Step 6

Organ acquisition costs and total usable organs from the as-filed CMS 2552 cost report for the payment year are used.

## IV. Final Reconciliation

Upon finalization of the CMS-2552 by the Medicare fiscal intermediary, the methodologies as prescribed above will be used to determine final Medicaid FFS cost, Medicaid managed care cost, and uninsured cost. The routine per diems and ancillary cost-to-charge ratios will be determined using cost, day and charge data from the finalized cost report. The Medicaid FFS, Medicaid managed care, and uninsured days, charges, and payment offsets will be updated with the latest MMIS reports and other auditable financial records.

Cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include:

1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS data to the per diem amount;

2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and

3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly excepted for Medicaid.

If, at the end of the reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Recoveries are updated and offset to cost as calculated per Steps above.

For hospitals whose cost report year is different from the state's fiscal year, the state will proportionally allocate to the state plan rate year the costs of two cost report periods encompassing the state Plan payment year. To do so, the state will obtain the actual Medicaid FFS, Medicaid managed care, and uninsured days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS, Medicaid managed care, and uninsured costs for the reporting periods; these costs will then be proportionally allocated to the state plan rate year. All allocations will be made based upon number of months. (For example, a hospital's cost reporting period ending 12/31/07 encompasses three-fourths of the state plan rate year ending 9/30/2007, and one-fourth of the state plan rate year ending 9/30/2008. To fulfill reconciliation requirements for state plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2006, to the state plan rate year.) The state will ensure that the total costs claimed in a state plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

**July 16, 2013**

Mr. Darin Gordon
Director
Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to amend the TennCare II section 1115 of the Social Security Act (the Act) demonstration (Project No. 11-W-00151/4). This amendment is effective as of October 1, 2013.

The Special Terms and Conditions (STCs) have been changed to reflect that the following groups under the demonstration will be subject to a $1.50 co-pay for generic outpatient prescriptions:

- TennCare Medicaid adults who are not exempt from cost sharing under 42 CFR 447.53
- TennCare Standard individuals under age 21 with incomes at or above 100 percent of the federal poverty level (FPL)
- TennCare Standard individuals aged 21 and older under the Standard Spend Down program
- CHOICES 3 and Interim CHOICES 3 enrollees that are at risk-for institutionalization

The approval is conditioned upon compliance with the enclosed STCs and is subject to our receiving your acknowledgement of the award and the acceptance of the STCs within 30 days of the date of this letter.

Your acceptance and any questions regarding the TennCare II program may be directed to your project officer, Jessica Woodard. Ms. Woodard can be reached at (410) 786-9249 or Jessica.Woodard@cms.hhs.gov.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

Cc: Jennifer Ryan, Acting Director, Children and Adults Health Programs Group
Diane T. Gerrits, Director, Division of State Demonstrations and Waivers
Jackie Glaze, Associate Regional Administrator, CMS Atlanta
Kenni Howard, CMS Atlanta
Jessica Woodard, CMCS

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**WAIVER LIST**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or specified as not applicable in the following list, shall apply to all TennCare II populations identified in paragraph 17 *(Eligibility)* of the Special Terms and Conditions.

The TennCare II Demonstration will operate under these waiver authorities and those provisions specified as "not applicable." The waiver authorities and the provisions specified as "not applicable" will continue through June 30, 2016, unless otherwise stated.

The following waivers shall enable Tennessee to implement the TennCare II Medicaid Section 1115 demonstration.

**WAIVERS OF TITLE XIX REQUIREMENTS FOR TENNCARE MEDICAID TITLE XIX STATE PLAN GROUPS**

**1. Statewideness/Uniformity** **Section 1902(a)(1)**
**42 CFR § 431.50**

To the extent necessary to enable the state to provide managed care plans or certain types of managed care plans only in certain geographical areas of the state. Certain managed care plans or certain types of managed care plans (e.g., risk-based plans) are only available in certain areas of the state.

**2. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR § 438.52**

To the extent necessary to permit the state to have only one pharmacy benefits manager and one dental benefits manager to provide services in a region of the state or statewide.

**3. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR § 435.831**

To the extent necessary to enable Tennessee to use streamlined eligibility procedures that provide for coverage of optional Medically Needy children and pregnant women and the Standard Spend Down demonstration population for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. In accordance with the Code of Federal Regulations, the "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

**4. Reasonable Promptness** **Section 1902(a)(8)**

To the extent necessary to enable the state to limit enrollment in CHOICES 2 and 3 to the enrollment target(s) established by the state, as authorized under 32.d. (*Enrollment Targets for TennCare CHOICES)* of the Special Terms and Conditions, and to allow the state to require applicants for long-term services and supports to complete a person-centered assessment and options counseling process.

**5. Access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Benefits** **Section 1902(a)(10) 42 CFR §§ 440.210 and 440.220**

To the extent necessary to enable the state to permit managed care contractors to limit coverage of FQHC and RHC services, so long as access to care is assured from other providers.

**6. Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B) 42 CFR 440 Subpart B**

To the extent necessary to enable the state to offer a reduced benefit package, a different benefit package, or cost-effective alternative benefit packages to different populations under the demonstration (except for individuals specified in Section 1902(l)(4) of the Act), to the extent authorized under Section V of the Special Terms and Conditions.

**7. Comparability and Amount Duration and Scope** **Sections 1902(a)(17) and 1902(a)(10)(B)**

Should the state change the level of care criteria for admission to nursing facilities, to the extent necessary to enable the state to determine whether an individual has a continuing need for nursing facility services, PACE services, or home and community-based services for the elderly and disabled, based on the criteria in use when the individual first was determined to need the service.

**8. Freedom of Choice** **Section 1902(a)(23)(A) 42 CFR § 431.51**

To enable the state to restrict freedom of choice of provider, through the use of mandatory enrollment in managed care plans or TennCare Select for the receipt of TennCare II and TennCare CHOICES covered services, including for individuals specified at Section 1932(a)(2) of the Social Security Act (the Act). No waiver of freedom of choice is authorized for family planning providers.

**9. Retroactive Eligibility** **Section 1902(a)(34) 42 CFR § 435.914**

To enable the state not to extend eligibility prior to the date that an application for assistance is made. This waiver authority will expire at the end of the extension period of the demonstration, June 30, 2016, unless otherwise approved based on the requirements of paragraph 8 (*Extension of the Demonstration*) of the STCs.

**10. Payment for Outpatient Drugs** **Section 1902(a)(54)**

**42 CFR §§ 440.120,**
**447.331-447.334,**
**and 456 Subpart K**

To the extent necessary to enable the state to establish a drug formulary that does not comply with the requirements of Section 1927(d)(4) of the Act.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under Section 1903, shall, for the period of this demonstration extension, be regarded as expenditures under the state's Medicaid title XIX state plan.

The following expenditure authorities shall enable Tennessee to implement the Medicaid Section 1115 demonstration (TennCare II).

**1. Expenditures Related to MCO Enrollment and Disenrollment.**
Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the Act specified below. Tennessee managed care plans will be required to meet all requirements of Section 1903(m) except the following:

- Section 1903(m)(2)(A)(vi) of the Act, Federal regulations at 42 CFR § 438.56, to the extent that the rules in Section 1932(a)(4) are inconsistent with the enrollment and disenrollment rules contained in paragraph 39 *(Plan Enrollment and Disenrollment)* of the demonstration's Special Terms and Conditions (STCs), such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 45 days of enrollment in an MCO. After 45 days, enrollees may disenroll from an MCO with cause at any time.

**2. Expenditures Related to Expansion of Existing Eligibility Groups.**
To enable Tennessee to use streamlined eligibility procedures and include eligibility standards and requirements that differ from those required by law.

a. Expenditures for Medical Assistance furnished to state plan optional Medically Needy children and pregnant women for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. The "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

b. Expenditures for Medical Assistance furnished to mandatory state plan Transitional Medical Assistance beneficiaries, who are eligible in accordance with section 1931(c)(1) of the Act, for the remainder of a 12-month eligibility period after the 4-month period specified in the statute.

**3. Expenditures for Expanded Benefits and Coverage of Cost-Effective Alternative Services.**

a. Expenditures for TennCare Medicaid and TennCare Standard child enrollees for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*. and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

b. Expenditures for TennCare Medicaid and TennCare Standard adult enrollees for optional services not covered under Tennessee's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*., paragraph 28 *(TennCare Benefits)*, and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

**4. Expenditures for Pool Payments.**
Expenditures for Graduate Medical Education, Essential Access Hospital, Critical Access Hospital, Meharry Medical College, Unreimbursed Public Hospital Costs for Certified Public Expenditures, Unreimbursed Hospital Cost, and Public Hospital Supplemental Payment pool payments to the extent specified in paragraph 55.d. through h. and j. through l. *(Extent of Federal Financial Participation for the Demonstration)* of the demonstration's STCs. This expenditure authority will expire December 31, 2015, unless otherwise approved based on the requirements of paragraph 8 *(Extension of the Demonstration)* of these STCs.

**5. Indirect Payment of Graduate Medical Education.**
Expenditures, up to $50 million in total computable expenditures for each demonstration year, for payments to universities that operate graduate physician medical education programs, which are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics.

**6. Payments for Non-Risk Contractor.**
Payments to the TennCare Select prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor more than what Medical Assistance would have paid fee-for-service under the state plan in accordance with the upper limits at 42 CFR § 447.362.

**7. Expenditures Related to Eligibility Expansion.**
Expenditures to provide Medical Assistance coverage to the following demonstration populations that are not covered under the Medicaid state plan and are enrolled in TennCare Standard :

a. **Medically Eligible Demonstration Population Children, Not CHIP Eligible.**
Uninsured children under age 19 who lose eligibility in TennCare Medicaid, have been determined to be "medically eligible" (uninsurable), have family income at

or above 200 percent of the Federal poverty level (FPL), and do not meet the definition of an optional targeted low-income child.

b. **Adult Demonstration Population Eligibles-Standard Spend Down (SSD):** Non-pregnant, non-postpartum adults aged 21 or older who have been determined to meet criteria patterned after the state plan Medically Needy requirements (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category* of the STCs), comprising:
   - Aged, blind, or disabled individuals; or
   - Caretaker relatives.

**8. CHIP-Related Medicaid Expansion Demonstration Population Children.**
Expenditures to provide Medical Assistance coverage to uninsured children who lose eligibility under TennCare, who meet the definition of optional targeted low-income child, and who have family income up to 200 percent of the FPL.

**9. The CHOICES 217-Like HCBS Group.**
Expenditures for TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with Section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under TennCare CHOICES were provided under an HCBS waiver granted to the state under Section 1915(c) of the Act, as of the initial approval date of the TennCare CHOICES component of this demonstration. This includes the application of the spousal impoverishment eligibility rules. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the STCs;

b. Home and community-based waiver-like services as specified in Table 2b, subject to the definitions in Attachment D of the STCs, net of beneficiary regular and spousal impoverishment post-eligibility responsibility for the cost of care, and with post-eligibility treatment of income for individuals receiving short-term nursing facility care calculated as if they were receiving HCBS in the community.

**10. HCBS Services for SSI-Eligibles.**
Expenditures for the provision of home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs that are not described in Section 1905(a) of the Act and not otherwise available under the approved state plan but could be provided under the authority of Section 1915(c) waivers, that are furnished to TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities with income at 100 percent of the Supplemental Security Income/Federal Benefit Rate and resources at or below $2,000 who either:

a. Meet the nursing facility institutional level of care; or

b. Do not meet the nursing facility institutional level of care but who, in the absence of TennCare CHOICES services, are "at risk" of institutionalization.

**11. The At Risk Demonstration Group.**

Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open new to enrollment until December 31, 2013. Persons enrolled in the At Risk Demonstration Group as of December 31, 2013, may continue to qualify in the group as long as they continue to meet nursing facility financial eligibility standards and the nursing facility level of care criteria in place on June 30, 2012, and remain continuously eligible and enrolled in the At Risk Demonstration Group.

Expenditures for these individuals are:

a. Services as presented in Table 2a of the STCs.

b. Home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs, net of beneficiary post-eligibility responsibility for the cost of care (including application of spousal impoverishment rules), and with post-eligibility treatment of income for individuals receiving short-term nursing facility care calculated as if they were receiving HCBS in the community.

**12. Continuing Receipt of Nursing Facility Care.**

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**13. Continuing Receipt of Home and Community-Based Services.**

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**14. Continuing Receipt of Program of All-Inclusive Care for the Elderly (PACE) Services.**

Expenditures for PACE-enrolled individuals, who upon redetermination do not meet the current nursing facility level of care criteria, but who continue to meet the level of care

criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the PACE Carryover Group.

**15. LTC Partnership.**
Expenditures for individuals in CHOICES 2 to participate in the Long Term Care Partnership Program.

## REQUIREMENTS NOT APPLICABLE TO TENNCARE STANDARD TITLE XIX DEMONSTRATION ELIGIBLE GROUPS

All Title XIX requirements that are waived for the TennCare Medicaid Groups are also not applicable to the TennCare Standard Title XIX Demonstration Eligible Groups. In addition, the following is not applicable to the Title XIX Demonstration Eligible Groups.

| | |
|---|---|
| **Cost Sharing** | **Section 1902(a)(14) and Section 1916**<br>**42 CFR §§ 447.51 – 447.56** |

To enable the state to charge cost sharing beyond applicable Medicaid limits to TennCare Standard demonstration populations, with cost-sharing subject to a quarterly aggregate cap of 5 percent of family income for children.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS (STCs)**

**NUMBER:** **11-W-00151/4 (Title XIX)**

**TITLE:** **TennCare II**

**AWARDEE:** **Tennessee Department of Finance and Administration**

**DEMONSTRATION EXTENSION PERIOD:** **July 1, 2013 through June 30, 2016**

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**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS**

**NUMBER:** **Title XIX No. 11-W-00151/4**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for Tennessee's TennCare II Section 1115(f) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to this agreement are the Tennessee Department of Finance and Administration, Bureau of TennCare ("state") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the demonstration project. The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the approval letter's date, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This demonstration extension is approved through June 30, 2016.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits; CHOICES Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality for the Demonstration; Evaluation of the Demonstration; TennCare Eligibility Redetermination and Disenrollment and Rights; Appeals Process for Changes in Benefits; Enrollment in Standard Spend Down; and the Schedule of State Deliverables During the Demonstration Extension.

## II. PROGRAM DESCRIPTION AND OBJECTIVES

TennCare II is a continuation of the state's demonstration, funded through titles XIX and XXI of the Social Security Act (the Act). TennCare began as an 1115(a) demonstration project in January 1994. A 3-year extension was approved for 1999-2001, and a 1-year extension was approved early in 2002. A new TennCare II 1115(a) demonstration was approved by CMS on May 30, 2002, and initiated on July 1, 2002, for a 5-year period. On October 5, 2007, an extension was granted under Section 1115(a) through June 30, 2010, with revised waiver and expenditure authorities and STCs. (Note: Temporary extensions under the existing TennCare II STCs were granted for the July 1 through October 5, 2007 period, in order to provide additional time to conclude discussions on a longer extension.) The most recent extension, granted in December 2009 under the authority of Section 1115(e) of the Act, was in effect from July 1, 2010 through June 30, 2013. The current extension is granted under the authority of Section 1115(f) of the Act and is in effect from July 1, 2013 through June 30, 2016.

As of October 2012, the TennCare II program had 1.213 million enrollees, about half of whom were children. All mandatory and optional populations eligible under Tennessee's state plan are enrolled in TennCare II, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only").

There are three components to the TennCare II demonstration program. **TennCare Medicaid** is the component that serves enrollees who are Medicaid-eligible under Tennessee's title XIX state plan. **TennCare Standard** is the component that serves title XIX Medicaid enrollees who are eligible only through the demonstration's expenditure authorities**.** Title XXI Medicaid expansion children are also served under TennCare Standard, with a more extensive benefits package and a different service delivery system than the children served under the title XXI stand-alone Children's Health Insurance Program (CHIP). Both TennCare Medicaid and TennCare Standard deliver all Medicaid services, except for services specified at paragraphs 28 *(TennCare Benefits)* and 30 *(Medicaid Benefits Carved Out of TennCare II Demonstration)* as excluded from the TennCare benefits package for specified populations.

The **CHOICES** Program is the newest component. CHOICES utilizes the existing for-risk, Medicaid managed care organizations to provide eligible individuals with nursing facility services or home and community based services. With the implementation of the CHOICES program in 2010, home and community based services and nursing facility services were added to the existing TennCare II benefit package of primary, acute, and behavioral health services for qualifying state plan and demonstration eligible individuals. This provides participating individuals with an integrated package of acute and long-term services and supports, through a managed care delivery system.

The goals of TennCare are the following:

- Use a managed care approach to provide services to Medicaid state plan and demonstration enrollees at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.

- Assure appropriate access to care for enrollees.
- Provide quality care to enrollees.
- Assure enrollees' satisfaction with services.
- Improve health care for program enrollees.
- Assure that participating health plans maintain stability and viability, while meeting all contract and program requirements.
- Provide appropriate, and cost-effective home and community based services that will improve the quality of life for persons who qualify for nursing facility care, as well as for persons who do not qualify for nursing facility care but who are "at risk" of institutional placement and that will help to rebalance long-term services and supports expenditures.

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with Section 1115 of the Act. The state must

not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 *(Amendment Process)* below.

**7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following

a. An explanation of the public process used by the state, consistent with the requirements of paragraph 15 *(Public Notice and Consultation with Interested Parties)*, to reach a decision regarding the requested amendment;

b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

Changes to TennCare II benefits described in the state plan shall be made by state plan amendment. Changes to TennCare II benefits not described in the state plan shall be made by amendment to the demonstration. Changes in benefits shall be implemented in accordance with the process set forth in Section XIII of these STCs.

Additions or Changes to CHOICES Benefits. All requests for changes in coverage of CHOICES benefits are subject to CMS approval. Changes in benefits defined in Attachment D must be submitted to CMS for approval at least 60 days in advance of the state's desired implementation date. Requests for services that are not defined in Attachment D must be submitted by the state to CMS as a request to amend the demonstration.

The state must send a courtesy copy of all Medicaid state plan amendment requests to the Project Officer. This requirement is in addition to the submissions that the state must make as part of the usual state plan amendment process, and is not meant to substitute for or supplant that process in any way.

**8. Extension of the Demonstration.**

a. Should the state intend to request an extension of the demonstration, the state must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9 *(Demonstration Phase-Out).*

b. Compliance with Transparency Requirements 42 CFR § 431.412. Effective April 27, 2012, as part of demonstration extension requests the state must provide documentation of compliance with the transparency requirements of 42 CFR § 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15 *(Public Notice and Consultation with Interested Parties).*

**9. Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, only consistent with the following requirements:

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of the phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §§ 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §§ 431.220 and 431.221. If a demonstration participant requests a hearing

before the date of action, the state must maintain benefits as required in 42 CFR § 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010 State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

**10.** **Post Award Forum**. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this paragraph. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 45 *(Quarterly Progress Reports)* associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 46 *(Annual Report).*

**11.** **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

**12.** **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

**13.** **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

**14.** **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

**15.** **Public Notice and Consultation with Interested Parties.** The state must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6 *(Changes Subject to the Amendment Process)*, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR § 431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 CFR § 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR § 447.205 for changes in statewide methods and standards for setting payment rates.

**16.** **FFP.** No Federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

## IV. ELIGIBILITY

**17. Eligibility.** Tennessee includes in the TennCare II demonstration all of the mandatory and optional populations eligible under the Tennessee Medicaid state plan, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only"). Also included in TennCare II are several title XIX demonstration-only eligible populations and one title XXI Medicaid Expansion demonstration population. Medicaid state plan-eligible individuals are served in the component of the program called TennCare Medicaid. Other demonstration-only eligible populations are served in the component called TennCare Standard.

The mandatory and optional Medicaid state plan populations described below derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the demonstration to generate savings for covering the Expansion populations, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.

The title XXI Medicaid Expansion demonstration population is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as otherwise listed as not applicable.

Under the TennCare II demonstration, Tennessee is not required to extend eligibility for medical assistance prior to the date that an application for assistance is made; however, the state may provide retroactive coverage for up to 3 months for class members in *Daniels, et al. v. Tenn. Dept. of Health and Env't., et al.*, (1) who have been terminated from TennCare on or before March 31, 2010, for failure to respond to a Request for Information and Expiration Notice in accordance with the process approved in the Federal court order dated January 8, 2009; (2) who subsequently complete a Request for Information within 60 days of termination; and (3) who are determined to have been eligible at the time of termination. The state must notify the Project Officer by letter if it intends to extend retroactive eligibility to Daniels class members as described above.

Any changes to eligibility must be submitted to CMS as an amendment request, subject to the process set forth in paragraphs 6 (*Changes Subject to the Amendment Process)* and 7 *(Amendment Process)* of these STCs.

The criteria for TennCare eligibility groups are as follows (Table 1a).

**Table 1a**
**TennCare Eligibility Groups**

Note: This table does not change the state plan requirements.

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **Title XIX State Plan Mandatory Groups – TennCare Medicaid** | | |
| 1931 recipients including:<br>• Children younger than 18/19<br>• Caretaker relatives<br>• Pregnant women with no other eligible children (coverage for third trimester) | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Transitional Medical Assistance – Medicaid Extension for families who lose TANF benefits due to:<br>• income from employment or work hours or loss of "income disregard"<br>• increased child or spousal support collections | 6 initial months + 6 months continued coverage<br>4 months continued coverage *and expenditure authority for 8 additional months* | 1, 2, 5, 6, 8, 9, 10 |
| Individuals who are ineligible for AFDC benefits solely due to requirements that are prohibited under Medicaid, including AFDC time limits | Income up to and including 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Poverty level pregnant & postpartum women | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level newborns under age 1 | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 1-5 | Income up to and including 133% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 6-18 | Income up to and including 100% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Deemed categorically eligible newborns: born to & living with a woman who was eligible and received Medicaid on the date of the child's birth | Eligible for 1 year as long as mother is eligible or would be if pregnant | 1, 2, 5, 8, 10 |
| Pregnant woman who would otherwise lose eligibility because of an increase in income remains eligible through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Woman who was eligible while pregnant continues eligibility through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Title IV-E eligible children in adoption subsidy or foster care | AFDC income standard | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash recipients: aged, blind or disabled (may or may not be receiving CHOICES benefits) | | 1, 2, 4, 5, 6, 7, 8, 9, 10, |
| Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87 | | 1, 2, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| "DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash ineligible for reasons prohibited by Title XIX. | | 1, 2, 5, 6, 8, 9, 10 |
| "Pickle" SSA Beneficiaries who lost SSI cash benefits due to cost of living adjustment (COLA) increase in Title II OASDI benefits | | 1, 2, 5, 6, 8, 9, 10 |
| "DWB" Disabled widow/widower who lost SSI or state supplement due to early receipt of OASDI benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| **Title XIX State Plan Optional Groups – TennCare Medicaid** | | |
| Presumptively eligible pregnant & postpartum women | Income up to 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Children under 21 who meet AFDC income & resource criteria—children in state custody, foster care, subsidized adoptions, institutionalized | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Persons who would be eligible for AFDC or SSI cash assistance except for their institutional status | | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Special income level group: individuals who are in a medical institution at least 30 consecutive days with income that does not exceed 300% of SSI income standard under 1902(a)(10)(ii)(V) of the Act. | Income no more than 300% of SSI rate; resources $2000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Categorically needy individuals under the state plan who are receiving home and community based services in accordance with 42 CFR § 435.217. (This group consists solely of enrollees in the ID waivers.) | | 1, 2, 5, 6, 8, 9, 10 |
| Non-IV-E children with special medical needs who receive a state adoption subsidy payment | | 1, 2, 5, 6, 8, 9, 10 |
| Women under 65 who need treatment for breast or cervical cancer, and are not otherwise eligible for Medicaid. State utilizes presumptive eligibility for this population. | | 1, 2, 5, 6, 8, 9, 10 |
| Medically needy children under 21 *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| Medically needy pregnant or postpartum women *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |
| **Title XIX Demonstration Eligible Groups– Carryover** | | |
| **CHOICES 1 and 2 Carryover Group:** Individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **PACE Carryover Group:** Individuals who were enrolled in a PACE program as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | As required under the state plan. | |
| **Title XIX Demonstration Eligible Groups – TennCare Standard** | | |
| **Medically Eligible Children:** uninsured children under 19 who have been determined to be "medically eligible" (uninsurable) (category is currently closed to new enrollment except for Medicaid rollovers *[*as defined in paragraph 20, *Rollover Definition]* who are not otherwise eligible for TennCare. See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*. | Income 200% FPL or higher without limit; no resource test | 1, 2, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Standard Spend Down (SSD):** non-pregnant/postpartum adults 21 or older who have been determined to meet criteria patterned after the medically needy requirements *(enrollment target: 100,000)*<br>• aged, blind, or disabled<br>• caretaker relatives<br>CMS approved an amendment to add this expansion population in Nov. 2006.<br>(Expenditure authority for 12-month coverage based on 1-month budget period.)<br>See paragraph 21.a. *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*. | Medically needy spend-down level ($241 for 1, etc.); resources $2000 | 1, 2,, 3, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Title XIX Demonstration Eligible Groups – CHOICES** | | |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **CHOICES 217-Like HCBS Group:** Aged and / or disabled categorically needy adults who meet the CHOICES NF level of care requirement, are receiving home and community based services and who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236, and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915 (c) waiver. This group is subject to the enrollment target for CHOICES 2 in paragraph 32.d *(Enrollment Targets for TennCare CHOICES)*. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **At Risk Demonstration Group:** Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of the TennCare Interim Choices 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open to enrollment starting July 1, 2012, and closed to new enrollment on December 31, 2013. | Income no more than 300% SSI/FBR; resources $2,000 | 1,2,4,5,6,7,8,9,10 |
| **Title XXI Medicaid Expansion Demonstration Eligible Group – TennCare Standard** | | |
| Optional Targeted Low-Income Children: uninsured children under 19 who:<br>• have lost Medicaid eligibility under the approved Medicaid state plan and who do not have access to insurance or<br>• were uninsured and enrolled in this category in the original TennCare demonstration as of 12/31/01, even if they had access to insurance, and have been continuously enrolled in this category since 12/31/01<br>See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*.. | Income up to 200% FPL | 1, 2, 5, 6, 8, 9, 10, and cost sharing "not applicable" |

## 18. TennCare CHOICES Eligibility Groups.

As further set forth in paragraph 32 *(Operations of the TennCare CHOICES Program)*, eligibility for enrollment in TennCare CHOICES depends on (a) the individual's TennCare Eligibility Group, (b) the nursing facility (NF) (or "At Risk," as applicable) level-of-care (LOC) criteria as established by the state, and (c) the type of long-term services and supports (LTSS) to be provided.

There are three principal eligibility groups for TennCare CHOICES. CHOICES 1 is for individuals receiving NF services. CHOICES 2 is for individuals who meet the NF LOC that are receiving HCBS as an alternative to NF care. CHOICES 3 is for individuals who do not meet the NF LOC, but are at risk of NF placement and are receiving HCBS to delay or prevent NF placement.

Effective July 1, 2012, the state elected to change the level of care that is medically necessary for admission to a NF. CHOICES 3 serves SSI eligibles enrolled after the implementation of the LOC change who do not meet the new LOC standard but who are "at risk" of institutionalization. Individuals in CHOICES 1 and CHOICES 2 who continue to meet the standard in place at the time of the individual's enrollment will continue to qualify for those services.

Between July 1, 2012, and December 31, 2013, the state opened Interim CHOICES 3 to serve SSI eligibles and other adults who meet the LOC standard and financial eligibility requirements in place prior to the change, allowing the state to abide by the "Maintenance of Effort" (MOE) requirements as specified by the Affordable Care Act, Section 2001.

Table 1b summarizes the CHOICES Eligibility Groups and addresses how a change in LOC criteria is taken into account in determining eligibility for each group.

**Table 1b**
**TennCare + CHOICES Eligibility Groups**

Note: This table does not change the state plan requirements. CHOICES 1, CHOICES 2, CHOICES 3, and Interim CHOICES 3 are defined in paragraph 32 *(Operations of the TennCare CHOICES Program).* The CHOICES 1 and 2 Carryover Group and the PACE Carryover Group are defined in Table 1a of paragraph 17 *(Eligibility).* With respect to benefits, cost-sharing, and similar issues, persons in the CHOICES 1 Carryover Group are treated as though they were in CHOICES 1; persons in the CHOICES 2 Carryover Group are treated as though they were in CHOICES 2; and persons in the PACE Carryover Group are treated as though they were in PACE.

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 1 | • Nursing facility residents who meet the NF LOC in place at the time of enrollment* | Yes | Yes, CHOICES 1 and 2 Carryover Group |
| CHOICES 2 | • Meet NF LOC in place at the time of HCBS<br>• Receive HCBS as alternative to NF care<br>• Age 65+ or 21+ and disabled | Yes, SSI only | Yes, CHOICES 217-Like HCBS Group and CHOICES 1 and 2 Carryover Group |
| CHOICES 3 | • "At risk" for institutionalization (as defined in Attachment D)<br>• Age 65+ or age 21+ and disabled | Yes, SSI only | No |
| INTERIM | • Same as CHOICES 3, but not limited | Yes, SSI only | Yes, At Risk |

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 3 (open to enrollment starting July 1, 2012 and closed to new enrollment on December 31, 2013) | to SSI recipients<br>• Must meet nursing facility financial eligibility criteria | | Demonstration Group |

***** The state may grant an exception for persons in the community seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

**19. Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed.** The state has closed enrollment into the following demonstration categories, except for "rollovers" (as defined in paragraph 20, *Rollover Definition*). Therefore, children are only eligible for a non-state plan demonstration population as a "rollover." If children lose Medicaid state plan eligibility, they may qualify for one of these demonstration-only groups rather than for the stand-alone title XXI CHIP program.

- Title XIX Medically Eligible Children: Individuals who are under age 19, are uninsured, have income that is 200 percent of the FPL or higher without limit, are not otherwise eligible for TennCare, and meet the state-defined criteria of "medically eligible" as having medical conditions that make them uninsurable. (There is no income or resource limit for this group.)

- Title XXI Medicaid Expansion Children: Individuals under age 19 who are uninsured, have family income less than 200 percent of the FPL, and meet the definition of an optional targeted low-income child. (There is no resource limit for this group.)

Individuals under age 19 who lose eligibility for a Medicaid category may roll over into a TennCare Standard category if they meet the criteria for the category.

**20. Rollover Definition.** For the purpose of this demonstration, a "rollover" eligible is an individual who qualifies for continued coverage through a TennCare Standard demonstration category upon losing Medicaid eligibility under any category included in Tennessee's title XIX state plan.

**21. Adult Non-State Plan Demonstration Population Categories.**

a. **Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category.** The SSD eligibility category is open to non-pregnant/postpartum adults ages 21 or older who are Caretaker Relatives or Aged, Blind, or Disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the state plan. The

SSD demonstration eligibility group has an enrollment cap of 105,000, with a target enrollment of 100,000. The state shall establish eligibility and enroll individuals into the SSD group in accordance with the process set forth in Section XIII of these STCs.

b. **CHOICES 217-Like HCBS Group**. This group consists of persons aged 65 and older or persons aged 21+ and who are disabled who: (1) meet the CHOICES NF level of care requirement; (2) are receiving home and community-based services; and (3) would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal Regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915(c) waiver. Paragraph 18 *(TennCare CHOICES Eligibility Groups)* and paragraph 32.b. *(Eligibility for TennCare CHOICES Benefits)* describe how the NF LOC requirements shall be determined for individuals in this group. The state retains the discretion to apply an enrollment target as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES)*.

c. **At Risk Demonstration Group.** As of July 1, 2012, this group consists of elderly adults and adults age 21 and older with physical disabilities who (1) meet nursing facility financial eligibility; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization.

d. **CHOICES 1 and 2 Carryover Group.** This group consists of individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who no longer qualify for CHOICES enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in CHOICES 1 or CHOICES 2 if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, (2) meet all the eligibility requirements for a CHOICES program; and (3) remain continuously enrolled in CHOICES 1 and/or 2, as specified below:

i. Persons enrolled in CHOICES 1 can continue in CHOICES 1 or transition to CHOICES 2, and persons enrolled in CHOICES 2 can continue in CHOICES 2; and

ii. The state may grant an exception to i. for persons in CHOICES 2 seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

e. **PACE Carryover Group.** This group consists of individuals who were enrolled in PACE as of June 30, 2012, but who no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in PACE if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, and (2) meet all other eligibility requirements for PACE in the Medicaid state plan. PACE remains under the Medicaid state plan.

**22. Medically Needy Eligibility Period.** Financial eligibility for state plan medically needy pregnant women and children and for Standard Spend Down adults is based on a 1-month budget period described in the state plan. Those determined eligible remain eligible for up to 1 year from the effective date of eligibility.

**23. Quality Review of Eligibility**. At least annually, the state shall submit a plan for a Medicaid Eligibility Quality Control (MEQC) pilot project to the CMS Regional Office for approval. When each pilot is complete, the state shall send a report to the CMS Regional Office for approval, and shall submit a plan for the next pilot project. The MEQC pilots must be conducted in accordance with Federal law, regulations, and policy.

**24. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.**

a. Except as specified in paragraph 24.b. below, in determining eligibility for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in Section 1924 of the Act and 42 CFR § 435.725 of the Federal regulations.

b. For an individual in CHOICES 2 or CHOICES 3 who is admitted for short-term nursing facility care (as defined in Attachment D), in order to ensure that the individual can maintain a community residence for transition back to the community, the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. After 90 days, or as soon as it appears that the inpatient stay will not be short-term, whichever comes first, the person will be transitioned to CHOICES 1 and the institutional post-eligibility calculation shall apply.

**25. Eligibility/Post-Eligibility Treatment of Income and Resources for the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group.** For individuals receiving 1915(c) like services in CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, or the PACE Carryover Group, the state must use institutional eligibility and post-eligibility rules for individuals who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a Section 1915(c) waiver.

26. **Post-Eligibility and Patient Liability for the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group.** The state assures that, for individuals receiving 1915(c) like services, under the post-eligibility process, the state must have a method to carve out / identify the cost of the 1915(c) like services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of the 1915(c) like services.

27. **Non-Payment of Patient Liability.** A provider (including an MCO) may decline to continue to provide services to an individual who fails to pay his or her patient liability. If an enrollee who has failed to pay patient liability is unable to find another provider or MCO who is willing to provide LTSS, then the individual may be disenrolled from the CHOICES program. If the beneficiary's eligibility for TennCare is dependent on the receipt of long-term institutional care or HCBS through TennCare CHOICES, as would be the case if an enrollee is a member of the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group, such individual may be disenrolled from TennCare if he or she is no longer able to receive such services, unless he/she qualifies in another Medicaid category. The consequences for failing to pay patient liability must be clearly explained to members upon enrollment in CHOICES. Nothing herein shall prejudice any individual from fully exercising his or her rights to reapply for Medicaid coverage.

## V. BENEFITS

**28. TennCare Benefits.** With the implementation of the CHOICES program, TennCare covers physical, behavioral, and long-term care benefits provided through managed care delivery systems.

a. All mandatory and optional Medicaid state plan eligible adults aged 21 or older, are enrolled in TennCare Medicaid, and receive all services covered under Tennessee's state plan according to the limitations specified in the state plan, including the services identified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration)* as appropriate. Additional TennCare benefits are provided as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)*.

b. Members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group or the CHOICES 1 and 2 Carryover Group, all of which are demonstration-only groups, are enrolled in TennCare Standard, but receive all benefits described in a. above. In addition, individuals in the CHOICES 217-Like HCBS Group are members of CHOICES 2 and members of the At Risk Demonstration Group are members of Interim CHOICES 3.

c. Demonstration-only eligible adults who are members of the Standard Spend Down population (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*) are enrolled in TennCare Standard and receive all state plan services, plus additional TennCare benefits as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)* as appropriate, except that they do not have access to the services discussed in Table 2b or Table 3. Medicare Parts A and B premiums and Medicare co-payments and deductibles are covered in accordance with paragraphs 30.b. and c.

d. All mandatory and optional Medicaid state plan eligible children younger than 21 years old enrolled in TennCare Medicaid receive all state plan and EPSDT covered services.

e. The demonstration-only eligible children enrolled in TennCare Standard receive the same benefits as the state plan eligible children enrolled in TennCare Medicaid, except as specified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration)*.

f. The Medicaid state plan mandatory and optional eligibility categories for poverty level pregnant or postpartum women receive all TennCare Medicaid benefits, because the state considers that all of these services are pregnancy-related services.

g. The following table (Table 2a) lists benefits for TennCare Medicaid and TennCare Standard adults aged 21 and older that are different from those

identified in the state plan. All benefits are limited by medical necessity as defined by the state. "State Plan Coverage for Adults" is provided for informational purposes only, and does not supersede the approved Medicaid state plan. CMS will issue an updated version of Table 2a in the event that future SPAs cause the Medicaid state plan to be in conflict with what appears in Table 2a.

**Table 2a**
**TennCare Medicaid and TennCare Standard Benefits for Adults Aged 21 and Older That Are Different Than State Plan Covered Services and Limitations**

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Diagnostic services not included in other service categories | Covered as medically necessary. | Not covered. |
| Home health | Covered as medically necessary, and in accordance with the definitions and limitations included in Attachment B. | Coverage limited to 60 visits per enrollee per state fiscal year. |
| Hospice care | Covered as medically necessary. | Coverage limited to 210 days per enrollee per state fiscal year. |
| Inpatient and outpatient substance abuse services | Covered as medically necessary | Not covered. |
| Inpatient hospital services | Covered as medically necessary. | Coverage limited to 43 days for heart transplants, 67 days for liver transplants, and 40 days for bone marrow transplants, per enrollee, per state fiscal year. |
| Lab and X-ray services | Covered as medically necessary. | Coverage limited to 30 occasions per enrollee per state fiscal year. |
| Medicare premiums and cost-sharing | Covered for state plan eligibles, SSD enrollees, members of the CHOICES 217-Like HCBS Group, and members of the At Risk Demonstration Group, in accordance with paragraphs 30.b. and c. | Covered for Medicare beneficiaries who are dually eligible for Medicaid according to their classification under the state plan (QMB, SLMB, Other Medicaid/Medicare Duals, etc.) |
| Mental health case management services | Covered as medically necessary. | Coverage limited to Targeted Case Management for persons who are Severely and/or Persistently Mentally Ill. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Occupational therapy | Covered as medically necessary. | Not covered. |
| Organ and tissue transplants | Covered as medically necessary, except that experimental or investigational transplants are not covered. | Coverage limited to renal, heart, liver, corneal, and bone marrow transplants. |
| Outpatient hospital services | Covered as medically necessary. | Coverage limited to 30 visits per enrollee per fiscal year. |
| Outpatient rehabilitation services | Covered as medically necessary. | Coverage limited to mental health services provided by Community Mental Health Agencies. |
| Pharmacy services | • Not covered for dually eligible adults.<br>• Covered for non-dual state plan eligibles in accordance with the state plan.<br>• Covered for non-dual SSD eligibles and non-dual At Risk Demonstration Group members, with the co-payments specified in Table 6 of paragraph 34.b. *(Co-Pays on Pharmacy).*<br>• Covered for non-dual CHOICES 217-Like HCBS Group enrollees, CHOICES 1 and 2 Carryover Group enrollees, and PACE Carryover enrollees in accordance with the state plan for Medicaid enrollees. | Coverage as specified in state plan. |
| Physical therapy services | Covered as medically necessary. | Not covered. |
| Physicians' services (including medical and surgical services furnished by a dentist) | Outpatient services: Covered as medically necessary.<br><br>Inpatient services: Covered as medically necessary. | Outpatient services: Coverage limited to 24 outpatient office visits per year, which includes 2 office visits for podiatrists and 4 office visits for optometrists.<br><br>Inpatient services: Coverage limited to 20 visits per enrollee per state fiscal year for services other than heart, liver, and bone marrow transplants, which are limited to 43, 67, and 40 days, respectively. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Preventive services | Covered as medically necessary. | Not covered. |
| Private duty nursing services | Covered when medically necessary to support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Definitions and limitations applicable to this service are contained in Attachment C. | Not covered. |
| Psychiatric residential treatment services (outside of an IMD) | Covered as medically necessary. | Not covered. |
| Screening services | Covered as medically necessary. | Not covered. |
| Speech, hearing, and language services | Covered as medically necessary. | Not covered. |
| Vision services | Covered for the first pair of cataract glasses following cataract surgery. | Not covered. |

h. The following table (Table 2b) lists HCBS benefits for TennCare Medicaid enrollees and CHOICES demonstration eligibles who are enrolled in the designated CHOICES groups (specified in paragraph 32.a., *Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition, the following rules apply to the CHOICES benefit.

i. The cost of medical assistance provided to an eligible participant in CHOICES 2 is limited to the amount calculated in the individual cost-neutrality test used in Section 1915(c) waivers as set forth in Section 1915(c)(4)(A). The state may delegate implementation of the cost neutrality test to the MCOs.

ii. For purposes of determining capitation rates, the cost of room and board, as defined in Attachment D, is not included in non-institutional care costs.

iii. For persons in CHOICES 3 or Interim CHOICES 3, in addition to the service limits stated in Table 2b, the total cost of the HCBS identified in

Table 2b shall not exceed $15,000 per calendar year, excluding the cost of minor home modifications.

iv. Definitions for CHOICES benefits are provided in Attachment D of these STCs.

**Table 2b**
**Benefits for Persons Enrolled in the CHOICES Program**

| **Benefit** (Definitions provided in Attachment D) | **CHOICES 1** | **CHOICES 2** | **CHOICES 3*** |
|---|---|---|---|
| Nursing facility care | X | Short-term only | Short-term only |
| Community-based residential alternatives | | X | |
| Personal care visits (up to 2 visits per day) | | X | X |
| Attendant care (up to 1080 hours per calendar year); up to 1400 hours per calendar year ONLY when Homemaker services are needed in addition to hands-on care | | X | X |
| Home-delivered meals (up to 1 meal per day) | | X | X |
| Personal Emergency Response Systems | | X | X |
| Adult day care (up to 2080 hours per calendar year) | | X | X |
| In-home respite care (up to 216 hours per calendar year) | | X | X |
| In-patient respite care (up to 9 days per calendar year) | | X | X |
| Assistive technology (up to $900 per calendar year) | | X | X |
| Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) | | X | X |
| Pest control (up to 9 units per calendar year) | | X | X |

*Subject to the limitations in 28.h.iii.

**29. Cost-Effective Alternatives.** TennCare MCOs and TennCare Select may provide services not listed in, or exceeding the individual service limits in, the Medicaid state plan or paragraph 28 (*TennCare Benefits*) of these STCs as allowed under their contracts with the TennCare program. Provision of these services is at the sole discretion of the MCO and TennCare Select. Capitation for the MCOs must be certified as actuarially sound (in accord with 42 CFR § 438.6), and comply with the Federal managed care regulations at 42 CFR §§ 438 et seq. TennCare Select must demonstrate to the state that a service not listed as covered in the Medicaid state plan or in paragraph 28 (TennCare Benefits) is a cost-effective alternative, in order for the state to reimburse TennCare Select for the service. The state must demonstrate to CMS annually as part of the annual report described in paragraph 46 (*Annual Report*) that utilization of these services by the MCOs and TennCare Select is cost-effective and is reimbursed in compliance with the Federal managed care regulations at 42 CFR §§ 438 et seq. Under the CHOICES program, cost-effective alternatives may include a Transition Allowance, as defined in Attachment D.

**30. Medicaid Benefits Carved Out of the TennCare II Demonstration.**

a. **"Base" Medicaid State plan services.** Base services are services carved out of TennCare II, and are provided, in accordance with the provisions of the Medicaid state plan, only to the mandatory and optional state plan eligibles and members of the PACE Carryover Group (in the case of PACE services only). The other TennCare II demonstration-only populations, which are eligible through the demonstration's expenditure authorities and enrolled in TennCare Standard, are not eligible for any of the services listed in Table 3. Expenditures for these "Base" services are not demonstration expenditures (see paragraph 51.a., *Tracking Expenditures*), are not included in the demonstration's budget neutrality, and should, therefore, be reported on the "Base" reporting schedules of the Form CMS-64 reports (or in the case of 1915(c) waiver services, the appropriate 1915(c) waiver schedule). Some carved out services were carved in as of the initial implementation of CHOICES (i.e., March 1, 2010), however, as indicated in Table 3, and must from that point forward be reported as TennCare II demonstration expenditures.

**Table 3**
**Base Services**

| **Services Carved Out of TennCare II** | |
|---|---|
| Nursing facility services | Services moved from the base to the demonstration as of March 1, 2010 (in Middle Tennessee) and August 1, 2010 (in East and West Tennessee) |
| Services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) | Base |
| State Plan targeted case management services | Base |
| Program of All Inclusive Care for the Elderly (PACE) | Base |
| Services covered by the home and community-based services waiver for individuals with intellectual disabilities under 1915(c) of the Social Security Act. | Base |
| Services covered through the state's agreement under Title V of the Social Security Act | Base |

b. **Medicare Parts A and B Buy-In Premiums.** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the Standard Spend Down group, the CHOICES 1 and 2 Carryover Group

and the PACE Carryover Group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare Buy-In premiums are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles as permitted in Section 1902(a)(10)(E) of the Act and 42 CFR § 431.625,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals),

(C) Dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the Standard Spend Down group (QMBs/SLMBs and Demo Duals), and

(E) Dually eligible members of the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group (QMBs, SLMBs, and Demo Duals).

ii. Medicare premiums paid on behalf of Demo Duals are demonstration expenditures, and must be reported on an appropriate Form CMS-64.9 or 9p Waiver, as described in paragraph 51.e. *(Use of Forms).*

iii. Medicare premium payments for other beneficiaries are excluded from TennCare II and must be reported as "Base" Medicaid expenditures on the CMS-64 reports.

iv. Records in CMS's Master Billing Record for Demo Duals and all buy-in transactions for Demo Duals must be identified using a specific Buy-In Eligibility Code (BIEC) value as agreed upon between the state and the Project Officer.

c. **Medicare Co-payments and Deductibles (i.e., Medicare crossover claims).** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, At Risk Demonstration Group, CHOICES 1 and 2 Carryover Group, the PACE Carryover Group or the Standard Spend Down group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare crossover claims are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs, and Demo Duals),

(C) Dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the CHOICES 1 and 2 Carryover Group and PACE Carryover Group, and

(E) Standard Spend Down enrollees (QMBs/SLMBs and Demo Duals).

The SSD population, the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group are the only demonstration populations for whom the state pays Medicare cost-sharing.

ii. For TennCare Medicaid enrollees, members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals), members of the At Risk Demonstration Group (QMBs, SLMBs, and Demo Duals), members of the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group (QMBs/SLMBs and Demo Duals), these expenditures are not demonstration expenditures and are not included in the budget neutrality calculations, so report these as "Base" Medicaid expenditures on the CMS-64 reports.

iii. For dually eligible SSD enrollees (QMBs/SLMBs and Demo Duals), these expenditures are included as demonstration expenditures that are subject to budget neutrality, so report these demonstration expenditures as "EG6E Expan Adult" on the CMS-64 reports. Medicare cost-sharing for SSD dual eligibles is covered in the same manner as Medicare cost-sharing would be covered for Medically Needy aged, blind, or disabled individuals and caretaker relatives, had these groups been included in the Medicaid state plan.

**31. Additional Provisions Related to Institutions for Mental Diseases (IMDs).** Expenditures for services rendered to TennCare II enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.

## VI. CHOICES ENROLLMENT

### 32. Operations of the TennCare CHOICES Program.

a. **Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group.** The CHOICES Program provides long-term services and supports (LTSS) as identified in Table 2b to four groups of people, as defined below:

i. **CHOICES 1.** This group consists of persons who are receiving Medicaid-reimbursed care in a nursing facility (NF).

ii. **CHOICES 2.** Persons age 65 and older and adults age 21 and older with physical disabilities who meet the NF level of care (LOC), who qualify either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to NF care. The demonstration population includes persons who could have been eligible under 42 CFR § 435.217 had the state continued its 1915(c) HCBS waiver for persons who are elderly and/or physically disabled.

iii. **CHOICES 3.** Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles, who do not meet the NF LOC, but who, in the absence of HCBS, are "at risk" for institutionalization, as defined by the state.

iv. **Interim CHOICES 3.** Elderly adults and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of the At Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. This group will close to new enrollment on December 31, 2013.

b. **Eligibility for TennCare CHOICES Benefits.** Individuals can be eligible for one of the four TennCare CHOICES groups defined in a. above depending upon their medical and / or functional needs, their TennCare eligibility group, and the ability of the state to provide them with safe, appropriate, and cost-effective LTSS.

i. Medical and / or functional needs are assessed according to LOC criteria published by the state in state rules.

(A) There will be one set of LOC criteria for NF care, which will be used in assessing eligibility for CHOICES 1 and CHOICES 2.

(B) On July 1, 2012, the state opened enrollment in CHOICES 3, which is subject to a separate set of criteria to determine the "At-Risk" population.

(C) For the purposes of redetermining whether a recipient of NF services (CHOICES 1) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial LOC determination for that individual at the time of enrollment into CHOICES 1.

(D) For the purposes of determining whether a recipient of HCBS for elderly and disabled (CHOICES 2) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial level of care determination for that individual at the time of HCBS enrollment, or for persons transitioning from a NF, at the time of enrollment into CHOICES 1.

(E) For purposes of enrollment into CHOICES 1, the state may grant an exception for persons in the community who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely be met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of initial enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

ii. Financial eligibility:

(A) Financial eligibility for CHOICES 1 is established according to the Medicaid state plan.

(B) In order to be financially eligible for CHOICES 2, an individual must be eligible for TennCare as an SSI recipient or meet the criteria for the CHOICES 217-Like HCBS Group, individuals who qualify under institutional income and resource rules, and who are receiving home and community-based services and would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.726, and 435.236 of the Federal regulations and Section 1924 of the Act, if the home and community based services were provided under a 1915(c) waiver.

(C) In order to be financially eligible for CHOICES 3, an individual must be eligible for TennCare as an SSI recipient.

(D) In order to be financially eligible for Interim CHOICES 3, an individual must be eligible for TennCare as an SSI recipient or as a member of the At Risk Demonstration Group. Members of the At Risk Demonstration Group must meet institutional income and resource criteria.

iii. The state's ability to provide applicants with appropriate home and community based services is determined by the availability of slots under an established enrollment target (see paragraph 32.d., *Enrollment Targets for TennCare CHOICES*) and, for persons in CHOICES 2, the determination by the MCO that the individual can be served appropriately at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i), and for persons in CHOICES 3 and Interim CHOICES 3, the determination by the MCO that the cost of HCBS will not exceed the limit in paragraph 28.h.iii. There is no enrollment target for Interim CHOICES 3.

c. **Enrollment in TennCare CHOICES.** The effective date of enrollment in TennCare CHOICES must be established by the state based on a determination that an applicant is eligible for and must begin receiving LTSS. Enrollment procedures differ depending upon whether or not the person is already enrolled in TennCare Medicaid.

i. **Persons Not Already Enrolled in TennCare.** Persons not already enrolled in TennCare who wish to enroll in TennCare CHOICES must enroll through the State's Single Point of Entry (SPOE). The SPOE must provide counseling and assistance in evaluating LTSS options, screening and intake for LTSS programs offered by the state (TennCare CHOICES as well as other programs), assistance in evaluating the individual's functional LOC for LTSS, and facilitation of Medicaid eligibility determination by the state.

(A) Individuals who are determined to be both medically and financially eligible for NF placement will always be allowed to receive TennCare CHOICES services in a NF as members of CHOICES 1, if they choose.

(B) Those individuals who meet the criteria for CHOICES 2 subject to the limitations set out in these STCs, will be allowed to choose HCBS as an alternative to NF placement if the determination is made that the individual can be served appropriately in CHOICES 2 at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i).

ii. **Persons Already Enrolled in TennCare.**

(A) **Nursing Facility Residents.** MCOs will conduct an assessment of NF residents who wish to move to HCBS to determine if they can be served appropriately in the community at a cost that does not exceed the cost neutrality test set forth in Section 1915(c)(4)(A), as individually applied. Even if an enrollment target has been reached for CHOICES 2, an MCO may transition persons from

CHOICES 1 to CHOICES 2 in accord with subparagraph 32.d.iii.(C) *(Transition from CHOICES 1 to CHOICES 2)*.

(B) TennCare enrollees who are not already participating in CHOICES may request enrollment in CHOICES through their MCOs, or they may be identified through other mechanisms that would trigger an assessment of their need for LTSS by the MCO. The MCO will provide counseling and assistance in evaluating LTSS options, and assistance in evaluating the individual's functional LOC eligibility for LTSS. The functional LOC determination for LTSS will be made by the Bureau of TennCare, using criteria published in state rules. Once individuals have established LOC and financial eligibility for LTSS, they can be enrolled in CHOICES in accordance with paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*).

d. **Enrollment Targets for TennCare CHOICES.** The state may establish enrollment targets for CHOICES 2 and CHOICES 3. (There will be no enrollment target for CHOICES 1 or Interim CHOICES 3.) The purpose of the targets is to permit the CHOICES program to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available state and Federal resources. Information on CHOICES Groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Progress Report as set forth in paragraphs 45 *(Quarterly Progress Reports)*, 49 *(Enrollment Reporting)* and Attachment A.

i. The state may establish an enrollment target for CHOICES 2, consistent with the upper and lower limits shown in the table below; with the actual target number to be published in state rules. The state may adjust the target as appropriate from time to time upon notification to CMS at least 30 days prior to the desired effective date of the change. Except as set forth in paragraph 32.d.iii., an increase in the enrollment target above the upper limit appropriate to the DY or a decrease below the lower limit will require an approved waiver amendment prior to implementation.

**Table 4**
**Enrollment Targets for Demonstration Years 12 Through 14**

| Demonstration Year | Lower Limit | Upper Limit |
|---|---|---|
| DY 12 | 12,000 | 16,000 |
| DY 13 | 13,500 | 17,500 |
| DY 14 | 15,000 | 18,500 |

ii. The state may also establish an enrollment target for CHOICES 3, if this group is established after a change in the level of care criteria. At a

minimum, this target will be set at 10% of the enrollment target for CHOICES 2. There will be no enrollment target for Interim CHOICES 3.

iii. If the enrollment target established by the state for CHOICES 2 or CHOICES 3 is reached or exceeded, the state shall not enroll additional persons in CHOICES 2 or CHOICES 3, except as indicated below. The state may also establish a waiting list for CHOICES, subject to the following:

(A) **Reserve Capacity.** The state may reserve slots in CHOICES 2 for individuals being discharged from a NF and for individuals being discharged from an acute care setting who are in imminent risk of being placed in a nursing facility setting absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved must be included as an attachment to the Annual Report (see paragraph 46). The state may establish additional criteria or modify procedures for allocating reserve slots upon 30 day advance written notification to CMS; the operational procedure documents included as attachments to subsequent Annual Reports must reflect any such changes. In each Quarterly Progress Report, the state must provide an accounting of their management of the reserve capacity, including a summary (as of the last day of the quarter) that states the total enrollment targets for CHOICES 2 and 3, the number enrolled in each CHOICES group, and the numbers of slots being held in reserve for various purposes.

(B) **HCBS as a Cost-Effective Alternative.** An MCO with a TennCare enrollee who meets the criteria for CHOICES 2, but which cannot enroll the individual in CHOICES 2 because the enrollment target for CHOICES 2 has been met, has the option, at its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care, in accordance with paragraph 29 *(Cost-Effective Alternatives).* (Consistent with paragraph 32.d.iii.(C), this person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.) The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. The state may require the MCO to provide documentation of its cost-effective alternative determination and assurance of provider capacity to meet the member's needs prior to enrollment in CHOICES.

(C) **Transition from CHOICES 1 to CHOICES 2.** An enrollee being served in CHOICES 1 who meets the requirements to enroll

in CHOICES 2 can enroll in CHOICES 2 at any time such a transition can be accomplished, even if an enrollment target for CHOICES 2 has been reached. This person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.

e. **Waiting Lists for TennCare CHOICES.** The use of enrollment targets as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*) may mean that there will be waiting lists for CHOICES 2 and/or 3. (There will be no enrollment target or waiting list for CHOICES 1 or the Interim CHOICES 3 Group.) These lists must be managed on a statewide basis using a standardized assessment tool and in accord with criteria to be established by the state. Waiting list policies must be based on objective criteria and applied consistently in all geographic areas served. The state may use separate criteria for prioritization of services under CHOICES 2 and CHOICES 3, and may revise these upon notification to CMS.

f. **Consumer Direction.** CHOICES members who have been determined by a care coordinator, as a part of the needs assessment and plan of care processes, to require attendant care, personal care, in-home respite services, companion care or other services specified by the state as eligible for consumer direction, will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e., consumer direction of HCBS). The state will notify CMS in advance of any changes to the list of services eligible for consumer direction. All CHOICES members requiring these services will be offered the option to participate in consumer direction of HCBS. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E.

g. **Miscellaneous Provisions Related to CHOICES Enrollment and Implementation**

i. The state will maintain an electronic visit verification system (as defined in Attachment D) as part of the CHOICES quality program.

ii. The state must ensure that the Care Plan is considered part of the medical record of a CHOICES participant, subject to all associated requirements and protections, and available for review by the state upon request.

## VII. COST SHARING

### 33. Cost Sharing.

a. TennCare Medicaid enrollees under the state plan are subject to cost sharing for pharmacy services (see Table 6 below).

b. Demonstration-only eligible adults enrolled in the SSD category or the At Risk Demonstration Group are subject to cost sharing for pharmacy services (see Table 6 below).

c. TennCare Standard children are subject to cost sharing for both non-pharmacy services and pharmacy services (see Table 5 and Table 6).

d. Individuals participating in CHOICES 1 or CHOICES 2 are exempt from all cost sharing.

e. Individuals participating in CHOICES 3 or Interim CHOICES 3 are subject to cost sharing for pharmacy services (see Table 6 below), similar to other Medicaid state plan adult enrollees.

**34. Co-Payments.** For demonstration-only eligible children in TennCare Standard (title XXI Medicaid Expansion children and medically eligible title XIX children), co-payments are collected by the provider when services are rendered. The requirements at Section 1916A of the Act and at 42 CFR §§ 447.50, 57, 58, and 62 through 82 will apply to cost sharing for this group.

a. **Non-Pharmacy Co-pays.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), the non-pharmacy co-pay amounts are presented in Table 5 (*TennCare Non-Pharmacy Co-Pays).*

**Table 5**
**TennCare Non-Pharmacy Co-pays**

| Poverty Level | Co-payment Amounts |
|---|---|
| 0%-99% | $0.00 |

| Poverty Level | Co-payment Amounts |
|---|---|
| 100% - 199% | $10.00 Non-emergency Hospital Emergency Room (waived if admitted)<br><br>$5.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$5.00 Physician Specialists (including Psychiatrists and Dentists)<br><br>$5.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |
| 200% and above | $50.00 Non-emergency Hospital Emergency Room (waived if admitted)<br><br>$15.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$20.00 Physician Specialists (including Psychiatrists and Dentists)<br><br>$100.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |

b. **Co-Pays on Pharmacy.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), and adults in the Standard Spend Down Demonstration Group, and persons in the At Risk Demonstration Group, co-pays on outpatient pharmacy services are presented in Table 6 (*Co-Pays on Pharmacy)*.

**Table 6**
**Co-Pays on Pharmacy**

| Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| TennCare Medicaid adults who are not exempt from cost-sharing under 42 CFR § 447.53 | $3.00 | $1.50 |
| TennCare Standard under age 21 with incomes below 100% FPL | $0 | $0 |
| TennCare Standard under age 21 with incomes at or above 100% FPL | $3.00 | $1.50 |
| TennCare Standard aged 21 and older -- SSD | $3.00 | $1.50 |

| Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| enrollees | | |
| CHOICES 1 and CHOICES 2 | $0 | $0 |
| Interim CHOICES 3 | $3.00 | $1.50 |
| CHOICES 3 | $3.00 | $1.50 |

**35. Compliance of TennCare Standard Cost Sharing With Federal Regulations.** The state submitted a plan for ensuring that cost sharing for TennCare Standard complies with the statutory and regulatory requirements, including the implementation of an aggregate cost sharing cap as described in 42 CFR § 447.78. The state implemented its plan on January 1, 2013.

## VIII. DELIVERY SYSTEMS

**36. Managed Care Entities.** TennCare II operates totally in a managed care environment and uses various types of managed care entities for delivering covered services to TennCare enrollees. The types of managed care entities used are listed in Table 7 below, with the reimbursement and rate-setting methodologies for each one. Title XXI Medicaid Expansion demonstration population children use the same delivery systems as other enrollees.

**Table 7– Types of Managed Care Entities**

| Type of Entity | BBA Definition | Description of Services Covered | Reimbursement and Rate-Setting Methodology |
|---|---|---|---|
| Managed Care Organizations (MCOs)—at full risk | MCO | All TennCare physical health, behavioral health, and LTSS* | MCO rates are actuarially certified by an independent third party actuary |
| TennCare Select—non-risk or partial risk | Prepaid Inpatient Health Plan (PIHP) | All TennCare physical health, behavioral health, and LTSS* for enrollees selected for participation in TennCare Select rather than enrolled in MCOs (see paragraph 38, *TennCare Select*) | Provider payment rates are negotiated between the PIHP and providers; an administrative fee is approved by CMS and paid to the PIHP |
| Dental Benefits Manager (DBM)—non-risk (may be renegotiated as at risk) | Prepaid Ambulatory Health Plan (PAHP) | Dental benefits for all TennCare enrollees with this coverage | Provider payment rates are established within DBM contract as approved by CMS; an administrative fee, approved by CMS, is paid to the DBM |
| Pharmacy Benefits Manager (PBM)—non-risk (may be renegotiated as at risk) | PAHP | Pharmacy benefits for all TennCare enrollees with this coverage. | Provider payment rates are established in accordance with the state plan; an administrative fee, approved by CMS, is paid to the PBM |

***LTSS refers to services for persons who are elderly or who have physical disabilities.

**37. Enrollment in Managed Care Organizations (MCOs).** With the exception of individuals enrolled in TennCare Select, all individuals eligible for TennCare (TennCare Medicaid or TennCare Standard), including those dually eligible for Medicare, shall be enrolled in a managed care organization providing the benefits described in paragraphs 28 *(TennCare Benefits)* and 29 *(Cost-Effective Alternatives)* of these STCs. In addition to the managed care organization, enrollees are enrolled with a Pharmacy Benefits Manager for covered pharmacy services and a Dental Benefits Manager for covered dental services. The Pharmacy Benefits Manager administers the pharmacy benefits program, using a preferred drug list that is established by the state (in consultation with a Pharmacy

Advisory Committee), taking into account the cost, therapeutic equivalency, and clinical efficacy in accordance with waiver authority.

**38. TennCare Select.** TennCare Select is a prepaid inpatient health plan (PIHP) (as defined in 42 CFR § 438.2) which operates in all areas of the state and covers the same services as the MCOs. The state's TennCare Select contractor is reimbursed on a non-risk, non-capitated basis or a partial risk basis for services rendered to covered populations, and in addition receives fees from the state to offset administrative costs.

a. The TennCare Medicaid and TennCare Standard populations included in the TennCare Select delivery system and the services provided to these populations by the TennCare Select contractor are as follows:

i. Children who are eligible for Supplemental Security Income. TennCare Select provides medical case management and all MCO covered services.

ii. Children in state custody and children leaving state custody for 6 months post-custody as long as the child remains eligible. TennCare Select provides medical case management, all MCO covered services, and coordination with the Department of Children's Services (DCS) around medical and behavioral services.

iii. Children who are receiving care in a nursing facility or an intermediate care facility for individuals with intellectual disabilities. For children and adults in a Home and Community Based Services 1915(c) waiver for individuals with intellectual disabilities, current enrollees may opt-in to receive services through TennCare Select, and new participants may opt-out of TennCare Select in order to receive services through another MCO. TennCare Select provides medical case management and all MCO covered services.

iv . Enrollees living in areas where there is insufficient capacity to serve them. TennCare Select provides medical case management and all MCO covered services.

After being assigned to TennCare Select, persons in categories i. and iii. above may choose to disenroll from TennCare Select and enroll in an MCO if one is available. Persons in categories ii. and iv. must remain in TennCare Select. The state must request a demonstration amendment (as described in paragraphs 6 and 7 regarding amendments) in order to change the list of populations included in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

b. TennCare Select also provides the following functions:

i. It is the back-up plan should one of the MCOs have to leave the TennCare program unexpectedly. For TennCare enrollees previously enrolled with

the MCO, TennCare Select provides medical case management and all MCO covered services.

ii. It is the only entity responsible for payment of the services described in 42 CFR § 431.52 (regarding services provided to residents temporarily absent from the state), and provides all MCO covered services (primarily emergency services).

iii. It is also the only entity responsible for payment of the services described in 42 CFR § 440.255 (regarding emergency services for aliens), and is responsible for payment of emergency medical services only. TennCare Select is paid an administrative fee for processing these claims.

**39. Plan Enrollment and Disenrollment.** The state maintains a managed care enrollment and disenrollment process that must comply with 42 CFR Part 438, except that, in accordance with waiver authority, TennCare participants have 45 days in which to disenroll from an MCO without cause. After 45 days, a participant may disenroll from an MCO only for cause, as set forth in 42 CFR § 438.56(d)(2). The "other reasons" that will be considered cause under 42 CFR § 438.56(d)(2)(iv) do not include the following:

- The enrollee is unhappy with the current plan or primary care provider (PCP), but there is no hardship medical situation (as defined by the state);
- The enrollee claims lack of access to services but the plan meets the state's access standards;
- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- The enrollee is concerned that a current provider might drop out of the plan in the future;
- The enrollee is a Medicare recipient who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation; and
- The enrollee's Primary Care Provider (PCP) is no longer in the MCO's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO.

In the event that a CHOICES member is determined, based on an assessment of needs, to require long term services and supports that are not currently available under the MCO in which he is currently enrolled, but that are available through another MCO, the state shall work with the current MCO to arrange for the provision of the required services, which may involve providing such services out-of-network. It shall be considered to be cause for disenrollment only if the current MCO, after working with the state, is unable to provide the required services. In such cases, the MCO that is unable to provide the required services after working with the state may be subject to sanctions.

**40. Contracts.** The following subparagraphs provide additional requirements pertaining to contracts awarded by the state for the provision of health care services under TennCare II.

a. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation.

b. Payments under contracts with public agencies that are not competitively bid in a process involving multiple bidders shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

c. With respect to CHOICES, the state established minimum guidelines regarding the person-centered service plan, the processes for the development of the plan, and the monitoring of its implementation. These expectations were submitted to CMS and are reflected in the MCO contract. Any changes in the contract requirements related to the subjects enumerated below will be submitted to CMS for review prior to executing a contract amendment with an MCO. CMS will respond within 15 working days of receipt of the draft. The required subject areas are as follows:

   i. The individuals who develop the person-centered service plan (and their requisite qualifications);

   ii. The individuals who are expected to participate in the plan development process;

   iii. Timing of the plan, how and when it is updated, including mechanisms to address changing circumstances and needs (and expectations regarding scheduling and location of meetings to accommodate individuals receiving services);

   iv. Types of assessments that are conducted as a part of the service plan development process;

   v. How participants are informed of the services available to them;

   vi. How the process ensures that the service plan addresses the participants' desired outcomes, needs and preferences; and

   vii. The plans' responsibilities for implementing and monitoring the plan of care.

d. The state will require the MCOs to develop and maintain emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. These contingency plans will be available for inspection by state officials upon request.

e. The state will monitor loss ratios of the managed care plans.

## IX. GENERAL REPORTING REQUIREMENTS

**41. General Financial Requirements.** The state shall comply with all general financial requirements under title XIX and title XXI set forth in these STCs.

**42. Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request.

**43. Additional Reporting Requirements.**

a. **Compliance with Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR §§ 438 *et seq.*

b. **Compliance with Specified HCBS Requirements.** The following regulations, which govern the provision of HCBS under Section 1915(c) waivers, shall apply to the HCBS program authorized under Section 1115 and provided through CHOICES:

- 42 CFR § 440.180(a);
- 42 CFR § 441.302;
  (a),
  (c) (insofar as it relates to NF level of care, and applying only to CHOICES 2),
  (d) (consistent with a waiver of Section 1902(a)(23) of the Act),
  (g) (applies only to CHOICES 2), and
  (j);
- 42 CFR § 441.303
  (a),
  (c) (except that the requirements following the semi-colon in (c)(2) do not apply to CHOICES 3 or Interim CHOICES 3),
  (d) (consistent with Table 2b, paragraph 28), and
  (e); and
- 42 CFR § 441.310.

Any conflict between the regulations listed in this subparagraph and these STCs shall be resolved in favor of the STCs. The state shall include a description of the steps taken to ensure compliance with these regulations as part of the Annual Report discussed in paragraph 46 *(Annual Report)*.

c. **Quality Improvement Strategy for the CHOICES Program.** The state must submit to CMS an integrated quality improvement (QI) strategy which builds on existing managed care quality requirements as defined in 42 CFR § 438, Subpart E, and incorporates applicable 1915(c) Home and Community-Based Services

waiver regulatory assurances as discussed in paragraph 43.b.

The state must identify: 1) measures of process, health outcomes, functional status, quality of life, member choice, autonomy, satisfaction, and TennCare and CHOICES system performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

The MCOs must be required to establish methods for discovery, remediation and systems improvement and, per state prescribed timeframes, regularly report on outcomes associated with continuous quality improvements.

The state must clearly demonstrate its oversight of the process.

The QI strategy must be submitted to CMS for approval prior to implementation.

No less frequently than annually, the state must provide to CMS information regarding QI activities which must include evidence regarding system performance based on identified objectives and measures, and which demonstrates efficacy in implementing the quality strategy, including but not limited to external quality review, discovery, remediation and systems improvement activities.

d. **CHOICES Data.**

i. **CHOICES Data Plan.** The state will collect and submit data to CMS, including the following data elements:

(A) Numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services at a point in time,

(B) Unduplicated numbers of persons receiving HCBS and unduplicated numbers of persons receiving NF services during a 12 month period,

(C) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period,

(D) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period as a percentage of total long-term services and supports expenditures (excluding expenditures on the population of persons with intellectual disabilities),

(E) Average per person HCBS expenditures and NF expenditures on the elderly and disabled populations during a 12 month period,

(F) Average length of stay in HCBS during a 12 month period,

(G) Percent of new LTSS recipients admitted to NFs during a 12 month period,

(H) Average length of stay in NFs during a 12 month period,

(I) Number of persons transitioned from NFs to HCBS during a 12 month period.

"Point in time" refers to June 30 of each year.

ii. **Electronic Collection of Choices Data.** The systems must be in place to record the requisite data elements for the CHOICES Program.

iii. **CHOICES Data Reporting.** The state must report to CMS, in the Quarterly and Annual Progress Reports, on data and trends of the designated CHOICES data elements. An electronic copy of the actual data addressing the required data elements must be submitted to CMS within 3 months following each point in time (e.g., by September 30 of each DY).

e. **Requirements Related to the Affordable Care Act.** Subparagraphs i. and ii. below describe elements that must be included in an extension proposal or phase-out plan, as discussed in paragraph 8 *(Extension of the Demonstration)* and paragraph 9 *(Demonstration Phase-Out)*.

i. **Affordable Care Act Transition Plan for Extension.** The extension proposal submitted to CMS in June 2012 included a Transition Plan. This plan will be updated consistent with the provisions of the Affordable Care Act and CMS regulations for any individuals enrolled in Demonstration Eligible Groups (as defined in paragraph 17, Table 1a) who will be eligible for coverage under the state plan as of January 1, 2014, including under the new Medicaid eligibility group identified in Section 1902(a)(10)(A)(i)(VIII) of the Act, or who elect to move to an Exchange plan. Persons who are demonstration eligibles at the time of transition will continue to receive demonstration benefits as long as they are enrolled in a Medicaid category and they continue to meet the criteria for their particular demonstration program. The updated Transition Plan will include procedures for ensuring that these individuals transition to their new eligibility status without interruption in coverage to the maximum extent possible.

ii. **Demonstration Phase-Out and Affordable Care Act Transition.** As part of a phase-out plan submitted under paragraph 9, the state must include a plan for using information already in its possession on members of demonstration Eligible Groups to make advance determinations of

eligibility for TennCare under its Medicaid state plan on January 1, 2014, consistent with guidance to be issued by CMS.

**44.** **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the state's progress on enrolling individuals into the TennCare Standard Spend Down Demonstration Group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

**45.** **Quarterly Progress Reports.** The state must submit progress reports containing the items listed below (see also Attachment A for format), no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. An updated CHIP allotment neutrality monitoring spreadsheet, if necessary;

c. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the TennCare Standard Spend Down Demonstration Group; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the demonstration; pertinent legislative or litigation activity; and other operational issues;

d. Action plans for addressing any policy, administrative, or budget issues identified;

e. Quarterly enrollment reports for demonstration eligibles that include the member months for each demonstration population;

f. Quarterly enrollment reports for individuals who would otherwise be eligible for Interim CHOICES 3 but who meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual;

g. Evaluation activities and interim findings; and

h. Other reports as indicated in these STCs.

**46. Annual Report.** The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The state shall also submit the title XXI annual state report for its Medicaid Expansion children in the demonstration, by December 31 of each year.

**47. Beneficiary Survey.** The state shall conduct a beneficiary survey each demonstration year for a statistically valid sample of all TennCare enrollees. The survey shall measure satisfaction, enrollee efforts to secure out-of-network care, average waiting time for physician office visits, and enrollee efforts to change plans, along with reasons for requesting plan changes. Results of the survey must be provided to CMS by September after the end of in each demonstration year (e.g. survey results for demonstration year 12 are due no later than September 30, 2014).

**48. Final Evaluation Report.** The state shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act and as specified in Section XII of these STCs.

**49. Enrollment Reporting.**

a. Each quarter the state will provide CMS with an enrollment report for the title XXI Medicaid Expansion demonstration population and for title XIX Medicaid children, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the state into the Statistical Enrollment Data System (SEDS) within 30 days after the end of each quarter. SEDS reporting is required for any title XXI-funded population, including Medicaid Expansions, and is also required for title XIX Medicaid child enrollment.

b. Enrollment reporting in the Quarterly and Annual Reports (see paragraphs 45 *Quarterly Progress Reports* and 46 *Annual Report*) is required by Eligibility Group (EG) and Type for the TennCare title XIX and XXI state plan and demonstration populations.

## X. GENERAL FINANCIAL REQUIREMENTS

**50. Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under Section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period and pool payments and certified public expenditures made for the demonstration period. CMS shall provide Federal financial participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X of these Terms and Conditions.

**51. Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Tennessee must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which capitation payments were made. For this purpose, demonstration year 1 (DY 1) is defined as the year beginning July 1, 2002, and ending June 30, 2003. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures should be reported on Forms CMS-64.9 Base/64.9P Base.

Expenditures for Medicaid Expansion children claimed under the authority of title XXI of the Act shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

b. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by demonstration year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the eligibility groups (EGs) from which collections were made (see paragraph 53, *Assignment of Expenditures and Member Months to EGs*). In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations shall be offset

against expenditures. These Section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver or 64.9P Waiver schedules, and allocated to forms named for the different EGs described in e.i. through e.xii. below as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to demonstration populations shall be offset against expenditures.

e. **Use of Forms**. The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration and title XIX expenditures made in other payment categories as follows. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system. The terms "EG1" through "EG12" refer to the demonstration Eligibility Groups defined in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)* of these STCs.

i. "EG1 Disabled" expenditures (see paragraph 53.a.i.)

ii. "EG2 Over 65" expenditures (see paragraph 53.a.ii.)

iii. "EG3 Children" expenditures (see paragraph 53.a.iii.)

iv. "EG4 Adults" expenditures (see paragraph 53.a.iv.)

v. "EG5 Duals" expenditures (see paragraph 53.a.v.)

vi. "EG6E Expan Adult" expenditures (see paragraph-53.b.i.)

vii. "EG7E Expan Child" expenditures (see paragraph 53.b.ii.)

viii. "EG8 Med Exp Child" expenditures (see paragraph 53.b.iii.)

ix. "EG9 H-Disabled" expenditures (see paragraph 53.b.iv.)

x. "EG10 H-Over 65" expenditures (see paragraph 53.b.v.)

xi. "EG11 H-Duals" expenditures (see paragraph 53.b.vi.)

xii. "EG12E Carryover" expenditures (see paragraph 53.b.vii.)

xiii. "GME" (Graduate Medical Education) (see paragraph 55.d.)

xiv. "EAH Pool" (Essential Access Hospital Pool) (see paragraph 55.e.)

xv. "CAH Pool" (Critical Access Hospital Pool) (see paragraph 55.f.)

xvi. "Meharry Pool" (see paragraph 55.g.)

xvii. "CPE" (Certified Public Expenditures) for Unreimbursed Public Hospital Costs Pool (see paragraph 55.h.)

xviii. "DSH" (Disproportionate Share Hospital Payments) (see paragraph 55.i.)

xix. "UHC Pool" (Unreimbursed Hospital Cost Pool) (see paragraph 55.k.)

xx. "PHSP Pool" (Public Hospital Supplemental Payment Pool) (see 55.l.)

f. **Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population.**

i. **Expenditures Subject to the Allotment Neutrality Limit.** The state will be subject to a limit on the amount of Federal title XXI funding that the state may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including available reallocated funds published in the *Federal Register*. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of demonstration until the next allotment becomes available.

ii. The state is eligible to receive title XXI funds for expenditures for TennCare Medicaid Expansion children described on the last row of Table 1a in Section IV, paragraph 17 *(Eligibility)*, up to the amount of its title XXI allotment. Waiver expenditures for these children under title XXI must be reported as a Medicaid expansion population on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver, in accordance with the instructions in Section 2115 of the State Medicaid Manual, under waiver name "Med Exp Child," identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which

capitation payments were made. They are reported in Column C for the enhanced match under title XXI.

iii. If the state exhausts its title XXI allotment, title XIX funds are available for title XXI children in this demonstration. To access this funding, the state must submit for approval a written request to CMS, referencing this STC, to access title XIX funds for the title XXI Medicaid Expansion Demonstration Group. This request must be submitted at least 90 days prior to the date on which the state anticipates its title XXI allotment will be exhausted, and must include:

(A) An updated budget neutrality assessment that adds Medicaid Expansion children to budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that removes Medicaid Expansion children.

iv. Once the title XXI allotment is again available, the state will claim title XXI funding for the title XXI children in this demonstration. To access this funding, the state shall submit for approval a written request to CMS, referencing this STC, to access title XXI funds for the title XXI Medicaid Expansion Demonstration Group, which includes a request to update the STCs related to claiming. This formal request must be submitted prior to the change in funding source and include:

(A) An updated budget neutrality assessment that removes Medicaid Expansion children from budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that adds Medicaid Expansion children.

v. During periods in which the state is claiming title XIX funds for Title XXI Medicaid Expansion demonstration population children, the member months attributable to this demonstration population will count toward calculation of the budget neutrality expenditure limit, using the per member per month (PMPM) amounts for "EG8 Med Exp Child." The expenditures will be considered expenditures subject to the budget neutrality expenditure limit, so that the state is not fully at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

g. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to:

i. All TennCare title XIX expenditures on behalf of individuals who are enrolled in this demonstration (excluding the services specified in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*), including all service expenditures and applicable administrative costs (see subparagraph h. below) net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse), and

ii. All expenditures described in paragraph 55.d. through i. *(Extent of Federal Financial Participation for the Demonstration).*

All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver, with the exception of those described in h. below.

h. **Administrative Costs.** In general, administrative costs are not included in the budget neutrality expenditure limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. Administrative costs subject to budget neutrality (see below) must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, according to the EGs for which the expenditure was made (following the list in e.i. through e.xii. above). Other administrative costs not subject to budget neutrality will not be broken out by EG, and will be reported under waiver name "TennCare II."

In accordance with Federal regulations at 42 CFR § 438.812(b)(2), during the periods that services are provided in accordance with MCO, pharmacy benefit manager, or dental benefit manager non-risk contracts, the portion of the state's payments that is for reimbursement of the non-risk contractors' administrative services can only be claimed by the state as an administration cost at the Federal matching rates available for the costs of administration of the Medicaid program. The administrative services portion of the amounts paid by the state to compensate any non-risk contractors for their administration costs incurred in accordance with non-risk contracts are costs of the demonstration waiver that are subject to the budget neutrality expenditure limit explained in Section XI of these STCs.

i. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the Section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.

**52. Reporting Member Months.** The following describes the reporting of member months for TennCare Medicaid and TennCare Standard enrollees:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 45 *(Quarterly Progress Reports)* of these STCs, the actual number of eligible member months for all TennCare Medicaid and TennCare Standard Eligibility Groups (EGs) defined in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)*. The state must submit a statement accompanying the quarterly report, which recognizes the accuracy of this information. Member months should be reported only for individuals who are included in TennCare, as defined in paragraph 17 *(Eligibility)*. Persons for whom Medicaid only pays for services carved out of TennCare (as described in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*) are not enrolled in TennCare (e.g., QMBs, SLMBs).

b. A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for Type 1 and Type 2 eligibles (as defined in paragraph 61, *Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement*) are reported in Section VIIIA of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for Type 3 demonstration expansion populations and for title XXI Medicaid Expansion demonstration eligibles are reported in Section VIIIB of the template, and are not used to calculate the budget neutrality expenditure limit. Detailed instructions for

assigning member months to Types and to EGs are provided in paragraphs 53 *(Assignment of Expenditures and Member Months to EGs)* and 61 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)*.

c. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the state must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

d. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

e. The state will ensure that eligible member month totals reported to CMS for the TennCare II demonstration from July 1, 2002, forward conform to the EG definitions contained in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)*.

**53. Assignment of Expenditures and Member Months to EGs:** The following rules govern the:

- Reporting of expenditures subject to the budget neutrality expenditure limit on separate waiver forms by EG, as described in paragraph 51.e. *(Use of Forms)* above, for the period beginning July 1, 2007, through the end of the TennCare II demonstration, and
- Reporting of eligible member months for the TennCare II demonstration from July 1, 2002, forward.

Beginning July 1, 2007, and as subsequently modified, the quarterly progress report template in Attachment A, Part VIII should be used to report separate member month totals for Type 1, Type 2, and Type 3 eligibles, and for other subgroups as specified below.

a. **<u>Title XIX State Plan Mandatory or Optional Groups (Type 1 Eligibles)– TennCare Medicaid:</u>**

i. For Medicaid eligibles of any age who have qualified for Medicaid on the basis of disability but who are not eligible for Medicare, report under **EG1 Disabled, Type 1.** This includes non-dual SSI eligibles in CHOICES 1, 2, and 3, the CHOICES 1 and 2 Carryover Group, or the PACE Carryover Group.

ii. For Medicaid eligibles who have not qualified for Medicaid on the basis of

disability, who are not eligible for Medicare, and who are 65 years of age or older, report under **EG2 Over 65, Type 1.**

iii. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are age 18 or younger, report under **EG3 Children, Type 1.**

iv. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are between the ages of 19 and 64, report under **EG4 Adults, Type 1.**

v, For Medicaid eligibles of any age who are also eligible for Medicare, report under **EG5 Duals, Type 1.** This category includes dually eligible Medicaid/Medicare individuals who have been classified as "disabled." It does not include any dually eligible members of demonstration populations such as the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group.

b. **Title XIX Demonstration Eligible Groups (Type 2 or 3 Eligibles) – TennCare Standard**

i. For demonstration eligibles who are enrolled in the Standard Spend Down category, report under **EG6E Expan Adult, Type 3.** This category includes SSD enrollees who have Medicare or who have been classified as "disabled."

ii. For demonstration eligible children under age 19 who have been determined to be "Medically Eligible" and who have incomes at or above 200 percent of poverty, report under **EG7E Expan Child, Type 3.**

iii. For demonstration eligible children under age 19 who have been determined to be uninsured and who have incomes below 200 percent of poverty, report under **EG8 Med Expan Child, Type 2, only when Title XIX funds are being used.** This is the Title XXI population. This EG is in effect only when the state is using Title XIX funds for this population. In periods when the state is using Title XXI funds, these children would not be included in any EG but would be reported as indicated in c. below.

iv. For persons in the CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are under age 65, report under **EG9 H-Disabled, Type 2.** This category should also be used for members of any age in the At Risk Demonstration Group who are not eligible for Medicare.

v. For persons in the CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are age 65 or older, report under **EG10 H-Over 65,**

**Type 2.**

vi. For persons in the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group who are also eligible for Medicare, report under **EG11 H-Duals, Type 2.**

vii. For demonstration eligible (non-SSI) persons in the CHOICES 1 and 2 Carryover Group or the PACE Carryover Group, report under **EG12E Carryover, Type 3.** This category should be used for both duals and non-duals in the Carryover Groups.

c. Expenditures for title XXI Medicaid Expansion children matched at the title XXI enhanced FMAP should be reported on Forms 64.21U Waiver/64.21UP Waiver, using waiver name "Med Exp Child." Report member months for quarterly reporting using Attachment A, Part VIII. For periods in which the state claims title XIX FMAP for this population (paragraph 51.f. *Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population*), follow the instructions in b.iii. above.

d. Type 2 eligibles can be identified as disabled for reporting purposes (see b.iv. above) if information exists in their enrollment record that would result in a capitation rate for disabled populations being paid on their behalf.

**54. Standard Funding Process.**

a. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

b. **Standard CHIP Funding Process.** The standard CHIP funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the allotment neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by

CMS. Within 30 days after the end of each quarter, the state must submit quarterly CHIP expenditure reports as described in paragraph 51.f. *(Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population)*, showing CHIP expenditures made in the quarter just ended. CMS shall reconcile expenditures with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

**55. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding (see Section X, paragraph 57, *Sources of Non-Federal Share*), CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section XI of these STCs.

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

d. **Graduate Medical Education (GME) Pool.** Actual cash disbursements, up to $50 million in total computable expenditures for each demonstration year, paid by the state from a supplemental pool to pay for GME costs in accordance with the pool distribution methodology described below. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology, authorized by the demonstration's expenditure authorities. Should CMS promulgate new regulations, the TennCare GME program must come into compliance in accordance with the effective date of the new regulations.

*GME Pool Methodology*: GME Pool payments will be made to the following medical universities that operate graduate physician medical education programs. These payments are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics: East Tennessee State University, Meharry Medical College, University of Tennessee at Memphis, and Vanderbilt University. The annual GME Pool funds will be allocated based on the annual ratio derived by dividing each hospital's average of its Primary Care Position Allocation and its Total Filled Positions Allocation by the aggregate of the medical hospitals' averages. The Primary Care Position Allocation is computed by taking each hospital's total number of primary care residents in years 1 through 4 of residency and dividing it by the total of all primary care residents in the medical hospitals in years 1 through 4 of residency.

The Total Filled Positions Allocation is computed by taking each hospital's total number of residents in years 1 through 4 of residency and dividing it by the total of the medical hospitals' number of residents in years 1 through 4 of residency. This annual ratio is applied to the total GME Pool funding to be allocated. The annual GME Pool funds will be disbursed quarterly. The state must make these payments directly to the universities, and not through any third party or intermediary.

e. **Essential Access Hospital (EAH) Pool.** Actual cash disbursements paid each quarter from a $25 million quarterly supplemental pool to pay for the uncompensated costs of the designated EAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and appropriate charity care patients in accordance with the pool distribution methodology described below. The purpose of this pool is to address the uncompensated care situation of high volume and charity hospitals that serve a disproportionate number of low-income patients with special needs. Hospitals designated as Critical Access Hospitals (CAHs) or as state mental health institutes do not participate in this pool. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

For FFYs 2008 and beyond, EAH Pool payments will be assumed to pertain to the FFY during which the payments were made. To the extent required by Federal law, EAH Pool payments made during a given FFY shall be reduced on a dollar for dollar basis by the amount of DSH payments made under the DSH allotment for that FFY.

*EAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Essential Access Hospitals.

*Qualifications* -- Hospitals eligible to receive EAH Pool payments include all hospitals licensed to operate in the State of Tennessee excluding the four (4) state mental health institutes and the CAHs. The four regional mental health institutes are Memphis Mental Health Institute, Moccasin Bend Mental Health Institute, Western Mental Health Institute, and Middle Tennessee Mental Health Institute. The CAHs receive cost-based reimbursement from the TennCare program subject to limitations outlined in subsection f. of this paragraph.

- All hospitals, with the exception of free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program.
- The free standing psychiatric hospitals must be a contracted provider with at least one of the Managed Care Organizations in the TennCare program and at least 30% of their total adjusted days must be covered by TennCare.

- All acute care hospitals must have either of the following: (i) at least 13.5% or more of their total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days.
- All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare cost.

*Allocation of the EAH Pool to Segments of Hospitals* -- The $25 million Pool should be segmented into 4 distinct parts as follows:

- Essential Service Safety Net – $12.5 Million -- These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved.
- Children's Safety Net – $1.25 Million -- These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children under the age of 21 in Tennessee.
- Free Standing Psychiatric Hospitals - $0.5 Million -- These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health for the provision of psychiatric hospital services in Tennessee, excluding the state mental health institutes.
- Other Essential Acute Care – $10.75 Million -- These hospitals include all other hospitals licensed by the Tennessee Department of Health to provide services in Tennessee, excluding the Critical Access Hospitals.

*Quarterly Reports* – The state must include in its Quarterly Progress Reports a list of the current hospitals in each of the above categories (see Attachment A).

*Data* -- Calculation of the quarterly payment amounts will be based on the most recently completed Joint Annual Report of Hospitals at the time of the first quarterly payment for a given fiscal year.

*Allocation will be based on an assignment of points for*:
- TennCare adjusted days expressed as a percent of total adjusted patient days; and
- Charity, medically indigent care, and bad debt expressed as a percent of total expenses.

*Calculation of Points*
**(1)** TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:

- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the critical access, pediatric and safety net providers;
- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 34.5%;
- 3 points – greater that 34.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

**(2)** Bad Debt, Charity and Medically Indigent – BDCHMI costs as a percent of total expenses

- 0 points - less than 4.5%
- 1 point - greater than or equal to 4.5% and less than 9.5%
- 2 points - greater than or equal to 9.5% and less than 14.5%
- 3 points - greater than or equal to 14.5%

*Calculation of Amounts of Pool Payments for Hospitals* -- These points will then be used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate included all inpatient costs (operating, capital, direct education) but excluded add-ons (indirect education, MDSA, return on equity). The GHR for Safety Net Hospitals is $908.52. The GHR for Other Essential Access Hospitals is $674.11. The points for each qualifying hospital will be summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each of the 4 pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initially calculated amount will then be adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. For example, if the sum of the initial calculated amounts for the pediatric group is $9 million and the total pool for children's hospitals is $5 million, each hospital's initial calculated amount will be multiplied by $5 million / $9 million.

*Pool Payments* -- Hospitals will be paid on a quarterly basis following the end of each quarter. The initial payment will include all quarters that have ended at the time that the payment is made. All subsequent quarterly payments will be made

following the end of the quarter. In order to receive a payment for the quarter, all hospitals, with the exception of the free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, with at least one Managed Care Organization, and must have contracted with TennCare Select for the entire quarter that the payment represents. In order for a free standing psychiatric hospital to receive a payment for the quarter, it must be a contracted provider with at least one of the Managed Care Organizations.

f. **Critical Access Hospital (CAH) Pool.** Actual cash disbursements, of up to $10 million per demonstration year, paid from a supplemental pool to pay for the uncompensated costs of the designated CAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and the appropriate charity care patients in accordance with the pool distribution methodology that has been given CMS prior approval. CAHs are designated by the Tennessee Department of Health, and they are typically small, rural hospitals that are part of a rural health network. CAHs allow communities to maintain access to primary care and emergency care when the maintenance of a full-service acute care hospital is no longer feasible. The purpose of this pool is to address the uncompensated care situation of CAHs in serving a disproportionate number of low-income patients in rural areas who have special needs. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

*CAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Critical Access Hospitals.

*Qualifications* -- To qualify for payment as a Critical Access Hospital, a hospital must meet the following criteria:

- The hospital is an acute care hospital located and licensed in the state of Tennessee;
- The hospital has been designated a Critical Access Hospital by the Tennessee Department of Health; and
- The hospital contracts with a managed care organization participating in TennCare.

*Reimbursement* -- TennCare will provide reimbursement to Critical Access Hospitals under the following terms. Reimbursement to hospitals will be limited to specific annual legislative appropriation. In any state fiscal year that reimbursable TennCare costs incurred by Critical Access Hospitals exceed annual appropriations, equitable adjustments will be made to the rates described below, in order to cap reimbursement at the annual appropriation.

***Inpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare inpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly with interim per diem rates and will be cost-

settled at year-end. Using the Joint Annual Reports filed for the most recent year available, interim per diem rates for TennCare inpatient services will be determined with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs. Inpatient Critical Access Hospital services will not include more than 15 acute inpatient beds. An exception to the 15 bed requirement is made for swing bed hospitals. Critical Access Hospitals are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that not more than 15 beds are used at any one time for acute care.

***Outpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare outpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly based on a percentage of charges with year-end cost settlements. Using the Joint Annual Reports filed for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges, with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs.

**Cost Settlements** -- Cost settlements are determined from provider submitted Medicare cost reports that include the title XIX schedules based on 100 percent (100%) of TennCare reasonable costs. The term “reasonable costs” is defined for this purpose as total reimbursable costs under Medicare principles of cost reimbursement for Critical Access Hospitals.

*New Designations of Critical Access Hospitals* -- For new hospitals that qualify after July 1, 2002, the state will begin reimbursement at the rates established by this part on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its Critical Access Hospital designation. At that time, interim rates will be established according to this part and the designation will be confirmed with the Tennessee Department of Health.

*Audit Trail and Audit Requirements* -- Each CAH is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than 5 years from the date of the submission of the Joint Annual Report, and the provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint Annual Reports are subject to audit at any time by Federal and state auditors, including the Comptroller of the Treasury and the Bureau of TennCare, or their designated representative.

g. **Meharry Medical College (Meharry) Pool.** Actual cash disbursements paid from a $10 million supplemental pool per demonstration year to pay for the uncompensated costs of the two Medicaid clinics operated by the Meharry Medical College for TennCare covered services provided to TennCare enrollees and the appropriate charity care patients. The Meharry Pool payments will be limited to the uncompensated costs of the care as determined by an independent audit each year and subject to the review and approval by the CMS staff. Before paying the annual pool amount to the providers, the state will provide CMS with a copy of the annual independent audit report. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

h. **Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (CPE).** Actual costs incurred by government operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients are eligible as CPE. The state must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital from the following sources: the MCOs; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds). With regard only to hospital CPE, the state will report actual CPE within 12 months after the end of each fiscal year. At that time, the state will revise its FFP claim to reconcile actual CPEs with the CPE estimates used during the preceding fiscal year (FY).

**State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the state of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

**CPE Methodology and Protocol.** The state must follow the CPE protocol, as contained in Attachment F of these STCs, which was approved by CMS for use beginning July 1, 2008.

i. **Disproportionate Share Hospital (DSH) Payments.** The Tax Relief and Health Care Act of 2006 (TRHCA 2006) established a DSH allotment for Tennessee for FFY 2007, as described at Section 1923(f)(6) of the Act. The relationship between DSH payments made by Tennessee under TRHCA 2006 and payments from the EAH Pool is further specified in the second paragraph of subparagraph (e) above. If Congress should establish a DSH allotment for Tennessee for any subsequent Federal fiscal year, the state may make DSH payments to hospitals on the basis of a state plan amendment approved by CMS. Depending on the specifics of the legislation establishing the DSH allotment, modifications to the budget neutrality expenditure limit may be required, in the manner specified in

paragraph 4.a. (*Impact on Demonstration of Changes in Federal Law, Regulation, and Policy).* Unless otherwise specified by law, DSH payments shall be considered payments made under the demonstration and subject to the budget neutrality expenditure limit and the limit described in subparagraph (j) below. When determining hospital-specific DSH limits and DSH payments, the state must take into account all Medicaid payments under the Medicaid state plan and demonstration projects including amounts paid to hospitals through the GME, EAH, Meharry Medical College, UHC, PHSP, and CAH Pools, as well as any payments by or on behalf of individuals with no source of third party coverage. The state must make these payments directly to the providers of the services as specified at Section 1923(i) of the Social Security Act.

j. Beginning in DY 6 (state fiscal year 2008), the combined total of the payments to hospitals listed in i. below shall not exceed annual limits described in iv. Beginning in DY 11 (state fiscal year 2013), the combined total of the payments to the hospitals listed in iii. below shall not exceed annual limits described in iv. Any unused amount from the annual cap for one DY may not be rolled over and added to the annual cap for any subsequent DY.

i. The following payments are subject to the limit in DY 6 through 9:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of DSH payments (see 55.i. subject to the allotment for the FFY ending during the DY);
- Three-quarters of DSH payments (see 55.i. subject to the allotment for the FFY beginning during the DY);
- Hospital CPE (see-55.h.).

ii. The following payments are subject to the limit in DY 10:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of the DSH payments (see 55.i., subject to the allotment for the FFY 2011);
- Additional DSH payments equal to the DSH allotment for the first quarter of FFY 2012;
- Hospital CPE (see 55.h.)

iii. The following payments are subject to the limit in DYs 11-14:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- Hospital CPE (see 55.h.).

iv. The annual limit for DY 6 – DY 14 shall be $540 million (total computable).

k. **Unreimbursed Hospital Cost (UHC) Pool.** Actual costs incurred by eligible Tennessee hospitals that are unreimbursed by TennCare. The total amount of funds to be distributed to hospitals each DY from the pool will be determined annually, in a manner defined by the Tennessee General Assembly's Annual Coverage Assessment Act and this subparagraph, but in no event may exceed the limit defined below. For any demonstration year in which it elects to make payments under the UHC Pool authority described in this paragraph, the state may not implement a reduction in benefits or elimination of coverage for any of the following services: physical therapy, occupational therapy, speech therapy, inpatient hospital, lab and x-ray, non-emergency outpatient hospital, physician, podiatrist, certified nurse practitioner, or physician assistant services; or implement any co-payment for non-emergency medical transportation. (Nothing in this paragraph is intended to limit the state's ability to manage utilization of these services through changes to prior authorization requirements or other managed care practices.)

***Eligible Hospitals.*** Hospitals eligible to receive a pool payment include all hospitals licensed to operate in the State of Tennessee, except the following groups:

- Critical Access Hospitals;
- Public hospitals eligible to certify public expenditures, including state mental health institutes;
- Rehabilitation and long term care hospitals; and
- Pediatric research hospitals that limit patients to those that meet research protocols.

Any hospitals that have closed between 2008 and the time that the amounts of the payments are calculated are not eligible to receive payments.

***Minimum Qualifications.*** In order to receive a payment, the hospital must be contracted with at least one TennCare MCO and must have unreimbursed TennCare costs, unless the hospital is capitated and accepts the capitation from TennCare as full reimbursement for services to TennCare patients.

***Data Source.*** The Joint Annual Report (JAR) of Hospitals, which is a report containing data that each licensed hospital in the state is required to file annually in accordance with T.C.A. 68-11-310. This law says:

> All hospitals that submit a joint annual report to the department of health as designated in this section shall also submit to the department, at the same time they send the signed paper copy of the report, a notarized statement from their chief financial officer stating that the financial data reported on the joint annual report is consistent with the audited financials

for the hospitals for that reporting year. The notarized statement shall also be attested to by the chief executive officer of the hospital.

Reports are submitted to the Tennessee Department of Health (DOH), edited by DOH, corrected by the hospital and placed in a final data file for that year by DOH. The instructions for completing the form require the hospitals to use the same accounting method required for the Medicare cost reports.

Payment amounts for each DY will be based on the final JAR from 3 years prior to the DY.

***Calculation.*** TennCare costs shall be determined by multiplying TennCare charges for hospital inpatient and outpatient services reported by the hospital by the ratio of reported total expenses to reported total charges (cost to charge ratio). Unreimbursed TennCare Costs are calculated as the difference between the calculated TennCare costs and the TennCare revenue as reported on the JAR.

Each hospital shall receive an annual payment each DY equal to a percentage of its Unreimbursed TennCare Costs, using the same percentage to calculate each hospital's payment.

***Funding.*** TennCare shall adjust payments if necessary to ensure no hospital receives supplemental payments in excess of unreimbursed TennCare costs. Payments may be prorated subject to available appropriations.

***Payments.*** The annual payment to each hospital shall be made in four equal quarterly payments.

***Annual Limit:*** The total amount of UHC Pool payments made each DY may not exceed $500 million total computable.

l. **Public Hospital Supplemental Payment (PHSP) Pool.** Actual cash disbursements paid from a $70 million (total computable) supplemental pool per demonstration year to selected public hospitals. The amount paid each DY to each hospital must not exceed the hospital's uncompensated cost of TennCare covered services provided to TennCare enrollees and uninsured patients. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10. PHSP Pool payments may be made to the following hospitals:

- Regional Medical Center at Memphis, and
- Nashville General Hospital at Meharry.

**56. Medicare Part D Drugs.** No FFP is available under this demonstration for Medicare Part D drugs.

**57. Sources of Non-Federal Share.** The state certifies that the matching non-Federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-Federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding.

c. Under all circumstances, health care providers must retain 100 percent of the TennCare II reimbursement amounts claimed by the state as a demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

**58. Monitoring the Demonstration.** The state shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

## XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

**59**. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of Federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, with an aggregate adjustment for projected disproportionate share hospital payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section X, paragraph 51 *(Reporting Expenditures in the Demonstration).*

**60.** **Risk.** Tennessee shall be at risk for the per capita cost (as determined by the method described below in this Section) for Type 1 and Type 2 TennCare enrollees in the eligibility groups (EGs) described in paragraph 61 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)* under this budget neutrality agreement, but not for the number of demonstration eligibles in each of the groups. By providing FFP for all Type 1 and Type 2 TennCare enrollees in the specified EGs, Tennessee shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Tennessee at risk for the per capita costs for TennCare enrollees in each of the EGs under this agreement, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration. Tennessee will be at risk for both per capita costs and enrollment for Type 3 TennCare eligibles.

**61.** **Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement.** Individuals who are eligible under TennCare and whose expenditures are funded at title XIX matching rates will be one of three types:

a. Type 1 - are currently eligible under Tennessee's Medicaid state plan (Title XIX state plan mandatory or optional eligible population) - counted in the "with" and "without" waiver calculations;

b. Type 2 - could be eligible under Tennessee's Medicaid state plan if Tennessee amended its state plan or could be eligible for a Section 1915(c) waiver for aged and disabled adults pursuant to 42 C.F.R. § 435.217 (Title XIX demonstration-eligible hypothetical population) or is eligible under the At Risk Demonstration Group for the Interim CHOICES 3 program - counted in the "with" and "without" waiver calculations (the state cannot generate savings from these populations); and

c. Type 3 – are only eligible with Section 1115 demonstration authority (Title XIX demonstration-eligible expansion population) - counted only in the "with" waiver calculations.

**62. Budget Neutrality Ceiling.** The following describes the method for calculating the budget neutrality expenditure limit:

a. For each DY of the budget neutrality agreement, an annual target is calculated as the sum of two components:

i. The sum of six sub-components calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the state in accordance with paragraph 52 *Reporting Member Months*) for Type 1 and Type 2 eligibles claimed under title XIX for the following six EGs: EG1 Disabled, EG2 Over 65, EG3 Children, EG4 Adults, EG5 Duals, and EG8 Med Exp Child (when title XXI allotment is exhausted); and

ii. A Disproportionate Share Hospital (DSH) adjustment for the year described in d. below.

b. Member months for the following populations are not used for calculation of the budget neutrality expenditure limit:

i. EG6E Expan Adult, EG7E Expan Child, and EG12E Carryover Type 3 eligibles

ii. Med Exp Child: Medicaid Expansion children funded at the title XXI enhanced FMAP.

c. The following tables give the projected PMPM costs for the calculation described in paragraph 62.a. by DY. The PMPM costs for DY 8 and earlier are calculated following Attachment B of the November 14, 2006 Special Terms and Conditions and paragraph 64.c. of the July 22, 2009 STCs.

**Table 8**
**Projected PMPM Costs After CHOICES Implementation**

| | Trend | DY 12 | DY 13 | DY 14 |
|---|---|---|---|---|
| **EG1 Disabled*** | 5.1% | $1,561.46 | $1,641.09 | $1,724.79 |
| **EG2 Over 65**** | 4.6% | $1,022.17 | $1,069.19 | $1,118.37 |
| **EG3 Children** | 3.4% | $468.46 | $484.39 | $500.86 |
| **EG4 Adults** | 4.9% | $917.79 | $962.76 | $1,009.94 |
| **EG5 Duals** | 4.6% | $652.99 | $683.02 | $714.44 |
| **EG8 Med Exp Child***** | 3.4% | $468.46 | $484.39 | $500.86 |

* Includes EG 9 H-Disabled
** Includes EG10 H-Over 65
***Optional Targeted Low Income Children funded using title XIX

d. The DSH adjustment is based upon Tennessee's DSH allotment for 1992 and calculated in accordance with current law.

i. For the purpose of this subparagraph, the Average FMAP (AFMAP) for each DY is defined as 0.25 times the FMAP applicable to DSH expenditures for the Federal fiscal year that ends during that DY, plus 0.75 times the FMAP applicable to DSH expenditures for the Federal fiscal year that begins during that DY.

ii. A DSH allotment has been established for Tennessee under provisions of TRHCA 2006 (and extended through subsequent legislation). Beginning with DY 5, the DSH adjustment will be based on the DSH allotments established for Tennessee, following Section 1923(f)(6)(A)(i) of the Act, which are published in the *Federal Register*. The Federal share of the DSH adjustment for each DY will be equal to one quarter of the DSH allotment for the FFY ending during the DY, plus three quarters of the DSH allotment for the FFY beginning during the DY. A total computable equivalent for each DSH adjustment can be calculated as the DSH adjustment divided by the AFMAP for that DY. For DY 5, the figure

$305,541,928 will be used to compute the Federal share of the DSH adjustment in place of the FFY 2006 DSH allotment.

iii. The calculation of the DSH adjustment will be appropriately altered if legislation is enacted that impacts the calculation of DSH allotments, including any law that would affect the calculation of the DSH allotment for Tennessee.

iv. Table 9 gives the DSH adjustments for DY 1 through DY 14, and shows both total computable and Federal share. These totals reflect changes to the calculation of DSH allotments resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the temporary increase in DSH allotments provided under Section 5002 of the American Recovery and Reinvestment Act of 2009. Some of the figures are labeled "preliminary" because the final DSH allotments needed to calculate them have not yet been published in the *Federal Register*, and are best estimates based on current law.

**Table 9**
**DSH Adjustments for DY 1 Through DY 14**

| | **DSH Adjustment (total computable)** | **DSH Adjustment (Federal share)** |
|---|---|---|
| **DY 1** | $413,700,907 | $268,409,148 |
| **DY 2** | $479,893,052 | $310,106,890 |
| **DY 3** | $479,893,052 | $310,538,794 |
| **DY 4** | $479,893,052 | $308,091,339 |
| **DY 5** | $479,356,649 | $305,451,928 |
| **DY 6** | $479,657,638 | $305,451,928 |
| **DY 7** | $485,299,094 | $311,270,839 |
| **DY 8** | $488,969,517 | $319,052,610 |
| **DY 9** | $470,369,327 | $309,408,043 |
| **DY 10** | $463,996,853 | $305,451,928 |
| **DY 11** | $463,996,853 | $305,451,928 |
| **DY 12 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 13 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 14 (preliminary)** | $463,996,853 | $305,451,928 |

e. The budget neutrality expenditure limit is the Federal share of the annual PMPM limits for the demonstration period, plus DSH adjustments, for DY 1 through 14, and represents the maximum amount of FFP that the state may receive for title XIX expenditures during the demonstration period, as described in paragraph 51.g. *(Reporting Expenditures in the Demonstration: Title XIX Expenditures*

*Subject to the Budget Neutrality Expenditure Limit).* The budget neutrality expenditure limit is equal to (1) the sum of all of the subcomponents described in a.i. above for all DYs, times the Composite Federal Share (defined in f. below), plus (2) the sum of the Federal shares to the DSH adjustments for all DYs, as defined in d. above.

f. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional demonstration expenditures or offsets such as, but not limited to, premium collections and administrative costs subject to budget neutrality under paragraph 51.h. *(Reporting Expenditures in the Demonstration: Administrative Costs)* by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for DSH payments made under the Medicaid state plan must be subtracted from the numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

**63. Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under TennCare II. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of Section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

**64. Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

| DY | Cumulative Target Definition | Percentage |
|---|---|---|
| Years 1 through 6 | Cumulative budget neutrality cap plus: | 0.5 percent |
| Years 1 through 7 | Cumulative budget neutrality cap plus: | 0.25 percent |
| Years 1 through 14 | Cumulative budget neutrality cap plus: | 0 percent |

**65. Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end of this demonstration period, the excess Federal funds shall be returned to CMS. If the demonstration is terminated prior to the end of the budget

neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

## XII. EVALUATION OF THE DEMONSTRATION

**66. Submission of a Draft Evaluation Plan.** The state shall submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after CMS approval of the demonstration extension. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

**67. Inclusion of CHOICES Special Study Components.** Suggested special study topics from which the state may choose for its Evaluation Plan include, but are not limited to, the following:

a. The rebalancing of the long-term care system including impacts on outcomes, utilization and cost;

b. Implementation lessons, successes and evolution of the Single Point of Entry and streamlined eligibility processes;

c. The expansion and development of a more robust HCBS infrastructure under managed care;

d. Implementation of Consumer Directed options under manage care;

e. Enrollee satisfaction, based on surveys that include feedback on assessment and care planning processes, quality of care coordination, actual service delivery, and (when relevant) the appeals process; and

f. Provider satisfaction from surveys.

When developing its research approach, CMS encourages Tennessee to consider adapting research questions and methodologies from the CMS sponsored Evaluation of the Money Follows the Person (MFP) Grant Program. MFP and CHOICES share many of the same goals, and by using a common study approach, the Tennessee's planned reforms can be viewed within a national context. CMS staff will be available to provide technical assistance in this regard.

**68. Evaluation of Eligibility and Enrollment Systems.** The state shall propose data collection and reporting measures designed to assess the ongoing need for retroactive

Medicaid eligibility after changes specified in the Affordable Care Act are effectuated. The interim evaluation report required in paragraph 8 *(Extension of the Demonstration)* and paragraph 70 *(Interim Evaluation Reports)* should contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid and the Exchange. CMS may issue further guidance to the state on the specific performance measures. The state may include the following areas of interest in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other relevant data.

a. Evaluation of eligibility determinations by type, e.g. application, redetermination, transfer to the Exchange.

b. Evaluation of Medicaid denial and termination reasons.

c. Evaluation of average application processing times and timeliness.

d. Evaluation of reasons for disenrollment and internal churn.

e. Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable.

**69. Evaluation of Uncompensated Care Costs for the Uninsured.** The state shall propose data collection and reporting measures designed to assess the ongoing need for payments to compensate hospitals for providing care to the uninsured after changes specified in the Affordable Care Act are effectuated. The state should provide documentation demonstrating cost expended for uncompensated care in relation to the number of uninsured individuals that receive care during the current approval period. CMS may issue further guidance to the state on specific data collection and tracking mechanisms. The state may include the following areas of interest in its interim evaluation report. This list is not all inclusive and the state may include any other relevant data.

a. Evaluation of uninsured patient cost and dates of service.

b. Evaluation of cost for medical services to charities and the indigent.

c. Evaluation of amounts expended for services to hospitals that serve a disproportionate number of low-income patients.

**70. Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request.

**71. Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation plan within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports. The state shall

submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

**72. Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

## XIII. TENNCARE ELIGIBILITY REDETERMINATION AND DISENROLLMENT AND RIGHTS; APPEALS PROCESS FOR CHANGES IN BENEFITS; AND ENROLLMENT IN STANDARD SPEND DOWN

The state will follow these procedures throughout the demonstration approval period unless modified through an approved demonstration amendment.

### PART I: MEDICALLY NEEDY AND TENNCARE STANDARD ELIGIBILITY REDETERMINATION AND DISENROLLMENT PROCESS

This Part summarizes the process Tennessee will use, in accordance with paragraph 21.a. *(Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category)*, of these STCs, to: (i) redetermine eligibility and terminate the adult (non-pregnant) Medically Needy; and (ii) disenroll adults who are TennCare/Medicare dual eligible, uninsured, and Medically Eligible. This process was approved as an amendment to the TennCare II demonstration on March 24, 2005. It is used for redetermining the eligibility of those enrollees whose eligibility is ending, including when their period of eligibility has ended or the category in which they have been enrolled is being closed. The state will continue to follow this process for all redeterminations and terminations of eligibility throughout the demonstration approval period unless modified through an approved demonstration amendment.

**I. Termination of Adult Non-Pregnant Medically Needy**

**1. Ex Parte Review**

A. The state will conduct a data match of the Social Security numbers of individuals classified as adult non-pregnant Medically Needy in its InterChange Information System (which contains information on TennCare enrollees) with Social Security Administration (SSA) data to determine whether the individual has lost supplemental security income (SSI) eligibility for reasons that would qualify them as Medicaid eligible.[1]

B. The state will conduct a data match of the Social Security numbers (SSNs) of individuals classified as adult non-pregnant Medically Needy in InterChange with individuals classified as participants in its Food Stamps or Families First (TANF) program in its ACCENT system (a database maintained by the Department of Human Services (DHS)). In all instances in which there is a match between an adult Medically Needy individual with an individual with an open Food Stamps or Families First record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

[1] Such reasons include (i) they lost SSI eligibility because of Social Security cost of living adjustment(s) ("COLA(s)") but would be SSI eligible if the COLA(s) was/were disregarded ("Passalong" eligibles); or (ii) they lost SSI eligibility for some reason other than a Social Security COLA, but would be eligible for SSI if the COLA(s) received since their SSI termination was/were disregarded ("Pickle" eligibles).

## 2. Request for Information

A. At least 30 days prior to the end of the individual's current eligibility period, the state will send notification (Request for Information) to those adult non-pregnant Medically Needy enrollees who have not been identified through the ex parte review process as eligible for open categories of TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for Medicaid is ending, and that they will only remain eligible for TennCare Medicaid if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for a Medicaid category that is not ending (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for open Medicaid categories. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for Medicaid and the enrollee will receive an advance notice that will provide appeal rights.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be fair hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with Limited English Proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as Seriously and/or Persistently Mentally Ill (SPMI). Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package—i.e., elimination of pharmacy coverage for adult non-institutionalized non-pregnant Medically Needy) until

DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a "Verification Request." Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package). If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain TennCare Medicaid coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), enrollees will retain Medicaid coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. The state will make the determination that enrollees are not eligible for open TennCare Medicaid categories in the following two scenarios: (i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or (ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Expiration Notice**

A. Upon making a determination that enrollees are no longer eligible for TennCare Medicaid, the state will provide a notice (Expiration Notice) to enrollees at least 20 days in advance of the end date of the enrollees' eligibility period.

B. Expiration Notices will:

i. Inform enrollees that they will be terminated from Medicaid as of a date specified in the notice because their current eligibility period has ended, their category of TennCare Medicaid is closed and they have not proven their eligibility for other open categories of TennCare Medicaid.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Expiration Notice to request a hearing for factual disputes related to the termination and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing prior to the date of termination specified in the Notice, Medicaid benefits for non-pregnant Medically Needy (subject to changes in the benefit package) will continue until the appeal has been resolved.

C. If enrollees submit information to qualify for Medicaid prior to their termination, enrollees will continue to be eligible for TennCare Medicaid for non-pregnant Medically Needy (subject to changes in the TennCare Medicaid benefit package) pending the determination as to whether the individual is eligible for other open TennCare Medicaid categories.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Expiration Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the termination. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. Valid factual disputes include:

i. Enrollees received the Expiration Notice in error (i.e., they are currently enrolled in other categories of TennCare Medicaid including Medically Needy pregnant women or enrollees under 21 years of age);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Request for Information but failed to extend the time;

iv. Enrollees requested assistance because of a health, mental health, learning problem, or disability but the state failed to provide this assistance; or

v. The state sent the Expiration Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the request for a hearing is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of termination identified in the Expiration Notice, TennCare Medicaid benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute as described above, or the appeal is resolved.

E. If the enrollee does not request a hearing prior to the date of termination identified in the Expiration Notice, the enrollee will be disenrolled from TennCare Medicaid.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## II. Disenrollment of Adult Medicare/TennCare Dual Eligible, Uninsured, Medically Eligible

### 1. Ex Parte Review

A. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in InterChange (which contains information on TennCare enrollees) with SSA data to determine whether the individual has lost SSI eligibility for reasons that would qualify them as Medicaid eligible.[2]

B. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in Interchange with individuals classified as participants in the state's TANF program in DHS' ACCENT system. In all instances when there is a match between an adult member of these demonstration populations with an individual with an open TANF record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

### 2. Request for Information

[2] See footnote 1

A. At least 30 days prior to disenrollment, the state will send a Request for Information to all adult Medicare/TennCare Dual Eligible, Uninsured, and Medically Eligible enrollees not identified through the ex parte review process as eligible for TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for TennCare Standard is ending and that they will only maintain coverage if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for Medicaid (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for TennCare Medicaid. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for TennCare Medicaid and the enrollee will receive a Disenrollment Notice prior to disenrollment from TennCare Standard.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with limited English proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as SPMI. Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Standard until DHS determines that the individual does not qualify for open categories of Medicaid (and proper disenrollment and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a Verification Request. Verification Requests will inform enrollees that they must submit

the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid. If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper disenrollment and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), the enrollee will retain coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in an appropriate TennCare Medicaid category. The state will make the determination that enrollees are no longer eligible for TennCare in the following two scenarios:

   i. if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or

   ii. if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

**3. <u>Termination Notice</u>**

A. Upon determination or confirming that enrollees are not eligible for TennCare Medicaid, the state will provide a Termination Notice to enrollees 20 days in advance of the date upon which the coverage will be terminated.

B. Termination Notices will:

   i. Inform enrollees that they will be disenrolled from TennCare as of the date specified in the Notice (20 days after the date of the Notice) because their category of TennCare Standard is ending and they have not proven their eligibility for open TennCare Medicaid categories.

   ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the notice to appeal factual disputes related to the action of disenrollment and inform enrollees how they may request a hearing.

   iii. Inform enrollees that if prior to the date of disenrollment specified in the Termination Notice, an enrollee appeals the action of disenrollment, he or she will not lose eligibility for TennCare until the state determines that the enrollee has not raised a valid factual dispute or the appeal is resolved.

iv. Inform enrollees that they may submit new information to demonstrate Medicaid eligibility at any time before or after disenrollment. Such information will be treated as a new application for Medicaid. The enrollee will not continue benefits pending the state's review and processing of this information.

**4. <u>Appeals Process</u>**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:

i. Enrollee received the Termination Notice in error (e.g., he or she is currently enrolled in Medicaid or in a TennCare Standard category that is not ending);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Termination Notice but failed to extend the time;

iv. Enrollee requested assistance because of a health, mental health, learning problem, or disability, but the state failed to provide this assistance; or

v. The state sent the Termination Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the appeal is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of disenrollment as identified in the Termination Notice, TennCare Standard benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute, or the appeal is resolved.

E. If the enrollee does not appeal prior to the date of disenrollment as identified in the Termination Notice, the enrollee will be disenrolled from TennCare Standard.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## PART II: NOTICE AND APPEALS PROCESS FOR CHANGES IN COVERAGE OF TENNCARE BENEFITS

This Part summarizes the process Tennessee will use upon and after the implementation of changes in coverage of TennCare benefits. These procedures were approved as an amendment to the TennCare II demonstration on March 31, 2006. This detailed process is used by the state to implement benefit changes, specifically benefit limits. It is used daily with enrollees who are subject to pharmacy benefit limits when they reach their monthly maximum. With this process, Tennessee provides one notice per month when benefit limits have been reached. The state will continue to follow this process with enrollees who are subject to pharmacy or other benefit limits throughout the Demonstration approval period unless modified through an approved Demonstration amendment. To change benefits covered under the Demonstration, the state must submit a Demonstration amendment in accordance with paragraphs 6 and 7 regarding amendments of these STCs.

### I. Implementation of Changes in Coverage Policies

#### 1. Initial Notice

A. At least 30 days prior to the effective date of changes in coverage of TennCare benefits (e.g., implementation of pharmacy benefit limits and elimination of covered services), the state shall provide a notice (Benefit Notice) to enrollees who are impacted by such changes in coverage of TennCare benefits.

B. Benefit Notices will:

i. Inform enrollees of how changes in coverage of TennCare benefits will apply to enrollees.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Benefit Notice to request a hearing for valid factual disputes related to the changes in coverage and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing for a valid factual dispute prior to the effective date of the change in coverage of TennCare benefits, benefits will be continued at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the level for Non-Institutionalized Medicaid Adults (Default Level). The state will apply the Default Level of benefits until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary. (The resolution of an appeal, for purposes of this Part, is defined as when the appeal is dismissed or resolved prior to a hearing or when a decision is rendered at or after the hearing.)

## 2. Appeals Process

A. An enrollee will have the opportunity to request a state fair hearing for 40 days (inclusive of mail time) from the date of the Benefit Notice.

B. The state will grant state fair hearings only for those enrollees raising valid factual disputes related to the changes in coverage. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to a different level of TennCare benefits than that identified in the Benefit Notice. Valid factual disputes include when an enrollee claims to have received the Benefit Notice in error (e.g., he or she is already in a TennCare category that is not subject to the particular changes in coverage).

C. When an enrollee requests a hearing prior to the effective date of changes in coverage as identified in the Benefit Notice, the enrollee shall continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the Default Level. The state will apply the Default Level until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary.

D. If the enrollee appeals, the changes in coverage in dispute shall become effective upon resolution of the appeal.

E. If the enrollee does not appeal prior to the effective date of changes in coverage as identified in the Benefit Notice, such changes in benefits will become effective, as applied to the enrollee, upon this date.

F. If the enrollee appeals and:

(i) The appeal is dismissed because the enrollee has not asserted a valid factual dispute; or

(ii) The enrollee is granted a hearing and the hearing decision sustains the state's action.

The state reserves its right to recover from the enrollee the cost of services provided as a result of the appeal.

# II. Post-Implementation Appeals from Denials of Prior Authorization for Pharmacy Products

## 1. Prior Authorization Requirements

A. Any prescription of a branded drug may be subjected to a prior authorization requirement by the state; and prior authorization will be required as a condition of coverage for branded prescription drugs that are not included on the state's Preferred Drug List.

B. Physicians (or other providers with prescribing authority) participating in TennCare will be responsible for requesting prior authorization, according to procedures to be established by the state.

**2. <u>Notice of Prior Authorization Denial</u>**

A. Requests for prior authorization of covered outpatient drugs shall be transmitted to and acted upon by appropriate staff of the Pharmacy Benefit Manager (PBM) Clinical Call Center.

B. Written notice of denial of a request for prior authorization shall be mailed by the PBM on behalf of the state to the enrollee and transmitted by facsimile to the prescribing physician. Such Notice will inform the enrollee that the request for prior authorization of the prescribed drug has been denied and that TennCare does not cover the drug absent prior authorization, briefly state the reason or reasons for denial of the request, explain the procedures that are available to the enrollee to appeal from that decision, and inform the enrollee that TennCare will not cover the cost of the prescribed medication during the pendency of any appeal. The state's failure to act on a request for prior authorization within a 24-hour period after receiving a submission that complies with the state's requirements for a completed prior authorization request may be deemed a denial from which the enrollee can appeal.

**3. <u>Procedures for Filing and Pursuing an Appeal</u>**

A. Appeals of denials of requests for prior authorization may be initiated within 20 days of the Notice of denial of prior authorization, at the option of the enrollee, by the enrollee (or an individual appointed or otherwise authorized under state law to act as the enrollee's representative) submitting to the TennCare Solutions Unit via hand delivery, mail, or facsimile, a written statement of intent to appeal on a form prescribed by the state. Such form will be available on the PBM Web site, and the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's managed care organization (MCO), or from the TennCare Solutions Unit. Undue delay by the state in deciding a prior authorization request (i.e., delay in excess of the 24-hour period permitted for such decisions) will be considered a denial of prior authorization for purposes of appeal.

B. The state will dismiss any appeal that does not raise a valid factual dispute without a hearing, and will retain the authority to determine whether an appeal raises a valid factual dispute relating to denial of a prior authorization request or the state's failure to act on a request for prior authorization within a 24-hour period after such request. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the prescribed drug. A dispute concerning whether a particular

drug or dosage is medically necessary for the enrollee, will be considered a valid factual dispute.

C. An initial determination on appeals involving issues of medical necessity will be made by appropriately qualified medical professionals on the staff of the TennCare Solutions Unit as promptly as possible after the enrollee's submission of the appeal. After submission of the appeal, the TennCare Solutions Unit may seek additional information or documentation in support of the appeal, before any initial determination is made.

D. Upon initially deciding an appeal, the state shall send a letter communicating its decision to the enrollee and stating the reasons for that decision, and shall also communicate any decision granting prior authorization to the enrollee and/or the prescribing physician by the fastest means practicable. A letter initially denying an appeal shall also inform the enrollee of his or her opportunity to request a state fair hearing, and the procedures that must be followed to pursue such further appeal.

**4. <u>Benefits During the Pendency of an Appeal</u>**

A. During the pendency of any appeal from denial of a pharmacy service due to the lack of required prior authorization, the enrollee will continue to be eligible for pharmacy benefits within applicable pharmacy service limits, but will not have any right to receive on a covered basis the drug that is the subject of the appeal.

B. If the enrollee chooses to purchase the unauthorized, prescribed drug at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the drug upon prevailing in his or her appeal, but only to the extent that applicable, monthly pharmacy benefit limits would not thereby be exceeded.

## III. <u>Post Implementation Appeals of Application of Benefit Limits</u>

**1. <u>Initial Notice</u>**

A. Pharmacists will be required to verify TennCare coverage for all prescriptions presented by enrollees through an electronic database maintained by the PBM. If, through the database, the PBM denies coverage of a prescription because the enrollee has reached or exceeded the monthly pharmacy benefit limit ("the pharmacy limit"), the PBM on behalf of the state will mail a written notice of the denial to the enrollee (Service Notice). Service Notice shall be provided only upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five prescription limit, and/or upon the first denial in that month of a pharmacy service sought by the enrollee that exceeds the two prescriptions limit on branded drugs. (For purposes of this Part, "the pharmacy limit" is defined as a five prescription limit per month, of which no more than two prescriptions or refills could be for branded drugs and at least three out of any five prescriptions or refills in the same month must be for generic drugs.)

B. If a pharmacist fills a prescription in excess of the pharmacy limit and submits a claim for such service, the PBM will deny payment for the claim. Upon denial of payment for such claim, the PBM on behalf of the state will mail a written notice (Notice of Limit) to enrollees.

C. If a provider denies a non-pharmacy service or charges the enrollee for the service because the enrollee has reached or exceeded a benefit limit, the provider need not give specific notice of appeal rights to the enrollee but must direct the enrollee to the responsible arm of the managed care contractor (MCC).

D. If a provider renders a non-pharmacy service in excess of a non-pharmacy benefit limit and the provider or the enrollee submits a claim for such service, the MCC will deny payment for the claim. Upon denial of payment for such claims, the MCC, on behalf of the state, will mail a Notice of Limit to enrollees. A Notice of Limit shall be provided only upon the first denial of coverage of a non-pharmacy service sought by the enrollee that exceeds the applicable limit for the kind and number of services during a given time period specified in the state's program.

E. The Notice of Limit and Service Notice will:

i. Inform an enrollee that he or she has reached or exceeded the applicable benefit limit.

ii. Provide enrollees with at least 20 days from the Notice of Limit or Service Notice to request a hearing for valid factual disputes related to the benefit limit and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing, they will not receive continuation of benefits (i.e., services in excess of the applicable limit) during the pendency of their appeal.

iv. Remind enrollees of any exceptions to the limits and inform them how to obtain more information about such exceptions.

**2. <u>Appeals Process</u>**

A. Enrollees will have the opportunity to request a state fair hearing for at least 20 days from the date of the Notice of Limit or Service Notice.

B. The enrollee will be required to submit a designated form in order to request a state fair hearing. The form, which must be signed by the enrollee (or an individual appointed or otherwise authorized to act as the enrollee's representative under state law), would include the basis for the appeal and the enrollee must attest, under penalty of perjury, that his contention is true to the best of his knowledge and is made in good faith. Enrollees may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its

discretion of an exemption from a signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or by an individual authorized under state law to act as the enrollee's representative.

C. The state will grant a state fair hearing only for those enrollees raising valid factual disputes related to the benefit limit. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the service that was denied because the enrollee had reached or exceeded the applicable benefit limit. Valid factual disputes include:

   i. An administrative error was allegedly made and the enrollee has not yet reached the relevant benefit limit.

   ii. The enrollee alleges that his or her circumstances have changed and he or she has been re-classified in a TennCare eligibility category that is not subject to the benefit limit the state has applied. The state, however, shall not grant a hearing to individuals who allege solely that they are not subject to the benefit limit without further alleging a change of circumstances that has been reported to TennCare and has resulted in a change in their eligibility category. These enrollees will be granted a hearing because they did not have the opportunity to appeal the application of the benefit limit to them in connection with the Benefit Notice.

   iii. The enrollee alleges an administrative error in the processing of a request for a special exemption to the benefit limit (i.e., the enrollee's physician submitted the required attestation necessary to obtain a special exemption from the benefit limit and the prescribed drug is on the special exemption list but coverage for the drug was nonetheless denied).

D. The enrollee shall not receive continuation of benefits when appealing a denial of services based on the application of a benefit limit. This policy shall apply even for items or services that have been previously authorized as medically necessary to the extent that the denial of services is based on the application of a benefit limit.

E. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal with respect to those benefits.

F. If the enrollee does not request a hearing, the benefit limit deemed applicable by the state will continue to apply to the enrollee.

G. Providers will be permitted to bill enrollees for services that were provided in excess of the benefit limits.

## IV. Post Implementation Appeals of Elimination of Coverage for Certain Services

1. Neither the state nor the MCC will provide notification in addition to the Benefit Notice described above with respect to services that are eliminated from TennCare coverage as those services are no longer covered by TennCare.

2. Upon denial of non-covered services, TennCare enrollees will have the opportunity to request a state fair hearing. The enrollee will be required to submit a designated form in order to request a hearing. Such form would include a statement, which must be signed by the enrollee, or an individual appointed or otherwise authorized to act as the enrollee's representative under state law that sets out or describes the factual contention on which the appeal is based, and attests, under penalty of perjury, that the contention is true to the best of the signatory's knowledge and is made in good faith. Enrollees or their representatives may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its discretion of an exemption from the signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or his/her authorized representative.

3. The state will grant a state fair hearing only for those enrollees who raise valid factual disputes related to the elimination of coverage. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to coverage of the disputed service. In the context of excluded services, valid factual disputes are limited to when an enrollee claims that he or she is already in a TennCare category that is entitled to coverage of the particular service at issue. Appeals that do not raise a valid factual dispute will be dismissed without a hearing.

4. If the request for a hearing is granted, the enrollee will not receive continuation of the benefits in dispute pending the appeal.

5. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee may be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal.

## PART III: ENROLLMENT IN TENNCARE STANDARD SPEND DOWN

TennCare Standard Spend Down (SSD) is open to people who are not currently eligible for Medicaid and who meet the criteria for the SSD program. Financial eligibility criteria for SSD will be based on criteria that apply to medically needy pregnant women and children eligible under the state plan.

Applicants will be enrolled only through a single toll-free telephone point of entry (the Call-In Line) initiated in periods of open enrollment. In each open enrollment period, the state will determine a specified number of calls that it will accept through the Call-In Line based on the number of applications that the state estimates it can process within federal timeliness standards. The state will not accept or track calls received outside of open enrollment periods.

Once the state has reached its targeted enrollment of 100,000 persons, new open enrollment periods will be scheduled when enrollment in the SSD program drops to 90 percent of target enrollment. Any subsequent open enrollment periods will remain open until a pre-determined number of calls to the Call-In Line have been received. The number of calls to be received will be established based on the state's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the state estimates it can process in a timely manner in accordance with federal standards. The state's decision to open or close enrollment is a policy decision that is within the state's discretion and the state is not required to provide fair hearings for challenges to these decisions.

Callers to the Call-In Line will be asked for basic demographic information and will be assigned a unique identifier. After conducting a match to verify that callers are not already enrolled in TennCare Medicaid as state plan eligibles, the state will send each non-enrolled caller a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within 30 days. (Those callers who are already enrolled in TennCare Medicaid as state plan eligibles will be sent letters advising them that they currently have benefits and need not apply.)

Completed signed applications received by the state by the 30-day deadline established by the state will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will still be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the state. If the individual does not mail back an application by the deadline, the state will send the individual a letter advising him or her that since no application was received, the state will not make an eligibility determination for him or her, but the individual is free to apply for SSD during any subsequent open enrollment period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he or she did submit a signed, written application within the deadline. Since all SSD applications received during an open enrollment period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open enrollment period will be carried forward to future open enrollment periods. The state will determine SSD eligibility within the timeframes specified by Federal regulations at 42

CFR § 435.911; such timeframes will begin on the date a signed written application is received by the state.

The effective date of SSD eligibility for individuals whose enrollment is originally initiated through the Call-In Line and who submit a timely signed application will be the later of: 1) the date that their call was received by the Call-In Line; or 2) the date spend down is met (which must be no later than the end of the 1-month budget period -- in this case, the end of the month of the original call to the Call-In Line). The effective date provisions contained herein only apply to SSD eligibility and do not apply to other categories of TennCare eligibility. All enrollees in the SSD demonstration category will have an eligibility period of 12 months from the effective date of the determination. At the end of the 12-month period the enrollee will need to have his eligibility status redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for TennCare Medicaid.

## XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

| | | |
|---|---|---|
| **Monthly Deliverables** | | |
| Monthly | Monitoring Call | ~~44~~ |
| **Quarterly Deliverables** | | |
| 60 days after end of each quarter | Quarterly progress reports | 45 |
| Per Sections 2500 & 2115 of State Medicaid Manual, or upon request | Quarterly expenditure, budget neutrality, member month reports | 41,42 Sections X and XI |
| **Annual Deliverables** | | |
| 120 days after end of each demonstration year | Draft Annual Progress Report | 46 |
| Within 30 days of receipt of comments from CMS on the Draft Annual Progress Report | Final Annual Progress Report | 46 |
| Dec. 31st of each year | Annual CHIP Report entered into CHIP Annual Report Template System (SARTS) | 46 |
| Sept. of each demonstration year | Annual beneficiary survey report | 47 |
| **Other Deliverables** | | |
| 6 months before expiration of demonstration | Request for extension | 8 |
| 5 months prior to suspending or terminating the demonstration | Phase-out plan | 9 |
| 6 months before expiration of demonstration | Interim evaluation report. | 8, 70 |
| 120 days after expiration of demonstration | Draft Final Evaluation Report | 48, 71 |
| 60 days after receipt of CMS comments on Draft Final | Final Evaluation Report | 48, 71 |

| | | |
|---|---|---|
| Evaluation Report | | |
| Implementation of compliance plan by January 1, 2013. | Enrollee notification and implementation of the new cost-sharing requirements | 35 |
| At least annually | MEQC plan proposal and report on findings | 23 |
| Upon receipt by state | Financial audits and quality assessment reviews of participating health plans, and other managed care and HCBS requirements | 40, 43 |
| Upon receipt by state | Fraud and abuse and program integrity reports related to 1115 Demonstration beneficiaries and providers | |
| As required by CMS | Corrective Action Plans and findings | |
| Upon submission to Regional Office | Courtesy copy of all state plan amendments to be sent to the CMS Project Officer | 7 |
| 60 days advance notice | Modification of CHOICES benefits defined in Attachment D | 7 |
| No later than 120 days prior to planned implementation and may not be implemented until approved | Demonstration amendments, including requests for services not defined in Attachment D | 6, 7 |
| 30 days advance notice | Notice on increases in CHOICES Enrollment Targets within allowable range | 32 |
| 3 months after each point in time. i.e. September 30 of each demonstration year | Submission of CHOICES data | 43.d. |
| Annually | Integrated Quality Improvement Strategy Update | 43.c. |
| Subject to CMS approval prior to implementation | Final MCO contracts developed for CMS approval | 40 |
| When issued or amended by state | Procedural manuals or operating protocols related to the 1115 Demonstration | |
| *All Reports Required by Sections 2500 and 2115 of the State Medicaid Manual* | | |

**ATTACHMENT A**
**QUARTERLY PROGRESS REPORT**

Under Section IX, paragraph 45 *(Quarterly Progress Reports)* of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

## NARRATIVE REPORT FORMAT:

**Title Line One –** TennCare II

**Title Line Two -** Section 1115 Quarterly Report

**Demonstration/Quarter Reporting Period:**
*Example: Demonstration Year: 6 (7/1/2007 – 6/30/2008)*
*Federal Fiscal Quarter: 1/2008 (10/07 - 12/07)*

**Footer:** Approval Period July 1, 2013 – June 30, 2016

## I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

## II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to TennCare eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.
    - Progress on implementing TennCare Standard Spend Down.
    - Progress on phasing out closed eligibility categories.
    - Other

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

**Enrollment Counts for Quarter**

Note: Enrollment counts should be person counts, not member months

| Demonstration Populations | Total No. TennCare Enrollees in current Quarter |
|---|---|
| **EG1 Disabled, Type 1 state plan eligibles** | |
| **EG 9 H-Disabled, Type 2 demonstration population** | |
| **EG2 Over 65, Type 1 state plan eligibles** | |
| **EG10 H-Over 65, Type 2 demonstration population** | |
| **EG3 Children, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 2 demonstration population** | |
| **EG5 Duals, Type 1 state plan eligibles and EG-11 H-Duals 65, Type 2 demonstration population** | |
| **EG6E Expan Adult, Type 3 demonstration population** | |
| **EG7E Expan Child, Type 3 demonstration population** | |
| **EG8, Med Exp Child, Type 2 demonstration population, Optional Targeted Low Income Children funded by Title XIX** | |
| **Med Exp Child, Title XXI demonstration population** | |
| **EG12E Carryover, Type 3, demonstration population** | |

**III. Outreach/Innovative Activities to Assure Access**

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for TennCare enrollees or potential eligibles.

**IV. Collection and Verification of Encounter Data and Enrollment Data**

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

**V. Operational/Policy/Systems/Fiscal Developments/Issues**

Identify all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

**VI. Action Plans for Addressing Any Issues Identified**

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration.

**VII. Financial/Budget Neutrality Development/Issues**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

## VIII. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

### A. For Use in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| ***Medicaid eligibles (Type 1)*** | | | | |
| **EG1 Disabled, Type 1 state plan eligibles (paragraph 53.a.i.)** | | | | |
| **EG2 Over 65, Type 1 state plan eligibles (paragraph 53.a.ii.)** | | | | |
| **EG3 Children, Type 1 state plan eligibles (paragraph 53.a.iii.)** | | | | |
| **EG4 Adults, Type 1 state plan eligibles (paragraph 53.a.iv.)** | | | | |
| **EG5 Duals, Type 1 state plan eligibles (paragraph 53.a.v.)** | | | | |
| ***Demonstration eligibles (Type 2)*** | | | | |
| **EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX (paragraph 53.b.iii.)** | | | | |
| **EG9 H-Disabled, Type 2 Demonstration Population (paragraph 53.b.iv.)** | | | | |
| **EG10 H-Over 65, Type 2 Demonstration Population (paragraph 53.b.v.)** | | | | |
| **EG11 H-Duals, Type 2 Demonstration Population (paragraph 53.b.vi.)** | | | | |

### B. Not Used in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **EG6E Expan Adult, Type 3, Demonstration Population (paragraph 53.b.i.)** | | | | |
| **EG7E Expan Child, Type 3, Demonstration Population (paragraph 53.b.ii.)** | | | | |
| **Med Exp Child, Title XXI Demonstration Population (paragraph 53.c.)** | | | | |
| **EG12E Carryover, Type 3, Demonstration Population (paragraph 53.b.vii.)** | | | | |

## IX. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

## X. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

## XI. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

## XII. Essential Access Hospital Pool

List the Essential Access Hospitals and specify their type from the following:
Essential Service Safety Net
Children's Safety Net
Free Standing Psychiatric Hospitals
Other Essential Acute Care

## XIII. Graduate Medical Education (GME) Hospitals

List the GME hospitals and their affiliated teaching universities.

## XIV. Critical Access Hospitals

List the Critical Access Hospitals.

## Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

## State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

## Date Submitted to CMS

## ATTACHMENT B
## LIMITATIONS ON HOME HEALTH SERVICES

Home health services are delivered in accordance with 42 CFR § 440.70. Prior authorization may be required. Definitions and coverage limitations used by the state are as follows:

1. Home health services shall include any of the following services ordered by a treating physician and provided by a licensed home health agency pursuant to a plan of care at an enrollee's place of residence.

   a. Part-time or intermittent nursing services.

      (1) To be considered "part-time and intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, AND no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide care combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. The above limits may be exceeded when medically necessary for children under the age of 21.

      (2) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on an as needed basis. Part-time or skilled nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.

   b. Home health aide services.

      (1) Home health aide care must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

      (2) The above limits may be exceeded when medically necessary for children under the age of 21.

   c. Physical therapy, occupational therapy, speech pathology and audiology services.

d. Medical supplies, equipment, and appliances ordered by a treating physician and suitable for use at an enrollee's place of residence.

2. Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, or preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:

   a. The child is non-ambulatory; and

   b. The child has no or extremely limited ability to interact with caregivers; and

   c. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and

   d. No other children shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult.

## ATTACHMENT C
## LIMITATIONS ON PRIVATE DUTY NURSING SERVICES

Private duty nursing services are delivered in accordance with 42 CFR § 440.80. Prior approval may be required. Definitions and coverage limitations used by the state are as follows:

PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period. A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members.

1. If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home that determines whether the nursing services are continuous or intermittent.

2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:

    a. Have a demonstrated understanding, ability, and commitment to the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration, and feeding, as applicable; and

    b. Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and

    c. Are willing and available as needed to meet the recipient's non-nursing support needs.

3. Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:

    a. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

    b. Has a functioning tracheostomy

        (1) Requiring suctioning, AND

(2) Oxygen supplementation, AND

(3) Receiving nebulizer treatments or requiring the use of Cough Assist/inexsufflator devices.

(4) In addition, for persons with a functioning tracheostomy, at least one from each of the following (I and II) must be met:

(I) Medication

(a) Receiving medication via a gastrostomy tube (G-tube), OR

(b) Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port. AND

(II) Nutrition

(a) Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube), OR

(b) Receiving total parenteral nutrition.

4. Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.

5. A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period, or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of this Attachment may receive medically necessary nursing care as an intermittent service under home health.

6. General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have other non-medical caregiving needs which must be met, to the extent that private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

a. The child is non-ambulatory; and

b. The child has no or extremely limited ability to interact with caregivers; and

c. The child would not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse would be present in the home without the presence of another responsible adult; and

d. No other children will be present in the home during the time the private duty nurse would be present in the home without the presence of another responsible adult.

## ATTACHMENT D
## GLOSSARY OF TERMS FOR TENNCARE CHOICES

**Adult care homes.** A state-licensed community-based residential alternative which offers 24-hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet nursing facility level of care, but who would prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-basis is living in the home with the individuals for whom they are providing care. Coverage shall not include the costs of room and board.

**Adult day care.** Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day provided pursuant to an individualized plan of care by a licensed provider not related to the participating adult.

**Assisted care living facility services**. Community-based residential alternative to nursing facility care in a licensed Assisted Care Living Facility that provides and/or arranges for daily meals, personal care, homemaker and other supportive services or health care including medication oversight (to the extent permitted under state law), in a home-like environment to persons who need assistance with activities of daily living. Coverage shall not include the costs of room and board.

**Assistive technology.** Assistive device, adaptive aids, controls or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive or control their environment. Examples include, but are not limited to, 'grabbers' to pick objects off the floor, strobe lights to signify the smoke alarm has been activated, etc.

**At-Risk.** As it relates to the CHOICES program, SSI eligible adults age 65+ or age 21+ with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined by the state in administrative rule, such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As is relates to Interim CHOICES 3, open for enrollment starting on July 1, 2012 and closed to enrollment on December 31, 2013, "at risk" is defined as adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meeting nursing facility financial eligibility criteria, and also meet the nursing facility level of care in effect on June 30, 2012.

**Attendant care.** Hands-on assistance, safety monitoring and supervision for an enrollee who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visits (more than four (4) hours per visit or visits at intervals of less than four (4) hours between visits). This may include assistance

with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, attendant care may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home, or continuous monitoring and supervision because there is no household member, relative, caregiver, or volunteer to meet the specified need. Attendant care shall not be provided for enrollees who do not require hands-on assistance with ADLs.

Attendant care does not include:

1) Care or assistance including meal preparation or household tasks for other residents of the same household;
2) Yard work; or
3) Care of non-service related pets and animals.

Only for persons who require homemaker services in addition to hands-on assistance with ADLs, the annual benefit shall be up to 1400 hours per full calendar year.

**Community-based residential alternatives to institutional care (Community-based residential alternatives).** Residential services which offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, assisted care living facilities, adult care homes, and companion care.

**Companion care.** A consumer-directed residential model in which a CHOICES member may choose to select, employ, supervise and pay, utilizing the services of a fiscal intermediary, on a daily, weekly, or monthly basis, as applicable, a live-in companion who will be present in the member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration. Such model will be available only for a CHOICES member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with activities of daily living or supervision and monitoring for extended periods of time that cannot be met more cost-effectively with other non-residential services. A CHOICES member who requires assistance in order to direct his or her companion care may designate a representative to assume consumer direction of companion care services on his/her behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.

**Consumer direction of eligible CHOICES HCBS.** The opportunity for a member assessed to need specified types of HCBS including attendant care, personal care visits, homemaker services (provided only as part of attendant care or personal care visits), in-home respite care, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such

services—primarily, the hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed service(s).

**Electronic visit verification (EVV) system**. An electronic system in which caregivers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of HCBS and which may also be utilized for submission of claims.

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

**Homemaker services.** Effective July 1, 2012, homemaker services are only available as part of attendant care or personal care visits for individuals who need hands-on assistance with ADLs. Services covered include general household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the member, changing the member's linens, making the member's bed, washing the member's dishes, doing the member's personal laundry, ironing, or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the member, assistance with maintenance of safe environment, and errands such as grocery shopping and having the member's prescriptions filled. Homemaker services are to be provided only for the member (and not for other household members) and only when the member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the member.

**In-home respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in the individual's place of residence, because of the absence or need for relief of those persons normally providing the care.

**In-patient respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in a licensed nursing facility or licensed community-based residential alternative, because of the absence or need for relief of those persons normally providing the care.

**Minor home modifications.** Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered

improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

**Nursing facility care.** See Social Security Act, Section 1919(a).

**Personal care visits.** Intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance to an enrollee who, due to age and/or physical disability, needs help with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, personal care visits may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need.

Personal care visits do not include:

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

**Personal emergency response system (PERS).** An electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. The individual may also wear a portable 'help' button to allow for mobility. The system is programmed to signal a response center once the 'help' button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed.

PERS services are limited to those individuals who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time, such that the individual's safety would be compromised without access to a PERS.

**Pest control.** The use of sprays, poisons and traps, as appropriate, in the enrollee's residence (excluding NF, ACLF) to regulate or eliminate the intrusion of roaches, wasps,

mice, rats and other species of pests into the household environment thereby removing an environmental issue that could be detrimental to a frail elderly or disabled enrollee's health and physical well-being.

**Reserve capacity.** The state's right to maintain some capacity within an established enrollment target to enroll individuals into HCBS under certain circumstances. These circumstances could include, but are not limited to: discharge from a nursing facility; discharge from an acute care setting where institutional placement is otherwise imminent, or other circumstances which the state may establish from time to time in accord with these STCs.

**Room and board.** Refers to lodging, meals, and utilities. The kinds of items that are considered "room and board" and are therefore not reimbursable by Medicaid include:

- Rent, or, if the individual owns his home, mortgage payments, depreciation, or mortgage interest
- Property taxes
- Insurance (title, mortgage, property and casualty)
- Building and/or grounds maintenance costs
- Resident "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included)
- Household supplies necessary for the room and board of the individual
- Furnishings used by the resident
- Utilities (electricity, water and sewer, gas)
- Resident telephone
- Resident cable television

**Short Term Nursing Facility Care.** The provision of nursing facility care for no more than 90 days to a CHOICES 2 or CHOICES 3 participant who was receiving home and community based services upon admission and who requires temporary placement in a nursing facility—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 90 days. Such CHOICES 2 or CHOICES 3 member must meet the nursing facility level of care upon admission (which for CHOICES 3 participants is anticipated to be due to a short-term condition), and in such case, while receiving short-term nursing facility care may continue enrollment in CHOICES 2 or CHOICES 3, as applicable, pending discharge from the nursing facility within no more than 90 days or until such time it is determined that discharge within 90 days from admission is not likely to occur, at which time the person shall be transitioned to CHOICES 1, as appropriate. The community personal needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

**Transition Allowance.** A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of a managed care organization, be

provided as a cost-effective alternative to continued institutional care for a CHOICES member in order to facilitate transition from a nursing facility to the community when such member will, upon transition, receive more cost-effective non-residential home and community based services or companion care. Items which may be purchased or reimbursed are only those items that the member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

## ATTACHMENT E
## BEST PRACTICES GUIDANCE REGARDING
## CONSUMER DIRECTION OF HOME AND COMMUNITY BASED SERVICES

The state will define services that eligible members may elect to direct. Members determined, as a part of the needs assessment and plan of care processes, to require such services will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e. consumer direction of HCBS).

All eligible members requiring these services will be offered the option to participate in consumer direction of HCBS.

i. Upon enrollment in HCBS and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.

ii. Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at anytime, service by service, without affecting their enrollment in HCBS. Only the state can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare.

iii. A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or be a member's paid worker.

iv. The state will utilize a fiscal employer agency (FEA) to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services rendered; and withholding, filing and paying applicable Federal, state and local income and employment taxes for workers) and to provide supports broker assistance.

v. The plan of care process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports, contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.

vi. Members will have the flexibility to hire persons close to them, including family members but excluding spouses, to serve as their workers. All workers must meet the state specified qualifications for providers of comparable non-consumer directed services and must sign a service agreement.

vii. Members will have flexibility in establishing payment rates that do not exceed the state specified ceiling for each service.

viii. Members and/or representatives must receive training prior to participating in consumer direction of HCBS and re-enrolling in consumer direction of HCBS. Ongoing training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.

ix. Workers must receive training, as a condition for hire, certain aspects of which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.

x. A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care, and the adequacy of payment rates.

## ATTACHMENT F
## CERTIFIED PUBLIC EXPENDITURES PROTOCOL

**Preamble**

This protocol governs the use of certified public expenditures to furnish the non-Federal share of expenditures claimed for Federal participation under the Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (paragraph 55.h.). The protocol is based on the following elements:

1) Units of government, including governmentally operated health care providers, may certify that costs have been incurred for providing services to TennCare and uninsured individuals. The CPE process contained in this attachment is in accordance with Federal regulations and CMS guidance or policy.

   i. Units of government have been determined by the state as eligible to certify public expenditures.

   ii. Certification must be supported by cost documentation, which represents both the Federal and non-Federal share of funds (i.e., total computable expenditures) under the Demonstration. Federal matching funds are available as a percentage of such eligible costs.

2) To the extent the state continues to utilize certified public expenditures (CPEs) as the funding mechanism for title XIX and XXI (or under Section 1115 authority) payments beyond the date defined in this section, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs as eligible under title XIX or XXI (or under Section 1115 authority) for purposes of certifying public expenditures.

3) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the state the amount of such tax revenue (state or local) appropriated to the non-governmental provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the state's claim for Federal match. Federal matching funds will be available as a percentage of such eligible costs.

### I. Cost Computation

#### A. TN CPE 1115 – Medicaid Fee-For-Service

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552)

covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from MMIS for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the

cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

## B. TN CPE 1115 – Medicaid Managed Care

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not

be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

## C. TN CPE 1115 – Hospital Uninsured Care

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently as-filed Medicare cost report (CMS 2552), as-filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the as-filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospital's audited financial statements and other auditable documentation. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of Uninsured care usable organs to total usable organs. This is determined by dividing the number of Uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible Uninsured care costs are determined by adding the Uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual Uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

## II. Payments and Recoveries

All payments and recoveries, from MCO's; BHO's; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds) including any related patient co-payments, or payments from other non-state payers will be offset against the costs computed in Section I above. Payments to the hospital from uninsured individuals for their care for the fiscal year are identified from the hospital's records. Such uninsured data must be supported by auditable documentation.

## III. Interim Reconciliation

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3

Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5

Actual Medicaid paid days and charges from MMIS paid claims data for services furnished during the payment year are used.

Step 6

Organ acquisition costs and total usable organs from the as-filed CMS 2552 cost report for the payment year are used.

## IV. Final Reconciliation

Upon finalization of the CMS-2552 by the Medicare fiscal intermediary, the methodologies as prescribed above will be used to determine final Medicaid FFS cost, Medicaid managed care cost, and uninsured cost. The routine per diems and ancillary cost-to-charge ratios will be determined using cost, day and charge data from the finalized cost report. The Medicaid FFS, Medicaid managed care, and uninsured days, charges, and payment offsets will be updated with the latest MMIS reports and other auditable financial records.

Cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include:

1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS data to the per diem amount;

2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and

3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly excepted for Medicaid.

If, at the end of the reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Recoveries are updated and offset to cost as calculated per Steps above.

For hospitals whose cost report year is different from the state's fiscal year, the state will proportionally allocate to the state plan rate year the costs of two cost report periods encompassing the state Plan payment year. To do so, the state will obtain the actual Medicaid FFS, Medicaid managed care, and uninsured days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS, Medicaid managed care, and uninsured costs for the reporting periods; these costs will then be proportionally allocated to the state plan rate year. All allocations will be made based upon number of months. (For example, a hospital's cost reporting period ending 12/31/07 encompasses three-fourths of the state plan rate year ending 9/30/2007, and one-fourth of the state plan rate year ending 9/30/2008. To fulfill reconciliation requirements for state plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2006, to the state plan rate year.) The state will ensure that the total costs claimed in a state plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Children and Adults Health Programs Group**

October 15, 2013

Darin J. Gordon
Director
Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

On August 21, 2013, your staff submitted a draft transition plan for your section 1115 demonstration, TennCare II (Project No. 11-W-00151/4). We appreciate the cooperation and collaboration your staff has provided during our review of your section 1115 demonstration transition plan.

Please find enclosed a redlined version of your transition plan. This document has been revised to reflect conversations we have had with your staff during the last several weeks. We ask that you review this document carefully and submit your confirmation of your transition plan as described in the enclosed document within 15 days.

Based on the enclosed version of your transition plan, at this time we have no further questions about your 2013 transition plan for your section 1115 demonstration populations. It is our understanding that you will be administratively transferring children in the Title XXI Medicaid Expansion population whose incomes are below 138 percent of the federal poverty level to the Medicaid state plan at the child's next scheduled redetermination. Other than this transition, we understand that there are no other eligibility changes to the populations served by your demonstration, though some individuals may shift eligibility categories at redetermination.

We would like to note that the state's inability to provide prepopulated renewal forms beginning on January 1, 2014 is inconsistent with our regulations at 42 CFR 435.916(a)(3). This item will require further discussion and an agreed-upon corrective action plan with a clear time frame to achieve compliance.

Please note that we will continue to work with you through the State Operations Technical Assistance (SOTA) process on issues related to overall eligibility and enrollment policies and practices for 2014, such as the grandfathering protections for beneficiaries. Other Centers for Medicare & Medicaid Services (CMS) components will continue to work with you on other Affordable Care Act-related items, such as your systems and data.

If you have any questions, please contact your transition plan project officer, Ms. Angela Britton, at either 410-786-3079 or by email at Angela.Britton@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Diane T. Gerrits
Director
Division of State Demonstrations & Waivers

Enclosure

cc: Eliot Fishman, Director, Children and Adults Health Programs Group
Jackie Glaze, Associate Regional Administrator, Region IV

# TennCare Transition Plan
# August 21, 2013

**Demonstration Eligibility Groups.** There are six demonstration populations in the TennCare demonstration. These populations, which are defined in STCs 19-21, include two children's groups and four adult groups. These groups, and the changes that will take effect on January 1, 2014, are listed below.

| Current Demonstration Groups | Demonstration Groups Effective 1/1/14 | Benefits | Delivery System |
|---|---|---|---|
| ***Children's Groups*** | | | |
| Title XIX Medically Eligible Children (no income ceiling) | Title XIX Medically Eligible Children (no income ceiling)[1] | No change, as long as the person continues to meet eligibility criteria | No change, as long as the person continues to meet eligibility criteria |
| Title XXI Medicaid Expansion Children with incomes less than 200 percent of FPL | Title XIX Medicaid Expansion Children with incomes between 138 percent and 211 percent of FPL | Children with incomes below 138 percent of FPL , as determined at their next reverification, will be moved to Medicaid under the authority of 1902(a)(10)(A)(i)(VII) | No change, as long as the person continues to meet eligibility criteria |
| ***Adult Groups*** | | | |
| Standard Spend Down | Standard Spend Down | No change, as long as the person continues to meet eligibility criteria | No change, as long as the person continues to meet eligibility criteria |
| CHOICES 217-Like HCBS Group | CHOICES 217-Like HCBS Group | No change, as long as the person continues to meet eligibility criteria | No change, as long as the person continues to meet eligibility criteria |
| At Risk Demonstration Group | At Risk Demonstration Group | This group will be closed to new enrollment on | This group will be closed to new enrollment on |

[1] It is unlikely that there would be any children in this group with incomes below 138 percent of FPL. Lower income uninsured children are enrolled in the Title XXI Medicaid Expansion Child category. However, if, upon reverification, a child in this category is found to have a family income below 138 percent of FPL, that child will be moved to Medicaid.

| Current Demonstration Groups | Demonstration Groups Effective 1/1/14 | Benefits | Delivery System |
|---|---|---|---|
| | | December 31, 2013; however, persons already enrolled in the group will experience no change in benefits, as long as they continue to meet eligibility criteria | December 31, 2013; however, persons already enrolled in the group will experience no change in benefits as long as they continue to meet eligibility criteria |
| CHOICES 1 and 2 Carryover Group | CHOICES 1 and 2 Carryover Group | No change, as long as the person continues to meet eligibility criteria | No change, as long as the person continues to meet eligibility criteria |
| PACE Carryover Group | PACE Carryover Group | No change, as long as the person continues to meet eligibility criteria | No change, as long as the person continues to meet eligibility criteria |

**Medicaid Eligibility Groups.** With respect to Medicaid groups, there may be some movement from one group to another after January 1, 2014, but the state is not reducing eligibility levels. For example, a child who is currently enrolled as a Medically Needy child under 21 may qualify for the new Former Foster Care Children Under Age 26. The benefits and delivery system will not change, however, in such situations. An individual will not need to take any action to maintain eligibility prior to the individual's scheduled redetermination date, or the report of a change in eligibility factor.

**Systems.** The state will be moving its eligibility and enrollment information from a legacy system to a new system. The state will migrate some basic eligibility information in December of 2013, and will then complete the data migration following verification at the individual's first renewal in 2014.

**Process for Transition.** Individuals go through reverification at least annually to determine that they still meet the eligibility criteria of the category in which they are enrolled. Any time an individual is found to lose eligibility for this category, he is reviewed for eligibility in other categories and moved to one of these categories, as appropriate. This is a process that is in place today and that will continue after January 1, 2014, with certain changes from what occurs today based on the availability of real-time data and the new application. There is no action that the enrollee needs to take to effectuate the transition.

After January 1, 2014, if a child who is enrolled as a Title XXI Medicaid Expansion Child is found, upon reverification, to have a family income below 138 percent of FPL, he will be moved to Medicaid. If a child between the ages of 6 and 19 who had been eligible because his family income was 100 percent of FPL and who is found to have a family income of an amount up to 138 percent of FPL, he will be moved to Medicaid.

**Process for Renewals.**
2013: The state will conduct an ex parte review for those scheduled for renewal between October and December 2013. If the state cannot determine eligibility through this process, the beneficiary will receive the current renewal form and be asked to complete and return the form. The state will review the beneficiary's eligibility based on information submitted. No prepopulated renewal forms will be available in 2013.

2014: The state will conduct an ex parte review for renewals scheduled in 2014. If a beneficiary cannot be renewed via the ex parte process, the state will send an application form in the mail. -The application form will not be pre-populated. Pre-populated renewal forms for MAGI populations will not be available until after the initial MAGI determination. It is unclear when prepopulated renewal forms will be available for non-MAGI populations. Tennessee will have the capability to do online renewals beginning April 1, 2014.

During the ex parte renewal process the state will check a beneficiary for~~'s~~ eligibility under other Medicaid categories prior to sending the beneficiary a renewal notice.

**Account Transfer**. The state has held discussions with CMS regarding an account transfer mitigation plan. Tennessee will be able to transfer accounts to the Marketplace for renewal and new applicants beginning on January 1, 2014.

**Notification.** A Title XXI Medicaid Expansion Child who is found to be eligible for Medicaid will be moved the next day. He will receive a notice of his new category, just as he would today. His notice will inform him that he no longer has a copay requirement. All TennCare notices contain multiple telephone numbers that persons can use if they have questions about the notice. The state will send notices on its standard renewal schedule.

**Content of Notices.** Since we are not proposing to do a bloc transfer of individuals, we will use existing TennCare notices, updated with any applicable ACA requirements or references. All TennCare notices are compliant with 42 CFR §§ 431.206, .210, and .213, and all include information on appeal and hearing rights as outlined in 42 CFR §§ 431.220 and .221.

**Community Outreach.** The reverification process is a routine part of TennCare operations. There is no need to organize extensive community outreach activities to explain an established and familiar process.

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

April 26, 2013

Jennifer Ryan, Acting Director
Family and Children's Health Programs Group
Centers for Medicare and Medicaid Services
Center for Medicaid, CHIP, and Survey & Certification
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 23244-1850

RE: TennCare II demonstration (No. 11-W-00151/4), Amendment #19

Dear Ms. Ryan:

We are requesting the addition of a $1.50 co-pay on generic prescription drugs for those TennCare Medicaid and TennCare Standard enrollees who currently have a $3.00 co-pay on brand name prescription drugs. Enrollees in the following eligibility groups would be affected by this change:

- All Medicaid adults aged 21 and older, other than those who are in exempt groups
- All TennCare Standard adults in the Standard Spend Down category and the CHOICES At-Risk Demonstration category
- All TennCare Standard children with family incomes at 100% of poverty or greater

Emergency pharmacy services, including a 72-hour emergency supply of a medication in an emergency situation, are exempt from co-pays, as are family planning supplies and preventive services.

We will be filing a State Plan Amendment as a companion to this waiver amendment request and would appreciate CMS's assistance in coordinating action on these two requests.

Proposed changes. The purpose of our proposed Amendment #19 is to introduce a new co-pay on generic prescription drugs. At present there is only one co-pay required of non-exempt TennCare Medicaid and TennCare Standard adults, and that is the $3.00 co-pay on prescription drugs. There are several co-pays that are applicable to TennCare Standard children with incomes at 100% of poverty or greater.

We believe that the use of co-pays can serve an important purpose, and that is to encourage enrollees to take more responsibility for their health care. Enrollees would likely pay more than $1.50 for non-covered over-the-counter drugs, so this small co-pay on their TennCare generic prescriptions should not be unduly burdensome.

Public notice. These changes have been published for public comment .in newspapers of general circulation, in accordance with the public notice requirements of paragraph 15 of the Special Terms and Conditions. Information about the proposals has been posted on the state's website, with a vehicle for comments included. We have received no comments.

CHIP Allotment Neutrality Worksheet. We do not believe that these changes will have a significant effect on CHIP allotment neutrality.

Evaluation Design. We do not anticipate modifying the Evaluation Design at this time.

Data Analysis. We are forwarding the worksheet electronically.

We will be glad to work with you and your staff as you review Amendment #19. We are requesting an October 1, 2013, implementation date. We will need to secure approval in time to provide notice to beneficiaries in accordance with Section XIII, Part II, of the Special Terms and Conditions.

Thank you for your attention to this important matter.

Sincerely,

Darin J. Gordon
Director, Bureau of TennCare

*cc:* Jessica Woodard, TennCare Project Officer, Center for Medicaid, CHIP and Survey & Certification, Baltimore
Andrea Casart, Technical Director, Center for Medicaid, CHIP and Survey & Certification, Baltimore
Jackie Glaze, Associate Regional Administrator, Atlanta Regional Office
Trina Roberts, Branch Manager, Medicaid and CHIP Policy, Atlanta Regional Office
Kenni Howard, State Coordinator for Tennessee, Atlanta Regional Office

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

April 26, 2013

Jennifer Ryan, Acting Director
Family and Children's Health Programs Group
Centers for Medicare and Medicaid Services
Center for Medicaid, CHIP, and Survey & Certification
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 23244-1850

RE: TennCare II demonstration {No. 11-W-00151/4), Amendment #17

Dear Ms. Ryan:

We are requesting withdrawal of our proposed Amendment #17.

The purpose of this amendment was to outline program reductions that would be required if the Tennessee General Assembly did not renew the hospital assessment fee. I am pleased to report that the fee has been renewed, and the program reductions that we requested will not be necessary.

Thank you for your attention to this important matter.

Sincerely,

Darin J. Gordon
Director, Bureau of TennCare

cc: Jessica Woodard, TennCare Project Officer, CMCS, Baltimore
Andrea Casart, Technical Director, CMCS, Baltimore
Jackie Glaze, Associate Regional Administrator, Atlanta Regional Office
Trina Roberts, Branch Manager, Medicaid and CHIP Policy, Atlanta Regional Office
Kenni Howard, State Coordinator for Tennessee, Atlanta Regional Office

# Amendment #17
# TennCare Demonstration (No. 11-W-00151/4)
# July 1, 2013

Amendment #17 is being submitted to the TennCare demonstration in accordance with paragraph #7 of the Special Terms and Conditions.

The amendment outlines specific TennCare benefit changes that were proposed in Amendment #9 in 2010, Amendment #12 in 2011, and Amendment #15 in 2012. The need for these changes in each of these years was postponed, however, by the General Assembly's approval and renewal of a one-year hospital assessment fee and CMS's approval of Amendment #10, which the State filed after the hospital fee was approved.

Tennessee is required by its State Constitution to enact a balanced budget each year. TennCare is also required by the terms of the demonstration to meet certain advance notice obligations whenever an amendment to the demonstration is filed. The benefits and services that are included in this Amendment are being provided in the current fiscal year with funds that are non-recurring after June 30, 2013. Should there be no new funds to replace the non-recurring funds, the changes outlined in this Amendment will be required as of July 1, 2013.

**Proposed changes.** The proposed changes involve adjustments to the TennCare benefit package for adults. There are no proposed changes to the benefit package for children**.** As noted below, certain of the changes will not apply to institutionalized adults or to pregnant women receiving pregnancy-related services. "Institutionalized adults" are defined as persons receiving TennCare-reimbursed services in Nursing Facilities, as well as persons who are receiving services in Home and Community Based Services waivers or the CHOICES program.

The changes we are requesting fall into two categories: (1) benefits that will be eliminated for all TennCare adults, and (2) benefit limits that will be implemented for non-institutionalized adults, with provisions being made for pregnant women to receive pregnancy-related services in excess of these benefit limits.

**(1) Benefits to be eliminated for all adults.** We are asking to be able to eliminate coverage of physical therapy, speech therapy, and occupational therapy for adults.

- **Physical therapy, speech therapy, and occupational therapy.** These services have been non-covered in the Tennessee Medicaid State plan for many years; they are offered to adults as demonstration benefits only. They will continue to be offered under certain HCBS waivers for persons with intellectual disabilities. Consistent with our elimination of these benefits when provided by independent practitioners, we will eliminate them as optional services for adults under the home health program.

(2) **Benefit limits to be implemented for non-institutionalized adults.** Pregnant women will be able to receive pregnancy-related services in excess of these limits. The new limits are as follows:

- **Inpatient hospital and psychiatric hospital services**, with a combined annual limit of eight (8) days per enrollee per year. Services in an Institution for Mental Diseases (IMD) for persons age 65 and older are not included in this limit.
- **Lab and X-ray services**, with an annual limit of eight (8) occasions (an occasion equals a day).
- **Non-emergency outpatient hospital services**, with an annual limit of eight (8) occasions (an occasion equals a day).
- **Health practitioners' office visits**, with a combined annual limit of eight (8) occasions (an occasion equals a day).

**Public notice.** These changes have been published for public comment in newspapers of general circulation, in accordance with the public notice requirements of paragraph 15 of the Special Terms and Conditions. Information about the proposals has been posted on the State's website, with a vehicle for comments included.

**CHIP Allotment Neutrality Worksheet.** There is no need for a CHIP Allotment Neutrality Worksheet, since the proposed changes do not affect children.

**Evaluation Design.** The State does not anticipate modifying the Evaluation Design at this time.

**Data Analysis.** See accompanying document.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Children and Adults Health Programs Group**

**June 7, 2013**

Mr. Darin Gordon
Director
Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to the Tennessee section 1115 Medicaid demonstration, entitled "TennCare II", (Project # 11-W-00151/4), under the authority of section 1115(f) of the Social Security Act (the Act) to ensure that the Special Terms and Conditions (STCs) reflect how the state is currently operating its demonstration.

Specifically, we are revising the STCs, the waiver and expenditure authorities approved on December 31, 2012, to reflect the following:

- CMS is deleting the word "admission", from expenditure authority #14 for individuals continuing to receive care under the Program of All-Inclusive Care for the Elderly (PACE). This change reflects that the individual is enrolled in TennCare, and not necessarily that they are admitted into the PACE program.

- TennCare enrollment numbers are updated in the Program Description and Objectives.

- In the Eligibility section, all references that allude to CHOICES not being fully implemented are removed. The effective date of the new nursing facility level of care requirements is updated. References to the adult Medically Needy Rollover group, which was closed in 2005, is removed. References are added to address the PACE Carryover group.

- Corrections are made to the Benefits section to accurately reflect benefits that apply to the Carryover groups.

- The CHOICES section is updated to reflect the new level of care beginning January 1, 2014 and the closure of the Interim CHOICES 3 group and clarified language related to CHOICES waiting lists and enrollment targets. Homemaker services are also consolidated as part of attendant care and personal care visit services provided for individuals in long-term care.

- The charts in the Cost Sharing section are updated to reflect the implementation of the state's compliance plan on January 1, 2013.

- Language in the Delivery Systems section is updated to reflect that the state has already submitted contract requirements related to person-centered service plans for individuals receiving long-term services and supports under the CHOICES programs.

- General Reporting Requirements are updated to coincide with the Schedule of Deliverables in Section XIV and the state has updated its progress on providing updates to its Transition Plan.

- Based on discussions during previous amendments, in the General Financial Requirements section, the eligibility groups are revised to accurately reflect under what categories TennCare II members fall. References to the demonstration years for the extension period are updated, i.e. DY 12 through DY 14.

- The Budget Neutrality section is updated to accurately reflect revised eligibility groups.

- In the Evaluation of the Demonstration section, the language for submitting a draft evaluation plan is removed since the state has an approved evaluation plan. The remainder of the evaluation plan language is added to STC 68 and 69 to require the state to submit measures that apply to the studies for retroactive eligibility and uncompensated care pools.

- The Final Annual Report is added to the Schedule of Deliverables section.

- Attachment A is given the title, "QUARTERLY PROGRESS REPORT", and the attachment format is updated to remove the eligibility groups that are no longer open under the demonstration.

- Some definitions of the CHOICES benefits are updated and moved to be in alphabetical order.

CMS has reviewed the changes and believes these changes are technical in nature. Most of the changes made to the STCs clarified language in the document based on the agreed terms between the state and CMS. Therefore, CMS has incorporated the technical changes into the latest version of the STCs, which are enclosed with this letter.

We look forward to continuing to work with your staff on the administration of this demonstration.

Sincerely,

/s/

Diane T. Gerrits
Director,
Division of State Demonstrations and Waivers

Enclosure

Cc: Kenni Howard, CMS Atlanta Regional Office
Jackie Glaze, CMS Atlanta Regional Office
Jessica Woodard, CMCS
Jennifer Ryan, CMCS

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**WAIVER LIST**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or specified as not applicable in the following list, shall apply to all TennCare II populations identified in paragraph 17 *(Eligibility)* of the Special Terms and Conditions.

The TennCare II Demonstration will operate under these waiver authorities and those provisions specified as "not applicable." The waiver authorities and the provisions specified as "not applicable" will continue through June 30, 2016, unless otherwise stated.

The following waivers shall enable Tennessee to implement the TennCare II Medicaid Section 1115 demonstration.

**WAIVERS OF TITLE XIX REQUIREMENTS FOR TENNCARE MEDICAID TITLE XIX STATE PLAN GROUPS**

**1. Statewideness/Uniformity** **Section 1902(a)(1)**
**42 CFR § 431.50**

To the extent necessary to enable the state to provide managed care plans or certain types of managed care plans only in certain geographical areas of the state. Certain managed care plans or certain types of managed care plans (e.g., risk-based plans) are only available in certain areas of the state.

**2. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR § 438.52**

To the extent necessary to permit the state to have only one pharmacy benefits manager and one dental benefits manager to provide services in a region of the state or statewide.

**3. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR § 435.831**

To the extent necessary to enable Tennessee to use streamlined eligibility procedures that provide for coverage of optional Medically Needy children and pregnant women and the Standard Spend Down demonstration population for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. In accordance with the Code of Federal Regulations, the "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

**4. Reasonable Promptness** **Section 1902(a)(8)**

To the extent necessary to enable the state to limit enrollment in CHOICES 2 and 3 to the enrollment target(s) established by the state, as authorized under 32.d. (*Enrollment Targets for TennCare CHOICES)* of the Special Terms and Conditions, and to allow the state to require applicants for long-term services and supports to complete a person-centered assessment and options counseling process.

**5. Access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Benefits** **Section 1902(a)(10) 42 CFR §§ 440.210 and 440.220**

To the extent necessary to enable the state to permit managed care contractors to limit coverage of FQHC and RHC services, so long as access to care is assured from other providers.

**6. Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B) 42 CFR 440 Subpart B**

To the extent necessary to enable the state to offer a reduced benefit package, a different benefit package, or cost-effective alternative benefit packages to different populations under the demonstration (except for individuals specified in Section 1902(l)(4) of the Act), to the extent authorized under Section V of the Special Terms and Conditions.

**7. Comparability and Amount Duration and Scope** **Sections 1902(a)(17) and 1902(a)(10)(B)**

Should the state change the level of care criteria for admission to nursing facilities, to the extent necessary to enable the state to determine whether an individual has a continuing need for nursing facility services, PACE services, or home and community-based services for the elderly and disabled, based on the criteria in use when the individual first was determined to need the service.

**8. Freedom of Choice** **Section 1902(a)(23)(A) 42 CFR § 431.51**

To enable the state to restrict freedom of choice of provider, through the use of mandatory enrollment in managed care plans or TennCare Select for the receipt of TennCare II and TennCare CHOICES covered services, including for individuals specified at Section 1932(a)(2) of the Social Security Act (the Act). No waiver of freedom of choice is authorized for family planning providers.

**9. Retroactive Eligibility** **Section 1902(a)(34) 42 CFR § 435.914**

To enable the state not to extend eligibility prior to the date that an application for assistance is made. This waiver authority will expire at the end of the extension period of the demonstration, June 30, 2016, unless otherwise approved based on the requirements of paragraph 8 (*Extension of the Demonstration*) of the STCs.

**10. Payment for Outpatient Drugs** **Section 1902(a)(54)**

**42 CFR §§ 440.120,**
**447.331-447.334,**
**and 456 Subpart K**

To the extent necessary to enable the state to establish a drug formulary that does not comply with the requirements of Section 1927(d)(4) of the Act.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under Section 1903, shall, for the period of this demonstration extension, be regarded as expenditures under the state's Medicaid title XIX state plan.

The following expenditure authorities shall enable Tennessee to implement the Medicaid Section 1115 demonstration (TennCare II).

**1. Expenditures Related to MCO Enrollment and Disenrollment.**
Expenditures made under contracts that do not meet the requirements in Section 1903(m) of the Act specified below. Tennessee managed care plans will be required to meet all requirements of Section 1903(m) except the following:

- Section 1903(m)(2)(A)(vi) of the Act, Federal regulations at 42 CFR § 438.56, to the extent that the rules in Section 1932(a)(4) are inconsistent with the enrollment and disenrollment rules contained in paragraph 39 *(Plan Enrollment and Disenrollment)* of the demonstration's Special Terms and Conditions (STCs), such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 45 days of enrollment in an MCO. After 45 days, enrollees may disenroll from an MCO with cause at any time.

**2. Expenditures Related to Expansion of Existing Eligibility Groups.**
To enable Tennessee to use streamlined eligibility procedures and include eligibility standards and requirements that differ from those required by law.

a. Expenditures for Medical Assistance furnished to state plan optional Medically Needy children and pregnant women for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. The "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

b. Expenditures for Medical Assistance furnished to mandatory state plan Transitional Medical Assistance beneficiaries, who are eligible in accordance with section 1931(c)(1) of the Act, for the remainder of a 12-month eligibility period after the 4-month period specified in the statute.

**3. Expenditures for Expanded Benefits and Coverage of Cost-Effective Alternative Services.**

a. Expenditures for TennCare Medicaid and TennCare Standard child enrollees for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*. and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

b. Expenditures for TennCare Medicaid and TennCare Standard adult enrollees for optional services not covered under Tennessee's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR §§ 438 *et seq*., paragraph 28 *(TennCare Benefits)*, and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

**4. Expenditures for Pool Payments.**
Expenditures for Graduate Medical Education, Essential Access Hospital, Critical Access Hospital, Meharry Medical College, Unreimbursed Public Hospital Costs for Certified Public Expenditures, Unreimbursed Hospital Cost, and Public Hospital Supplemental Payment pool payments to the extent specified in paragraph 55.d. through h. and j. through l. *(Extent of Federal Financial Participation for the Demonstration)* of the demonstration's STCs. This expenditure authority will expire December 31, 2015, unless otherwise approved based on the requirements of paragraph 8 *(Extension of the Demonstration)* of these STCs.

**5. Indirect Payment of Graduate Medical Education.**
Expenditures, up to $50 million in total computable expenditures for each demonstration year, for payments to universities that operate graduate physician medical education programs, which are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics.

**6. Payments for Non-Risk Contractor.**
Payments to the TennCare Select prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor more than what Medical Assistance would have paid fee-for-service under the state plan in accordance with the upper limits at 42 CFR § 447.362.

**7. Expenditures Related to Eligibility Expansion.**
Expenditures to provide Medical Assistance coverage to the following demonstration populations that are not covered under the Medicaid state plan and are enrolled in TennCare Standard :

a. **Medically Eligible Demonstration Population Children, Not CHIP Eligible.**
Uninsured children under age 19 who lose eligibility in TennCare Medicaid, have been determined to be "medically eligible" (uninsurable), have family income at

or above 200 percent of the Federal poverty level (FPL), and do not meet the definition of an optional targeted low-income child.

b. **Adult Demonstration Population Eligibles-Standard Spend Down (SSD):** Non-pregnant, non-postpartum adults aged 21 or older who have been determined to meet criteria patterned after the state plan Medically Needy requirements (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category* of the STCs), comprising:
   - Aged, blind, or disabled individuals; or
   - Caretaker relatives.

**8. CHIP-Related Medicaid Expansion Demonstration Population Children.**
Expenditures to provide Medical Assistance coverage to uninsured children who lose eligibility under TennCare, who meet the definition of optional targeted low-income child, and who have family income up to 200 percent of the FPL.

**9. The CHOICES 217-Like HCBS Group.**
Expenditures for TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with Section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under TennCare CHOICES were provided under an HCBS waiver granted to the state under Section 1915(c) of the Act, as of the initial approval date of the TennCare CHOICES component of this demonstration. This includes the application of the spousal impoverishment eligibility rules. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the STCs;

b. Home and community-based waiver-like services as specified in Table 2b, subject to the definitions in Attachment D of the STCs, net of beneficiary regular and spousal impoverishment post-eligibility responsibility for the cost of care, and with post-eligibility treatment of income for individuals receiving short-term nursing facility care calculated as if they were receiving HCBS in the community.

**10. HCBS Services for SSI-Eligibles.**
Expenditures for the provision of home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs that are not described in Section 1905(a) of the Act and not otherwise available under the approved state plan but could be provided under the authority of Section 1915(c) waivers, that are furnished to TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities with income at 100 percent of the Supplemental Security Income/Federal Benefit Rate and resources at or below $2,000 who either:

a. Meet the nursing facility institutional level of care; or

b. Do not meet the nursing facility institutional level of care but who, in the absence of TennCare CHOICES services, are "at risk" of institutionalization.

**11. The At Risk Demonstration Group.**

Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open new to enrollment until December 31, 2013. Persons enrolled in the At Risk Demonstration Group as of December 31, 2013, may continue to qualify in the group as long as they continue to meet nursing facility financial eligibility standards and the nursing facility level of care criteria in place on June 30, 2012, and remain continuously eligible and enrolled in the At Risk Demonstration Group.

Expenditures for these individuals are:

a. Services as presented in Table 2a of the STCs.

b. Home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs, net of beneficiary post-eligibility responsibility for the cost of care (including application of spousal impoverishment rules), and with post-eligibility treatment of income for individuals receiving short-term nursing facility care calculated as if they were receiving HCBS in the community.

**12. Continuing Receipt of Nursing Facility Care.**

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**13. Continuing Receipt of Home and Community-Based Services.**

Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but who continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**14. Continuing Receipt of Program of All-Inclusive Care for the Elderly (PACE) Services.**

Expenditures for PACE-enrolled individuals, who upon redetermination do not meet the current nursing facility level of care criteria, but who continue to meet the level of care

criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the PACE Carryover Group.

**15. LTC Partnership.**
Expenditures for individuals in CHOICES 2 to participate in the Long Term Care Partnership Program.

## REQUIREMENTS NOT APPLICABLE TO TENNCARE STANDARD TITLE XIX DEMONSTRATION ELIGIBLE GROUPS

All Title XIX requirements that are waived for the TennCare Medicaid Groups are also not applicable to the TennCare Standard Title XIX Demonstration Eligible Groups. In addition, the following is not applicable to the Title XIX Demonstration Eligible Groups.

| | |
|---|---|
| **Cost Sharing** | **Section 1902(a)(14) and Section 1916**<br>**42 CFR §§ 447.51 – 447.56** |

To enable the state to charge cost sharing beyond applicable Medicaid limits to TennCare Standard demonstration populations, with cost-sharing subject to a quarterly aggregate cap of 5 percent of family income for children.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS (STCs)**

**NUMBER:** **11-W-00151/4 (Title XIX)**

**TITLE:** **TennCare II**

**AWARDEE:** **Tennessee Department of Finance and Administration**

**DEMONSTRATION EXTENSION PERIOD:** **July 1, 2013 through June 30, 2016**

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**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS**

**NUMBER:** **Title XIX No. 11-W-00151/4**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for Tennessee's TennCare II Section 1115(f) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to this agreement are the Tennessee Department of Finance and Administration, Bureau of TennCare ("state") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the demonstration project. The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the approval letter's date, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This demonstration extension is approved through June 30, 2016.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits; CHOICES Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality for the Demonstration; Evaluation of the Demonstration; TennCare Eligibility Redetermination and Disenrollment and Rights; Appeals Process for Changes in Benefits; Enrollment in Standard Spend Down; and the Schedule of State Deliverables During the Demonstration Extension.

## II. PROGRAM DESCRIPTION AND OBJECTIVES

TennCare II is a continuation of the state's demonstration, funded through titles XIX and XXI of the Social Security Act (the Act). TennCare began as an 1115(a) demonstration project in January 1994. A 3-year extension was approved for 1999-2001, and a 1-year extension was approved early in 2002. A new TennCare II 1115(a) demonstration was approved by CMS on May 30, 2002, and initiated on July 1, 2002, for a 5-year period. On October 5, 2007, an extension was granted under Section 1115(a) through June 30, 2010, with revised waiver and expenditure authorities and STCs. (Note: Temporary extensions under the existing TennCare II STCs were granted for the July 1 through October 5, 2007 period, in order to provide additional time to conclude discussions on a longer extension.) The most recent extension, granted in December 2009 under the authority of Section 1115(e) of the Act, was in effect from July 1, 2010 through June 30, 2013. The current extension is granted under the authority of Section 1115(f) of the Act and is in effect from July 1, 2013 through June 30, 2016.

As of October 2012, the TennCare II program had 1.213 million enrollees, about half of whom were children. All mandatory and optional populations eligible under Tennessee's state plan are enrolled in TennCare II, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only").

There are three components to the TennCare II demonstration program. **TennCare Medicaid** is the component that serves enrollees who are Medicaid-eligible under Tennessee's title XIX state plan. **TennCare Standard** is the component that serves title XIX Medicaid enrollees who are eligible only through the demonstration's expenditure authorities**.** Title XXI Medicaid expansion children are also served under TennCare Standard, with a more extensive benefits package and a different service delivery system than the children served under the title XXI stand-alone Children's Health Insurance Program (CHIP). Both TennCare Medicaid and TennCare Standard deliver all Medicaid services, except for services specified at paragraphs 28 *(TennCare Benefits)* and 30 *(Medicaid Benefits Carved Out of TennCare II Demonstration)* as excluded from the TennCare benefits package for specified populations.

The **CHOICES** Program is the newest component. CHOICES utilizes the existing for-risk, Medicaid managed care organizations to provide eligible individuals with nursing facility services or home and community based services. With the implementation of the CHOICES program in 2010, home and community based services and nursing facility services were added to the existing TennCare II benefit package of primary, acute, and behavioral health services for qualifying state plan and demonstration eligible individuals. This provides participating individuals with an integrated package of acute and long-term services and supports, through a managed care delivery system.

The goals of TennCare are the following:

- Use a managed care approach to provide services to Medicaid state plan and demonstration enrollees at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.

- Assure appropriate access to care for enrollees.
- Provide quality care to enrollees.
- Assure enrollees' satisfaction with services.
- Improve health care for program enrollees.
- Assure that participating health plans maintain stability and viability, while meeting all contract and program requirements.
- Provide appropriate, and cost-effective home and community based services that will improve the quality of life for persons who qualify for nursing facility care, as well as for persons who do not qualify for nursing facility care but who are "at risk" of institutional placement and that will help to rebalance long-term services and supports expenditures.

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with Section 1115 of the Act. The state must

not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 *(Amendment Process)* below.

**7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following

a. An explanation of the public process used by the state, consistent with the requirements of paragraph 15 *(Public Notice and Consultation with Interested Parties)*, to reach a decision regarding the requested amendment;

b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

Changes to TennCare II benefits described in the state plan shall be made by state plan amendment. Changes to TennCare II benefits not described in the state plan shall be made by amendment to the demonstration. Changes in benefits shall be implemented in accordance with the process set forth in Section XIII of these STCs.

Additions or Changes to CHOICES Benefits. All requests for changes in coverage of CHOICES benefits are subject to CMS approval. Changes in benefits defined in Attachment D must be submitted to CMS for approval at least 60 days in advance of the state's desired implementation date. Requests for services that are not defined in Attachment D must be submitted by the state to CMS as a request to amend the demonstration.

The state must send a courtesy copy of all Medicaid state plan amendment requests to the Project Officer. This requirement is in addition to the submissions that the state must make as part of the usual state plan amendment process, and is not meant to substitute for or supplant that process in any way.

**8. Extension of the Demonstration.**

a. Should the state intend to request an extension of the demonstration, the state must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9 *(Demonstration Phase-Out).*

b. Compliance with Transparency Requirements 42 CFR § 431.412. Effective April 27, 2012, as part of demonstration extension requests the state must provide documentation of compliance with the transparency requirements of 42 CFR § 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15 *(Public Notice and Consultation with Interested Parties).*

**9. Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, only consistent with the following requirements:

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of the phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §§ 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §§ 431.220 and 431.221. If a demonstration participant requests a hearing

before the date of action, the state must maintain benefits as required in 42 CFR § 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010 State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

**10.** **Post Award Forum**. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this paragraph. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 45 *(Quarterly Progress Reports)* associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 46 *(Annual Report).*

**11.** **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

**12.** **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

**13.** **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

**14.** **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

**15.** **Public Notice and Consultation with Interested Parties.** The state must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6 *(Changes Subject to the Amendment Process)*, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR § 431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 CFR § 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR § 447.205 for changes in statewide methods and standards for setting payment rates.

**16.** **FFP.** No Federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

## IV. ELIGIBILITY

**17. Eligibility.** Tennessee includes in the TennCare II demonstration all of the mandatory and optional populations eligible under the Tennessee Medicaid state plan, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only"). Also included in TennCare II are several title XIX demonstration-only eligible populations and one title XXI Medicaid Expansion demonstration population. Medicaid state plan-eligible individuals are served in the component of the program called TennCare Medicaid. Other demonstration-only eligible populations are served in the component called TennCare Standard.

The mandatory and optional Medicaid state plan populations described below derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the demonstration to generate savings for covering the Expansion populations, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.

The title XXI Medicaid Expansion demonstration population is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as otherwise listed as not applicable.

Under the TennCare II demonstration, Tennessee is not required to extend eligibility for medical assistance prior to the date that an application for assistance is made; however, the state may provide retroactive coverage for up to 3 months for class members in *Daniels, et al. v. Tenn. Dept. of Health and Env't., et al.*, (1) who have been terminated from TennCare on or before March 31, 2010, for failure to respond to a Request for Information and Expiration Notice in accordance with the process approved in the Federal court order dated January 8, 2009; (2) who subsequently complete a Request for Information within 60 days of termination; and (3) who are determined to have been eligible at the time of termination. The state must notify the Project Officer by letter if it intends to extend retroactive eligibility to Daniels class members as described above.

Any changes to eligibility must be submitted to CMS as an amendment request, subject to the process set forth in paragraphs 6 (*Changes Subject to the Amendment Process)* and 7 *(Amendment Process)* of these STCs.

The criteria for TennCare eligibility groups are as follows (Table 1a).

**Table 1a**
**TennCare Eligibility Groups**

Note: This table does not change the state plan requirements.

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **Title XIX State Plan Mandatory Groups – TennCare Medicaid** | | |
| 1931 recipients including:<br>• Children younger than 18/19<br>• Caretaker relatives<br>• Pregnant women with no other eligible children (coverage for third trimester) | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Transitional Medical Assistance – Medicaid Extension for families who lose TANF benefits due to:<br>• income from employment or work hours or loss of "income disregard"<br>• increased child or spousal support collections | 6 initial months + 6 months continued coverage<br>4 months continued coverage *and expenditure authority for 8 additional months* | 1, 2, 5, 6, 8, 9, 10 |
| Individuals who are ineligible for AFDC benefits solely due to requirements that are prohibited under Medicaid, including AFDC time limits | Income up to and including 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Poverty level pregnant & postpartum women | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level newborns under age 1 | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 1-5 | Income up to and including 133% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 6-18 | Income up to and including 100% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Deemed categorically eligible newborns: born to & living with a woman who was eligible and received Medicaid on the date of the child's birth | Eligible for 1 year as long as mother is eligible or would be if pregnant | 1, 2, 5, 8, 10 |
| Pregnant woman who would otherwise lose eligibility because of an increase in income remains eligible through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Woman who was eligible while pregnant continues eligibility through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Title IV-E eligible children in adoption subsidy or foster care | AFDC income standard | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash recipients: aged, blind or disabled (may or may not be receiving CHOICES benefits) | | 1, 2, 4, 5, 6, 7, 8, 9, 10, |
| Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87 | | 1, 2, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| "DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash ineligible for reasons prohibited by Title XIX. | | 1, 2, 5, 6, 8, 9, 10 |
| "Pickle" SSA Beneficiaries who lost SSI cash benefits due to cost of living adjustment (COLA) increase in Title II OASDI benefits | | 1, 2, 5, 6, 8, 9, 10 |
| "DWB" Disabled widow/widower who lost SSI or state supplement due to early receipt of OASDI benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| **Title XIX State Plan Optional Groups – TennCare Medicaid** | | |
| Presumptively eligible pregnant & postpartum women | Income up to 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Children under 21 who meet AFDC income & resource criteria—children in state custody, foster care, subsidized adoptions, institutionalized | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Persons who would be eligible for AFDC or SSI cash assistance except for their institutional status | | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Special income level group: individuals who are in a medical institution at least 30 consecutive days with income that does not exceed 300% of SSI income standard under 1902(a)(10)(ii)(V) of the Act. | Income no more than 300% of SSI rate; resources $2000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Categorically needy individuals under the state plan who are receiving home and community based services in accordance with 42 CFR § 435.217. (This group consists solely of enrollees in the ID waivers.) | | 1, 2, 5, 6, 8, 9, 10 |
| Non-IV-E children with special medical needs who receive a state adoption subsidy payment | | 1, 2, 5, 6, 8, 9, 10 |
| Women under 65 who need treatment for breast or cervical cancer, and are not otherwise eligible for Medicaid. State utilizes presumptive eligibility for this population. | | 1, 2, 5, 6, 8, 9, 10 |
| Medically needy children under 21 *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| Medically needy pregnant or postpartum women *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |
| **Title XIX Demonstration Eligible Groups– Carryover** | | |
| **CHOICES 1 and 2 Carryover Group:** Individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **PACE Carryover Group:** Individuals who were enrolled in a PACE program as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | As required under the state plan. | |
| **Title XIX Demonstration Eligible Groups – TennCare Standard** | | |
| **Medically Eligible Children:** uninsured children under 19 who have been determined to be "medically eligible" (uninsurable) (category is currently closed to new enrollment except for Medicaid rollovers *[*as defined in paragraph 20, *Rollover Definition]* who are not otherwise eligible for TennCare. See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*. | Income 200% FPL or higher without limit; no resource test | 1, 2, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Standard Spend Down (SSD):** non-pregnant/postpartum adults 21 or older who have been determined to meet criteria patterned after the medically needy requirements *(enrollment target: 100,000)*<br>• aged, blind, or disabled<br>• caretaker relatives<br>CMS approved an amendment to add this expansion population in Nov. 2006.<br>(Expenditure authority for 12-month coverage based on 1-month budget period.)<br>See paragraph 21.a. *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*. | Medically needy spend-down level ($241 for 1, etc.); resources $2000 | 1, 2,, 3, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Title XIX Demonstration Eligible Groups – CHOICES** | | |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **CHOICES 217-Like HCBS Group:** Aged and / or disabled categorically needy adults who meet the CHOICES NF level of care requirement, are receiving home and community based services and who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236, and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915 (c) waiver. This group is subject to the enrollment target for CHOICES 2 in paragraph 32.d *(Enrollment Targets for TennCare CHOICES)*. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **At Risk Demonstration Group:** Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of the TennCare Interim Choices 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open to enrollment starting July 1, 2012, and closed to new enrollment on December 31, 2013. | Income no more than 300% SSI/FBR; resources $2,000 | 1,2,4,5,6,7,8,9,10 |
| **Title XXI Medicaid Expansion Demonstration Eligible Group – TennCare Standard** | | |
| Optional Targeted Low-Income Children: uninsured children under 19 who:<br>• have lost Medicaid eligibility under the approved Medicaid state plan and who do not have access to insurance or<br>• were uninsured and enrolled in this category in the original TennCare demonstration as of 12/31/01, even if they had access to insurance, and have been continuously enrolled in this category since 12/31/01<br>See paragraph 19, *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*.. | Income up to 200% FPL | 1, 2, 5, 6, 8, 9, 10, and cost sharing "not applicable" |

## 18. TennCare CHOICES Eligibility Groups.

As further set forth in paragraph 32 *(Operations of the TennCare CHOICES Program)*, eligibility for enrollment in TennCare CHOICES depends on (a) the individual's TennCare Eligibility Group, (b) the nursing facility (NF) (or "At Risk," as applicable) level-of-care (LOC) criteria as established by the state, and (c) the type of long-term services and supports (LTSS) to be provided.

There are three principal eligibility groups for TennCare CHOICES. CHOICES 1 is for individuals receiving NF services. CHOICES 2 is for individuals who meet the NF LOC that are receiving HCBS as an alternative to NF care. CHOICES 3 is for individuals who do not meet the NF LOC, but are at risk of NF placement and are receiving HCBS to delay or prevent NF placement.

Effective July 1, 2012, the state elected to change the level of care that is medically necessary for admission to a NF. CHOICES 3 serves SSI eligibles enrolled after the implementation of the LOC change who do not meet the new LOC standard but who are "at risk" of institutionalization. Individuals in CHOICES 1 and CHOICES 2 who continue to meet the standard in place at the time of the individual's enrollment will continue to qualify for those services.

Between July 1, 2012, and December 31, 2013, the state opened Interim CHOICES 3 to serve SSI eligibles and other adults who meet the LOC standard and financial eligibility requirements in place prior to the change, allowing the state to abide by the "Maintenance of Effort" (MOE) requirements as specified by the Affordable Care Act, Section 2001.

Table 1b summarizes the CHOICES Eligibility Groups and addresses how a change in LOC criteria is taken into account in determining eligibility for each group.

**Table 1b**
**TennCare + CHOICES Eligibility Groups**

Note: This table does not change the state plan requirements. CHOICES 1, CHOICES 2, CHOICES 3, and Interim CHOICES 3 are defined in paragraph 32 *(Operations of the TennCare CHOICES Program).* The CHOICES 1 and 2 Carryover Group and the PACE Carryover Group are defined in Table 1a of paragraph 17 *(Eligibility).* With respect to benefits, cost-sharing, and similar issues, persons in the CHOICES 1 Carryover Group are treated as though they were in CHOICES 1; persons in the CHOICES 2 Carryover Group are treated as though they were in CHOICES 2; and persons in the PACE Carryover Group are treated as though they were in PACE.

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 1 | • Nursing facility residents who meet the NF LOC in place at the time of enrollment* | Yes | Yes, CHOICES 1 and 2 Carryover Group |
| CHOICES 2 | • Meet NF LOC in place at the time of HCBS<br>• Receive HCBS as alternative to NF care<br>• Age 65+ or 21+ and disabled | Yes, SSI only | Yes, CHOICES 217-Like HCBS Group and CHOICES 1 and 2 Carryover Group |
| CHOICES 3 | • "At risk" for institutionalization (as defined in Attachment D)<br>• Age 65+ or age 21+ and disabled | Yes, SSI only | No |
| INTERIM | • Same as CHOICES 3, but not limited | Yes, SSI only | Yes, At Risk |

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 3 (open to enrollment starting July 1, 2012 and closed to new enrollment on December 31, 2013) | to SSI recipients<br>• Must meet nursing facility financial eligibility criteria | | Demonstration Group |

***** The state may grant an exception for persons in the community seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

**19. Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed.** The state has closed enrollment into the following demonstration categories, except for "rollovers" (as defined in paragraph 20, *Rollover Definition*). Therefore, children are only eligible for a non-state plan demonstration population as a "rollover." If children lose Medicaid state plan eligibility, they may qualify for one of these demonstration-only groups rather than for the stand-alone title XXI CHIP program.

- Title XIX Medically Eligible Children: Individuals who are under age 19, are uninsured, have income that is 200 percent of the FPL or higher without limit, are not otherwise eligible for TennCare, and meet the state-defined criteria of "medically eligible" as having medical conditions that make them uninsurable. (There is no income or resource limit for this group.)

- Title XXI Medicaid Expansion Children: Individuals under age 19 who are uninsured, have family income less than 200 percent of the FPL, and meet the definition of an optional targeted low-income child. (There is no resource limit for this group.)

Individuals under age 19 who lose eligibility for a Medicaid category may roll over into a TennCare Standard category if they meet the criteria for the category.

**20. Rollover Definition.** For the purpose of this demonstration, a "rollover" eligible is an individual who qualifies for continued coverage through a TennCare Standard demonstration category upon losing Medicaid eligibility under any category included in Tennessee's title XIX state plan.

**21. Adult Non-State Plan Demonstration Population Categories.**

a. **Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category.** The SSD eligibility category is open to non-pregnant/postpartum adults ages 21 or older who are Caretaker Relatives or Aged, Blind, or Disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the state plan. The

SSD demonstration eligibility group has an enrollment cap of 105,000, with a target enrollment of 100,000. The state shall establish eligibility and enroll individuals into the SSD group in accordance with the process set forth in Section XIII of these STCs.

b. **CHOICES 217-Like HCBS Group**. This group consists of persons aged 65 and older or persons aged 21+ and who are disabled who: (1) meet the CHOICES NF level of care requirement; (2) are receiving home and community-based services; and (3) would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal Regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a 1915(c) waiver. Paragraph 18 *(TennCare CHOICES Eligibility Groups)* and paragraph 32.b. *(Eligibility for TennCare CHOICES Benefits)* describe how the NF LOC requirements shall be determined for individuals in this group. The state retains the discretion to apply an enrollment target as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES)*.

c. **At Risk Demonstration Group.** As of July 1, 2012, this group consists of elderly adults and adults age 21 and older with physical disabilities who (1) meet nursing facility financial eligibility; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization.

d. **CHOICES 1 and 2 Carryover Group.** This group consists of individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who no longer qualify for CHOICES enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in CHOICES 1 or CHOICES 2 if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, (2) meet all the eligibility requirements for a CHOICES program; and (3) remain continuously enrolled in CHOICES 1 and/or 2, as specified below:

i. Persons enrolled in CHOICES 1 can continue in CHOICES 1 or transition to CHOICES 2, and persons enrolled in CHOICES 2 can continue in CHOICES 2; and

ii. The state may grant an exception to i. for persons in CHOICES 2 seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

e. **PACE Carryover Group.** This group consists of individuals who were enrolled in PACE as of June 30, 2012, but who no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in PACE if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, and (2) meet all other eligibility requirements for PACE in the Medicaid state plan. PACE remains under the Medicaid state plan.

**22. Medically Needy Eligibility Period.** Financial eligibility for state plan medically needy pregnant women and children and for Standard Spend Down adults is based on a 1-month budget period described in the state plan. Those determined eligible remain eligible for up to 1 year from the effective date of eligibility.

**23. Quality Review of Eligibility**. At least annually, the state shall submit a plan for a Medicaid Eligibility Quality Control (MEQC) pilot project to the CMS Regional Office for approval. When each pilot is complete, the state shall send a report to the CMS Regional Office for approval, and shall submit a plan for the next pilot project. The MEQC pilots must be conducted in accordance with Federal law, regulations, and policy.

**24. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.**

a. Except as specified in paragraph 24.b. below, in determining eligibility for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in Section 1924 of the Act and 42 CFR § 435.725 of the Federal regulations.

b. For an individual in CHOICES 2 or CHOICES 3 who is admitted for short-term nursing facility care (as defined in Attachment D), in order to ensure that the individual can maintain a community residence for transition back to the community, the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. After 90 days, or as soon as it appears that the inpatient stay will not be short-term, whichever comes first, the person will be transitioned to CHOICES 1 and the institutional post-eligibility calculation shall apply.

**25. Eligibility/Post-Eligibility Treatment of Income and Resources for the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group.** For individuals receiving 1915(c) like services in CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, or the PACE Carryover Group, the state must use institutional eligibility and post-eligibility rules for individuals who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236 and 435.726 of the Federal regulations and Section 1924 of the Social Security Act, if the home and community based services were provided under a Section 1915(c) waiver.

26. **Post-Eligibility and Patient Liability for the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group.** The state assures that, for individuals receiving 1915(c) like services, under the post-eligibility process, the state must have a method to carve out / identify the cost of the 1915(c) like services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of the 1915(c) like services.

27. **Non-Payment of Patient Liability.** A provider (including an MCO) may decline to continue to provide services to an individual who fails to pay his or her patient liability. If an enrollee who has failed to pay patient liability is unable to find another provider or MCO who is willing to provide LTSS, then the individual may be disenrolled from the CHOICES program. If the beneficiary's eligibility for TennCare is dependent on the receipt of long-term institutional care or HCBS through TennCare CHOICES, as would be the case if an enrollee is a member of the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group, such individual may be disenrolled from TennCare if he or she is no longer able to receive such services, unless he/she qualifies in another Medicaid category. The consequences for failing to pay patient liability must be clearly explained to members upon enrollment in CHOICES. Nothing herein shall prejudice any individual from fully exercising his or her rights to reapply for Medicaid coverage.

## V. BENEFITS

**28. TennCare Benefits.** With the implementation of the CHOICES program, TennCare covers physical, behavioral, and long-term care benefits provided through managed care delivery systems.

a. All mandatory and optional Medicaid state plan eligible adults aged 21 or older, are enrolled in TennCare Medicaid, and receive all services covered under Tennessee's state plan according to the limitations specified in the state plan, including the services identified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration)* as appropriate. Additional TennCare benefits are provided as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)*.

b. Members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group or the CHOICES 1 and 2 Carryover Group, all of which are demonstration-only groups, are enrolled in TennCare Standard, but receive all benefits described in a. above. In addition, individuals in the CHOICES 217-Like HCBS Group are members of CHOICES 2 and members of the At Risk Demonstration Group are members of Interim CHOICES 3.

c. Demonstration-only eligible adults who are members of the Standard Spend Down population (see paragraph 21.a., *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*) are enrolled in TennCare Standard and receive all state plan services, plus additional TennCare benefits as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)* as appropriate, except that they do not have access to the services discussed in Table 2b or Table 3. Medicare Parts A and B premiums and Medicare co-payments and deductibles are covered in accordance with paragraphs 30.b. and c.

d. All mandatory and optional Medicaid state plan eligible children younger than 21 years old enrolled in TennCare Medicaid receive all state plan and EPSDT covered services.

e. The demonstration-only eligible children enrolled in TennCare Standard receive the same benefits as the state plan eligible children enrolled in TennCare Medicaid, except as specified in paragraph 30 *(Medicaid Benefits Carved Out of the TennCare II Demonstration)*.

f. The Medicaid state plan mandatory and optional eligibility categories for poverty level pregnant or postpartum women receive all TennCare Medicaid benefits, because the state considers that all of these services are pregnancy-related services.

g. The following table (Table 2a) lists benefits for TennCare Medicaid and TennCare Standard adults aged 21 and older that are different from those

identified in the state plan. All benefits are limited by medical necessity as defined by the state. "State Plan Coverage for Adults" is provided for informational purposes only, and does not supersede the approved Medicaid state plan. CMS will issue an updated version of Table 2a in the event that future SPAs cause the Medicaid state plan to be in conflict with what appears in Table 2a.

**Table 2a**
**TennCare Medicaid and TennCare Standard Benefits for Adults Aged 21 and Older That Are Different Than State Plan Covered Services and Limitations**

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Diagnostic services not included in other service categories | Covered as medically necessary. | Not covered. |
| Home health | Covered as medically necessary, and in accordance with the definitions and limitations included in Attachment B. | Coverage limited to 60 visits per enrollee per state fiscal year. |
| Hospice care | Covered as medically necessary. | Coverage limited to 210 days per enrollee per state fiscal year. |
| Inpatient and outpatient substance abuse services | Covered as medically necessary | Not covered. |
| Inpatient hospital services | Covered as medically necessary. | Coverage limited to 43 days for heart transplants, 67 days for liver transplants, and 40 days for bone marrow transplants, per enrollee, per state fiscal year. |
| Lab and X-ray services | Covered as medically necessary. | Coverage limited to 30 occasions per enrollee per state fiscal year. |
| Medicare premiums and cost-sharing | Covered for state plan eligibles, SSD enrollees, members of the CHOICES 217-Like HCBS Group, and members of the At Risk Demonstration Group, in accordance with paragraphs 30.b. and c. | Covered for Medicare beneficiaries who are dually eligible for Medicaid according to their classification under the state plan (QMB, SLMB, Other Medicaid/Medicare Duals, etc.) |
| Mental health case management services | Covered as medically necessary. | Coverage limited to Targeted Case Management for persons who are Severely and/or Persistently Mentally Ill. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Occupational therapy | Covered as medically necessary. | Not covered. |
| Organ and tissue transplants | Covered as medically necessary, except that experimental or investigational transplants are not covered. | Coverage limited to renal, heart, liver, corneal, and bone marrow transplants. |
| Outpatient hospital services | Covered as medically necessary. | Coverage limited to 30 visits per enrollee per fiscal year. |
| Outpatient rehabilitation services | Covered as medically necessary. | Coverage limited to mental health services provided by Community Mental Health Agencies. |
| Pharmacy services | • Not covered for dually eligible adults.<br>• Covered for non-dual state plan eligibles in accordance with the state plan.<br>• Covered for non-dual SSD eligibles and non-dual At Risk Demonstration Group members, with the co-payments specified in Table 6 of paragraph 34.b. *(Co-Pays on Pharmacy).*<br>• Covered for non-dual CHOICES 217-Like HCBS Group enrollees, CHOICES 1 and 2 Carryover Group enrollees, and PACE Carryover enrollees in accordance with the state plan for Medicaid enrollees. | Coverage as specified in state plan. |
| Physical therapy services | Covered as medically necessary. | Not covered. |
| Physicians' services (including medical and surgical services furnished by a dentist) | Outpatient services: Covered as medically necessary.<br><br>Inpatient services: Covered as medically necessary. | Outpatient services: Coverage limited to 24 outpatient office visits per year, which includes 2 office visits for podiatrists and 4 office visits for optometrists.<br><br>Inpatient services: Coverage limited to 20 visits per enrollee per state fiscal year for services other than heart, liver, and bone marrow transplants, which are limited to 43, 67, and 40 days, respectively. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Preventive services | Covered as medically necessary. | Not covered. |
| Private duty nursing services | Covered when medically necessary to support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Definitions and limitations applicable to this service are contained in Attachment C. | Not covered. |
| Psychiatric residential treatment services (outside of an IMD) | Covered as medically necessary. | Not covered. |
| Screening services | Covered as medically necessary. | Not covered. |
| Speech, hearing, and language services | Covered as medically necessary. | Not covered. |
| Vision services | Covered for the first pair of cataract glasses following cataract surgery. | Not covered. |

h. The following table (Table 2b) lists HCBS benefits for TennCare Medicaid enrollees and CHOICES demonstration eligibles who are enrolled in the designated CHOICES groups (specified in paragraph 32.a., *Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition, the following rules apply to the CHOICES benefit.

i. The cost of medical assistance provided to an eligible participant in CHOICES 2 is limited to the amount calculated in the individual cost-neutrality test used in Section 1915(c) waivers as set forth in Section 1915(c)(4)(A). The state may delegate implementation of the cost neutrality test to the MCOs.

ii. For purposes of determining capitation rates, the cost of room and board, as defined in Attachment D, is not included in non-institutional care costs.

iii. For persons in CHOICES 3 or Interim CHOICES 3, in addition to the service limits stated in Table 2b, the total cost of the HCBS identified in

Table 2b shall not exceed $15,000 per calendar year, excluding the cost of minor home modifications.

iv. Definitions for CHOICES benefits are provided in Attachment D of these STCs.

**Table 2b**
**Benefits for Persons Enrolled in the CHOICES Program**

| **Benefit** (Definitions provided in Attachment D) | **CHOICES 1** | **CHOICES 2** | **CHOICES 3*** |
|---|---|---|---|
| Nursing facility care | X | Short-term only | Short-term only |
| Community-based residential alternatives | | X | |
| Personal care visits (up to 2 visits per day) | | X | X |
| Attendant care (up to 1080 hours per calendar year); up to 1400 hours per calendar year ONLY when Homemaker services are needed in addition to hands-on care | | X | X |
| Home-delivered meals (up to 1 meal per day) | | X | X |
| Personal Emergency Response Systems | | X | X |
| Adult day care (up to 2080 hours per calendar year) | | X | X |
| In-home respite care (up to 216 hours per calendar year) | | X | X |
| In-patient respite care (up to 9 days per calendar year) | | X | X |
| Assistive technology (up to $900 per calendar year) | | X | X |
| Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) | | X | X |
| Pest control (up to 9 units per calendar year) | | X | X |

*Subject to the limitations in 28.h.iii.

**29. Cost-Effective Alternatives.** TennCare MCOs and TennCare Select may provide services not listed in, or exceeding the individual service limits in, the Medicaid state plan or paragraph 28 (*TennCare Benefits*) of these STCs as allowed under their contracts with the TennCare program. Provision of these services is at the sole discretion of the MCO and TennCare Select. Capitation for the MCOs must be certified as actuarially sound (in accord with 42 CFR § 438.6), and comply with the Federal managed care regulations at 42 CFR §§ 438 et seq. TennCare Select must demonstrate to the state that a service not listed as covered in the Medicaid state plan or in paragraph 28 (TennCare Benefits) is a cost-effective alternative, in order for the state to reimburse TennCare Select for the service. The state must demonstrate to CMS annually as part of the annual report described in paragraph 46 (*Annual Report*) that utilization of these services by the MCOs and TennCare Select is cost-effective and is reimbursed in compliance with the Federal managed care regulations at 42 CFR §§ 438 et seq. Under the CHOICES program, cost-effective alternatives may include a Transition Allowance, as defined in Attachment D.

**30. Medicaid Benefits Carved Out of the TennCare II Demonstration.**

a. **"Base" Medicaid State plan services.** Base services are services carved out of TennCare II, and are provided, in accordance with the provisions of the Medicaid state plan, only to the mandatory and optional state plan eligibles and members of the PACE Carryover Group (in the case of PACE services only). The other TennCare II demonstration-only populations, which are eligible through the demonstration's expenditure authorities and enrolled in TennCare Standard, are not eligible for any of the services listed in Table 3. Expenditures for these "Base" services are not demonstration expenditures (see paragraph 51.a., *Tracking Expenditures*), are not included in the demonstration's budget neutrality, and should, therefore, be reported on the "Base" reporting schedules of the Form CMS-64 reports (or in the case of 1915(c) waiver services, the appropriate 1915(c) waiver schedule). Some carved out services were carved in as of the initial implementation of CHOICES (i.e., March 1, 2010), however, as indicated in Table 3, and must from that point forward be reported as TennCare II demonstration expenditures.

**Table 3**
**Base Services**

| **Services Carved Out of TennCare II** | |
|---|---|
| Nursing facility services | Services moved from the base to the demonstration as of March 1, 2010 (in Middle Tennessee) and August 1, 2010 (in East and West Tennessee) |
| Services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) | Base |
| State Plan targeted case management services | Base |
| Program of All Inclusive Care for the Elderly (PACE) | Base |
| Services covered by the home and community-based services waiver for individuals with intellectual disabilities under 1915(c) of the Social Security Act. | Base |
| Services covered through the state's agreement under Title V of the Social Security Act | Base |

b. **Medicare Parts A and B Buy-In Premiums.** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the Standard Spend Down group, the CHOICES 1 and 2 Carryover Group

and the PACE Carryover Group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare Buy-In premiums are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles as permitted in Section 1902(a)(10)(E) of the Act and 42 CFR § 431.625,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals),

(C) Dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the Standard Spend Down group (QMBs/SLMBs and Demo Duals), and

(E) Dually eligible members of the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group (QMBs, SLMBs, and Demo Duals).

ii. Medicare premiums paid on behalf of Demo Duals are demonstration expenditures, and must be reported on an appropriate Form CMS-64.9 or 9p Waiver, as described in paragraph 51.e. *(Use of Forms).*

iii. Medicare premium payments for other beneficiaries are excluded from TennCare II and must be reported as "Base" Medicaid expenditures on the CMS-64 reports.

iv. Records in CMS's Master Billing Record for Demo Duals and all buy-in transactions for Demo Duals must be identified using a specific Buy-In Eligibility Code (BIEC) value as agreed upon between the state and the Project Officer.

c. **Medicare Co-payments and Deductibles (i.e., Medicare crossover claims).** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, At Risk Demonstration Group, CHOICES 1 and 2 Carryover Group, the PACE Carryover Group or the Standard Spend Down group, but not described in Section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare crossover claims are covered for the following groups:

(A) Dually eligible Medicaid state plan eligibles,

(B) Dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs, and Demo Duals),

(C) Dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),

(D) Dually eligible members of the CHOICES 1 and 2 Carryover Group and PACE Carryover Group, and

(E) Standard Spend Down enrollees (QMBs/SLMBs and Demo Duals).

The SSD population, the CHOICES 217-Like HCBS Group, the At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, and the PACE Carryover Group are the only demonstration populations for whom the state pays Medicare cost-sharing.

ii. For TennCare Medicaid enrollees, members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals), members of the At Risk Demonstration Group (QMBs, SLMBs, and Demo Duals), members of the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group (QMBs/SLMBs and Demo Duals), these expenditures are not demonstration expenditures and are not included in the budget neutrality calculations, so report these as "Base" Medicaid expenditures on the CMS-64 reports.

iii. For dually eligible SSD enrollees (QMBs/SLMBs and Demo Duals), these expenditures are included as demonstration expenditures that are subject to budget neutrality, so report these demonstration expenditures as "EG6E Expan Adult" on the CMS-64 reports. Medicare cost-sharing for SSD dual eligibles is covered in the same manner as Medicare cost-sharing would be covered for Medically Needy aged, blind, or disabled individuals and caretaker relatives, had these groups been included in the Medicaid state plan.

**31. Additional Provisions Related to Institutions for Mental Diseases (IMDs).** Expenditures for services rendered to TennCare II enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.

## VI. CHOICES ENROLLMENT

### 32. Operations of the TennCare CHOICES Program.

a. **Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group.** The CHOICES Program provides long-term services and supports (LTSS) as identified in Table 2b to four groups of people, as defined below:

i. **CHOICES 1.** This group consists of persons who are receiving Medicaid-reimbursed care in a nursing facility (NF).

ii. **CHOICES 2.** Persons age 65 and older and adults age 21 and older with physical disabilities who meet the NF level of care (LOC), who qualify either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to NF care. The demonstration population includes persons who could have been eligible under 42 CFR § 435.217 had the state continued its 1915(c) HCBS waiver for persons who are elderly and/or physically disabled.

iii. **CHOICES 3.** Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles, who do not meet the NF LOC, but who, in the absence of HCBS, are "at risk" for institutionalization, as defined by the state.

iv. **Interim CHOICES 3.** Elderly adults and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of the At Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. This group will close to new enrollment on December 31, 2013.

b. **Eligibility for TennCare CHOICES Benefits.** Individuals can be eligible for one of the four TennCare CHOICES groups defined in a. above depending upon their medical and / or functional needs, their TennCare eligibility group, and the ability of the state to provide them with safe, appropriate, and cost-effective LTSS.

i. Medical and / or functional needs are assessed according to LOC criteria published by the state in state rules.

(A) There will be one set of LOC criteria for NF care, which will be used in assessing eligibility for CHOICES 1 and CHOICES 2.

(B) On July 1, 2012, the state opened enrollment in CHOICES 3, which is subject to a separate set of criteria to determine the "At-Risk" population.

(C) For the purposes of redetermining whether a recipient of NF services (CHOICES 1) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial LOC determination for that individual at the time of enrollment into CHOICES 1.

(D) For the purposes of determining whether a recipient of HCBS for elderly and disabled (CHOICES 2) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial level of care determination for that individual at the time of HCBS enrollment, or for persons transitioning from a NF, at the time of enrollment into CHOICES 1.

(E) For purposes of enrollment into CHOICES 1, the state may grant an exception for persons in the community who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely be met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of initial enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

ii. Financial eligibility:

(A) Financial eligibility for CHOICES 1 is established according to the Medicaid state plan.

(B) In order to be financially eligible for CHOICES 2, an individual must be eligible for TennCare as an SSI recipient or meet the criteria for the CHOICES 217-Like HCBS Group, individuals who qualify under institutional income and resource rules, and who are receiving home and community-based services and would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.726, and 435.236 of the Federal regulations and Section 1924 of the Act, if the home and community based services were provided under a 1915(c) waiver.

(C) In order to be financially eligible for CHOICES 3, an individual must be eligible for TennCare as an SSI recipient.

(D) In order to be financially eligible for Interim CHOICES 3, an individual must be eligible for TennCare as an SSI recipient or as a member of the At Risk Demonstration Group. Members of the At Risk Demonstration Group must meet institutional income and resource criteria.

iii. The state's ability to provide applicants with appropriate home and community based services is determined by the availability of slots under an established enrollment target (see paragraph 32.d., *Enrollment Targets for TennCare CHOICES*) and, for persons in CHOICES 2, the determination by the MCO that the individual can be served appropriately at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i), and for persons in CHOICES 3 and Interim CHOICES 3, the determination by the MCO that the cost of HCBS will not exceed the limit in paragraph 28.h.iii. There is no enrollment target for Interim CHOICES 3.

c. **Enrollment in TennCare CHOICES.** The effective date of enrollment in TennCare CHOICES must be established by the state based on a determination that an applicant is eligible for and must begin receiving LTSS. Enrollment procedures differ depending upon whether or not the person is already enrolled in TennCare Medicaid.

i. **Persons Not Already Enrolled in TennCare.** Persons not already enrolled in TennCare who wish to enroll in TennCare CHOICES must enroll through the State's Single Point of Entry (SPOE). The SPOE must provide counseling and assistance in evaluating LTSS options, screening and intake for LTSS programs offered by the state (TennCare CHOICES as well as other programs), assistance in evaluating the individual's functional LOC for LTSS, and facilitation of Medicaid eligibility determination by the state.

(A) Individuals who are determined to be both medically and financially eligible for NF placement will always be allowed to receive TennCare CHOICES services in a NF as members of CHOICES 1, if they choose.

(B) Those individuals who meet the criteria for CHOICES 2 subject to the limitations set out in these STCs, will be allowed to choose HCBS as an alternative to NF placement if the determination is made that the individual can be served appropriately in CHOICES 2 at a cost that does not exceed the cost neutrality test (see paragraph 28.h.i).

ii. **Persons Already Enrolled in TennCare.**

(A) **Nursing Facility Residents.** MCOs will conduct an assessment of NF residents who wish to move to HCBS to determine if they can be served appropriately in the community at a cost that does not exceed the cost neutrality test set forth in Section 1915(c)(4)(A), as individually applied. Even if an enrollment target has been reached for CHOICES 2, an MCO may transition persons from

CHOICES 1 to CHOICES 2 in accord with subparagraph 32.d.iii.(C) *(Transition from CHOICES 1 to CHOICES 2)*.

(B) TennCare enrollees who are not already participating in CHOICES may request enrollment in CHOICES through their MCOs, or they may be identified through other mechanisms that would trigger an assessment of their need for LTSS by the MCO. The MCO will provide counseling and assistance in evaluating LTSS options, and assistance in evaluating the individual's functional LOC eligibility for LTSS. The functional LOC determination for LTSS will be made by the Bureau of TennCare, using criteria published in state rules. Once individuals have established LOC and financial eligibility for LTSS, they can be enrolled in CHOICES in accordance with paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*).

d. **Enrollment Targets for TennCare CHOICES.** The state may establish enrollment targets for CHOICES 2 and CHOICES 3. (There will be no enrollment target for CHOICES 1 or Interim CHOICES 3.) The purpose of the targets is to permit the CHOICES program to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available state and Federal resources. Information on CHOICES Groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Progress Report as set forth in paragraphs 45 *(Quarterly Progress Reports)*, 49 *(Enrollment Reporting)* and Attachment A.

i. The state may establish an enrollment target for CHOICES 2, consistent with the upper and lower limits shown in the table below; with the actual target number to be published in state rules. The state may adjust the target as appropriate from time to time upon notification to CMS at least 30 days prior to the desired effective date of the change. Except as set forth in paragraph 32.d.iii., an increase in the enrollment target above the upper limit appropriate to the DY or a decrease below the lower limit will require an approved waiver amendment prior to implementation.

**Table 4**
**Enrollment Targets for Demonstration Years 12 Through 14**

| Demonstration Year | Lower Limit | Upper Limit |
|---|---|---|
| DY 12 | 12,000 | 16,000 |
| DY 13 | 13,500 | 17,500 |
| DY 14 | 15,000 | 18,500 |

ii. The state may also establish an enrollment target for CHOICES 3, if this group is established after a change in the level of care criteria. At a

minimum, this target will be set at 10% of the enrollment target for CHOICES 2. There will be no enrollment target for Interim CHOICES 3.

iii. If the enrollment target established by the state for CHOICES 2 or CHOICES 3 is reached or exceeded, the state shall not enroll additional persons in CHOICES 2 or CHOICES 3, except as indicated below. The state may also establish a waiting list for CHOICES, subject to the following:

(A) **Reserve Capacity.** The state may reserve slots in CHOICES 2 for individuals being discharged from a NF and for individuals being discharged from an acute care setting who are in imminent risk of being placed in a nursing facility setting absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved must be included as an attachment to the Annual Report (see paragraph 46). The state may establish additional criteria or modify procedures for allocating reserve slots upon 30 day advance written notification to CMS; the operational procedure documents included as attachments to subsequent Annual Reports must reflect any such changes. In each Quarterly Progress Report, the state must provide an accounting of their management of the reserve capacity, including a summary (as of the last day of the quarter) that states the total enrollment targets for CHOICES 2 and 3, the number enrolled in each CHOICES group, and the numbers of slots being held in reserve for various purposes.

(B) **HCBS as a Cost-Effective Alternative.** An MCO with a TennCare enrollee who meets the criteria for CHOICES 2, but which cannot enroll the individual in CHOICES 2 because the enrollment target for CHOICES 2 has been met, has the option, at its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care, in accordance with paragraph 29 *(Cost-Effective Alternatives).* (Consistent with paragraph 32.d.iii.(C), this person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.) The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. The state may require the MCO to provide documentation of its cost-effective alternative determination and assurance of provider capacity to meet the member's needs prior to enrollment in CHOICES.

(C) **Transition from CHOICES 1 to CHOICES 2.** An enrollee being served in CHOICES 1 who meets the requirements to enroll

in CHOICES 2 can enroll in CHOICES 2 at any time such a transition can be accomplished, even if an enrollment target for CHOICES 2 has been reached. This person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.

e. **Waiting Lists for TennCare CHOICES.** The use of enrollment targets as described in paragraph 32.d. *(Enrollment Targets for TennCare CHOICES*) may mean that there will be waiting lists for CHOICES 2 and/or 3. (There will be no enrollment target or waiting list for CHOICES 1 or the Interim CHOICES 3 Group.) These lists must be managed on a statewide basis using a standardized assessment tool and in accord with criteria to be established by the state. Waiting list policies must be based on objective criteria and applied consistently in all geographic areas served. The state may use separate criteria for prioritization of services under CHOICES 2 and CHOICES 3, and may revise these upon notification to CMS.

f. **Consumer Direction.** CHOICES members who have been determined by a care coordinator, as a part of the needs assessment and plan of care processes, to require attendant care, personal care, in-home respite services, companion care or other services specified by the state as eligible for consumer direction, will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e., consumer direction of HCBS). The state will notify CMS in advance of any changes to the list of services eligible for consumer direction. All CHOICES members requiring these services will be offered the option to participate in consumer direction of HCBS. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E.

g. **Miscellaneous Provisions Related to CHOICES Enrollment and Implementation**

i. The state will maintain an electronic visit verification system (as defined in Attachment D) as part of the CHOICES quality program.

ii. The state must ensure that the Care Plan is considered part of the medical record of a CHOICES participant, subject to all associated requirements and protections, and available for review by the state upon request.

## VII. COST SHARING

### 33. Cost Sharing.

a. TennCare Medicaid enrollees under the state plan are subject to cost sharing for pharmacy services (see Table 6 below).

b. Demonstration-only eligible adults enrolled in the SSD category or the At Risk Demonstration Group are subject to cost sharing for pharmacy services (see Table 6 below).

c. TennCare Standard children are subject to cost sharing for both non-pharmacy services and pharmacy services (see Table 5 and Table 6).

d. Individuals participating in CHOICES 1 or CHOICES 2 are exempt from all cost sharing.

e. Individuals participating in CHOICES 3 or Interim CHOICES 3 are subject to cost sharing for pharmacy services (see Table 6 below), similar to other Medicaid state plan adult enrollees.

**34. Co-Payments.** For demonstration-only eligible children in TennCare Standard (title XXI Medicaid Expansion children and medically eligible title XIX children), co-payments are collected by the provider when services are rendered. The requirements at Section 1916A of the Act and at 42 CFR §§ 447.50, 57, 58, and 62 through 82 will apply to cost sharing for this group.

a. **Non-Pharmacy Co-pays.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), the non-pharmacy co-pay amounts are presented in Table 5 (*TennCare Non-Pharmacy Co-Pays).*

**Table 5**
**TennCare Non-Pharmacy Co-pays**

| Poverty Level | Co-payment Amounts |
|---|---|
| 0%-99% | $0.00 |

| Poverty Level | Co-payment Amounts |
|---|---|
| 100% - 199% | $10.00 Non-emergency Hospital Emergency Room (waived if admitted)<br><br>$5.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$5.00 Physician Specialists (including Psychiatrists and Dentists)<br><br>$5.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |
| 200% and above | $50.00 Non-emergency Hospital Emergency Room (waived if admitted)<br><br>$15.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$20.00 Physician Specialists (including Psychiatrists and Dentists)<br><br>$100.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |

b. **Co-Pays on Pharmacy.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), and adults in the Standard Spend Down Demonstration Group, and persons in the At Risk Demonstration Group, co-pays on outpatient pharmacy services are presented in Table 6 (*Co-Pays on Pharmacy)*.

**Table 6**
**Co-Pays on Pharmacy**

| Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| TennCare Medicaid adults who are not exempt from cost-sharing under 42 CFR § 447.53 | $3.00 | $0 |
| TennCare Standard under age 21 with incomes below 100% FPL | $0 | $0 |
| TennCare Standard under age 21 with incomes at or above 100% FPL | $3.00 | $0 |
| TennCare Standard aged 21 and older -- SSD | $3.00 | $0 |

| Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| enrollees | | |
| CHOICES 1 and CHOICES 2 | $0 | $0 |
| Interim CHOICES 3 | $3.00 | $0 |
| CHOICES 3 | $3.00 | $0 |

**35. Compliance of TennCare Standard Cost Sharing With Federal Regulations.** The state submitted a plan for ensuring that cost sharing for TennCare Standard complies with the statutory and regulatory requirements, including the implementation of an aggregate cost sharing cap as described in 42 CFR § 447.78. The state implemented its plan on January 1, 2013.

## VIII. DELIVERY SYSTEMS

**36. Managed Care Entities.** TennCare II operates totally in a managed care environment and uses various types of managed care entities for delivering covered services to TennCare enrollees. The types of managed care entities used are listed in Table 7 below, with the reimbursement and rate-setting methodologies for each one. Title XXI Medicaid Expansion demonstration population children use the same delivery systems as other enrollees.

**Table 7– Types of Managed Care Entities**

| Type of Entity | BBA Definition | Description of Services Covered | Reimbursement and Rate-Setting Methodology |
|---|---|---|---|
| Managed Care Organizations (MCOs)—at full risk | MCO | All TennCare physical health, behavioral health, and LTSS* | MCO rates are actuarially certified by an independent third party actuary |
| TennCare Select—non-risk or partial risk | Prepaid Inpatient Health Plan (PIHP) | All TennCare physical health, behavioral health, and LTSS* for enrollees selected for participation in TennCare Select rather than enrolled in MCOs (see paragraph 38, *TennCare Select*) | Provider payment rates are negotiated between the PIHP and providers; an administrative fee is approved by CMS and paid to the PIHP |
| Dental Benefits Manager (DBM)—non-risk (may be renegotiated as at risk) | Prepaid Ambulatory Health Plan (PAHP) | Dental benefits for all TennCare enrollees with this coverage | Provider payment rates are established within DBM contract as approved by CMS; an administrative fee, approved by CMS, is paid to the DBM |
| Pharmacy Benefits Manager (PBM)—non-risk (may be renegotiated as at risk) | PAHP | Pharmacy benefits for all TennCare enrollees with this coverage. | Provider payment rates are established in accordance with the state plan; an administrative fee, approved by CMS, is paid to the PBM |

***LTSS refers to services for persons who are elderly or who have physical disabilities.

**37. Enrollment in Managed Care Organizations (MCOs).** With the exception of individuals enrolled in TennCare Select, all individuals eligible for TennCare (TennCare Medicaid or TennCare Standard), including those dually eligible for Medicare, shall be enrolled in a managed care organization providing the benefits described in paragraphs 28 *(TennCare Benefits)* and 29 *(Cost-Effective Alternatives)* of these STCs. In addition to the managed care organization, enrollees are enrolled with a Pharmacy Benefits Manager for covered pharmacy services and a Dental Benefits Manager for covered dental services. The Pharmacy Benefits Manager administers the pharmacy benefits program, using a preferred drug list that is established by the state (in consultation with a Pharmacy

Advisory Committee), taking into account the cost, therapeutic equivalency, and clinical efficacy in accordance with waiver authority.

**38. TennCare Select.** TennCare Select is a prepaid inpatient health plan (PIHP) (as defined in 42 CFR § 438.2) which operates in all areas of the state and covers the same services as the MCOs. The state's TennCare Select contractor is reimbursed on a non-risk, non-capitated basis or a partial risk basis for services rendered to covered populations, and in addition receives fees from the state to offset administrative costs.

a. The TennCare Medicaid and TennCare Standard populations included in the TennCare Select delivery system and the services provided to these populations by the TennCare Select contractor are as follows:

i. Children who are eligible for Supplemental Security Income. TennCare Select provides medical case management and all MCO covered services.

ii. Children in state custody and children leaving state custody for 6 months post-custody as long as the child remains eligible. TennCare Select provides medical case management, all MCO covered services, and coordination with the Department of Children's Services (DCS) around medical and behavioral services.

iii. Children who are receiving care in a nursing facility or an intermediate care facility for individuals with intellectual disabilities. For children and adults in a Home and Community Based Services 1915(c) waiver for individuals with intellectual disabilities, current enrollees may opt-in to receive services through TennCare Select, and new participants may opt-out of TennCare Select in order to receive services through another MCO. TennCare Select provides medical case management and all MCO covered services.

iv . Enrollees living in areas where there is insufficient capacity to serve them. TennCare Select provides medical case management and all MCO covered services.

After being assigned to TennCare Select, persons in categories i. and iii. above may choose to disenroll from TennCare Select and enroll in an MCO if one is available. Persons in categories ii. and iv. must remain in TennCare Select. The state must request a demonstration amendment (as described in paragraphs 6 and 7 regarding amendments) in order to change the list of populations included in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

b. TennCare Select also provides the following functions:

i. It is the back-up plan should one of the MCOs have to leave the TennCare program unexpectedly. For TennCare enrollees previously enrolled with

the MCO, TennCare Select provides medical case management and all MCO covered services.

ii. It is the only entity responsible for payment of the services described in 42 CFR § 431.52 (regarding services provided to residents temporarily absent from the state), and provides all MCO covered services (primarily emergency services).

iii. It is also the only entity responsible for payment of the services described in 42 CFR § 440.255 (regarding emergency services for aliens), and is responsible for payment of emergency medical services only. TennCare Select is paid an administrative fee for processing these claims.

**39. Plan Enrollment and Disenrollment.** The state maintains a managed care enrollment and disenrollment process that must comply with 42 CFR Part 438, except that, in accordance with waiver authority, TennCare participants have 45 days in which to disenroll from an MCO without cause. After 45 days, a participant may disenroll from an MCO only for cause, as set forth in 42 CFR § 438.56(d)(2). The "other reasons" that will be considered cause under 42 CFR § 438.56(d)(2)(iv) do not include the following:

- The enrollee is unhappy with the current plan or primary care provider (PCP), but there is no hardship medical situation (as defined by the state);
- The enrollee claims lack of access to services but the plan meets the state's access standards;
- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- The enrollee is concerned that a current provider might drop out of the plan in the future;
- The enrollee is a Medicare recipient who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation; and
- The enrollee's Primary Care Provider (PCP) is no longer in the MCO's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO.

In the event that a CHOICES member is determined, based on an assessment of needs, to require long term services and supports that are not currently available under the MCO in which he is currently enrolled, but that are available through another MCO, the state shall work with the current MCO to arrange for the provision of the required services, which may involve providing such services out-of-network. It shall be considered to be cause for disenrollment only if the current MCO, after working with the state, is unable to provide the required services. In such cases, the MCO that is unable to provide the required services after working with the state may be subject to sanctions.

**40. Contracts.** The following subparagraphs provide additional requirements pertaining to contracts awarded by the state for the provision of health care services under TennCare II.

a. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation.

b. Payments under contracts with public agencies that are not competitively bid in a process involving multiple bidders shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

c. With respect to CHOICES, the state established minimum guidelines regarding the person-centered service plan, the processes for the development of the plan, and the monitoring of its implementation. These expectations were submitted to CMS and are reflected in the MCO contract. Any changes in the contract requirements related to the subjects enumerated below will be submitted to CMS for review prior to executing a contract amendment with an MCO. CMS will respond within 15 working days of receipt of the draft. The required subject areas are as follows:

   i. The individuals who develop the person-centered service plan (and their requisite qualifications);

   ii. The individuals who are expected to participate in the plan development process;

   iii. Timing of the plan, how and when it is updated, including mechanisms to address changing circumstances and needs (and expectations regarding scheduling and location of meetings to accommodate individuals receiving services);

   iv. Types of assessments that are conducted as a part of the service plan development process;

   v. How participants are informed of the services available to them;

   vi. How the process ensures that the service plan addresses the participants' desired outcomes, needs and preferences; and

   vii. The plans' responsibilities for implementing and monitoring the plan of care.

d. The state will require the MCOs to develop and maintain emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. These contingency plans will be available for inspection by state officials upon request.

e. The state will monitor loss ratios of the managed care plans.

## IX. GENERAL REPORTING REQUIREMENTS

**41. General Financial Requirements.** The state shall comply with all general financial requirements under title XIX and title XXI set forth in these STCs.

**42. Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request.

**43. Additional Reporting Requirements.**

a. **Compliance with Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR §§ 438 *et seq.*

b. **Compliance with Specified HCBS Requirements.** The following regulations, which govern the provision of HCBS under Section 1915(c) waivers, shall apply to the HCBS program authorized under Section 1115 and provided through CHOICES:

- 42 CFR § 440.180(a);
- 42 CFR § 441.302;
  (a),
  (c) (insofar as it relates to NF level of care, and applying only to CHOICES 2),
  (d) (consistent with a waiver of Section 1902(a)(23) of the Act),
  (g) (applies only to CHOICES 2), and
  (j);
- 42 CFR § 441.303
  (a),
  (c) (except that the requirements following the semi-colon in (c)(2) do not apply to CHOICES 3 or Interim CHOICES 3),
  (d) (consistent with Table 2b, paragraph 28), and
  (e); and
- 42 CFR § 441.310.

Any conflict between the regulations listed in this subparagraph and these STCs shall be resolved in favor of the STCs. The state shall include a description of the steps taken to ensure compliance with these regulations as part of the Annual Report discussed in paragraph 46 *(Annual Report)*.

c. **Quality Improvement Strategy for the CHOICES Program.** The state must submit to CMS an integrated quality improvement (QI) strategy which builds on existing managed care quality requirements as defined in 42 CFR § 438, Subpart E, and incorporates applicable 1915(c) Home and Community-Based Services

waiver regulatory assurances as discussed in paragraph 43.b.

The state must identify: 1) measures of process, health outcomes, functional status, quality of life, member choice, autonomy, satisfaction, and TennCare and CHOICES system performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

The MCOs must be required to establish methods for discovery, remediation and systems improvement and, per state prescribed timeframes, regularly report on outcomes associated with continuous quality improvements.

The state must clearly demonstrate its oversight of the process.

The QI strategy must be submitted to CMS for approval prior to implementation.

No less frequently than annually, the state must provide to CMS information regarding QI activities which must include evidence regarding system performance based on identified objectives and measures, and which demonstrates efficacy in implementing the quality strategy, including but not limited to external quality review, discovery, remediation and systems improvement activities.

d. **CHOICES Data.**

i. **CHOICES Data Plan.** The state will collect and submit data to CMS, including the following data elements:

(A) Numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services at a point in time,

(B) Unduplicated numbers of persons receiving HCBS and unduplicated numbers of persons receiving NF services during a 12 month period,

(C) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period,

(D) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period as a percentage of total long-term services and supports expenditures (excluding expenditures on the population of persons with intellectual disabilities),

(E) Average per person HCBS expenditures and NF expenditures on the elderly and disabled populations during a 12 month period,

(F) Average length of stay in HCBS during a 12 month period,

(G) Percent of new LTSS recipients admitted to NFs during a 12 month period,

(H) Average length of stay in NFs during a 12 month period,

(I) Number of persons transitioned from NFs to HCBS during a 12 month period.

"Point in time" refers to June 30 of each year.

ii. **Electronic Collection of Choices Data.** The systems must be in place to record the requisite data elements for the CHOICES Program.

iii. **CHOICES Data Reporting.** The state must report to CMS, in the Quarterly and Annual Progress Reports, on data and trends of the designated CHOICES data elements. An electronic copy of the actual data addressing the required data elements must be submitted to CMS within 3 months following each point in time (e.g., by September 30 of each DY).

e. **Requirements Related to the Affordable Care Act.** Subparagraphs i. and ii. below describe elements that must be included in an extension proposal or phase-out plan, as discussed in paragraph 8 *(Extension of the Demonstration)* and paragraph 9 *(Demonstration Phase-Out)*.

i. **Affordable Care Act Transition Plan for Extension.** The extension proposal submitted to CMS in June 2012 included a Transition Plan. This plan will be updated consistent with the provisions of the Affordable Care Act and CMS regulations for any individuals enrolled in Demonstration Eligible Groups (as defined in paragraph 17, Table 1a) who will be eligible for coverage under the state plan as of January 1, 2014, including under the new Medicaid eligibility group identified in Section 1902(a)(10)(A)(i)(VIII) of the Act, or who elect to move to an Exchange plan. Persons who are demonstration eligibles at the time of transition will continue to receive demonstration benefits as long as they are enrolled in a Medicaid category and they continue to meet the criteria for their particular demonstration program. The updated Transition Plan will include procedures for ensuring that these individuals transition to their new eligibility status without interruption in coverage to the maximum extent possible.

ii. **Demonstration Phase-Out and Affordable Care Act Transition.** As part of a phase-out plan submitted under paragraph 9, the state must include a plan for using information already in its possession on members of demonstration Eligible Groups to make advance determinations of

eligibility for TennCare under its Medicaid state plan on January 1, 2014, consistent with guidance to be issued by CMS.

**44.** **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the state's progress on enrolling individuals into the TennCare Standard Spend Down Demonstration Group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

**45.** **Quarterly Progress Reports.** The state must submit progress reports containing the items listed below (see also Attachment A for format), no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. An updated CHIP allotment neutrality monitoring spreadsheet, if necessary;

c. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the TennCare Standard Spend Down Demonstration Group; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the demonstration; pertinent legislative or litigation activity; and other operational issues;

d. Action plans for addressing any policy, administrative, or budget issues identified;

e. Quarterly enrollment reports for demonstration eligibles that include the member months for each demonstration population;

f. Quarterly enrollment reports for individuals who would otherwise be eligible for Interim CHOICES 3 but who meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual;

g. Evaluation activities and interim findings; and

h. Other reports as indicated in these STCs.

**46. Annual Report.** The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The state shall also submit the title XXI annual state report for its Medicaid Expansion children in the demonstration, by December 31 of each year.

**47. Beneficiary Survey.** The state shall conduct a beneficiary survey each demonstration year for a statistically valid sample of all TennCare enrollees. The survey shall measure satisfaction, enrollee efforts to secure out-of-network care, average waiting time for physician office visits, and enrollee efforts to change plans, along with reasons for requesting plan changes. Results of the survey must be provided to CMS by September after the end of in each demonstration year (e.g. survey results for demonstration year 12 are due no later than September 30, 2014).

**48. Final Evaluation Report.** The state shall submit a Final Evaluation Report pursuant to the requirements of Section 1115 of the Act and as specified in Section XII of these STCs.

**49. Enrollment Reporting.**

a. Each quarter the state will provide CMS with an enrollment report for the title XXI Medicaid Expansion demonstration population and for title XIX Medicaid children, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the state into the Statistical Enrollment Data System (SEDS) within 30 days after the end of each quarter. SEDS reporting is required for any title XXI-funded population, including Medicaid Expansions, and is also required for title XIX Medicaid child enrollment.

b. Enrollment reporting in the Quarterly and Annual Reports (see paragraphs 45 *Quarterly Progress Reports* and 46 *Annual Report*) is required by Eligibility Group (EG) and Type for the TennCare title XIX and XXI state plan and demonstration populations.

## X. GENERAL FINANCIAL REQUIREMENTS

**50. Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under Section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period and pool payments and certified public expenditures made for the demonstration period. CMS shall provide Federal financial participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X of these Terms and Conditions.

**51. Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Tennessee must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which capitation payments were made. For this purpose, demonstration year 1 (DY 1) is defined as the year beginning July 1, 2002, and ending June 30, 2003. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures should be reported on Forms CMS-64.9 Base/64.9P Base.

Expenditures for Medicaid Expansion children claimed under the authority of title XXI of the Act shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

b. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by demonstration year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the eligibility groups (EGs) from which collections were made (see paragraph 53, *Assignment of Expenditures and Member Months to EGs*). In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations shall be offset

against expenditures. These Section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver or 64.9P Waiver schedules, and allocated to forms named for the different EGs described in e.i. through e.xii. below as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to demonstration populations shall be offset against expenditures.

e. **Use of Forms**. The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration and title XIX expenditures made in other payment categories as follows. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system. The terms "EG1" through "EG12" refer to the demonstration Eligibility Groups defined in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)* of these STCs.

i. "EG1 Disabled" expenditures (see paragraph 53.a.i.)

ii. "EG2 Over 65" expenditures (see paragraph 53.a.ii.)

iii. "EG3 Children" expenditures (see paragraph 53.a.iii.)

iv. "EG4 Adults" expenditures (see paragraph 53.a.iv.)

v. "EG5 Duals" expenditures (see paragraph 53.a.v.)

vi. "EG6E Expan Adult" expenditures (see paragraph-53.b.i.)

vii. "EG7E Expan Child" expenditures (see paragraph 53.b.ii.)

viii. "EG8 Med Exp Child" expenditures (see paragraph 53.b.iii.)

ix. "EG9 H-Disabled" expenditures (see paragraph 53.b.iv.)

x. "EG10 H-Over 65" expenditures (see paragraph 53.b.v.)

xi. "EG11 H-Duals" expenditures (see paragraph 53.b.vi.)

xii. "EG12E Carryover" expenditures (see paragraph 53.b.vii.)

xiii. "GME" (Graduate Medical Education) (see paragraph 55.d.)

xiv. "EAH Pool" (Essential Access Hospital Pool) (see paragraph 55.e.)

xv. "CAH Pool" (Critical Access Hospital Pool) (see paragraph 55.f.)

xvi. "Meharry Pool" (see paragraph 55.g.)

xvii. "CPE" (Certified Public Expenditures) for Unreimbursed Public Hospital Costs Pool (see paragraph 55.h.)

xviii. "DSH" (Disproportionate Share Hospital Payments) (see paragraph 55.i.)

xix. "UHC Pool" (Unreimbursed Hospital Cost Pool) (see paragraph 55.k.)

xx. "PHSP Pool" (Public Hospital Supplemental Payment Pool) (see 55.l.)

f. **Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population.**

i. **Expenditures Subject to the Allotment Neutrality Limit.** The state will be subject to a limit on the amount of Federal title XXI funding that the state may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including available reallocated funds published in the *Federal Register*. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of demonstration until the next allotment becomes available.

ii. The state is eligible to receive title XXI funds for expenditures for TennCare Medicaid Expansion children described on the last row of Table 1a in Section IV, paragraph 17 *(Eligibility)*, up to the amount of its title XXI allotment. Waiver expenditures for these children under title XXI must be reported as a Medicaid expansion population on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver, in accordance with the instructions in Section 2115 of the State Medicaid Manual, under waiver name "Med Exp Child," identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which

capitation payments were made. They are reported in Column C for the enhanced match under title XXI.

iii. If the state exhausts its title XXI allotment, title XIX funds are available for title XXI children in this demonstration. To access this funding, the state must submit for approval a written request to CMS, referencing this STC, to access title XIX funds for the title XXI Medicaid Expansion Demonstration Group. This request must be submitted at least 90 days prior to the date on which the state anticipates its title XXI allotment will be exhausted, and must include:

(A) An updated budget neutrality assessment that adds Medicaid Expansion children to budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that removes Medicaid Expansion children.

iv. Once the title XXI allotment is again available, the state will claim title XXI funding for the title XXI children in this demonstration. To access this funding, the state shall submit for approval a written request to CMS, referencing this STC, to access title XXI funds for the title XXI Medicaid Expansion Demonstration Group, which includes a request to update the STCs related to claiming. This formal request must be submitted prior to the change in funding source and include:

(A) An updated budget neutrality assessment that removes Medicaid Expansion children from budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that adds Medicaid Expansion children.

v. During periods in which the state is claiming title XIX funds for Title XXI Medicaid Expansion demonstration population children, the member months attributable to this demonstration population will count toward calculation of the budget neutrality expenditure limit, using the per member per month (PMPM) amounts for "EG8 Med Exp Child." The expenditures will be considered expenditures subject to the budget neutrality expenditure limit, so that the state is not fully at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

g. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to:

i. All TennCare title XIX expenditures on behalf of individuals who are enrolled in this demonstration (excluding the services specified in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*), including all service expenditures and applicable administrative costs (see subparagraph h. below) net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse), and

ii. All expenditures described in paragraph 55.d. through i. *(Extent of Federal Financial Participation for the Demonstration).*

All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver, with the exception of those described in h. below.

h. **Administrative Costs.** In general, administrative costs are not included in the budget neutrality expenditure limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. Administrative costs subject to budget neutrality (see below) must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, according to the EGs for which the expenditure was made (following the list in e.i. through e.xii. above). Other administrative costs not subject to budget neutrality will not be broken out by EG, and will be reported under waiver name "TennCare II."

In accordance with Federal regulations at 42 CFR § 438.812(b)(2), during the periods that services are provided in accordance with MCO, pharmacy benefit manager, or dental benefit manager non-risk contracts, the portion of the state's payments that is for reimbursement of the non-risk contractors' administrative services can only be claimed by the state as an administration cost at the Federal matching rates available for the costs of administration of the Medicaid program. The administrative services portion of the amounts paid by the state to compensate any non-risk contractors for their administration costs incurred in accordance with non-risk contracts are costs of the demonstration waiver that are subject to the budget neutrality expenditure limit explained in Section XI of these STCs.

i. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the Section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.

**52. Reporting Member Months.** The following describes the reporting of member months for TennCare Medicaid and TennCare Standard enrollees:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 45 *(Quarterly Progress Reports)* of these STCs, the actual number of eligible member months for all TennCare Medicaid and TennCare Standard Eligibility Groups (EGs) defined in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)*. The state must submit a statement accompanying the quarterly report, which recognizes the accuracy of this information. Member months should be reported only for individuals who are included in TennCare, as defined in paragraph 17 *(Eligibility)*. Persons for whom Medicaid only pays for services carved out of TennCare (as described in paragraph 30, *Medicaid Benefits Carved Out Of the TennCare II Demonstration*) are not enrolled in TennCare (e.g., QMBs, SLMBs).

b. A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for Type 1 and Type 2 eligibles (as defined in paragraph 61, *Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement*) are reported in Section VIIIA of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for Type 3 demonstration expansion populations and for title XXI Medicaid Expansion demonstration eligibles are reported in Section VIIIB of the template, and are not used to calculate the budget neutrality expenditure limit. Detailed instructions for

assigning member months to Types and to EGs are provided in paragraphs 53 *(Assignment of Expenditures and Member Months to EGs)* and 61 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)*.

c. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the state must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

d. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

e. The state will ensure that eligible member month totals reported to CMS for the TennCare II demonstration from July 1, 2002, forward conform to the EG definitions contained in paragraph 53 *(Assignment of Expenditures and Member Months to EGs)*.

**53. Assignment of Expenditures and Member Months to EGs:** The following rules govern the:

- Reporting of expenditures subject to the budget neutrality expenditure limit on separate waiver forms by EG, as described in paragraph 51.e. *(Use of Forms)* above, for the period beginning July 1, 2007, through the end of the TennCare II demonstration, and
- Reporting of eligible member months for the TennCare II demonstration from July 1, 2002, forward.

Beginning July 1, 2007, and as subsequently modified, the quarterly progress report template in Attachment A, Part VIII should be used to report separate member month totals for Type 1, Type 2, and Type 3 eligibles, and for other subgroups as specified below.

a. **<u>Title XIX State Plan Mandatory or Optional Groups (Type 1 Eligibles)– TennCare Medicaid:</u>**

i. For Medicaid eligibles of any age who have qualified for Medicaid on the basis of disability but who are not eligible for Medicare, report under **EG1 Disabled, Type 1.** This includes non-dual SSI eligibles in CHOICES 1, 2, and 3, the CHOICES 1 and 2 Carryover Group, or the PACE Carryover Group.

ii. For Medicaid eligibles who have not qualified for Medicaid on the basis of

disability, who are not eligible for Medicare, and who are 65 years of age or older, report under **EG2 Over 65, Type 1.**

iii. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are age 18 or younger, report under **EG3 Children, Type 1.**

iv. For Medicaid eligibles who have not qualified for Medicaid on the basis of disability, who are not eligible for Medicare, and who are between the ages of 19 and 64, report under **EG4 Adults, Type 1.**

v, For Medicaid eligibles of any age who are also eligible for Medicare, report under **EG5 Duals, Type 1.** This category includes dually eligible Medicaid/Medicare individuals who have been classified as "disabled." It does not include any dually eligible members of demonstration populations such as the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group.

b. **Title XIX Demonstration Eligible Groups (Type 2 or 3 Eligibles) – TennCare Standard**

i. For demonstration eligibles who are enrolled in the Standard Spend Down category, report under **EG6E Expan Adult, Type 3.** This category includes SSD enrollees who have Medicare or who have been classified as "disabled."

ii. For demonstration eligible children under age 19 who have been determined to be "Medically Eligible" and who have incomes at or above 200 percent of poverty, report under **EG7E Expan Child, Type 3.**

iii. For demonstration eligible children under age 19 who have been determined to be uninsured and who have incomes below 200 percent of poverty, report under **EG8 Med Expan Child, Type 2, only when Title XIX funds are being used.** This is the Title XXI population. This EG is in effect only when the state is using Title XIX funds for this population. In periods when the state is using Title XXI funds, these children would not be included in any EG but would be reported as indicated in c. below.

iv. For persons in the CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are under age 65, report under **EG9 H-Disabled, Type 2.** This category should also be used for members of any age in the At Risk Demonstration Group who are not eligible for Medicare.

v. For persons in the CHOICES 217-Like HCBS Group who are not eligible for Medicare and who are age 65 or older, report under **EG10 H-Over 65,**

**Type 2.**

vi. For persons in the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group who are also eligible for Medicare, report under **EG11 H-Duals, Type 2.**

vii. For demonstration eligible (non-SSI) persons in the CHOICES 1 and 2 Carryover Group or the PACE Carryover Group, report under **EG12E Carryover, Type 3.** This category should be used for both duals and non-duals in the Carryover Groups.

c. Expenditures for title XXI Medicaid Expansion children matched at the title XXI enhanced FMAP should be reported on Forms 64.21U Waiver/64.21UP Waiver, using waiver name "Med Exp Child." Report member months for quarterly reporting using Attachment A, Part VIII. For periods in which the state claims title XIX FMAP for this population (paragraph 51.f. *Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population*), follow the instructions in b.iii. above.

d. Type 2 eligibles can be identified as disabled for reporting purposes (see b.iv. above) if information exists in their enrollment record that would result in a capitation rate for disabled populations being paid on their behalf.

**54. Standard Funding Process.**

a. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

b. **Standard CHIP Funding Process.** The standard CHIP funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the allotment neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by

CMS. Within 30 days after the end of each quarter, the state must submit quarterly CHIP expenditure reports as described in paragraph 51.f. *(Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population)*, showing CHIP expenditures made in the quarter just ended. CMS shall reconcile expenditures with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

**55. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding (see Section X, paragraph 57, *Sources of Non-Federal Share*), CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section XI of these STCs.

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

d. **Graduate Medical Education (GME) Pool.** Actual cash disbursements, up to $50 million in total computable expenditures for each demonstration year, paid by the state from a supplemental pool to pay for GME costs in accordance with the pool distribution methodology described below. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology, authorized by the demonstration's expenditure authorities. Should CMS promulgate new regulations, the TennCare GME program must come into compliance in accordance with the effective date of the new regulations.

*GME Pool Methodology*: GME Pool payments will be made to the following medical universities that operate graduate physician medical education programs. These payments are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics: East Tennessee State University, Meharry Medical College, University of Tennessee at Memphis, and Vanderbilt University. The annual GME Pool funds will be allocated based on the annual ratio derived by dividing each hospital's average of its Primary Care Position Allocation and its Total Filled Positions Allocation by the aggregate of the medical hospitals' averages. The Primary Care Position Allocation is computed by taking each hospital's total number of primary care residents in years 1 through 4 of residency and dividing it by the total of all primary care residents in the medical hospitals in years 1 through 4 of residency.

The Total Filled Positions Allocation is computed by taking each hospital's total number of residents in years 1 through 4 of residency and dividing it by the total of the medical hospitals' number of residents in years 1 through 4 of residency. This annual ratio is applied to the total GME Pool funding to be allocated. The annual GME Pool funds will be disbursed quarterly. The state must make these payments directly to the universities, and not through any third party or intermediary.

e. **Essential Access Hospital (EAH) Pool.** Actual cash disbursements paid each quarter from a $25 million quarterly supplemental pool to pay for the uncompensated costs of the designated EAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and appropriate charity care patients in accordance with the pool distribution methodology described below. The purpose of this pool is to address the uncompensated care situation of high volume and charity hospitals that serve a disproportionate number of low-income patients with special needs. Hospitals designated as Critical Access Hospitals (CAHs) or as state mental health institutes do not participate in this pool. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

For FFYs 2008 and beyond, EAH Pool payments will be assumed to pertain to the FFY during which the payments were made. To the extent required by Federal law, EAH Pool payments made during a given FFY shall be reduced on a dollar for dollar basis by the amount of DSH payments made under the DSH allotment for that FFY.

*EAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Essential Access Hospitals.

*Qualifications* -- Hospitals eligible to receive EAH Pool payments include all hospitals licensed to operate in the State of Tennessee excluding the four (4) state mental health institutes and the CAHs. The four regional mental health institutes are Memphis Mental Health Institute, Moccasin Bend Mental Health Institute, Western Mental Health Institute, and Middle Tennessee Mental Health Institute. The CAHs receive cost-based reimbursement from the TennCare program subject to limitations outlined in subsection f. of this paragraph.

- All hospitals, with the exception of free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program.
- The free standing psychiatric hospitals must be a contracted provider with at least one of the Managed Care Organizations in the TennCare program and at least 30% of their total adjusted days must be covered by TennCare.

- All acute care hospitals must have either of the following: (i) at least 13.5% or more of their total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days.
- All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare cost.

*Allocation of the EAH Pool to Segments of Hospitals* -- The $25 million Pool should be segmented into 4 distinct parts as follows:

- Essential Service Safety Net – $12.5 Million -- These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved.
- Children's Safety Net – $1.25 Million -- These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children under the age of 21 in Tennessee.
- Free Standing Psychiatric Hospitals - $0.5 Million -- These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health for the provision of psychiatric hospital services in Tennessee, excluding the state mental health institutes.
- Other Essential Acute Care – $10.75 Million -- These hospitals include all other hospitals licensed by the Tennessee Department of Health to provide services in Tennessee, excluding the Critical Access Hospitals.

*Quarterly Reports* – The state must include in its Quarterly Progress Reports a list of the current hospitals in each of the above categories (see Attachment A).

*Data* -- Calculation of the quarterly payment amounts will be based on the most recently completed Joint Annual Report of Hospitals at the time of the first quarterly payment for a given fiscal year.

*Allocation will be based on an assignment of points for*:
- TennCare adjusted days expressed as a percent of total adjusted patient days; and
- Charity, medically indigent care, and bad debt expressed as a percent of total expenses.

*Calculation of Points*
**(1)** TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:

- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the critical access, pediatric and safety net providers;
- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 34.5%;
- 3 points – greater that 34.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

**(2)** Bad Debt, Charity and Medically Indigent – BDCHMI costs as a percent of total expenses

- 0 points - less than 4.5%
- 1 point - greater than or equal to 4.5% and less than 9.5%
- 2 points - greater than or equal to 9.5% and less than 14.5%
- 3 points - greater than or equal to 14.5%

*Calculation of Amounts of Pool Payments for Hospitals* -- These points will then be used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate included all inpatient costs (operating, capital, direct education) but excluded add-ons (indirect education, MDSA, return on equity). The GHR for Safety Net Hospitals is $908.52. The GHR for Other Essential Access Hospitals is $674.11. The points for each qualifying hospital will be summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each of the 4 pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initially calculated amount will then be adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. For example, if the sum of the initial calculated amounts for the pediatric group is $9 million and the total pool for children's hospitals is $5 million, each hospital's initial calculated amount will be multiplied by $5 million / $9 million.

*Pool Payments* -- Hospitals will be paid on a quarterly basis following the end of each quarter. The initial payment will include all quarters that have ended at the time that the payment is made. All subsequent quarterly payments will be made

following the end of the quarter. In order to receive a payment for the quarter, all hospitals, with the exception of the free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, with at least one Managed Care Organization, and must have contracted with TennCare Select for the entire quarter that the payment represents. In order for a free standing psychiatric hospital to receive a payment for the quarter, it must be a contracted provider with at least one of the Managed Care Organizations.

f. **Critical Access Hospital (CAH) Pool.** Actual cash disbursements, of up to $10 million per demonstration year, paid from a supplemental pool to pay for the uncompensated costs of the designated CAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and the appropriate charity care patients in accordance with the pool distribution methodology that has been given CMS prior approval. CAHs are designated by the Tennessee Department of Health, and they are typically small, rural hospitals that are part of a rural health network. CAHs allow communities to maintain access to primary care and emergency care when the maintenance of a full-service acute care hospital is no longer feasible. The purpose of this pool is to address the uncompensated care situation of CAHs in serving a disproportionate number of low-income patients in rural areas who have special needs. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

*CAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Critical Access Hospitals.

*Qualifications* -- To qualify for payment as a Critical Access Hospital, a hospital must meet the following criteria:

- The hospital is an acute care hospital located and licensed in the state of Tennessee;
- The hospital has been designated a Critical Access Hospital by the Tennessee Department of Health; and
- The hospital contracts with a managed care organization participating in TennCare.

*Reimbursement* -- TennCare will provide reimbursement to Critical Access Hospitals under the following terms. Reimbursement to hospitals will be limited to specific annual legislative appropriation. In any state fiscal year that reimbursable TennCare costs incurred by Critical Access Hospitals exceed annual appropriations, equitable adjustments will be made to the rates described below, in order to cap reimbursement at the annual appropriation.

***Inpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare inpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly with interim per diem rates and will be cost-

settled at year-end. Using the Joint Annual Reports filed for the most recent year available, interim per diem rates for TennCare inpatient services will be determined with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs. Inpatient Critical Access Hospital services will not include more than 15 acute inpatient beds. An exception to the 15 bed requirement is made for swing bed hospitals. Critical Access Hospitals are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that not more than 15 beds are used at any one time for acute care.

***Outpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare outpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly based on a percentage of charges with year-end cost settlements. Using the Joint Annual Reports filed for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges, with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs.

**Cost Settlements** -- Cost settlements are determined from provider submitted Medicare cost reports that include the title XIX schedules based on 100 percent (100%) of TennCare reasonable costs. The term “reasonable costs” is defined for this purpose as total reimbursable costs under Medicare principles of cost reimbursement for Critical Access Hospitals.

*New Designations of Critical Access Hospitals* -- For new hospitals that qualify after July 1, 2002, the state will begin reimbursement at the rates established by this part on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its Critical Access Hospital designation. At that time, interim rates will be established according to this part and the designation will be confirmed with the Tennessee Department of Health.

*Audit Trail and Audit Requirements* -- Each CAH is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than 5 years from the date of the submission of the Joint Annual Report, and the provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint Annual Reports are subject to audit at any time by Federal and state auditors, including the Comptroller of the Treasury and the Bureau of TennCare, or their designated representative.

g. **Meharry Medical College (Meharry) Pool.** Actual cash disbursements paid from a $10 million supplemental pool per demonstration year to pay for the uncompensated costs of the two Medicaid clinics operated by the Meharry Medical College for TennCare covered services provided to TennCare enrollees and the appropriate charity care patients. The Meharry Pool payments will be limited to the uncompensated costs of the care as determined by an independent audit each year and subject to the review and approval by the CMS staff. Before paying the annual pool amount to the providers, the state will provide CMS with a copy of the annual independent audit report. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10.

h. **Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (CPE).** Actual costs incurred by government operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients are eligible as CPE. The state must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital from the following sources: the MCOs; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds). With regard only to hospital CPE, the state will report actual CPE within 12 months after the end of each fiscal year. At that time, the state will revise its FFP claim to reconcile actual CPEs with the CPE estimates used during the preceding fiscal year (FY).

**State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the state of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

**CPE Methodology and Protocol.** The state must follow the CPE protocol, as contained in Attachment F of these STCs, which was approved by CMS for use beginning July 1, 2008.

i. **Disproportionate Share Hospital (DSH) Payments.** The Tax Relief and Health Care Act of 2006 (TRHCA 2006) established a DSH allotment for Tennessee for FFY 2007, as described at Section 1923(f)(6) of the Act. The relationship between DSH payments made by Tennessee under TRHCA 2006 and payments from the EAH Pool is further specified in the second paragraph of subparagraph (e) above. If Congress should establish a DSH allotment for Tennessee for any subsequent Federal fiscal year, the state may make DSH payments to hospitals on the basis of a state plan amendment approved by CMS. Depending on the specifics of the legislation establishing the DSH allotment, modifications to the budget neutrality expenditure limit may be required, in the manner specified in

paragraph 4.a. (*Impact on Demonstration of Changes in Federal Law, Regulation, and Policy).* Unless otherwise specified by law, DSH payments shall be considered payments made under the demonstration and subject to the budget neutrality expenditure limit and the limit described in subparagraph (j) below. When determining hospital-specific DSH limits and DSH payments, the state must take into account all Medicaid payments under the Medicaid state plan and demonstration projects including amounts paid to hospitals through the GME, EAH, Meharry Medical College, UHC, PHSP, and CAH Pools, as well as any payments by or on behalf of individuals with no source of third party coverage. The state must make these payments directly to the providers of the services as specified at Section 1923(i) of the Social Security Act.

j. Beginning in DY 6 (state fiscal year 2008), the combined total of the payments to hospitals listed in i. below shall not exceed annual limits described in iv. Beginning in DY 11 (state fiscal year 2013), the combined total of the payments to the hospitals listed in iii. below shall not exceed annual limits described in iv. Any unused amount from the annual cap for one DY may not be rolled over and added to the annual cap for any subsequent DY.

i. The following payments are subject to the limit in DY 6 through 9:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of DSH payments (see 55.i. subject to the allotment for the FFY ending during the DY);
- Three-quarters of DSH payments (see 55.i. subject to the allotment for the FFY beginning during the DY);
- Hospital CPE (see-55.h.).

ii. The following payments are subject to the limit in DY 10:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- One-quarter of the DSH payments (see 55.i., subject to the allotment for the FFY 2011);
- Additional DSH payments equal to the DSH allotment for the first quarter of FFY 2012;
- Hospital CPE (see 55.h.)

iii. The following payments are subject to the limit in DYs 11-14:
- EAH Pool payments for the four quarters of the DY (see 55.e.);
- CAH Pool payments for the DY (see 55.f.);
- Meharry Pool payments for the DY (see 55.g.);
- Hospital CPE (see 55.h.).

iv. The annual limit for DY 6 – DY 14 shall be $540 million (total computable).

k. **Unreimbursed Hospital Cost (UHC) Pool.** Actual costs incurred by eligible Tennessee hospitals that are unreimbursed by TennCare. The total amount of funds to be distributed to hospitals each DY from the pool will be determined annually, in a manner defined by the Tennessee General Assembly's Annual Coverage Assessment Act and this subparagraph, but in no event may exceed the limit defined below. For any demonstration year in which it elects to make payments under the UHC Pool authority described in this paragraph, the state may not implement a reduction in benefits or elimination of coverage for any of the following services: physical therapy, occupational therapy, speech therapy, inpatient hospital, lab and x-ray, non-emergency outpatient hospital, physician, podiatrist, certified nurse practitioner, or physician assistant services; or implement any co-payment for non-emergency medical transportation. (Nothing in this paragraph is intended to limit the state's ability to manage utilization of these services through changes to prior authorization requirements or other managed care practices.)

***Eligible Hospitals.*** Hospitals eligible to receive a pool payment include all hospitals licensed to operate in the State of Tennessee, except the following groups:

- Critical Access Hospitals;
- Public hospitals eligible to certify public expenditures, including state mental health institutes;
- Rehabilitation and long term care hospitals; and
- Pediatric research hospitals that limit patients to those that meet research protocols.

Any hospitals that have closed between 2008 and the time that the amounts of the payments are calculated are not eligible to receive payments.

***Minimum Qualifications.*** In order to receive a payment, the hospital must be contracted with at least one TennCare MCO and must have unreimbursed TennCare costs, unless the hospital is capitated and accepts the capitation from TennCare as full reimbursement for services to TennCare patients.

***Data Source.*** The Joint Annual Report (JAR) of Hospitals, which is a report containing data that each licensed hospital in the state is required to file annually in accordance with T.C.A. 68-11-310. This law says:

> All hospitals that submit a joint annual report to the department of health as designated in this section shall also submit to the department, at the same time they send the signed paper copy of the report, a notarized statement from their chief financial officer stating that the financial data reported on the joint annual report is consistent with the audited financials

for the hospitals for that reporting year. The notarized statement shall also be attested to by the chief executive officer of the hospital.

Reports are submitted to the Tennessee Department of Health (DOH), edited by DOH, corrected by the hospital and placed in a final data file for that year by DOH. The instructions for completing the form require the hospitals to use the same accounting method required for the Medicare cost reports.

Payment amounts for each DY will be based on the final JAR from 3 years prior to the DY.

***Calculation.*** TennCare costs shall be determined by multiplying TennCare charges for hospital inpatient and outpatient services reported by the hospital by the ratio of reported total expenses to reported total charges (cost to charge ratio). Unreimbursed TennCare Costs are calculated as the difference between the calculated TennCare costs and the TennCare revenue as reported on the JAR.

Each hospital shall receive an annual payment each DY equal to a percentage of its Unreimbursed TennCare Costs, using the same percentage to calculate each hospital's payment.

***Funding.*** TennCare shall adjust payments if necessary to ensure no hospital receives supplemental payments in excess of unreimbursed TennCare costs. Payments may be prorated subject to available appropriations.

***Payments.*** The annual payment to each hospital shall be made in four equal quarterly payments.

***Annual Limit:*** The total amount of UHC Pool payments made each DY may not exceed $500 million total computable.

l. **Public Hospital Supplemental Payment (PHSP) Pool.** Actual cash disbursements paid from a $70 million (total computable) supplemental pool per demonstration year to selected public hospitals. The amount paid each DY to each hospital must not exceed the hospital's uncompensated cost of TennCare covered services provided to TennCare enrollees and uninsured patients. The state must make these payments directly to the providers of the services as specified in 42 CFR § 447.10. PHSP Pool payments may be made to the following hospitals:

- Regional Medical Center at Memphis, and
- Nashville General Hospital at Meharry.

**56. Medicare Part D Drugs.** No FFP is available under this demonstration for Medicare Part D drugs.

**57. Sources of Non-Federal Share.** The state certifies that the matching non-Federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-Federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding.

c. Under all circumstances, health care providers must retain 100 percent of the TennCare II reimbursement amounts claimed by the state as a demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

**58. Monitoring the Demonstration.** The state shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

## XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

**59**. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of Federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, with an aggregate adjustment for projected disproportionate share hospital payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section X, paragraph 51 *(Reporting Expenditures in the Demonstration).*

**60.** **Risk.** Tennessee shall be at risk for the per capita cost (as determined by the method described below in this Section) for Type 1 and Type 2 TennCare enrollees in the eligibility groups (EGs) described in paragraph 61 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)* under this budget neutrality agreement, but not for the number of demonstration eligibles in each of the groups. By providing FFP for all Type 1 and Type 2 TennCare enrollees in the specified EGs, Tennessee shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Tennessee at risk for the per capita costs for TennCare enrollees in each of the EGs under this agreement, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration. Tennessee will be at risk for both per capita costs and enrollment for Type 3 TennCare eligibles.

**61.** **Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement.** Individuals who are eligible under TennCare and whose expenditures are funded at title XIX matching rates will be one of three types:

a. Type 1 - are currently eligible under Tennessee's Medicaid state plan (Title XIX state plan mandatory or optional eligible population) - counted in the "with" and "without" waiver calculations;

b. Type 2 - could be eligible under Tennessee's Medicaid state plan if Tennessee amended its state plan or could be eligible for a Section 1915(c) waiver for aged and disabled adults pursuant to 42 C.F.R. § 435.217 (Title XIX demonstration-eligible hypothetical population) or is eligible under the At Risk Demonstration Group for the Interim CHOICES 3 program - counted in the "with" and "without" waiver calculations (the state cannot generate savings from these populations); and

c. Type 3 – are only eligible with Section 1115 demonstration authority (Title XIX demonstration-eligible expansion population) - counted only in the "with" waiver calculations.

**62. Budget Neutrality Ceiling.** The following describes the method for calculating the budget neutrality expenditure limit:

a. For each DY of the budget neutrality agreement, an annual target is calculated as the sum of two components:

i. The sum of six sub-components calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the state in accordance with paragraph 52 *Reporting Member Months*) for Type 1 and Type 2 eligibles claimed under title XIX for the following six EGs: EG1 Disabled, EG2 Over 65, EG3 Children, EG4 Adults, EG5 Duals, and EG8 Med Exp Child (when title XXI allotment is exhausted); and

ii. A Disproportionate Share Hospital (DSH) adjustment for the year described in d. below.

b. Member months for the following populations are not used for calculation of the budget neutrality expenditure limit:

i. EG6E Expan Adult, EG7E Expan Child, and EG12E Carryover Type 3 eligibles

ii. Med Exp Child: Medicaid Expansion children funded at the title XXI enhanced FMAP.

c. The following tables give the projected PMPM costs for the calculation described in paragraph 62.a. by DY. The PMPM costs for DY 8 and earlier are calculated following Attachment B of the November 14, 2006 Special Terms and Conditions and paragraph 64.c. of the July 22, 2009 STCs.

**Table 8**
**Projected PMPM Costs After CHOICES Implementation**

| | Trend | DY 12 | DY 13 | DY 14 |
|---|---|---|---|---|
| **EG1 Disabled*** | 5.1% | $1,561.46 | $1,641.09 | $1,724.79 |
| **EG2 Over 65**** | 4.6% | $1,022.17 | $1,069.19 | $1,118.37 |
| **EG3 Children** | 3.4% | $468.46 | $484.39 | $500.86 |
| **EG4 Adults** | 4.9% | $917.79 | $962.76 | $1,009.94 |
| **EG5 Duals** | 4.6% | $652.99 | $683.02 | $714.44 |
| **EG8 Med Exp Child***** | 3.4% | $468.46 | $484.39 | $500.86 |

* Includes EG 9 H-Disabled
** Includes EG10 H-Over 65
***Optional Targeted Low Income Children funded using title XIX

d. The DSH adjustment is based upon Tennessee's DSH allotment for 1992 and calculated in accordance with current law.

i. For the purpose of this subparagraph, the Average FMAP (AFMAP) for each DY is defined as 0.25 times the FMAP applicable to DSH expenditures for the Federal fiscal year that ends during that DY, plus 0.75 times the FMAP applicable to DSH expenditures for the Federal fiscal year that begins during that DY.

ii. A DSH allotment has been established for Tennessee under provisions of TRHCA 2006 (and extended through subsequent legislation). Beginning with DY 5, the DSH adjustment will be based on the DSH allotments established for Tennessee, following Section 1923(f)(6)(A)(i) of the Act, which are published in the *Federal Register*. The Federal share of the DSH adjustment for each DY will be equal to one quarter of the DSH allotment for the FFY ending during the DY, plus three quarters of the DSH allotment for the FFY beginning during the DY. A total computable equivalent for each DSH adjustment can be calculated as the DSH adjustment divided by the AFMAP for that DY. For DY 5, the figure

$305,541,928 will be used to compute the Federal share of the DSH adjustment in place of the FFY 2006 DSH allotment.

iii. The calculation of the DSH adjustment will be appropriately altered if legislation is enacted that impacts the calculation of DSH allotments, including any law that would affect the calculation of the DSH allotment for Tennessee.

iv. Table 9 gives the DSH adjustments for DY 1 through DY 14, and shows both total computable and Federal share. These totals reflect changes to the calculation of DSH allotments resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the temporary increase in DSH allotments provided under Section 5002 of the American Recovery and Reinvestment Act of 2009. Some of the figures are labeled "preliminary" because the final DSH allotments needed to calculate them have not yet been published in the *Federal Register*, and are best estimates based on current law.

**Table 9**
**DSH Adjustments for DY 1 Through DY 14**

| | **DSH Adjustment (total computable)** | **DSH Adjustment (Federal share)** |
|---|---|---|
| **DY 1** | $413,700,907 | $268,409,148 |
| **DY 2** | $479,893,052 | $310,106,890 |
| **DY 3** | $479,893,052 | $310,538,794 |
| **DY 4** | $479,893,052 | $308,091,339 |
| **DY 5** | $479,356,649 | $305,451,928 |
| **DY 6** | $479,657,638 | $305,451,928 |
| **DY 7** | $485,299,094 | $311,270,839 |
| **DY 8** | $488,969,517 | $319,052,610 |
| **DY 9** | $470,369,327 | $309,408,043 |
| **DY 10** | $463,996,853 | $305,451,928 |
| **DY 11** | $463,996,853 | $305,451,928 |
| **DY 12 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 13 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 14 (preliminary)** | $463,996,853 | $305,451,928 |

e. The budget neutrality expenditure limit is the Federal share of the annual PMPM limits for the demonstration period, plus DSH adjustments, for DY 1 through 14, and represents the maximum amount of FFP that the state may receive for title XIX expenditures during the demonstration period, as described in paragraph 51.g. *(Reporting Expenditures in the Demonstration: Title XIX Expenditures*

*Subject to the Budget Neutrality Expenditure Limit).* The budget neutrality expenditure limit is equal to (1) the sum of all of the subcomponents described in a.i. above for all DYs, times the Composite Federal Share (defined in f. below), plus (2) the sum of the Federal shares to the DSH adjustments for all DYs, as defined in d. above.

f. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional demonstration expenditures or offsets such as, but not limited to, premium collections and administrative costs subject to budget neutrality under paragraph 51.h. *(Reporting Expenditures in the Demonstration: Administrative Costs)* by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for DSH payments made under the Medicaid state plan must be subtracted from the numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

**63. Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under TennCare II. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of Section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

**64. Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

| DY | Cumulative Target Definition | Percentage |
|---|---|---|
| Years 1 through 6 | Cumulative budget neutrality cap plus: | 0.5 percent |
| Years 1 through 7 | Cumulative budget neutrality cap plus: | 0.25 percent |
| Years 1 through 14 | Cumulative budget neutrality cap plus: | 0 percent |

**65. Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end of this demonstration period, the excess Federal funds shall be returned to CMS. If the demonstration is terminated prior to the end of the budget

neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

## XII. EVALUATION OF THE DEMONSTRATION

**66. Submission of a Draft Evaluation Plan.** The state shall submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after CMS approval of the demonstration extension. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

**67. Inclusion of CHOICES Special Study Components.** Suggested special study topics from which the state may choose for its Evaluation Plan include, but are not limited to, the following:

a. The rebalancing of the long-term care system including impacts on outcomes, utilization and cost;

b. Implementation lessons, successes and evolution of the Single Point of Entry and streamlined eligibility processes;

c. The expansion and development of a more robust HCBS infrastructure under managed care;

d. Implementation of Consumer Directed options under manage care;

e. Enrollee satisfaction, based on surveys that include feedback on assessment and care planning processes, quality of care coordination, actual service delivery, and (when relevant) the appeals process; and

f. Provider satisfaction from surveys.

When developing its research approach, CMS encourages Tennessee to consider adapting research questions and methodologies from the CMS sponsored Evaluation of the Money Follows the Person (MFP) Grant Program. MFP and CHOICES share many of the same goals, and by using a common study approach, the Tennessee's planned reforms can be viewed within a national context. CMS staff will be available to provide technical assistance in this regard.

**68. Evaluation of Eligibility and Enrollment Systems.** The state shall propose data collection and reporting measures designed to assess the ongoing need for retroactive

Medicaid eligibility after changes specified in the Affordable Care Act are effectuated. The interim evaluation report required in paragraph 8 *(Extension of the Demonstration)* and paragraph 70 *(Interim Evaluation Reports)* should contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid and the Exchange. CMS may issue further guidance to the state on the specific performance measures. The state may include the following areas of interest in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other relevant data.

a. Evaluation of eligibility determinations by type, e.g. application, redetermination, transfer to the Exchange.

b. Evaluation of Medicaid denial and termination reasons.

c. Evaluation of average application processing times and timeliness.

d. Evaluation of reasons for disenrollment and internal churn.

e. Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable.

**69. Evaluation of Uncompensated Care Costs for the Uninsured.** The state shall propose data collection and reporting measures designed to assess the ongoing need for payments to compensate hospitals for providing care to the uninsured after changes specified in the Affordable Care Act are effectuated. The state should provide documentation demonstrating cost expended for uncompensated care in relation to the number of uninsured individuals that receive care during the current approval period. CMS may issue further guidance to the state on specific data collection and tracking mechanisms. The state may include the following areas of interest in its interim evaluation report. This list is not all inclusive and the state may include any other relevant data.

a. Evaluation of uninsured patient cost and dates of service.

b. Evaluation of cost for medical services to charities and the indigent.

c. Evaluation of amounts expended for services to hospitals that serve a disproportionate number of low-income patients.

**70. Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request.

**71. Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation plan within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports. The state shall

submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

**72. Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

## XIII. TENNCARE ELIGIBILITY REDETERMINATION AND DISENROLLMENT AND RIGHTS; APPEALS PROCESS FOR CHANGES IN BENEFITS; AND ENROLLMENT IN STANDARD SPEND DOWN

The state will follow these procedures throughout the demonstration approval period unless modified through an approved demonstration amendment.

### PART I: MEDICALLY NEEDY AND TENNCARE STANDARD ELIGIBILITY REDETERMINATION AND DISENROLLMENT PROCESS

This Part summarizes the process Tennessee will use, in accordance with paragraph 21.a. *(Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category)*, of these STCs, to: (i) redetermine eligibility and terminate the adult (non-pregnant) Medically Needy; and (ii) disenroll adults who are TennCare/Medicare dual eligible, uninsured, and Medically Eligible. This process was approved as an amendment to the TennCare II demonstration on March 24, 2005. It is used for redetermining the eligibility of those enrollees whose eligibility is ending, including when their period of eligibility has ended or the category in which they have been enrolled is being closed. The state will continue to follow this process for all redeterminations and terminations of eligibility throughout the demonstration approval period unless modified through an approved demonstration amendment.

**I. Termination of Adult Non-Pregnant Medically Needy**

**1. Ex Parte Review**

A. The state will conduct a data match of the Social Security numbers of individuals classified as adult non-pregnant Medically Needy in its InterChange Information System (which contains information on TennCare enrollees) with Social Security Administration (SSA) data to determine whether the individual has lost supplemental security income (SSI) eligibility for reasons that would qualify them as Medicaid eligible.[1]

B. The state will conduct a data match of the Social Security numbers (SSNs) of individuals classified as adult non-pregnant Medically Needy in InterChange with individuals classified as participants in its Food Stamps or Families First (TANF) program in its ACCENT system (a database maintained by the Department of Human Services (DHS)). In all instances in which there is a match between an adult Medically Needy individual with an individual with an open Food Stamps or Families First record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

[1] Such reasons include (i) they lost SSI eligibility because of Social Security cost of living adjustment(s) ("COLA(s)") but would be SSI eligible if the COLA(s) was/were disregarded ("Passalong" eligibles); or (ii) they lost SSI eligibility for some reason other than a Social Security COLA, but would be eligible for SSI if the COLA(s) received since their SSI termination was/were disregarded ("Pickle" eligibles).

## 2. Request for Information

A. At least 30 days prior to the end of the individual's current eligibility period, the state will send notification (Request for Information) to those adult non-pregnant Medically Needy enrollees who have not been identified through the ex parte review process as eligible for open categories of TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for Medicaid is ending, and that they will only remain eligible for TennCare Medicaid if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for a Medicaid category that is not ending (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for open Medicaid categories. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for Medicaid and the enrollee will receive an advance notice that will provide appeal rights.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be fair hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with Limited English Proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as Seriously and/or Persistently Mentally Ill (SPMI). Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package—i.e., elimination of pharmacy coverage for adult non-institutionalized non-pregnant Medically Needy) until

DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a "Verification Request." Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package). If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain TennCare Medicaid coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), enrollees will retain Medicaid coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. The state will make the determination that enrollees are not eligible for open TennCare Medicaid categories in the following two scenarios: (i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or (ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Expiration Notice**

A. Upon making a determination that enrollees are no longer eligible for TennCare Medicaid, the state will provide a notice (Expiration Notice) to enrollees at least 20 days in advance of the end date of the enrollees' eligibility period.

B. Expiration Notices will:

i. Inform enrollees that they will be terminated from Medicaid as of a date specified in the notice because their current eligibility period has ended, their category of TennCare Medicaid is closed and they have not proven their eligibility for other open categories of TennCare Medicaid.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Expiration Notice to request a hearing for factual disputes related to the termination and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing prior to the date of termination specified in the Notice, Medicaid benefits for non-pregnant Medically Needy (subject to changes in the benefit package) will continue until the appeal has been resolved.

C. If enrollees submit information to qualify for Medicaid prior to their termination, enrollees will continue to be eligible for TennCare Medicaid for non-pregnant Medically Needy (subject to changes in the TennCare Medicaid benefit package) pending the determination as to whether the individual is eligible for other open TennCare Medicaid categories.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Expiration Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the termination. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. Valid factual disputes include:

i. Enrollees received the Expiration Notice in error (i.e., they are currently enrolled in other categories of TennCare Medicaid including Medically Needy pregnant women or enrollees under 21 years of age);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Request for Information but failed to extend the time;

iv. Enrollees requested assistance because of a health, mental health, learning problem, or disability but the state failed to provide this assistance; or

v. The state sent the Expiration Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the request for a hearing is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of termination identified in the Expiration Notice, TennCare Medicaid benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute as described above, or the appeal is resolved.

E. If the enrollee does not request a hearing prior to the date of termination identified in the Expiration Notice, the enrollee will be disenrolled from TennCare Medicaid.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## II. Disenrollment of Adult Medicare/TennCare Dual Eligible, Uninsured, Medically Eligible

### 1. Ex Parte Review

A. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in InterChange (which contains information on TennCare enrollees) with SSA data to determine whether the individual has lost SSI eligibility for reasons that would qualify them as Medicaid eligible.[2]

B. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in Interchange with individuals classified as participants in the state's TANF program in DHS' ACCENT system. In all instances when there is a match between an adult member of these demonstration populations with an individual with an open TANF record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

### 2. Request for Information

[2] See footnote 1

A. At least 30 days prior to disenrollment, the state will send a Request for Information to all adult Medicare/TennCare Dual Eligible, Uninsured, and Medically Eligible enrollees not identified through the ex parte review process as eligible for TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for TennCare Standard is ending and that they will only maintain coverage if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for Medicaid (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for TennCare Medicaid. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for TennCare Medicaid and the enrollee will receive a Disenrollment Notice prior to disenrollment from TennCare Standard.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with limited English proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as SPMI. Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Standard until DHS determines that the individual does not qualify for open categories of Medicaid (and proper disenrollment and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a Verification Request. Verification Requests will inform enrollees that they must submit

the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid. If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper disenrollment and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), the enrollee will retain coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in an appropriate TennCare Medicaid category. The state will make the determination that enrollees are no longer eligible for TennCare in the following two scenarios:

   i. if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or

   ii. if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

**3. <u>Termination Notice</u>**

A. Upon determination or confirming that enrollees are not eligible for TennCare Medicaid, the state will provide a Termination Notice to enrollees 20 days in advance of the date upon which the coverage will be terminated.

B. Termination Notices will:

   i. Inform enrollees that they will be disenrolled from TennCare as of the date specified in the Notice (20 days after the date of the Notice) because their category of TennCare Standard is ending and they have not proven their eligibility for open TennCare Medicaid categories.

   ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the notice to appeal factual disputes related to the action of disenrollment and inform enrollees how they may request a hearing.

   iii. Inform enrollees that if prior to the date of disenrollment specified in the Termination Notice, an enrollee appeals the action of disenrollment, he or she will not lose eligibility for TennCare until the state determines that the enrollee has not raised a valid factual dispute or the appeal is resolved.

iv. Inform enrollees that they may submit new information to demonstrate Medicaid eligibility at any time before or after disenrollment. Such information will be treated as a new application for Medicaid. The enrollee will not continue benefits pending the state's review and processing of this information.

**4. <u>Appeals Process</u>**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:

i. Enrollee received the Termination Notice in error (e.g., he or she is currently enrolled in Medicaid or in a TennCare Standard category that is not ending);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Termination Notice but failed to extend the time;

iv. Enrollee requested assistance because of a health, mental health, learning problem, or disability, but the state failed to provide this assistance; or

v. The state sent the Termination Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the appeal is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of disenrollment as identified in the Termination Notice, TennCare Standard benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute, or the appeal is resolved.

E. If the enrollee does not appeal prior to the date of disenrollment as identified in the Termination Notice, the enrollee will be disenrolled from TennCare Standard.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## PART II: NOTICE AND APPEALS PROCESS FOR CHANGES IN COVERAGE OF TENNCARE BENEFITS

This Part summarizes the process Tennessee will use upon and after the implementation of changes in coverage of TennCare benefits. These procedures were approved as an amendment to the TennCare II demonstration on March 31, 2006. This detailed process is used by the state to implement benefit changes, specifically benefit limits. It is used daily with enrollees who are subject to pharmacy benefit limits when they reach their monthly maximum. With this process, Tennessee provides one notice per month when benefit limits have been reached. The state will continue to follow this process with enrollees who are subject to pharmacy or other benefit limits throughout the Demonstration approval period unless modified through an approved Demonstration amendment. To change benefits covered under the Demonstration, the state must submit a Demonstration amendment in accordance with paragraphs 6 and 7 regarding amendments of these STCs.

### I. Implementation of Changes in Coverage Policies

#### 1. Initial Notice

A. At least 30 days prior to the effective date of changes in coverage of TennCare benefits (e.g., implementation of pharmacy benefit limits and elimination of covered services), the state shall provide a notice (Benefit Notice) to enrollees who are impacted by such changes in coverage of TennCare benefits.

B. Benefit Notices will:

i. Inform enrollees of how changes in coverage of TennCare benefits will apply to enrollees.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Benefit Notice to request a hearing for valid factual disputes related to the changes in coverage and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing for a valid factual dispute prior to the effective date of the change in coverage of TennCare benefits, benefits will be continued at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the level for Non-Institutionalized Medicaid Adults (Default Level). The state will apply the Default Level of benefits until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary. (The resolution of an appeal, for purposes of this Part, is defined as when the appeal is dismissed or resolved prior to a hearing or when a decision is rendered at or after the hearing.)

## 2. Appeals Process

A. An enrollee will have the opportunity to request a state fair hearing for 40 days (inclusive of mail time) from the date of the Benefit Notice.

B. The state will grant state fair hearings only for those enrollees raising valid factual disputes related to the changes in coverage. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to a different level of TennCare benefits than that identified in the Benefit Notice. Valid factual disputes include when an enrollee claims to have received the Benefit Notice in error (e.g., he or she is already in a TennCare category that is not subject to the particular changes in coverage).

C. When an enrollee requests a hearing prior to the effective date of changes in coverage as identified in the Benefit Notice, the enrollee shall continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the Default Level. The state will apply the Default Level until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary.

D. If the enrollee appeals, the changes in coverage in dispute shall become effective upon resolution of the appeal.

E. If the enrollee does not appeal prior to the effective date of changes in coverage as identified in the Benefit Notice, such changes in benefits will become effective, as applied to the enrollee, upon this date.

F. If the enrollee appeals and:

(i) The appeal is dismissed because the enrollee has not asserted a valid factual dispute; or

(ii) The enrollee is granted a hearing and the hearing decision sustains the state's action.

The state reserves its right to recover from the enrollee the cost of services provided as a result of the appeal.

# II. Post-Implementation Appeals from Denials of Prior Authorization for Pharmacy Products

## 1. Prior Authorization Requirements

A. Any prescription of a branded drug may be subjected to a prior authorization requirement by the state; and prior authorization will be required as a condition of coverage for branded prescription drugs that are not included on the state's Preferred Drug List.

B. Physicians (or other providers with prescribing authority) participating in TennCare will be responsible for requesting prior authorization, according to procedures to be established by the state.

**2. <u>Notice of Prior Authorization Denial</u>**

A. Requests for prior authorization of covered outpatient drugs shall be transmitted to and acted upon by appropriate staff of the Pharmacy Benefit Manager (PBM) Clinical Call Center.

B. Written notice of denial of a request for prior authorization shall be mailed by the PBM on behalf of the state to the enrollee and transmitted by facsimile to the prescribing physician. Such Notice will inform the enrollee that the request for prior authorization of the prescribed drug has been denied and that TennCare does not cover the drug absent prior authorization, briefly state the reason or reasons for denial of the request, explain the procedures that are available to the enrollee to appeal from that decision, and inform the enrollee that TennCare will not cover the cost of the prescribed medication during the pendency of any appeal. The state's failure to act on a request for prior authorization within a 24-hour period after receiving a submission that complies with the state's requirements for a completed prior authorization request may be deemed a denial from which the enrollee can appeal.

**3. <u>Procedures for Filing and Pursuing an Appeal</u>**

A. Appeals of denials of requests for prior authorization may be initiated within 20 days of the Notice of denial of prior authorization, at the option of the enrollee, by the enrollee (or an individual appointed or otherwise authorized under state law to act as the enrollee's representative) submitting to the TennCare Solutions Unit via hand delivery, mail, or facsimile, a written statement of intent to appeal on a form prescribed by the state. Such form will be available on the PBM Web site, and the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's managed care organization (MCO), or from the TennCare Solutions Unit. Undue delay by the state in deciding a prior authorization request (i.e., delay in excess of the 24-hour period permitted for such decisions) will be considered a denial of prior authorization for purposes of appeal.

B. The state will dismiss any appeal that does not raise a valid factual dispute without a hearing, and will retain the authority to determine whether an appeal raises a valid factual dispute relating to denial of a prior authorization request or the state's failure to act on a request for prior authorization within a 24-hour period after such request. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the prescribed drug. A dispute concerning whether a particular

drug or dosage is medically necessary for the enrollee, will be considered a valid factual dispute.

C. An initial determination on appeals involving issues of medical necessity will be made by appropriately qualified medical professionals on the staff of the TennCare Solutions Unit as promptly as possible after the enrollee's submission of the appeal. After submission of the appeal, the TennCare Solutions Unit may seek additional information or documentation in support of the appeal, before any initial determination is made.

D. Upon initially deciding an appeal, the state shall send a letter communicating its decision to the enrollee and stating the reasons for that decision, and shall also communicate any decision granting prior authorization to the enrollee and/or the prescribing physician by the fastest means practicable. A letter initially denying an appeal shall also inform the enrollee of his or her opportunity to request a state fair hearing, and the procedures that must be followed to pursue such further appeal.

**4. <u>Benefits During the Pendency of an Appeal</u>**

A. During the pendency of any appeal from denial of a pharmacy service due to the lack of required prior authorization, the enrollee will continue to be eligible for pharmacy benefits within applicable pharmacy service limits, but will not have any right to receive on a covered basis the drug that is the subject of the appeal.

B. If the enrollee chooses to purchase the unauthorized, prescribed drug at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the drug upon prevailing in his or her appeal, but only to the extent that applicable, monthly pharmacy benefit limits would not thereby be exceeded.

## III. <u>Post Implementation Appeals of Application of Benefit Limits</u>

**1. <u>Initial Notice</u>**

A. Pharmacists will be required to verify TennCare coverage for all prescriptions presented by enrollees through an electronic database maintained by the PBM. If, through the database, the PBM denies coverage of a prescription because the enrollee has reached or exceeded the monthly pharmacy benefit limit ("the pharmacy limit"), the PBM on behalf of the state will mail a written notice of the denial to the enrollee (Service Notice). Service Notice shall be provided only upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five prescription limit, and/or upon the first denial in that month of a pharmacy service sought by the enrollee that exceeds the two prescriptions limit on branded drugs. (For purposes of this Part, "the pharmacy limit" is defined as a five prescription limit per month, of which no more than two prescriptions or refills could be for branded drugs and at least three out of any five prescriptions or refills in the same month must be for generic drugs.)

B. If a pharmacist fills a prescription in excess of the pharmacy limit and submits a claim for such service, the PBM will deny payment for the claim. Upon denial of payment for such claim, the PBM on behalf of the state will mail a written notice (Notice of Limit) to enrollees.

C. If a provider denies a non-pharmacy service or charges the enrollee for the service because the enrollee has reached or exceeded a benefit limit, the provider need not give specific notice of appeal rights to the enrollee but must direct the enrollee to the responsible arm of the managed care contractor (MCC).

D. If a provider renders a non-pharmacy service in excess of a non-pharmacy benefit limit and the provider or the enrollee submits a claim for such service, the MCC will deny payment for the claim. Upon denial of payment for such claims, the MCC, on behalf of the state, will mail a Notice of Limit to enrollees. A Notice of Limit shall be provided only upon the first denial of coverage of a non-pharmacy service sought by the enrollee that exceeds the applicable limit for the kind and number of services during a given time period specified in the state's program.

E. The Notice of Limit and Service Notice will:

i. Inform an enrollee that he or she has reached or exceeded the applicable benefit limit.

ii. Provide enrollees with at least 20 days from the Notice of Limit or Service Notice to request a hearing for valid factual disputes related to the benefit limit and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing, they will not receive continuation of benefits (i.e., services in excess of the applicable limit) during the pendency of their appeal.

iv. Remind enrollees of any exceptions to the limits and inform them how to obtain more information about such exceptions.

**2. <u>Appeals Process</u>**

A. Enrollees will have the opportunity to request a state fair hearing for at least 20 days from the date of the Notice of Limit or Service Notice.

B. The enrollee will be required to submit a designated form in order to request a state fair hearing. The form, which must be signed by the enrollee (or an individual appointed or otherwise authorized to act as the enrollee's representative under state law), would include the basis for the appeal and the enrollee must attest, under penalty of perjury, that his contention is true to the best of his knowledge and is made in good faith. Enrollees may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its

discretion of an exemption from a signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or by an individual authorized under state law to act as the enrollee's representative.

C. The state will grant a state fair hearing only for those enrollees raising valid factual disputes related to the benefit limit. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the service that was denied because the enrollee had reached or exceeded the applicable benefit limit. Valid factual disputes include:

   i. An administrative error was allegedly made and the enrollee has not yet reached the relevant benefit limit.

   ii. The enrollee alleges that his or her circumstances have changed and he or she has been re-classified in a TennCare eligibility category that is not subject to the benefit limit the state has applied. The state, however, shall not grant a hearing to individuals who allege solely that they are not subject to the benefit limit without further alleging a change of circumstances that has been reported to TennCare and has resulted in a change in their eligibility category. These enrollees will be granted a hearing because they did not have the opportunity to appeal the application of the benefit limit to them in connection with the Benefit Notice.

   iii. The enrollee alleges an administrative error in the processing of a request for a special exemption to the benefit limit (i.e., the enrollee's physician submitted the required attestation necessary to obtain a special exemption from the benefit limit and the prescribed drug is on the special exemption list but coverage for the drug was nonetheless denied).

D. The enrollee shall not receive continuation of benefits when appealing a denial of services based on the application of a benefit limit. This policy shall apply even for items or services that have been previously authorized as medically necessary to the extent that the denial of services is based on the application of a benefit limit.

E. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal with respect to those benefits.

F. If the enrollee does not request a hearing, the benefit limit deemed applicable by the state will continue to apply to the enrollee.

G. Providers will be permitted to bill enrollees for services that were provided in excess of the benefit limits.

## IV. Post Implementation Appeals of Elimination of Coverage for Certain Services

1. Neither the state nor the MCC will provide notification in addition to the Benefit Notice described above with respect to services that are eliminated from TennCare coverage as those services are no longer covered by TennCare.

2. Upon denial of non-covered services, TennCare enrollees will have the opportunity to request a state fair hearing. The enrollee will be required to submit a designated form in order to request a hearing. Such form would include a statement, which must be signed by the enrollee, or an individual appointed or otherwise authorized to act as the enrollee's representative under state law that sets out or describes the factual contention on which the appeal is based, and attests, under penalty of perjury, that the contention is true to the best of the signatory's knowledge and is made in good faith. Enrollees or their representatives may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its discretion of an exemption from the signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or his/her authorized representative.

3. The state will grant a state fair hearing only for those enrollees who raise valid factual disputes related to the elimination of coverage. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to coverage of the disputed service. In the context of excluded services, valid factual disputes are limited to when an enrollee claims that he or she is already in a TennCare category that is entitled to coverage of the particular service at issue. Appeals that do not raise a valid factual dispute will be dismissed without a hearing.

4. If the request for a hearing is granted, the enrollee will not receive continuation of the benefits in dispute pending the appeal.

5. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee may be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal.

## PART III: ENROLLMENT IN TENNCARE STANDARD SPEND DOWN

TennCare Standard Spend Down (SSD) is open to people who are not currently eligible for Medicaid and who meet the criteria for the SSD program. Financial eligibility criteria for SSD will be based on criteria that apply to medically needy pregnant women and children eligible under the state plan.

Applicants will be enrolled only through a single toll-free telephone point of entry (the Call-In Line) initiated in periods of open enrollment. In each open enrollment period, the state will determine a specified number of calls that it will accept through the Call-In Line based on the number of applications that the state estimates it can process within federal timeliness standards. The state will not accept or track calls received outside of open enrollment periods.

Once the state has reached its targeted enrollment of 100,000 persons, new open enrollment periods will be scheduled when enrollment in the SSD program drops to 90 percent of target enrollment. Any subsequent open enrollment periods will remain open until a pre-determined number of calls to the Call-In Line have been received. The number of calls to be received will be established based on the state's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the state estimates it can process in a timely manner in accordance with federal standards. The state's decision to open or close enrollment is a policy decision that is within the state's discretion and the state is not required to provide fair hearings for challenges to these decisions.

Callers to the Call-In Line will be asked for basic demographic information and will be assigned a unique identifier. After conducting a match to verify that callers are not already enrolled in TennCare Medicaid as state plan eligibles, the state will send each non-enrolled caller a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within 30 days. (Those callers who are already enrolled in TennCare Medicaid as state plan eligibles will be sent letters advising them that they currently have benefits and need not apply.)

Completed signed applications received by the state by the 30-day deadline established by the state will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will still be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the state. If the individual does not mail back an application by the deadline, the state will send the individual a letter advising him or her that since no application was received, the state will not make an eligibility determination for him or her, but the individual is free to apply for SSD during any subsequent open enrollment period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he or she did submit a signed, written application within the deadline. Since all SSD applications received during an open enrollment period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open enrollment period will be carried forward to future open enrollment periods. The state will determine SSD eligibility within the timeframes specified by Federal regulations at 42

CFR § 435.911; such timeframes will begin on the date a signed written application is received by the state.

The effective date of SSD eligibility for individuals whose enrollment is originally initiated through the Call-In Line and who submit a timely signed application will be the later of: 1) the date that their call was received by the Call-In Line; or 2) the date spend down is met (which must be no later than the end of the 1-month budget period -- in this case, the end of the month of the original call to the Call-In Line). The effective date provisions contained herein only apply to SSD eligibility and do not apply to other categories of TennCare eligibility. All enrollees in the SSD demonstration category will have an eligibility period of 12 months from the effective date of the determination. At the end of the 12-month period the enrollee will need to have his eligibility status redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for TennCare Medicaid.

## XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

| | | |
|---|---|---|
| **Monthly Deliverables** | | |
| Monthly | Monitoring Call | ~~44~~ |
| **Quarterly Deliverables** | | |
| 60 days after end of each quarter | Quarterly progress reports | 45 |
| Per Sections 2500 & 2115 of State Medicaid Manual, or upon request | Quarterly expenditure, budget neutrality, member month reports | 41,42 Sections X and XI |
| **Annual Deliverables** | | |
| 120 days after end of each demonstration year | Draft Annual Progress Report | 46 |
| Within 30 days of receipt of comments from CMS on the Draft Annual Progress Report | Final Annual Progress Report | 46 |
| Dec. 31st of each year | Annual CHIP Report entered into CHIP Annual Report Template System (SARTS) | 46 |
| Sept. of each demonstration year | Annual beneficiary survey report | 47 |
| **Other Deliverables** | | |
| 6 months before expiration of demonstration | Request for extension | 8 |
| 5 months prior to suspending or terminating the demonstration | Phase-out plan | 9 |
| 6 months before expiration of demonstration | Interim evaluation report. | 8, 70 |
| 120 days after expiration of demonstration | Draft Final Evaluation Report | 48, 71 |
| 60 days after receipt of CMS comments on Draft Final | Final Evaluation Report | 48, 71 |

| | | |
|---|---|---|
| Evaluation Report | | |
| Implementation of compliance plan by January 1, 2013. | Enrollee notification and implementation of the new cost-sharing requirements | 35 |
| At least annually | MEQC plan proposal and report on findings | 23 |
| Upon receipt by state | Financial audits and quality assessment reviews of participating health plans, and other managed care and HCBS requirements | 40, 43 |
| Upon receipt by state | Fraud and abuse and program integrity reports related to 1115 Demonstration beneficiaries and providers | |
| As required by CMS | Corrective Action Plans and findings | |
| Upon submission to Regional Office | Courtesy copy of all state plan amendments to be sent to the CMS Project Officer | 7 |
| 60 days advance notice | Modification of CHOICES benefits defined in Attachment D | 7 |
| No later than 120 days prior to planned implementation and may not be implemented until approved | Demonstration amendments, including requests for services not defined in Attachment D | 6, 7 |
| 30 days advance notice | Notice on increases in CHOICES Enrollment Targets within allowable range | 32 |
| 3 months after each point in time. i.e. September 30 of each demonstration year | Submission of CHOICES data | 43.d. |
| Annually | Integrated Quality Improvement Strategy Update | 43.c. |
| Subject to CMS approval prior to implementation | Final MCO contracts developed for CMS approval | 40 |
| When issued or amended by state | Procedural manuals or operating protocols related to the 1115 Demonstration | |
| *All Reports Required by Sections 2500 and 2115 of the State Medicaid Manual* | | |

**ATTACHMENT A**
**QUARTERLY PROGRESS REPORT**

Under Section IX, paragraph 45 *(Quarterly Progress Reports)* of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

## NARRATIVE REPORT FORMAT:

**Title Line One –** TennCare II

**Title Line Two -** Section 1115 Quarterly Report

**Demonstration/Quarter Reporting Period:**
*Example: Demonstration Year: 6 (7/1/2007 – 6/30/2008)*
*Federal Fiscal Quarter: 1/2008 (10/07 - 12/07)*

**Footer:** Approval Period July 1, 2013 – June 30, 2016

## I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

## II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to TennCare eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.
    - Progress on implementing TennCare Standard Spend Down.
    - Progress on phasing out closed eligibility categories.
    - Other

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

**Enrollment Counts for Quarter**

Note: Enrollment counts should be person counts, not member months

| Demonstration Populations | Total No. TennCare Enrollees in current Quarter |
|---|---|
| **EG1 Disabled, Type 1 state plan eligibles** | |
| **EG 9 H-Disabled, Type 2 demonstration population** | |
| **EG2 Over 65, Type 1 state plan eligibles** | |
| **EG10 H-Over 65, Type 2 demonstration population** | |
| **EG3 Children, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 2 demonstration population** | |
| **EG5 Duals, Type 1 state plan eligibles and EG-11 H-Duals 65, Type 2 demonstration population** | |
| **EG6E Expan Adult, Type 3 demonstration population** | |
| **EG7E Expan Child, Type 3 demonstration population** | |
| **EG8, Med Exp Child, Type 2 demonstration population, Optional Targeted Low Income Children funded by Title XIX** | |
| **Med Exp Child, Title XXI demonstration population** | |
| **EG12E Carryover, Type 3, demonstration population** | |

**III. Outreach/Innovative Activities to Assure Access**

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for TennCare enrollees or potential eligibles.

**IV. Collection and Verification of Encounter Data and Enrollment Data**

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

**V. Operational/Policy/Systems/Fiscal Developments/Issues**

Identify all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

**VI. Action Plans for Addressing Any Issues Identified**

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration.

**VII. Financial/Budget Neutrality Development/Issues**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

## VIII. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

### A. For Use in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| ***Medicaid eligibles (Type 1)*** | | | | |
| **EG1 Disabled, Type 1 state plan eligibles (paragraph 53.a.i.)** | | | | |
| **EG2 Over 65, Type 1 state plan eligibles (paragraph 53.a.ii.)** | | | | |
| **EG3 Children, Type 1 state plan eligibles (paragraph 53.a.iii.)** | | | | |
| **EG4 Adults, Type 1 state plan eligibles (paragraph 53.a.iv.)** | | | | |
| **EG5 Duals, Type 1 state plan eligibles (paragraph 53.a.v.)** | | | | |
| ***Demonstration eligibles (Type 2)*** | | | | |
| **EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX (paragraph 53.b.iii.)** | | | | |
| **EG9 H-Disabled, Type 2 Demonstration Population (paragraph 53.b.iv.)** | | | | |
| **EG10 H-Over 65, Type 2 Demonstration Population (paragraph 53.b.v.)** | | | | |
| **EG11 H-Duals, Type 2 Demonstration Population (paragraph 53.b.vi.)** | | | | |

### B. Not Used in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **EG6E Expan Adult, Type 3, Demonstration Population (paragraph 53.b.i.)** | | | | |
| **EG7E Expan Child, Type 3, Demonstration Population (paragraph 53.b.ii.)** | | | | |
| **Med Exp Child, Title XXI Demonstration Population (paragraph 53.c.)** | | | | |
| **EG12E Carryover, Type 3, Demonstration Population (paragraph 53.b.vii.)** | | | | |

## IX. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

## X. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

## XI. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

## XII. Essential Access Hospital Pool

List the Essential Access Hospitals and specify their type from the following:
Essential Service Safety Net
Children's Safety Net
Free Standing Psychiatric Hospitals
Other Essential Acute Care

## XIII. Graduate Medical Education (GME) Hospitals

List the GME hospitals and their affiliated teaching universities.

## XIV. Critical Access Hospitals

List the Critical Access Hospitals.

## Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

## State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

## Date Submitted to CMS

## ATTACHMENT B
## LIMITATIONS ON HOME HEALTH SERVICES

Home health services are delivered in accordance with 42 CFR § 440.70. Prior authorization may be required. Definitions and coverage limitations used by the state are as follows:

1. Home health services shall include any of the following services ordered by a treating physician and provided by a licensed home health agency pursuant to a plan of care at an enrollee's place of residence.

   a. Part-time or intermittent nursing services.

      (1) To be considered "part-time and intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, AND no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide care combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. The above limits may be exceeded when medically necessary for children under the age of 21.

      (2) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on an as needed basis. Part-time or skilled nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.

   b. Home health aide services.

      (1) Home health aide care must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

      (2) The above limits may be exceeded when medically necessary for children under the age of 21.

   c. Physical therapy, occupational therapy, speech pathology and audiology services.

d. Medical supplies, equipment, and appliances ordered by a treating physician and suitable for use at an enrollee's place of residence.

2. Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, or preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:

   a. The child is non-ambulatory; and

   b. The child has no or extremely limited ability to interact with caregivers; and

   c. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and

   d. No other children shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult.

## ATTACHMENT C
## LIMITATIONS ON PRIVATE DUTY NURSING SERVICES

Private duty nursing services are delivered in accordance with 42 CFR § 440.80. Prior approval may be required. Definitions and coverage limitations used by the state are as follows:

PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period. A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members.

1. If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home that determines whether the nursing services are continuous or intermittent.

2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:

    a. Have a demonstrated understanding, ability, and commitment to the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration, and feeding, as applicable; and

    b. Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and

    c. Are willing and available as needed to meet the recipient's non-nursing support needs.

3. Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:

    a. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

    b. Has a functioning tracheostomy

        (1) Requiring suctioning, AND

(2) Oxygen supplementation, AND

(3) Receiving nebulizer treatments or requiring the use of Cough Assist/inexsufflator devices.

(4) In addition, for persons with a functioning tracheostomy, at least one from each of the following (I and II) must be met:

(I) Medication

(a) Receiving medication via a gastrostomy tube (G-tube), OR

(b) Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port. AND

(II) Nutrition

(a) Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube), OR

(b) Receiving total parenteral nutrition.

4. Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.

5. A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period, or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of this Attachment may receive medically necessary nursing care as an intermittent service under home health.

6. General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have other non-medical caregiving needs which must be met, to the extent that private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

a. The child is non-ambulatory; and

b. The child has no or extremely limited ability to interact with caregivers; and

c. The child would not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse would be present in the home without the presence of another responsible adult; and

d. No other children will be present in the home during the time the private duty nurse would be present in the home without the presence of another responsible adult.

## ATTACHMENT D
## GLOSSARY OF TERMS FOR TENNCARE CHOICES

**Adult care homes.** A state-licensed community-based residential alternative which offers 24-hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet nursing facility level of care, but who would prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-basis is living in the home with the individuals for whom they are providing care. Coverage shall not include the costs of room and board.

**Adult day care.** Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day provided pursuant to an individualized plan of care by a licensed provider not related to the participating adult.

**Assisted care living facility services**. Community-based residential alternative to nursing facility care in a licensed Assisted Care Living Facility that provides and/or arranges for daily meals, personal care, homemaker and other supportive services or health care including medication oversight (to the extent permitted under state law), in a home-like environment to persons who need assistance with activities of daily living. Coverage shall not include the costs of room and board.

**Assistive technology.** Assistive device, adaptive aids, controls or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive or control their environment. Examples include, but are not limited to, 'grabbers' to pick objects off the floor, strobe lights to signify the smoke alarm has been activated, etc.

**At-Risk.** As it relates to the CHOICES program, SSI eligible adults age 65+ or age 21+ with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined by the state in administrative rule, such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As is relates to Interim CHOICES 3, open for enrollment starting on July 1, 2012 and closed to enrollment on December 31, 2013, "at risk" is defined as adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meeting nursing facility financial eligibility criteria, and also meet the nursing facility level of care in effect on June 30, 2012.

**Attendant care.** Hands-on assistance, safety monitoring and supervision for an enrollee who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visits (more than four (4) hours per visit or visits at intervals of less than four (4) hours between visits). This may include assistance

with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, attendant care may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home, or continuous monitoring and supervision because there is no household member, relative, caregiver, or volunteer to meet the specified need. Attendant care shall not be provided for enrollees who do not require hands-on assistance with ADLs.

Attendant care does not include:

1) Care or assistance including meal preparation or household tasks for other residents of the same household;
2) Yard work; or
3) Care of non-service related pets and animals.

Only for persons who require homemaker services in addition to hands-on assistance with ADLs, the annual benefit shall be up to 1400 hours per full calendar year.

**Community-based residential alternatives to institutional care (Community-based residential alternatives).** Residential services which offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, assisted care living facilities, adult care homes, and companion care.

**Companion care.** A consumer-directed residential model in which a CHOICES member may choose to select, employ, supervise and pay, utilizing the services of a fiscal intermediary, on a daily, weekly, or monthly basis, as applicable, a live-in companion who will be present in the member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration. Such model will be available only for a CHOICES member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with activities of daily living or supervision and monitoring for extended periods of time that cannot be met more cost-effectively with other non-residential services. A CHOICES member who requires assistance in order to direct his or her companion care may designate a representative to assume consumer direction of companion care services on his/her behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.

**Consumer direction of eligible CHOICES HCBS.** The opportunity for a member assessed to need specified types of HCBS including attendant care, personal care visits, homemaker services (provided only as part of attendant care or personal care visits), in-home respite care, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such

services—primarily, the hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed service(s).

**Electronic visit verification (EVV) system**. An electronic system in which caregivers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of HCBS and which may also be utilized for submission of claims.

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

**Homemaker services.** Effective July 1, 2012, homemaker services are only available as part of attendant care or personal care visits for individuals who need hands-on assistance with ADLs. Services covered include general household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the member, changing the member's linens, making the member's bed, washing the member's dishes, doing the member's personal laundry, ironing, or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the member, assistance with maintenance of safe environment, and errands such as grocery shopping and having the member's prescriptions filled. Homemaker services are to be provided only for the member (and not for other household members) and only when the member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the member.

**In-home respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in the individual's place of residence, because of the absence or need for relief of those persons normally providing the care.

**In-patient respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in a licensed nursing facility or licensed community-based residential alternative, because of the absence or need for relief of those persons normally providing the care.

**Minor home modifications.** Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered

improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

**Nursing facility care.** See Social Security Act, Section 1919(a).

**Personal care visits.** Intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance to an enrollee who, due to age and/or physical disability, needs help with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, personal care visits may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need.

Personal care visits do not include:

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

**Personal emergency response system (PERS).** An electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. The individual may also wear a portable 'help' button to allow for mobility. The system is programmed to signal a response center once the 'help' button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed.

PERS services are limited to those individuals who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time, such that the individual's safety would be compromised without access to a PERS.

**Pest control.** The use of sprays, poisons and traps, as appropriate, in the enrollee's residence (excluding NF, ACLF) to regulate or eliminate the intrusion of roaches, wasps,

mice, rats and other species of pests into the household environment thereby removing an environmental issue that could be detrimental to a frail elderly or disabled enrollee's health and physical well-being.

**Reserve capacity.** The state's right to maintain some capacity within an established enrollment target to enroll individuals into HCBS under certain circumstances. These circumstances could include, but are not limited to: discharge from a nursing facility; discharge from an acute care setting where institutional placement is otherwise imminent, or other circumstances which the state may establish from time to time in accord with these STCs.

**Room and board.** Refers to lodging, meals, and utilities. The kinds of items that are considered "room and board" and are therefore not reimbursable by Medicaid include:

- Rent, or, if the individual owns his home, mortgage payments, depreciation, or mortgage interest
- Property taxes
- Insurance (title, mortgage, property and casualty)
- Building and/or grounds maintenance costs
- Resident "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included)
- Household supplies necessary for the room and board of the individual
- Furnishings used by the resident
- Utilities (electricity, water and sewer, gas)
- Resident telephone
- Resident cable television

**Short Term Nursing Facility Care.** The provision of nursing facility care for no more than 90 days to a CHOICES 2 or CHOICES 3 participant who was receiving home and community based services upon admission and who requires temporary placement in a nursing facility—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 90 days. Such CHOICES 2 or CHOICES 3 member must meet the nursing facility level of care upon admission (which for CHOICES 3 participants is anticipated to be due to a short-term condition), and in such case, while receiving short-term nursing facility care may continue enrollment in CHOICES 2 or CHOICES 3, as applicable, pending discharge from the nursing facility within no more than 90 days or until such time it is determined that discharge within 90 days from admission is not likely to occur, at which time the person shall be transitioned to CHOICES 1, as appropriate. The community personal needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

**Transition Allowance.** A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of a managed care organization, be

provided as a cost-effective alternative to continued institutional care for a CHOICES member in order to facilitate transition from a nursing facility to the community when such member will, upon transition, receive more cost-effective non-residential home and community based services or companion care. Items which may be purchased or reimbursed are only those items that the member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

## ATTACHMENT E
## BEST PRACTICES GUIDANCE REGARDING
## CONSUMER DIRECTION OF HOME AND COMMUNITY BASED SERVICES

The state will define services that eligible members may elect to direct. Members determined, as a part of the needs assessment and plan of care processes, to require such services will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e. consumer direction of HCBS).

All eligible members requiring these services will be offered the option to participate in consumer direction of HCBS.

i. Upon enrollment in HCBS and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.

ii. Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at anytime, service by service, without affecting their enrollment in HCBS. Only the state can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare.

iii. A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or be a member's paid worker.

iv. The state will utilize a fiscal employer agency (FEA) to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services rendered; and withholding, filing and paying applicable Federal, state and local income and employment taxes for workers) and to provide supports broker assistance.

v. The plan of care process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports, contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.

vi. Members will have the flexibility to hire persons close to them, including family members but excluding spouses, to serve as their workers. All workers must meet the state specified qualifications for providers of comparable non-consumer directed services and must sign a service agreement.

vii. Members will have flexibility in establishing payment rates that do not exceed the state specified ceiling for each service.

viii. Members and/or representatives must receive training prior to participating in consumer direction of HCBS and re-enrolling in consumer direction of HCBS. Ongoing training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.

ix. Workers must receive training, as a condition for hire, certain aspects of which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.

x. A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care, and the adequacy of payment rates.

## ATTACHMENT F
## CERTIFIED PUBLIC EXPENDITURES PROTOCOL

**Preamble**

This protocol governs the use of certified public expenditures to furnish the non-Federal share of expenditures claimed for Federal participation under the Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (paragraph 55.h.). The protocol is based on the following elements:

1) Units of government, including governmentally operated health care providers, may certify that costs have been incurred for providing services to TennCare and uninsured individuals. The CPE process contained in this attachment is in accordance with Federal regulations and CMS guidance or policy.

   i. Units of government have been determined by the state as eligible to certify public expenditures.

   ii. Certification must be supported by cost documentation, which represents both the Federal and non-Federal share of funds (i.e., total computable expenditures) under the Demonstration. Federal matching funds are available as a percentage of such eligible costs.

2) To the extent the state continues to utilize certified public expenditures (CPEs) as the funding mechanism for title XIX and XXI (or under Section 1115 authority) payments beyond the date defined in this section, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs as eligible under title XIX or XXI (or under Section 1115 authority) for purposes of certifying public expenditures.

3) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the state the amount of such tax revenue (state or local) appropriated to the non-governmental provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the state's claim for Federal match. Federal matching funds will be available as a percentage of such eligible costs.

### I. Cost Computation

#### A. TN CPE 1115 – Medicaid Fee-For-Service

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552)

covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from MMIS for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the

cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

## B. TN CPE 1115 – Medicaid Managed Care

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not

be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

## C. TN CPE 1115 – Hospital Uninsured Care

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently as-filed Medicare cost report (CMS 2552), as-filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the as-filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospital's audited financial statements and other auditable documentation. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of Uninsured care usable organs to total usable organs. This is determined by dividing the number of Uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible Uninsured care costs are determined by adding the Uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual Uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

## II. Payments and Recoveries

All payments and recoveries, from MCO's; BHO's; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds) including any related patient co-payments, or payments from other non-state payers will be offset against the costs computed in Section I above. Payments to the hospital from uninsured individuals for their care for the fiscal year are identified from the hospital's records. Such uninsured data must be supported by auditable documentation.

## III. Interim Reconciliation

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3

Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5

Actual Medicaid paid days and charges from MMIS paid claims data for services furnished during the payment year are used.

Step 6

Organ acquisition costs and total usable organs from the as-filed CMS 2552 cost report for the payment year are used.

## IV. Final Reconciliation

Upon finalization of the CMS-2552 by the Medicare fiscal intermediary, the methodologies as prescribed above will be used to determine final Medicaid FFS cost, Medicaid managed care cost, and uninsured cost. The routine per diems and ancillary cost-to-charge ratios will be determined using cost, day and charge data from the finalized cost report. The Medicaid FFS, Medicaid managed care, and uninsured days, charges, and payment offsets will be updated with the latest MMIS reports and other auditable financial records.

Cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include:

1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS data to the per diem amount;

2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and

3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly excepted for Medicaid.

If, at the end of the reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Recoveries are updated and offset to cost as calculated per Steps above.

For hospitals whose cost report year is different from the state's fiscal year, the state will proportionally allocate to the state plan rate year the costs of two cost report periods encompassing the state Plan payment year. To do so, the state will obtain the actual Medicaid FFS, Medicaid managed care, and uninsured days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS, Medicaid managed care, and uninsured costs for the reporting periods; these costs will then be proportionally allocated to the state plan rate year. All allocations will be made based upon number of months. (For example, a hospital's cost reporting period ending 12/31/07 encompasses three-fourths of the state plan rate year ending 9/30/2007, and one-fourth of the state plan rate year ending 9/30/2008. To fulfill reconciliation requirements for state plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2006, to the state plan rate year.) The state will ensure that the total costs claimed in a state plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**7500 Security Boulevard, Mail Stop S2-26-12**
**Baltimore, Maryland 21244-1850**

Center for Medicaid and State Operations

December 31, 2012

Mr. Darin Gordon
Director
Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to extend the TennCare II section 1115 of the Social Security Act (the Act) demonstration (Project No. 11-W-00151/4). This extension is effective July 1, 2013 through June 30, 2016. The extension is granted under the authority of section 1115(f) of the Act.

There are several changes to the Standard Terms and Conditions (STCs) included in this approval that are noteworthy.

- Removing the Transition Group and the Discontinued Demonstration Group from the STCs and adding an end date for new enrollment into the At-Risk Demonstration Group and Interim CHOICES 3 Group.
- Updating the waiver authority for freedom of choice to clarify that the waiver does not include waiving freedom of choice for family planning providers.
- Clarifying TennCare's cost sharing requirements.
- Two authorities are set to expire. Funding pools for uncompensated care will expire on December 31, 2015. Tennessee's waiver of retroactive eligibility will expire on June 30, 2016. The state must evaluate uncompensated care costs for the uninsured and also evaluate seamless coverage provided by TennCare in relation to health coverage administered through the Exchange.

This approval is subject to our receiving your written acknowledgement of the award and acceptance of the STCs and waiver and expenditure authorities within 30 days of the date of this letter. CMS is also requesting responses to follow up questions regarding budget neutrality.

Your acceptance and any questions regarding TennCare II program may be directed to your project officer, Jessica Woodard. Ms. Woodard's can be reached at (410) 786-9249 or Jessica.Woodard@cms.hhs.gov.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

Cc: Jennifer Ryan, CMCS
Angela D. Garner, CMCS
Jessica Woodard, CMCS
Kenni Howard, CMS Atlanta
Jackie Glaze, CMS Atlanta

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**WAIVER LIST**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or specified as not applicable in the following list, shall apply to all TennCare II populations identified in paragraph 17 *(Eligibility)* of the Special Terms and Conditions.

The TennCare II Demonstration will operate under these waiver authorities and those provisions specified as "not applicable". The waiver authorities and the provisions specified as "not applicable" will continue through June 30, 2016, unless otherwise stated.

The following waivers shall enable Tennessee to implement the TennCare II Medicaid section 1115 demonstration.

**WAIVERS OF TITLE XIX REQUIREMENTS FOR TENNCARE MEDICAID TITLE XIX STATE PLAN GROUPS**

**1. Statewideness/Uniformity** **Section 1902(a)(1)**
**42 CFR 431.50**

To the extent necessary to enable the state to provide managed care plans or certain types of managed care plans only in certain geographical areas of the state. Certain managed care plans or certain types of managed care plans (e.g., risk-based plans) are only available in certain areas of the state.

**2. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR 438.52**

To the extent necessary to permit the state to have only one pharmacy benefits manager and one dental benefits manager to provide services in a region of the state or statewide.

**3. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR 435.831**

To the extent necessary to enable Tennessee to use streamlined eligibility procedures that provide for coverage of optional Medically Needy children and pregnant women and the Standard Spend Down demonstration population for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. In accordance with the Code of Federal Regulations, the "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

**4. Reasonable Promptness** **Section 1902(a)(8)**

To the extent necessary to enable the state to limit enrollment in CHOICES 2 and 3 to the enrollment target(s) established by the state, as authorized under 32(e) (*Enrollment Targets for TennCare CHOICES)* of the Special Terms and Conditions, and to allow the state to require applicants for long-term care services to complete a person-centered assessment and options counseling process.

**5. Access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Benefits** **Section 1902(a)(10)**
**42 CFR 440.210 and 440.220**

To the extent necessary to enable the state to permit managed care contractors to limit coverage of FQHC and RHC services, so long as access to care is assured from other providers.

**6. Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B)**
**42 CFR 440 Subpart B**

To the extent necessary to enable the state to offer a reduced benefit package, a different benefit package, or cost-effective alternative benefit packages to different populations under the demonstration (except for individuals specified in section 1902(l)(4) of the Act), to the extent authorized under section V of the Special Terms and Conditions.

**7. Comparability and Amount Duration and Scope** **Sections 1902(a)(17)**
**and 1902(a)(10)(B)**

Should the state change the level of care criteria for admission to nursing facilities, to the extent necessary to enable the state to determine whether an individual has a continuing need for nursing facility services, PACE services, or home and community-based services for the elderly and disabled, based on the criteria in use when the individual first was determined to need the service.

**8. Freedom of Choice** **Section 1902(a)(23)(A)**
**42 CFR 431.51**

To enable the state to restrict freedom of choice of provider, through the use of mandatory enrollment in managed care plans or TennCare Select for the receipt of TennCare II and TennCare CHOICES covered services, including for individuals specified at section 1932(a)(2) of the Social Security Act (the Act). No waiver of freedom of choice is authorized for family planning providers.

**9. Retroactive Eligibility** **Section 1902(a)(34)**
**42 CFR 435.914**

To enable the state not to extend eligibility prior to the date that an application for assistance is made. This waiver authority will expire at the end of the extension period of the demonstration, June 30, 2016, unless otherwise approved based on the requirements of paragraph 8 (*Extension of the Demonstration*) of the STCs.

**10. Payment for Outpatient Drugs** **Section 1902(a)(54)**
**42 CFR 440.120,**
**447.331-447.334,**
**and 456 Subpart K**

To the extent necessary to enable the state to establish a drug formulary that does not comply with the requirements of section 1927(d)(4) of the Act.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this demonstration extension, be regarded as expenditures under the state's Medicaid title XIX state plan.

The following expenditure authorities shall enable Tennessee to implement the Medicaid section 1115 demonstration (TennCare II).

**1. Expenditures Related to MCO Enrollment and Disenrollment**

Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Tennessee managed care plans will be required to meet all requirements of section 1903(m) except the following:

- Section 1903(m)(2)(A)(vi) of the Act, Federal regulations at 42 CFR 438.56, to the extent that the rules in section 1932(a)(4) are inconsistent with the enrollment and disenrollment rules contained in paragraph 39 *(Plan Enrollment and Disenrollment)* of the demonstration's Special Terms and Conditions (STCs), such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 45 days of enrollment in an MCO. After 45 days, enrollees may disenroll from an MCO with cause at any time.

**2. Expenditures Related to Expansion of Existing Eligibility Groups**

To enable Tennessee to use streamlined eligibility procedures and include eligibility standards and requirements that differ from those required by law.

a. Expenditures for Medical Assistance furnished to state plan optional Medically Needy children and pregnant women for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. The "budget period" is the period of time used by the state to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

b. Expenditures for Medical Assistance furnished to mandatory state plan Transitional Medical Assistance beneficiaries, who are eligible in accordance with section 1931(c)(1) of the Act, for the remainder of a 12-month eligibility period after the 4-month period specified in the statute.

**3. Expenditures for Expanded Benefits and Coverage of Cost-Effective Alternative Services**

a. Expenditures for TennCare Medicaid and TennCare Standard child enrollees for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR 438 *et seq*. and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STCs.

b. Expenditures for TennCare Medicaid and TennCare Standard adult enrollees for optional services not covered under Tennessee's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR 438 *et seq*., paragraph 28 *(TennCare Benefits),* and paragraph 29 *(Cost-Effective Alternatives)* of the demonstration's STC.

**4. Expenditures for Pool Payments**

Expenditures for Graduate Medical Education, Essential Access Hospital, Critical Access Hospital, Meharry Medical College, Unreimbursed Public Hospital Costs for Certified Public Expenditures, Unreimbursed Hospital Cost, and Public Hospital Supplemental Payment pool payments to the extent specified in paragraph 54(d) through (h) and (j) through (l) *(Extent of Federal Financial Participation for the Demonstration)* of the demonstration's STCs. This expenditure authority will expire December 31, 2015.

**5. Indirect Payment of Graduate Medical Education**

Expenditures, up to $50 million in total computable expenditures for each demonstration year, for payments to universities that operate graduate physician medical education programs, which are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics.

**6. Payments for Non-Risk Contractor**

Payments to the TennCare Select prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor more than what Medical Assistance would have paid fee-for-service under the state plan in accordance with the upper limits at 42 CFR 447.362.

**7. Expenditures Related to Eligibility Expansion**

Expenditures to provide Medical Assistance coverage to the following demonstration populations that are not covered under the Medicaid state plan and are enrolled in TennCare Standard :

a. **Medically Eligible Demonstration Population Children, Not CHIP Eligible**
Uninsured children under age 19 who lose eligibility in TennCare Medicaid, have been determined to be "medically eligible" (uninsurable), have family income at or above 200 percent of the Federal poverty level (FPL), and do not meet the definition of an optional targeted low-income child.

b. **Adult Demonstration Population Eligibles- Standard Spend Down (SSD):** Non-pregnant, non-postpartum adults aged 21 or older who have been determined to meet criteria patterned after the state plan Medically Needy requirements (see paragraph 21, *Standard Spend Down (SSD) – Adult Non-State Plan Demonstration* of the STCs), comprising:

- Aged, blind, or disabled individuals; or
- Caretaker relatives.

**8. CHIP-Related Medicaid Expansion Demonstration Population Children**

Expenditures to provide Medical Assistance coverage to uninsured children who lose eligibility under TennCare, meet the definition of optional targeted low-income child, and have family income up to 200 percent of the FPL.

**9. The CHOICES 217-Like HCBS Group.**

Expenditures for TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under TennCare CHOICES were provided under a HCBS waiver granted to the state under section 1915(c) of the Act, as of the initial approval date of the TennCare CHOICES component of this demonstration. This includes the application of the spousal impoverishment eligibility rules. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the STCs;

b. Home and community-based waiver-like services as specified in Table 2b, subject to the definitions in Attachment D of the STCs, net of beneficiary regular and spousal impoverishment post-eligibility responsibility for the cost of care, and with post-eligibility treatment of income for individuals receiving short-term Nursing Facility care calculated as if they were receiving HCBS in the community.

**10. HCBS Services for SSI-Eligibles.**

Expenditures for the provision of home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs that are not described in section 1905(a) of the Act and not otherwise available under the approved state plan but could be provided under the authority of section 1915(c) waivers, that are furnished to TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities with income at 100 percent of the Supplemental Security Income/Federal Benefit Rate and resources at or below $2,000 who either:

a. Meet the nursing facility institutional level of care; or

b. Do not meet the nursing facility institutional level of care but who, in the absence of TennCare CHOICES services, are “at risk” of institutionalization.

**11. The At Risk Demonstration Group.**
Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open new to enrollment until December 31, 2013. Persons enrolled in the At Risk Demonstration Group as of December 31, 2013 may continue to qualify in the group as long as they continue to meet nursing facility financial eligibility standards and the nursing facility level of care criteria in place on June 30, 2012, and remain continuously eligible and enrolled in the At Risk Demonstration Group.

Expenditures for these individuals are:

a. Services as presented in Table 2a of the STCs.

b. Home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs, net of beneficiary post-eligibility responsibility for the cost of care (including application of spousal impoverishment rules), and with post-eligibility treatment of income for individuals receiving short-term. Nursing Facility care calculated as if they were receiving HCBS in the community.

**12. Continuing Receipt of Nursing Facility Care.**
Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**13. Continuing Receipt of Home and Community-Based Services.**
Expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria in effect as of July 1, 2012, but continue to meet the level of care criteria in place at the time of enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the CHOICES 1 and 2 Carryover Group.

**14. Continuing Receipt of Program of All-Inclusive Care for the Elderly (PACE) Services.**
Expenditures for PACE-enrolled individuals, who upon redetermination do not meet the current nursing facility level of care criteria, but continue to meet the level of care criteria in place at the time of admission/enrollment. For purposes of this demonstration, individuals meeting these criteria constitute the PACE Carryover Group.

**15. LTC Partnership.**
Expenditures for individuals in CHOICES 2 to participate in the Long Term Care Partnership Program.

## REQUIREMENTS NOT APPLICABLE TO TENNCARE STANDARD TITLE XIX DEMONSTRATION ELIGIBLE GROUPS

All Title XIX requirements that are waived for the TennCare Medicaid Groups are also not applicable to the TennCare Standard Title XIX Demonstration Eligible Groups. In addition, the following is not applicable to the Title XIX Demonstration Eligible Groups.

| | |
|---|---|
| **Cost Sharing** | **Section 1902(a)(14) and Section 1916**<br>**42 CFR 447.51 – 447.56** |

To enable the state to charge cost sharing beyond applicable Medicaid limits to TennCare Standard demonstration populations, with cost-sharing subject to a quarterly aggregate cap of 5 percent of family income for children.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS (STCs)**

**NUMBER:** **11-W-00151/4 (Title XIX)**

**TITLE:** **TennCare II**

**AWARDEE:** **Tennessee Department of Finance and Administration**

**DEMONSTRATION EXTENSION PERIOD:** **July 1, 2013 through June 30, 2016**

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**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS**

**NUMBER:** **Title XIX No. 11-W-00151/4**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for Tennessee's TennCare II section 1115(f) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to this agreement are the Tennessee Department of Finance and Administration, Bureau of TennCare ("state") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the demonstration project. The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the approval letter's date, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This demonstration extension is approved through June 30, 2016.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits; CHOICES Enrollment , Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality for the Demonstration; Evaluation of the Demonstration; TennCare Eligibility Redetermination and Disenrollment and Rights; Appeals Process for Changes in Benefits; Enrollment in Standard Spend Down; and the Schedule of State Deliverables During the Demonstration Extension.

## II. PROGRAM DESCRIPTION AND OBJECTIVES

TennCare II is a continuation of the state's demonstration, funded through titles XIX and XXI of the Social Security Act (the Act). TennCare began as an 1115(a) demonstration project in January 1994. A 3-year extension was approved for 1999-2001, and a 1-year extension was approved early in 2002. A new TennCare II 1115(a) demonstration was approved by CMS on May 30, 2002, and initiated on July 1, 2002, for a 5-year period. On October 5, 2007, an extension was granted under section 1115(a) through June 30, 2010, with revised waiver and expenditure authorities and STCs. (Note: Temporary extensions under the existing TennCare II STCs were granted for the July 1 through October 5, 2007 period, in order to provide additional time to conclude discussions on a longer extension.) The most recent extension, granted in December 2009 under the authority of section 1115(e) of the Act, was in effect from July 1, 2010 through June 30, 2013. The current extension is granted under the authority of section 1115(f) of the Act and will be in effect from July 1, 2013 through June 30, 2016.

As of June 2009, the TennCare II program had 1.236 million enrollees, about half of whom were children. All mandatory and optional populations eligible under Tennessee's state plan are enrolled in TennCare II, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only").

There are three components to the TennCare II demonstration program. **TennCare Medicaid** is the component that serves enrollees who are Medicaid-eligible under Tennessee's title XIX state plan. **TennCare Standard** is the component that serves title XIX Medicaid enrollees who are eligible only through the demonstration's expenditure authorities**.** Title XXI Medicaid expansion children are also served under TennCare Standard, with a more extensive benefits package and different service delivery system than the children served under the title XXI stand-alone Children's Health Insurance Program (CHIP). Both TennCare Medicaid and TennCare Standard deliver all Medicaid services, except for services specified at paragraphs 28 *(TennCare Benefits)* and 30 *(Medicaid Benefits Carved Out of TennCare II Demonstration)* as excluded from the TennCare benefits package for specified populations.

The **CHOICES** Program is the newest component. CHOICES utilizes the existing for-risk, Medicaid managed care organizations to provide eligible individuals with nursing facility services or home and community based services. With the implementation of the CHOICES program in 2010, home and community based services and nursing facility services were added to the existing TennCare II benefit package of primary, acute, and behavioral health services for qualifying state plan and demonstration eligible individuals. This provides participating individuals with an integrated package of acute and long-term care service benefits, through a managed care delivery system.

The goals of TennCare are the following:

- Use a managed care approach to provide services to Medicaid state plan and demonstration enrollees at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.

- Assure appropriate access to care for enrollees.
- Provide quality care to enrollees.
- Assure enrollees' satisfaction with services.
- Improve health care for program enrollees.
- Assure that participating health plans maintain stability and viability, while meeting all contract and program requirements.
- Provide appropriate, and cost-effective home and community based services that will improve the quality of life for persons who qualify for Nursing Facility care, as well as for persons who do not qualify for Nursing Facility care but are "at risk" of institutional placement and that will help to rebalance long-term services and supports expenditures.

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must

not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

**7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following

a. An explanation of the public process used by the state, consistent with the requirements of STC 15, to reach a decision regarding the requested amendment;

b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d. If applicable, a description of how the evaluations design will be modified to incorporate the amendment provisions.

Changes to TennCare II benefits described in the state plan shall be made by state plan amendment. Changes to TennCare II benefits not described in the state plan shall be made by amendment to the demonstration. Changes in benefits shall be implemented in accordance with the process set forth in Section XIII of these STCs.

Additions or Changes to CHOICES Benefits. All requests for changes in coverage of CHOICES benefits are subject to CMS approval. Changes in benefits defined in Attachment D must be submitted to CMS for approval at least 60 days in advance of the state's desired implementation date. Requests for services that are not defined in Attachment D must be submitted by the state to CMS as a request to amend the demonstration.

The state must send a courtesy copy of all Medicaid state plan amendment requests to the Project Officer. This requirement is in addition to the submissions that the state must make as part of the usual state plan amendment process, and is not meant to substitute for or supplant that process in any way.

**8. Extension of the Demonstration.**

a. States that intend to request demonstration extension under section 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 9.

b. Compliance with Transparency Requirements 42 CFR Section 431.412. Effective April 27, 2012, as part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements of 42 CFR 431.412 and the public notice and tribal consultation requirements outlined in STC 15.

**9. Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

   The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of the phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all

affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010 State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

**10.** **Post Award Forum**. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC 44 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 45.

**11.** **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

**12.** **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

**13.** **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

**14.** **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

**15.** **Public Notice and Consultation with Interested Parties.** The state must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR 431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 CFR 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

**16.** **FFP.** No Federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

## IV. ELIGIBILITY

**17. Eligibility.** Tennessee includes in the TennCare II demonstration all of the mandatory and optional populations eligible under the Tennessee Medicaid state plan, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only"). Also included in TennCare II are several title XIX demonstration-only eligible populations and one title XXI Medicaid Expansion demonstration population. Medicaid state plan-eligible individuals are served in the component of the program called TennCare Medicaid. Other demonstration-only eligible populations are served in the component called TennCare Standard.

The mandatory and optional Medicaid state plan populations described below derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the demonstration to generate savings for covering the Expansion populations, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.

The title XXI Medicaid Expansion demonstration population is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as otherwise listed as not applicable.

Under the TennCare II demonstration, Tennessee is not required to extend eligibility for medical assistance prior to the date that an application for assistance is made; however, the state may provide retroactive coverage for up to 3 months for class members in *Daniels, et al. v. Tenn. Dept. of Health and Env't., et al.*, (1) who have been terminated from TennCare on or before March 31, 2010, for failure to respond to a Request for Information and Expiration Notice in accordance with the process approved in the Federal court order dated January 8, 2009; (2) who subsequently complete a Request for Information within 60 days of termination; and (3) who are determined to have been eligible at the time of termination. The state must notify the Project Officer by letter if it intends to extend retroactive eligibility to Daniels class members as described above.

Any changes to eligibility must be submitted to CMS as an amendment request, subject to the process set forth in paragraphs 6 (*Changes Subject to the Amendment Process)* and 7 *(Amendment Process)* of these STCs.

The criteria for TennCare eligibility groups are as follows (Table 1a).

**Table 1a – TennCare Eligibility Groups**

Note: This table does not change the state plan requirements.

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **Title XIX State Plan Mandatory Groups – TennCare Medicaid** | | |
| 1931 recipients including:<br>• Children younger than 18/19<br>• Caretaker relatives<br>• Pregnant women with no other eligible children (coverage for third trimester) | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Transitional Medical Assistance – Medicaid Extension for families who lose TANF benefits due to:<br>• income from employment or work hours or loss of "income disregard"<br>• increased child or spousal support collections | 6 initial months + 6 months continued coverage<br>4 months continued coverage *and expenditure authority for 8 additional months* | 1, 2, 5, 6, 8, 9, 10 |
| Individuals who are ineligible for AFDC benefits solely due to requirements that are prohibited under Medicaid, including AFDC time limits | Income up to and including 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Poverty level pregnant & postpartum women | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level newborns under age 1 | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 1-5 | Income up to and including 133% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 6-18 | Income up to and including 100% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Deemed categorically eligible newborns: born to & living with a woman who was eligible and received Medicaid on the date of the child's birth | Eligible for 1 year as long as mother is eligible or would be if pregnant | 1, 2, 5, 8, 10 |
| Pregnant woman who would otherwise lose eligibility because of an increase in income remains eligible through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Woman who was eligible while pregnant continues eligibility through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Title IV-E eligible children in adoption subsidy or foster care | AFDC income standard | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash recipients: aged, blind or disabled (may or may not be receiving CHOICES benefits) | | 1, 2, 4, 5, 6, 7, 8, 9, 10, |
| Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87 | | 1, 2, 5, 6, 8, 9, 10 |
| "DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash ineligible for reasons prohibited by Title XIX. | | 1, 2, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| "Pickle" SSA Beneficiaries who lost SSI cash benefits due to cost of living adjustment (COLA) increase in Title II OASDI benefits | | 1, 2, 5, 6, 8, 9, 10 |
| "DWB" Disabled widow/widower who lost SSI or state supplement due to early receipt of OASDI benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| **Title XIX State Plan Optional Groups – TennCare Medicaid** | | |
| Presumptively eligible pregnant & postpartum women | Income up to 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Children under 21 who meet AFDC income & resource criteria—children in state custody, foster care, subsidized adoptions, institutionalized | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Persons who would be eligible for AFDC or SSI cash assistance except for their institutional status | | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Special income level group: individuals who are in a medical institution at least 30 consecutive days with income that does not exceed 300% of SSI income standard under 1902(a)(10)(ii)(V) of the Act. | Income no more than 300% of SSI rate; resources $2000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Categorically needy individuals under the state plan who are receiving home and community based services in accordance with 42 CFR 435.217. After the full implementation of CHOICES, this group will consist solely of enrollees in the ID waivers). | | 1, 2, 5, 6, 8, 9, 10 |
| Non-IV-E children with special medical needs who receive a state adoption subsidy payment | | 1, 2, 5, 6, 8, 9, 10 |
| Women under 65 who need treatment for breast or cervical cancer, and are not otherwise eligible for Medicaid. State utilizes presumptive eligibility for this population. | | 1, 2, 5, 6, 8, 9, 10 |
| Medically needy children under 21 *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |
| Medically needy pregnant or postpartum women *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |
| | | |
| | | |
| **Title XIX Demonstration Eligible Groups– Carryover** | | |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **CHOICES 1 and 2 Carryover Group:** Individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **PACE Carryover Group:** Individuals who were enrolled in a PACE program as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the state's modification of its nursing facility level of care criteria. | As required under the state plan. | |
| **Title XIX Demonstration Eligible Groups – TennCare Standard** | | |
| **Medically Eligible Children:** uninsured children under 19 who have been determined to be "medically eligible" (uninsurable) (category is currently closed to new enrollment except for Medicaid rollovers [as defined in paragraph 20 *Rollover Definition*] who are not otherwise eligible for TennCare [See paragraph 19 *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*]. | Income 200% FPL or higher without limit; no resource test | 1, 2, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Standard Spend Down (SSD):** non-pregnant/postpartum adults 21 or older who have been determined to meet criteria patterned after the medically needy requirements *(enrollment target: 100,000)*<br>• aged, blind, or disabled<br>• caretaker relatives<br>CMS approved an amendment to add this expansion population in Nov. 2006. This category will be opened to new enrollment.<br>(expenditure authority for 12-month coverage based on 1-month budget period)<br>[See paragraph 21(a) *Standard Spend Down (SSD) – Adult Non-State Plan Demonstration Population Category*] | Medically needy spend-down level ($241 for 1, etc.); resources $2000 | 1, 2,, 3, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| | | |
| **Title XIX Demonstration Eligible Groups – CHOICES** | | |
| **CHOICES 217-Like HCBS Group:** Aged and / or disabled categorically needy adults who meet the CHOICES NF level of care requirement, are receiving home and community based services and who would be eligible in the same manner as specified under 42 CFR 435.217, 435.236, and 435.726 of the Federal regulations and section 1924 of the Social Security Act, if the home and community based services were provided under a 1915 (c) waiver. This group exists only in regions of the state where the CHOICES program has been implemented, and is subject to the enrollment target for CHOICES 2 in paragraph 32(e) *(Enrollment Targets for TennCare CHOICES)*. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **At Risk Demonstration Group:** Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of the TennCare Interim Choices 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open to enrollment starting July 1, 2012 and closed to new enrollment on December 31, 2013.. | Income no more than 300% SSI/FBR; resources $2,000 | 1,2,4,5,6,7,8,9,10 |
| **Title XXI Medicaid Expansion Demonstration Eligible Group – TennCare Standard** | | |
| Optional Targeted Low-Income Children: uninsured children under 19 who:<br>• have lost Medicaid eligibility under the approved Medicaid state plan and who do not have access to insurance or<br>• were uninsured and enrolled in this category in the original TennCare demonstration as of 12/31/01, even if they had access to insurance, and have been continuously enrolled in this category since 12/31/01<br>[See paragraph 19 *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*] | Income up to 200% FPL | 1, 2, 5, 6, 8, 9, 10, and cost sharing "not applicable" |

## 18. TennCare CHOICES Eligibility Groups.

As further set forth in paragraph 32 *(Operations of the TennCare CHOICES Program)*, eligibility for enrollment in TennCare CHOICES depends on (a) the individual's TennCare Eligibility Group, (b) the Nursing Facility (NF) (or "At Risk," as applicable) level-of-care (LOC) criteria as established by the state, and (c) the type of long-term care services to be provided.

There are three principal eligibility groups for TennCare CHOICES. CHOICES 1 is for individuals receiving NF services. CHOICES 2 is for individuals who meet the NF LOC that are receiving HCBS as an alternative to NF care. CHOICES 3 is for individuals who do not meet the NF LOC, but are at risk of NF placement and a re receiving HCBS to delay or prevent NF placement

The state elected to change the level of care that is medically necessary for admission to a NF. CHOICES 3 will serve SSI eligibles enrolled after the implementation of the LOC change who do not meet the new LOC standard but who are "at risk" of institutionalization. Individuals in CHOICES 1 and CHOICES 2 who continue to meet

the standard in place at the time of the individual's enrollment will continue to qualify for those services.

Between July 1, 2012 and December 31, 2013,, the state opened Interim CHOICES 3 to serve SSI eligibles and other adults who meet the LOC standard and financial eligibility requirements in place prior to the change, allowing the state to abide by the "Maintenance of Effort" (MOE) requirements as specified by the Affordable Care Act, Section 2001.

Table 1b summarizes the CHOICES Eligibility Groups and addresses how a change in LOC criteria will be taken into account in determining eligibility for each group.

**Table 1b – TennCare + CHOICES Eligibility Groups**

Note: This table does not change the state plan requirements. CHOICES 1, CHOICES 2, CHOICES 3, and Interim CHOICES 3 are defined in paragraph 32 *(Operations of the TennCare CHOICES Program)*. The CHOICES 1 and 2 Carryover Group and the PACE Carryover Group are defined in Table 1a of paragraph 17 (Eligibility). With respect to benefits, cost-sharing, and similar issues, persons in the CHOICES 1 Carryover Group are treated as though they were in CHOICES 1; persons in the CHOICES 2 Carryover Group are treated as though they were in CHOICES 2; and persons in the PACE Carryover Group are treated as though they were in PACE.

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 1 | • Nursing facility residents who meet the NF LOC in place at the time of enrollment* | Yes | Yes, CHOICES 1 and 2 Carryover Group |
| CHOICES 2 | • Meet NF LOC in place at the time of HCBS Receive HCBS as alternative to NF care<br>• Age 65+ or 21+ and disabled | Yes, SSI only | Yes, CHOICES 217-Like HCBS Group and CHOICES 1 and 2 Carryover Group |
| CHOICES 3 | • "At risk" for institutionalization (as defined in Attachment D)<br>• Age 65+ or age 21+ and disabled | Yes, SSI only | No |
| INTERIM CHOICES 3 (open to enrollment starting July 1, 2012 and closed to new enrollment on December 31, 2013) | • Same as CHOICES 3, but not limited to SSI recipients<br>• Must meet nursing facility financial eligibility criteria | Yes, SSI only | Yes, At Risk Demonstration Group |

***** The state may grant an exception for persons in the community seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

**19. Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed.** The state has closed enrollment into the following demonstration categories, except for "rollovers" (as defined in paragraph 20 *Rollover Definition*). Therefore, children are only eligible for a non-state plan demonstration population as a "rollover." If children lose Medicaid state plan eligibility, they may qualify for one of these demonstration-only groups rather than for the standalone title XXI CHIP program.

- Title XIX Medically Eligible Children: Individuals who are under age 19, are uninsured, have income that is 200 percent of the FPL or higher without limit, are not otherwise eligible for TennCare, and meet the state-defined criteria of "medically eligible" as having medical conditions that make them uninsurable. (There is no income or resource limit for this group.)

- Title XXI Medicaid Expansion Children: Individuals under age 19 who are uninsured, have family income less than 200 percent of the FPL, and meet the definition of an optional targeted low-income child. (There is no resource limit for this group.)

Individuals under age 19 who lose eligibility for a Medicaid category may roll over into a TennCare Standard category if they meet the criteria for the category.

**20. Rollover Definition.**

a. Rollover. For the purpose of this demonstration, a "rollover" eligible is an individual who qualifies for continued coverage through a TennCare Standard demonstration category upon losing Medicaid eligibility under any category included in Tennessee's title XIX state plan.

b. Medically Needy Rollover. A rollover eligible, except for an individual rolling over into Standard Spend Down (SSD) eligibility from Medicaid eligibility, is termed a "medically needy rollover" and included in Type 2 for budget neutrality purposes if the individual is (1) age 19 or older and (2) the individual's prior Medicaid state plan eligibility was in a medically needy eligibility group (see paragraph 55b *Title XIX Demonstration Eligible Groups – TennCare Standard (Types 2 and 3 Eligibles*).

**21. Adult Non-State Plan Demonstration Population Categories.**

a. **Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category.** The SSD eligibility category is open to non-pregnant/postpartum adults ages 21 or older who are Caretaker Relatives or Aged, Blind, or Disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the state plan. The SSD demonstration eligibility group has an enrollment cap of 105,000, with a target enrollment of 100,000. The state shall establish eligibility and enroll

individuals into the SSD group in accordance with the process set forth in Section XIII of these STCs.

b. **CHOICES 217-Like HCBS Group**. This group consists of persons aged 65 and older or persons aged 21+ and who are disabled who: (1) Meet the CHOICES NF level of care requirement; (2) Are receiving home and community-based services; and (3) Would be eligible in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 of the Federal Regulations and section 1924 of the Social Security Act, if the home and community based services were provided under a 1915(c) waiver. Paragraph 18 *(TennCare CHOICES Eligibility Groups)* and paragraph 32(b) *(Eligibility for TennCare CHOICES Benefits)* describe how the NF LOC requirements shall be determined for individuals in this group. The state retains the discretion to apply an enrollment target as described in paragraph 32(e) *(Enrollment Targets for TennCare CHOICES).*

c. **At Risk Demonstration Group.** As of July 1, 2012, this group consists of elderly adults and adults age 21 and older with physical disabilities who (1) meet nursing facility financial eligibility; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization.

d. **CHOICES 1 and 2 Carryover Group.** This group consists of individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who no longer qualify for CHOICES enrollment due solely to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in CHOICES 1 or CHOICES 2 if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, (2) meet all the eligibility requirements for a CHOICES program; and (3) remain continuously enrolled in CHOICES 1 and/or 2, as specified below:

   i. Persons enrolled in CHOICES 1 can continue in CHOICES 1 or transition to CHOICES 2, and persons enrolled in CHOICES 2 can continue in CHOICES 2; and

   ii. The state may grant an exception to (i) for persons in CHOICES 2 seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely be met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

e. **PACE Carryover Group.** This group consists of individuals who were enrolled in PACE as of June 30, 2012, but who no longer qualify for enrollment due solely

to the state's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in PACE if they (1) continue to meet the criteria for nursing facility level of care employed by the state at the time they were enrolled, and (2) meet all other eligibility requirements for PACE in the Medicaid state plan. PACE remains under the Medicaid state plan.

**22. Medically Needy Eligibility Period.** Financial eligibility for state plan medically needy pregnant women and children and for Standard Spend Down adults is based on a 1-month budget period described in the state plan. Those determined eligible remain eligible for up to 1 year from the effective date of eligibility.

**23. Quality Review of Eligibility**. At least annually, the state shall submit a plan for a Medicaid Eligibility Quality Control (MEQC) pilot project to the CMS Regional Office for approval. When each pilot is complete, the state shall send a report to the CMS Regional Office for approval, and shall submit a plan for the next pilot project. The MEQC pilots must be conducted in accordance with Federal law, regulations, and policy.

**24. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.**

a. Except as specified in paragraph 24(b), below, in determining eligibility for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 CFR Section 435.725 of the Federal regulations.

b. For an individual in CHOICES 2 or CHOICES 3 who is admitted for short-term nursing facility care (as defined in Attachment D), in order to ensure that the individual can maintain a community residence for transition back to the community, the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. After 90 days, or as soon as it appears that the inpatient stay will not be short-term, whichever comes first, the person will be transitioned to CHOICES 1 and the institutional post-eligibility calculation shall apply.

**25. Eligibility/Post-Eligibility Treatment of Income and Resources for the CHOICES 217-Like HCBS Group, At Risk Demonstration Group and CHOICES 1 and 2 Carryover Group.** For individuals receiving 1915(c) like services in CHOICES 217-Like HCBS Group, the At Risk Demonstration Group or the CHOICES 1 and 2 Carryover Group, the state must use institutional eligibility and post-eligibility rules for individuals who would be eligible in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 of the Federal regulations and section 1924 of the Social Security Act, if the home and community based services were provided under a section 1915(c) waiver.

26. **Post-Eligibility and Patient Liability for CHOICES 217-Like HCBS Group, At Risk Demonstration Group and CHOICES 1 and 2 Carryover Group.** The state assures that, for individuals receiving 1915(c) like services, under the post-eligibility process, the state must have a method to carve out / identify the cost of the 1915(c) like services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of the 1915(c) like services.

27. **Non-Payment of Patient Liability.** A provider (including an MCO) may decline to continue to provide services to an individual who fails to pay his or her patient liability. If an enrollee who has failed to pay patient liability is unable to find another provider or MCO who is willing to provide LTC services and supports, then the individual may be disenrolled from the CHOICES program. If the beneficiary's eligibility for TennCare is dependent on the receipt of long-term institutional care or HCBS through TennCare CHOICES, as would be the case if an enrollee is a member of the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group, such individual may be disenrolled from TennCare if he or she is no longer able to receive such services, unless he/she qualifies in another Medicaid category. The consequences for failing to pay patient liability must be clearly explained to members upon enrollment in CHOICES. Nothing herein shall prejudice any individual from fully exercising his or her rights to reapply for Medicaid coverage.

## V. BENEFITS

**28. TennCare Benefits.** With the implementation of the CHOICES program, TennCare covers physical, behavioral, and long-term care benefits provided through managed care delivery systems.

a. All mandatory and optional Medicaid state plan eligible adults aged 21 or older, , are enrolled in TennCare Medicaid, and receive all services covered under Tennessee's state plan according to the limitations specified in the state plan, including the services identified in paragraph 30 *(Medicaid Benefits Carved Out Of The TennCare II Demonstration)* as appropriate. Additional TennCare benefits are provided as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)*.

b. Members of the Choices 217-Like HCBS Group, the At Risk Demonstration Group or the CHOICES 1 and 2 Carryover Group, all of which are demonstration-only groups, are enrolled in TennCare Standard, but receive all benefits described in (a) above. In addition, individuals in the CHOICES 217-Like HCBS Group are members of CHOICES 2 and members of the At Risk Demonstration Group are members of Interim CHOICES 3.

c. Demonstration-only eligible adults who are members of the Standard Spend Down population (see paragraph 21(a) *Standard Spend Down (SSD) – Adult Non-State Plan Demonstration Population Category*) are enrolled in TennCare Standard and receive all state plan services, plus additional TennCare benefits as specified in Table 2a and paragraph 29 *(Cost-Effective Alternatives)* as appropriate, except that they do not have access to the services discussed in Table 2b or Table 3. Medicare Parts A and B premiums and Medicare co-payments and deductibles are covered in accordance with paragraphs 30(b) and (c).

d. All mandatory and optional Medicaid state plan eligible children younger than 21 years old enrolled in TennCare Medicaid receive all state plan and EPSDT covered services.

e. The demonstration-only eligible children enrolled in TennCare Standard receive the same benefits as the state plan eligible children enrolled in TennCare Medicaid, except as specified in paragraph 30 *(Medicaid Benefits Carved Out Of The TennCare II Demonstration)*.

f. The Medicaid state plan mandatory and optional eligibility categories for poverty level pregnant or postpartum women receive all TennCare Medicaid benefits, because the state considers that all of these services are pregnancy-related services.

g. The following table (Table 2a) lists benefits for TennCare Medicaid and TennCare Standard adults aged 21 and older that are different from those identified in the state plan. All benefits are limited by medical necessity as defined by the state. "State Plan Coverage for Adults" is provided for informational purposes only, and does not supersede the approved Medicaid state plan. CMS will issue an updated version of Table 2a in the event that future SPAs cause the Medicaid state plan to be in conflict with what appears in Table 2a.

**Table 2a—TennCare Medicaid and TennCare Standard Benefits for Adults Aged 21 and Older That Are Different Than State Plan Covered Services and Limitations**

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Diagnostic services not included in other service categories | Covered as medically necessary. | Not covered. |
| Home health | Covered as medically necessary, and in accordance with the definitions and limitations included in Attachment B. | Coverage limited to 60 visits per enrollee per state fiscal year. |
| Hospice care | Covered as medically necessary. | Coverage limited to 210 days per enrollee per state fiscal year. |
| Inpatient and outpatient substance abuse services | Covered as medically necessary | Not covered. |
| Inpatient hospital services | Covered as medically necessary. | Coverage limited to 43 days for heart transplants, 67 days for liver transplants, and 40 days for bone marrow transplants, per enrollee, per state fiscal year. |
| Lab and X-ray services | Covered as medically necessary. | Coverage limited to 30 occasions per enrollee per state fiscal year. |
| Medicare premiums and cost-sharing | • Covered for state plan eligibles, SSD enrollees members of the CHOICES 217-Like HCBS Group, and members of the At Risk Demonstration Group, in accordance with paragraphs 30(b) and 30(c). | Covered for Medicare beneficiaries who are dually eligible for Medicaid according to their classification under the state plan (QMB, SLMB, Other Medicaid/Medicare Duals, etc.) |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Mental health case management services | Covered as medically necessary. | Coverage limited to Targeted Case Management for persons who are Severely and/or Persistently Mentally Ill. |
| Occupational therapy | Covered as medically necessary. | Not covered. |
| Organ and tissue transplants | Covered as medically necessary, except that experimental or investigational transplants are not covered. | Coverage limited to renal, heart, liver, corneal, and bone marrow transplants. |
| Outpatient hospital services | Covered as medically necessary. | Coverage limited to 30 visits per enrollee per fiscal year. |
| Outpatient rehabilitation services | Covered as medically necessary. | Coverage limited to mental health services provided by Community Mental Health Agencies. |
| Pharmacy services | • Covered for state plan eligibles in accordance with the state plan.<br>• Covered for non-dual SSD eligibles and non-dual At Risk Demonstration Group members, with the co-payments specified in Table 6 of paragraph 34 *(Co-Payments)*.<br>• Covered for CHOICES 217-Like HCBS Group enrollees in accordance with the state plan for Medicaid enrollees. | Coverage as specified in state plan. |
| Physical therapy services | Covered as medically necessary. | Not covered. |
| Physicians' services (including medical and surgical services furnished by a dentist) | Outpatient services: Covered as medically necessary.<br><br>Inpatient services: Covered as medically necessary. | Outpatient services: Coverage limited to 24 outpatient office visits per year, which includes 2 office visits for podiatrists and 4 office visits for optometrists.<br><br>Inpatient services: Coverage limited to 20 visits per enrollee per state fiscal year for services other than heart, liver, and bone |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| | | marrow transplants, which are limited to 43, 67, and 40 days, respectively. |
| Preventive services | Covered as medically necessary. | Not covered. |
| Private duty nursing services | Covered when medically necessary to support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Definitions and limitations applicable to this service are contained in Attachment C. | Not covered. |
| Psychiatric residential treatment services (outside of an IMD) | Covered as medically necessary. | Not covered. |
| Screening services | Covered as medically necessary. | Not covered. |
| Speech, hearing, and language services | Covered as medically necessary. | Not covered. |
| Vision services | Covered for the first pair of cataract glasses following cataract surgery. | Not covered. |

h. The following table (Table 2b) lists HCBS benefits for TennCare Medicaid enrollees and CHOICES demonstration eligibles who are enrolled in the designated CHOICES groups (specified in paragraph 32(a) *Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition, the following rules apply to the CHOICES benefit.

i. The cost of medical assistance provided to an eligible participant in CHOICES 2 is limited to the amount calculated in the individual cost-neutrality test used in section 1915(c) waivers as set forth in section 1915(c)(4)(A). The state may delegate implementation of the cost neutrality test to the MCOs.

ii. For purposes of determining capitation rates, the cost of room and board, as defined in Attachment D, is not included in non-institutional care costs.

iii. For persons in CHOICES 3 or Interim CHOICES 3, in addition to the service limits stated in Table 2b, the total cost of the HCBS identified in Table 2b shall not exceed $15,000 per calendar year, excluding the cost of minor home modifications.

iv. Definitions for CHOICES benefits are provided in Attachment D of these STCs.

**Table 2b Benefits for Persons Enrolled in the CHOICES Program**

| **Benefit** (Definitions provided in Attachment D) | **CHOICES 1** | **CHOICES 2** | **CHOICES 3*** |
|---|---|---|---|
| Nursing facility care | X | Short-term only | Short-term only |
| Community-based residential alternatives | | X | |
| Personal care visits (up to 2 visits per day) | | X | X |
| Attendant care (up to 1080 hours per calendar year) | | X | X |
| Homemaker services (up to 3 visits per week) | | X | X |
| Home-delivered meals (up to 1 meal per day) | | X | X |
| Personal Emergency Response Systems | | X | X |
| Adult day care (up to 2080 hours per calendar year) | | X | X |
| In-home respite care (up to 216 hours per calendar year) | | X | X |
| In-patient respite care (up to 9 days per calendar year) | | X | X |
| Assistive technology (up to $900 per calendar year) | | X | X |
| Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) | | X | X |
| Pest control (up to 9 units per calendar year) | | X | X |

*Subject to the limitations in 30(h)(iii).

**29. Cost-Effective Alternatives.** TennCare MCOs and TennCare Select may provide services not listed in, or exceeding the individual service limits in, the Medicaid state plan or paragraph 28 (*TennCare Benefits*) of these STCs as allowed under their contracts with the TennCare program. Provision of these services is at the sole discretion of the MCO and TennCare Select. Capitation for the MCOs must be certified as actuarially sound (in accord with 42 CFR section 438.6), and comply with the Federal managed care regulations at 42 CFR 438 et seq. TennCare Select must demonstrate to the state that a service not listed as covered in the Medicaid state plan or in paragraph 28 (TennCare Benefits) is a cost-effective alternative, in order for the state to reimburse TennCare Select for the service. The state must demonstrate to CMS annually as part of the annual report described in paragraph 45 (*Annual Report*) that utilization of these services by the MCOs and TennCare Select is cost-effective and is reimbursed in compliance with the Federal managed care regulations at 42 CFR 438 et seq. Under the CHOICES program,

cost-effective alternatives may include a Transition Allowance, as defined in Attachment D.

**30. Medicaid Benefits Carved Out Of the TennCare II Demonstration.**

a. **"Base" Medicaid State plan services.** Base services are services carved out of TennCare II, and are provided, in accordance with the provisions of the Medicaid state plan, only to the mandatory and optional state plan eligibles, members of the CHOICES 217-Like HCBS Group, and members of Interim CHOICES 3. The other TennCare II demonstration-only populations, which are eligible through the demonstration's expenditure authorities and enrolled in TennCare Standard, are not eligible for any of the services listed in Table 3. Expenditures for these "Base" services are not demonstration expenditures (see paragraph 50(a) *Tracking Expenditures*), are not included in the demonstration's budget neutrality, and should, therefore, be reported on the "Base" reporting schedules of the Form CMS-64 reports (or in the case of 1915(c) waiver services, the appropriate 1915(c) waiver schedule). Some carved out services were carved in as of the initial implementation of CHOICES (i.e., March 1, 2010), however, as indicated in Table 3, and must from that point forward be reported as TennCare II demonstration expenditures.

**Table 3: Base Services**

| **Services Carved Out of TennCare II** | |
|---|---|
| Nursing facility services | Services |
| Services in an intermediate care facility for individuals with intellectual disabilities (ID) | Base |
| State Plan targeted case management services | Base |
| Program of All Inclusive Care for the Elderly (PACE) | Base |
| Services covered by the home and community-based services waiver for individuals with intellectual disabilities under 1915(c) of the Social Security Act. | Base |
| Services covered through the state's agreement under Title V of the Social Security Act | Base |

b. Medicare Parts A and B Buy-In Premiums: Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration

Group, Standard Spend Down group, the CHOICES 1 and 2 Carryover Group and the PACE Carryover Group, but not described in section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare Buy-In premiums are covered for dually eligible Medicaid state plan eligibles as permitted in section 1902(a)(10)(E) of the Act and 42 CFR 431.625, for all dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals), dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals), and for all dually eligible members of the Standard Spend Down group (QMBs/SLMBs and Demo Duals) and CHOICES 1 and 2 Carryover Group and PACE Carryover Group.

ii. Medicare premiums paid on behalf of Demo Duals are demonstration expenditures, and must be reported on an appropriate Form CMS-64.9 or 9p Waiver, as described in paragraph 50(e).

iii. Medicare premium payments for other beneficiaries are excluded from TennCare II and must be reported as "Base" Medicaid expenditures on the CMS-64 reports.

iv. Records in CMS's Master Billing Record for Demo Duals and all buy-in transactions for Demo Duals must be identified using a specific Buy-In Eligibility Code (BIEC) value as agreed upon between the state and the Project Officer.

c. Medicare Co-payments and Deductibles (i.e., Medicare crossover claims): Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, At Risk Demonstration Group, CHOICES 1 and 2 Carryover Group, the PACE Carryover Group or Standard Spend Down group, but not described in section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare crossover claims are covered for dually eligible Medicaid state plan eligibles, CHOICES 217-Like HCBS Group, At Risk Demonstration Group (QMBs/SLMBs and Demo Duals), CHOICES 1 and 2 Carryover Group, PACE Carryover Group and for Standard Spend Down enrollees (QMBs/SLMBs and Demo Duals). The SSD population, the CHOICES 217-Like HCBS Group, and the At Risk Demonstration Group are the only demonstration populations for whom the state pays Medicare cost-sharing.

ii. For TennCare Medicaid enrollees, members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals), and members of the At Risk Demonstration Group who are dually eligible for Medicare, these expenditures are not demonstration expenditures and are not included in

the budget neutrality calculations, so report these as "Base" Medicaid expenditures on the CMS-64 reports.

iii. For dually eligible SSD enrollees (QMBs/SLMBs and Demo Duals), these expenditures are included as demonstration expenditures that are subject to budget neutrality, so report these demonstration expenditures as "EG6E Expan Adult" on the CMS-64 reports. Medicare cost-sharing for SSD dual eligibles is covered in the same manner as Medicare cost-sharing would be covered for Medically Needy aged, blind, or disabled individuals and caretaker relatives, had these groups been included in the Medicaid state plan.

**31. Additional Provisions Related to Institutions for Mental Diseases (**IMDs). Expenditures for services rendered to TennCare II enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.

## VI. CHOICES ENROLLMENT

### 32. Operations of the TennCare CHOICES Program.

a. **Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group.** The CHOICES Program provides long-term care benefits as identified in Table 2b to three groups of people, as defined below:

i. **CHOICES 1.** This group consists of persons who are receiving Medicaid-reimbursed care in a Nursing Facility (NF).

ii. **CHOICES 2.** Persons age 65 and older and adults age 21 and older with physical disabilities who meet the NF level of care (LOC), who qualify either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to NF care. The demonstration population includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for persons who are elderly and/or physically disabled.

iii. **CHOICES 3.** Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles, who do not meet the NF LOC, but who, in the absence of HCBS, are "at risk" for institutionalization, as defined by the state.

iv. **Interim CHOICES 3.**
Elderly adults and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of the At Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012.

b. **Eligibility for TennCare CHOICES Benefits.** Individuals can be eligible for one of the four TennCare CHOICES groups defined in (a) above depending upon their medical and / or functional needs, their TennCare eligibility group, and the ability of the state to provide them with safe, appropriate, and cost-effective LTC services.

i. Medical and / or functional needs are assessed according to LOC criteria published by the state in state rules. There will be one set of LOC criteria for NF care, which will be used in assessing eligibility for CHOICES 1 and CHOICES 2. The state opened enrollment in CHOICES 3, which will be subject to a separate set of criteria to determine the "At-Risk" population. For the purposes of redetermining whether a recipient of NF services (CHOICES 1) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial LOC determination for that individual at the time of enrollment into CHOICES 1. For the purposes of determining whether a recipient of HCBS for

elderly and disabled (CHOICES 2) continues to require the LOC provided in a NF, the state must use criteria consistent with those used to make the initial level of care determination for that individual at the time of HCBS enrollment, or for persons transitioning from a NF, at the time of enrollment into CHOICES 1. For purposes of enrollment into CHOICES 1, the state may grant an exception for persons in the community who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely be met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of initial enrollment into CHOICES 1 when such person has transitioned to the community and requires readmission to the NF.

ii. Financial eligibility:

(A) Financial eligibility for CHOICES 1 is established according to the Medicaid state plan.

(B) In order to be financially eligible for CHOICES 2, an individual must be eligible for TennCare as an SSI recipient or meet the criteria for the CHOICES 217-Like HCBS Group, individuals who qualify under institutional income and resource rules, and who are receiving home and community-based services and would be eligible in the same manner as specified under 42 CFR 435.217, 435.726, and 435.236 of the Federal regulations and section 1924 of the Act, if the home and community based services were provided under a 1915(c) waiver.

(C) In order to be financially eligible for CHOICES 3, an individual must be eligible for TennCare as an SSI recipient.

(D) In order to be financially eligible for Interim CHOICES 3, an individual must be eligible for TennCare as an SSI recipient or as a member of the At Risk Demonstration Group. Members of the At Risk Demonstration Group must meet institutional income and resource criteria.

iii**.** The state's ability to provide applicants with appropriate home and community based services is determined by the availability of slots under an established enrollment target (see paragraph 32(e) *Enrollment Targets for TennCare CHOICES*) and, for persons in CHOICES 2, the determination by the MCO that the individual can be served appropriately at a cost that does not exceed the cost neutrality test (see paragraph 28(h)(i) *TennCare Benefits*), and for persons in CHOICES 3 and Interim CHOICES 3, the determination by the MCO that the cost of HCBS will

not exceed the limit in paragraph 28(h)(iii) (*TennCare Benefits***)**. There is no enrollment target for Interim CHOICES 3.

c. **Enrollment in TennCare CHOICES.** The effective date of enrollment in TennCare CHOICES must be established by the state based on a determination that an applicant is eligible for and must begin receiving LTC services. Enrollment procedures differ depending upon whether or not the person is already enrolled in TennCare Medicaid.

i. **Persons Not Already Enrolled in TennCare.** Persons not already enrolled in TennCare who wish to enroll in TennCare CHOICES must enroll through the State's Single Point of Entry (SPOE). The SPOE must provide counseling and assistance in evaluating long-term care options, screening and intake for long-term care programs offered by the state (TennCare CHOICES as well as other programs), assistance in evaluating the individual's functional LOC for LTC, and facilitation of Medicaid eligibility determination by the state.

(A) Individuals who are determined to be both medically and financially eligible for NF placement will always be allowed to receive TennCare CHOICES services in a NF as members of CHOICES 1, if they choose.

(B) Those individuals, who meet the criteria for CHOICES 2 and, subject to the limitations set out in these STCs, will be allowed to choose HCBS as an alternative to NF placement if the determination is made that the individual can be served appropriately in CHOICES 2 at a cost that does not exceed the cost neutrality test (see paragraph 28(h)(i) *TennCare Benefits*).

ii. **Persons Already Enrolled in TennCare.**

(A) **Nursing Facility Residents.** MCOs will conduct an assessment of NF residents who wish to move to HCBS to determine if they can be served appropriately in the community at a cost that does not exceed the cost neutrality test set forth in Section 1915(c)(4)(A), as individually applied. Even if an enrollment target has been reached for CHOICES 2, an MCO may transition persons from CHOICES 1 to CHOICES 2 in accord with subparagraph 32(e)(iii)(C) *(Transition from CHOICES 1 to CHOICES 2)*.

(B) TennCare enrollees who are not already participating in CHOICES may request enrollment in CHOICES through their MCOs, or they may be identified through other mechanisms that would trigger an

assessment of their need for LTC by the MCO. The MCO will provide counseling and assistance in evaluating long-term care options, and assistance in evaluating the individual's functional LOC eligibility for LTC. The functional LOC determination for LTC will be made by the Bureau of TennCare, using criteria published in state rules. Once individuals have established LOC and financial eligibility for LTC, they can be enrolled in CHOICES in accordance with paragraph 32(e) *(Enrollment Targets for TennCare CHOICES*).

e. **Enrollment Targets for TennCare CHOICES.** The state may establish enrollment targets for CHOICES 2 and CHOICES 3. (There will be no enrollment target for CHOICES 1 or Interim CHOICES 3.) The purpose of the targets is to permit the CHOICES program to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available state and Federal resources. Information on enrollment for each 1915(c) and CHOICES Groups targets and enrollment numbers must be supplied to CMS in the Quarterly Progress Report as set forth in paragraphs 44 *(Quarterly Progress Reports),* 48 *(Enrollment Reporting)* and Attachment A.

i. The state may establish an enrollment target for CHOICES 2, consistent with the upper and lower limits shown in the table below; with the actual target number to be published in state rules. The state may adjust the target as appropriate from time to time upon notification to CMS at least 30 days prior to the desired effective date of the change. Except as set forth in paragraph 32(e)(ii) *(Enrollment Targets for TennCare CHOICES),* an increase in the enrollment target above the upper limit appropriate to the DY or a decrease below the lower limit will require an approved waiver amendment prior to implementation.

**Table 4 – Enrollment Targets for Demonstration Years 12 Through 14**

| Demonstration Year | Lower Limit | Upper Limit |
|---|---|---|
| DY 12 | 12,000 | 16,000 |
| DY 13 | 13,500 | 17,500 |
| DY 14 | 15,000 | 18,500 |

ii. The state may also establish an enrollment target for CHOICES 3, if this group is established after a change in the level of care criteria. At a minimum, this target will be set at 10% of the enrollment target for CHOICES 2. In the event that there is not a change in the level of care that would warrant opening CHOICES 3, the state may at its discretion exceed the maximum enrollment target described in paragraph 32(e)(i) *(Enrollment Targets for TennCare CHOICES)* for CHOICES 2 by 10%. There will be no enrollment target for Interim CHOICES 3.

iii. If the enrollment target established by the state for CHOICES 2 or CHOICES 3 is reached or exceeded, the state shall not enroll additional persons in CHOICES 2 or CHOICES 3, except as indicated below. The state may also establish a waiting list for CHOICES, subject to the following:

(A) **Reserve Capacity.** The state may reserve slots in CHOICES 2 for individuals being discharged from a NF and for individuals being discharged from an acute care setting who are in imminent risk of being placed in a nursing facility setting absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved must be included as an attachment to the Annual Report (see paragraph 45). The state may establish additional criteria or modify procedures for allocating reserve slots upon 30 day advance written notification to CMS; the operational procedure documents included as attachments to subsequent Annual Reports must reflect any such changes. In each Quarterly Progress Report, the state must provide an accounting of their management of the reserve capacity, including a summary (as of the last day of the quarter) that states the total enrollment target for CHOICES 2 and 3, the number enrolled in each CHOICES group, and the numbers of slots being held in reserve for various purposes.

(B) **HCBS as a Cost-Effective Alternative.** An MCO with a TennCare enrollee who meets the criteria for CHOICES 2, but who cannot enroll the individual in CHOICES 2 because the enrollment target for CHOICES 2 has been met, has the option, at its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care, in accordance with paragraph 29 *(Cost Effective Alternatives)*. (Consistent with paragraph 32(e)(iii)(C), this person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available). The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. The state may require the MCO to provide documentation of its cost-effective alternative determination and assurance of provider capacity to meet the member's needs prior to enrollment in CHOICES.

(C) **Transition from CHOICES 1 to CHOICES 2.** An enrollee being served in CHOICES 1 who meets the requirements to enroll in CHOICES 2 can enroll in CHOICES 2 at any time such a transition can be accomplished, even if an enrollment target for

CHOICES 2 has been reached. This person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.

f. **Waiting Lists for TennCare CHOICES.** The use of enrollment targets as described in paragraph 32(e) *(Enrollment Targets for TennCare CHOICES*) may mean that there will be waiting lists for CHOICES 2 and/or 3. (There will be no waiting list for CHOICES 1.) These lists must be managed on a statewide basis using a standardized assessment tool and in accord with criteria to be established by the state. Waiting list policies must be based on objective criteria and applied consistently in all geographic areas served. The state may use separate criteria for prioritization of services under CHOICES 2 and CHOICES 3, and may revise these upon notification to CMS. There shall not be any enrollment target or waiting list for the Interim CHOICES 3 Group.

g. **Consumer Direction.** CHOICES members who have been determined by a care coordinator, as a part of the needs assessment and plan of care processes, to require attendant care, personal care, homemaker, in-home respite services, companion care or other services specified by the state as eligible for consumer direction, will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e., consumer direction of HCBS). The state will notify CMS in advance of any changes to the list of services eligible for consumer direction. All CHOICES members requiring these services will be offered the option to participate in consumer direction of HCBS. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E.

h. **Miscellaneous Provisions Related to CHOICES Enrollment and Implementation**

i. The state will maintain an electronic visit verification system (as defined in Attachment D) as part of the quality program.

ii. The state must ensure that the Care Plan is considered part of the medical record of a CHOICES participant, subject to all associated requirements and protections, and available for review by the state upon request.

## VII. COST SHARING

### 33. Cost Sharing.

a. TennCare Medicaid enrollees under the state plan are subject to cost sharing for pharmacy services (see Table 6 below).

b. Demonstration-only eligible adults enrolled in the SSD category and the At Risk Demonstration Group are subject to cost sharing for pharmacy services (see Table 6 below).

c. TennCare Standard children are subject to cost sharing for both non-pharmacy services and pharmacy services (see Table 5 and Table 6).

d. Individuals participating in CHOICES 1 and CHOICES 2 are exempt from all cost sharing.

e. Individuals participating in CHOICES 3 and Interim CHOICES 3 are subject to cost sharing for pharmacy services, similar to other Medicaid state plan adult enrollees.

**34. Co-Payments.** For demonstration-only eligible children in TennCare Standard (title XXI Medicaid Expansion children and medically eligible title XIX children), co-payments are collected by the provider when services are rendered. The requirements at section 1916A of the Act and at 42 CFR 447.50, 57, 58, and 62 through 82 will apply to cost sharing for this group.

a. **Non-Pharmacy Co-pays.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children, the non-pharmacy co-pay amounts are presented in Table 5 (*TennCare Non-Pharmacy Co-Pays).*

**Table 5 - TennCare Non-Pharmacy Co-pays**

| Poverty Level | Co-payment Amounts |
|---|---|
| 0%-99% | $0.00 |
| 100% - 199% | $10.00 Hospital Emergency Room (waived if admitted)<br><br>$5.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$5.00 Physician Specialists (including Psychiatrists)<br><br>$5.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |
| 200% and above | $50.00 Hospital Emergency Room (waived if admitted)<br><br>$10.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care (The state may increase this amount to $15.00 upon completion of the compliance plan required in paragraph 37.)<br><br>$20.00 Physician Specialists (including Psychiatrists)<br><br>$100.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |

b. **Co-Pays on Pharmacy.** For demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children), and adults in the Standard Spend Down Demonstration Group, and persons in the At Risk Demonstration Group, co-pays on outpatient pharmacy services are presented in Table 6 (*Co-Pays on Pharmacy).*

**Table 6 –Co-Pays on Pharmacy**

| Demonstration Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| TennCare Standard under age 21 with incomes below 100% FPL | $0 | $0 |
| TennCare Standard under age 21 with incomes at or above 100% FPL | $3.00 | $0 |
| TennCare Standard aged 21 and older -- other than enrollees in the SSD program | Not applicable (outpatient pharmacy services are not covered for this group) | Not applicable (outpatient pharmacy services are not covered for this group) |
| TennCare Standard aged 21 and older -- SSD enrollees | $3.00 | $0 |
| CHOICES 1 and CHOICES 2 Participants | $0 | $0 |
| Interim CHOICES 3 | $3.00 | $0 |
| CHOICES 3 | $3.00 | $0 |

**35. Compliance of TennCare Standard Cost Sharing With Federal Regulations.** The state submitted a plan for ensuring that cost sharing for TennCare Standard complies with the statutory and regulatory requirements, including the implementation of an aggregate cost sharing cap as described in 42 CFR 447.78. The state will come into compliance by January 1, 2013.

## VIII. DELIVERY SYSTEMS

**36. Managed Care Entities.** TennCare II operates totally in a managed care environment and uses various types of managed care entities for delivering covered services to TennCare enrollees. The types of managed care entities used are listed in Table 7 below, with the reimbursement and rate-setting methodologies for each one. Title XXI Medicaid Expansion demonstration population children use the same delivery systems as other enrollees.

**Table 7– Types of Managed Care Entities**

| Type of Entity | BBA Definition | Description of Services Covered | Reimbursement and Rate-Setting Methodology |
|---|---|---|---|
| Managed Care Organizations (MCOs)—at full risk | MCO | All TennCare physical health, behavioral health, and long-term care services | MCO rates are actuarially certified by an independent third party actuary |
| TennCare Select—non-risk or partial risk | Prepaid Inpatient Health Plan (PIHP) | All TennCare physical health, behavioral health, and long-term care services for enrollees selected for participation in TennCare Select rather than enrolled in MCOs (see paragraph 40 *TennCare Select*) | Provider payment rates negotiated between the PIHP and providers; administrative fee, approved by CMS, paid to the PIHP |
| Dental Benefits Manager (DBM)—non-risk (may be renegotiated as at risk) | Prepaid Ambulatory Health Plan (PAHP) | Dental benefits for all TennCare enrollees with this coverage | Provider payment rates are established within DBM contract as approved by CMS; administrative fee, approved by CMS, is paid to the DBM |
| Pharmacy Benefits Manager (PBM)—non-risk (may be renegotiated as at risk) | PAHP | Pharmacy benefits for all TennCare enrollees with this coverage. | Provider payment rates are established in accordance with the state plan; administrative fee, approved by CMS, is paid to the PBM |

**37. Enrollment in Managed Care Organizations (MCOs).** With the exception of individuals enrolled in TennCare Select, all individuals eligible for TennCare (TennCare Medicaid or TennCare Standard), including those dually eligible for Medicare, shall be enrolled in a managed care organization providing the benefits described in paragraphs 28 *(TennCare Benefits)* and 29 *(Cost-Effective Alternatives)* of these STCs. In addition to the managed care organization, enrollees are enrolled with a Pharmacy Benefits Manager for covered pharmacy services and a Dental Benefits Manager for covered dental services. The Pharmacy Benefits Manager administers the pharmacy benefits program, using a preferred drug list that is established by the state (in consultation with a Pharmacy

Advisory Committee), taking into account the cost, therapeutic equivalency, and clinical efficacy in accordance with waiver authority.

**38. TennCare Select.** TennCare Select is a prepaid inpatient health plan (PIHP) (as defined in 42 CFR 438.2) which operates in all areas of the state and covers the same services as the MCOs. The state's TennCare Select contractor is reimbursed on a non-risk, non-capitated basis or a partial risk basis for services rendered to covered populations, and in addition receives fees from the state to offset administrative costs.

a. The TennCare Medicaid and TennCare Standard populations included in the TennCare Select delivery system and the services provided to these populations by the TennCare Select contractor are as follows:

i. Children who are eligible for Supplemental Security Income. TennCare Select provides medical case management and all MCO covered services.

ii. Children in state custody and children leaving state custody for 6 months post-custody as long as the child remains eligible. TennCare Select provides medical case management, all MCO covered services, and coordination with the Department of Children's Services (DCS) around medical and behavioral services.

iii. Children who are receiving care in a Nursing Facility or an Intermediate Care Facility for the Individuals with Intellectual Disabilities. For children and adults in a Home and Community Based Services 1915(c) waiver for individuals with intellectual disabilities, current enrollees may opt-in to receive services through TennCare Select, and new participants may opt-out of TennCare Select in order to receive services through another MCO. TennCare Select provides medical case management and all MCO covered services.

iv . Enrollees living in areas where there is insufficient capacity to service them. TennCare Select provides medical case management and all MCO covered services.

After being assigned to TennCare Select, persons in categories (i) and (iii) above may choose to disenroll from TennCare Select and enroll in an MCO if one is available. Persons in categories (ii) and (iv) must remain in TennCare Select. The state must request a demonstration amendment (as described in paragraphs 6 and 7 regarding amendments) in order to change the list of populations included in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

b. TennCare Select also provides the following functions:

i. It is the back-up plan should one of the MCOs have to leave the TennCare program unexpectedly. For TennCare enrollees previously enrolled with

the MCO, TennCare Select provides medical case management and all MCO covered services.

ii. It is the only entity responsible for payment of the services described in 42 CFR 431.52 (services provided to residents temporarily absent from the state), and provides all MCO covered services (primarily emergency services).

iii. It is also the only entity responsible for payment of the services described in 42 CFR 440.255 (emergency services for aliens), and is responsible for payment of emergency medical services only. TennCare Select is paid an administrative fee for processing these claims.

**39. Plan Enrollment and Disenrollment.** The state maintains a managed care enrollment and disenrollment process that must comply with 42 CFR Part 438, except that, in accordance with waiver authority, TennCare participants have 45 days in which to disenroll from an MCO without cause. After 45 days, a participant may disenroll from an MCO only for cause, as set forth in 42 CFR 438.56(d)(2). The "other reasons" that will be considered cause under 42 CFR 438.56(d)(2)(iv) do not include the following:

- The enrollee is unhappy with the current plan or primary care provider (PCP), but there is no hardship medical situation (as defined by the state);
- The enrollee claims lack of access to services but the plan meets the state's access standards;
- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- The enrollee is concerned that a current provider might drop out of the plan in the future; and
- The enrollee is a Medicare recipient who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation.
- The enrollee's Primary Care Provider (PCP) is no longer in the MCO's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO.

In the event that a CHOICES member is determined, based on an assessment of needs, to require a long term services and supports that is not currently available under the MCO in which he is currently enrolled, but that is available through another MCO, the state shall work with the current MCO to arrange for the provision of the required services, which may involve providing such services out-of-network. It shall be considered to be cause for disenrollment only if the current MCO, after working with the state, is unable to provide the required services. In such cases, the MCO that is unable to provide the required services after working with the state may be subject to sanctions.

**40. Contracts.** The following subparagraphs provide additional requirements pertaining to contracts awarded by the state for the provision of health care services under TennCare II.

a. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation.

b. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

c. With respect to CHOICES, the state will establish minimum guidelines regarding the person-centered service plan, the processes for the development of the plan, and the monitoring of its implementation. These expectations must be reflected in the MCO contract. The state must submit a draft of the contract requirements related to the subjects enumerated below to CMS for review prior to executing a contract amendment with an MCO. CMS will respond within 15 working days of receipt of the draft. The required subject areas are as follows:

i. The individuals who develop the person-centered service plan (and their requisite qualifications);

ii. The individuals who are expected to participate in the plan development process;

iii. Timing of the plan, how and when it is updated, including mechanisms to address changing circumstances and needs (and expectations regarding scheduling and location of meetings to accommodate individuals receiving services);

iv. Types of assessments that are conducted as a part of the service plan development process;

v. How participants are informed of the services available to them;

vi. How the process ensures that the service plan addresses the participants' desired outcomes, needs and preferences;

vii. The plans' responsibilities for implementing and monitoring the plan of care.

d. The state will require the MCOs to develop and maintain emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. These contingency plans will be available for inspection by state officials upon request.

e. The state will monitor loss ratios of the managed care plans.

## IX. GENERAL REPORTING REQUIREMENTS

**41. General Financial Requirements.** The state shall comply with all general financial requirements under title XIX and title XXI set forth in these STCs.

**42. Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request.

**44. Additional Reporting Requirements.**

a. **Compliance with Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR 438 *et seq.*

b. **Compliance with Specified HCBS Requirements.** The following regulations, which govern the provision of HCBS under section 1915(c) waivers, shall apply to the HCBS program authorized under section 1115 and provided through CHOICES:

- 42 CFR 440.180(a);
- 42 CFR 441.302;
  (a),
  (c) (insofar as it relates to NF level of care, and applying only to CHOICES 2),
  (d) (consistent with a waiver of section 1902(a)(23) of the Act),
  (g) (applies only to CHOICES 2), and
  (j);
- 42 CFR 441.303
  (a),
  (c) (except that the requirements following the semi-colon in (c)(2) do not apply to CHOICES 3 or Interim CHOICES 3),
  (d) (consistent with Table 2b, paragraph 28), and
  (e); and
- 42 CFR 441.310.

Any conflict between the regulations listed in this subparagraph and these STCs shall be resolved in favor of the STCs. The state shall include a description of the steps taken to ensure compliance with these regulations as part of the Annual Report discussed in paragraph 45.

c. **Quality Improvement Strategy for the CHOICES Program.** The state must submit to CMS an integrated quality improvement (QI) strategy which builds on existing managed care quality requirements as defined in 42 CFR 438, Subpart E, and incorporates applicable 1915(c) Home and Community-Based Services

waiver regulatory assurances as discussed in paragraph 45(b).

The state must identify: 1) measures of process, health outcomes, functional status, quality of life, member choice, autonomy, satisfaction, and TennCare and CHOICES system performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

The MCOs must be required to establish methods for discovery, remediation and systems improvement and, per state prescribed timeframes, regularly report on outcomes associated with continuous quality improvements.

The state must clearly demonstrate its oversight of the process.

The QI strategy must be submitted to CMS for approval prior to implementation.

No less frequently than annually, the state must provide to CMS information regarding QI activities which must include evidence regarding system performance based on identified objectives and measures, and which demonstrates efficacy in implementing the quality strategy, including but not limited to external quality review, discovery, remediation and systems improvement activities.

i. **CHOICES Data.** The state will collect and submit data to CMS, including the following data elements:

(A) Numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services at a point in time,

(B) Unduplicated numbers of persons receiving HCBS and unduplicated numbers of persons receiving NF services during a 12 month period,

(C) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period,

(D) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period as a percentage of total long-term care expenditures (excluding expenditures on the population of persons with intellectual disabilities),

(E) Average per person HCBS expenditures and NF expenditures on the elderly and disabled populations during a 12 month period,

(F) Average length of stay in HCBS during a 12 month period,

(G) Percent of new long-term care recipients admitted to NF during a 12 month period,

(H) Average length of stay in NFs during a 12 month period,

(I) Number of persons transitioned from NFs to HCBS during a 12 month period.

"Point in time" refers to June 30 of each year.

ii. **Electronic Collection of Choices Data.** The systems must be in place to record the requisite data elements for the CHOICES Program.

iii. **CHOICES Data Reporting.** The state must report to CMS, in the Quarterly and Annual Progress Reports, on data and trends of the designated CHOICES data elements.

e. **Requirements Related to the Affordable Care Act.** Subparagraphs (i) and (ii) describe elements that must be included in an extension proposal or phase-out plan, as discussed in paragraph 8 and paragraph 9.

i. **Affordable Care Act Transition Plan for Extension.** The extension proposal must include a Transition Plan consistent with the provisions of the Affordable Care Act and CMS regulations for any individuals enrolled in Demonstration Eligible Groups (as defined in paragraph 17, Table 1a) who will be eligible for coverage under the state plan as of January 1, 2014, including under the new Medicaid eligibility group identified in Section 1902(a)(10)(A)(i)(VIII) of the Act, or who elect to move to an Exchange plan. Persons who are demonstration eligibles at the time of transition will continue to receive demonstration benefits as long as they are enrolled in a Medicaid category and they continue to meet the criteria for their particular demonstration program. The Transition Plan will include procedures for ensuring that these individuals transition to their new eligibility status without interruption in coverage to the maximum extent possible.

ii. **Demonstration Phase-Out and Affordable Care Act Transition.** As part of a phase-out plan submitted under paragraph 9, the state must include a plan for using information already in its possession on members of Demonstration Eligible Groups to make advance determinations of eligibility for TennCare under its Medicaid state plan on January 1, 2014, consistent with guidance to be issued by CMS.

**43.** **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated

developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the state's progress on enrolling individuals into the TennCare Standard Spend Down Demonstration Group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

**44. Quarterly Progress Reports.** The state must submit progress reports in the format outlined below (see also Attachment A), no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. An updated CHIP allotment neutrality monitoring spreadsheet, if necessary;

c. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; progress on implementation and/or enrollment progress of the TennCare Standard Spend Down Demonstration Group; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the demonstration; pertinent legislative or litigation activity; and other operational issues;

d. Action plans for addressing any policy, administrative, or budget issues identified;

e. Quarterly enrollment reports for Demonstration eligibles that include the member months for each demonstration population;

f. Quarterly enrollment reports for individuals that would otherwise be eligible for Interim CHOICES 3 but meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual;

g. Evaluation activities and interim findings; and

h. Other reports as indicated in these STCs.

**45. Annual Report.** The state shall submit a draft annual report documenting

accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The state shall also submit the title XXI annual state report for its Medicaid Expansion children in the demonstration, by December 31 of each year.

**46.** **Beneficiary Survey.** The state shall conduct a beneficiary survey each demonstration year for a statistically valid sample of all TennCare enrollees. The survey shall measure satisfaction, enrollee efforts to secure out-of-network care, average waiting time for physician office visits, and enrollee efforts to change plans, along with reasons for requesting plan changes. Results of the survey must be provided to CMS by September after the end of in each demonstration year e.g. survey results for demonstration year 12 is due no later than September 30, 2014..

**47.** **Final Evaluation Report.** The state shall submit a Final Evaluation Report pursuant to the requirements of section 1115 of the Act and as specified in Section XII of these STCs.

**48. Enrollment Reporting.**

a. Each quarter the state will provide CMS with an enrollment report for the title XXI Medicaid Expansion demonstration population and for title XIX Medicaid children, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the state into the Statistical Enrollment Data System (SEDS) within 30 days after the end of each quarter. SEDS reporting is required for any title XXI-funded population, including Medicaid Expansions, and is also required for title XIX Medicaid child enrollment.

b. Enrollment reporting in the Quarterly and Annual Reports (see paragraphs 44 *Quarterly Progress Reports* and 45 *Annual Report*) is required by Eligibility Group (EG) and Type for the TennCare title XIX and XXI state plan and demonstration populations.

## X. GENERAL FINANCIAL REQUIREMENTS

**49.** **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period and pool payments and certified public expenditures made for the demonstration period. CMS shall provide Federal financial participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section X of these Terms and Conditions.

**50.** **Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Tennessee must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and section 2115 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which capitation payments were made. For this purpose, demonstration year 1 (DY 1) is defined as the year beginning July 1, 2002, and ending June 30, 2003. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures should be reported on Forms CMS-64.9 Base/64.9P Base.

Expenditures for Medicaid Expansion children claimed under the authority of title XXI of the Act shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

b. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by demonstration Year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the eligibility groups (EGs) from which collections were made (see paragraph 52 *Assignment of Expenditures and Member Months to EGs*). In the calculation of expenditures subject to the budget neutrality expenditure limit,

premium collections applicable to demonstration populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the state Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver or 64.9P Waiver schedules, and allocated to forms named for the different EGs described in (e)(1) through (e)(8) below as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to demonstration populations shall be offset against expenditures.

e. **Use of Forms**. The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration and title XIX expenditures made in other payment categories as follows. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system. The terms "EG1" through "EG12" refer to the demonstration Eligibility Groups defined in paragraph 52 *(Assignment of Expenditures and Member Months to EGs)* of these STCs.

(1) "EG1 Disabled" expenditures (see paragraph 52(a)(ii) and (b)(iv))

(2) "EG2 Over 65" expenditures (see paragraph 52(a)(iv) and (b)(vi))

(3) "EG3 Children" expenditures (see paragraph 52(a)(iii) and (b)(v))

(4) "EG4 Adults" expenditures (see paragraph 52(a)(v) and (b)(vii))

(5) "EG5 Duals" expenditures (see paragraph 52(a)(i))

(6) "EG6E Expan Adult" expenditures (see paragraph 52(b)(i)(A))

(7) "EG7E Expan Child" expenditures (see paragraph 52(b)(i)(B))

(8) "EG8 Med Exp Child" expenditures (see paragraph 52(b)(ii))

(9) "EG9 H-Disabled" expenditures (see paragraph 52(a)(ii) and (b)(iv))

(10) "EG10 H-Over 65" expenditures (see paragraph 52(a)(iv) and (b)(vi))

(11) "EG11 H-Duals" expenditures (see paragraph 52(b)(iii))

(12) "CAH Pool" (Critical Access Hospital Pool) (see paragraph 54f)

(12) "EAH Pool" (Essential Access Hospital Pool) (see paragraph 54e)

(13) "Meharry Pool" (see paragraph 54g)

(14) "GME" (Graduate Medical Education) (see paragraph 54d)

(15) "CPE" (Certified Public Expenditures) for Unreimbursed Public Hospital Costs Pool (see paragraph 54h)

(16) "DSH" (Disproportionate Share Hospital Payments) (see paragraph 54i)

(17) "UHC Pool" (Unreimbursed Hospital Cost Pool) (see paragraph 54k)

(18) "PHSP Pool" (Public Hospital Supplemental Payment Pool) (see paragraph 54l)

(19) "EG12E Carryover" expenditures (see paragraph 52(b)(i)(C)).

f. **Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population.**

(1) **Expenditures Subject to the Allotment Neutrality Limit.** The state will be subject to a limit on the amount of Federal title XXI funding that the state may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including available reallocated funds published in the *Federal Register*. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of demonstration until the next allotment becomes available.

(2) The state is eligible to receive title XXI funds for expenditures for TennCare Medicaid Expansion children described on the last row of Table 1a in Section IV, paragraph 17 *(Eligibility)*, up to the amount of its title XXI allotment. Waiver expenditures for these children under title XXI must be reported as a Medicaid expansion population on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver, in accordance with the instructions in section 2115 of the State Medicaid Manual, under waiver name "Med Exp Child," identified by the demonstration project number

assigned by CMS, including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which capitation payments were made. They are reported in Column C for the enhanced match under title XXI.

(3) If the state exhausts its title XXI allotment, title XIX funds are available for title XXI children in this demonstration. To access this funding, the state must submit for approval a written request to CMS, referencing this STC, to access title XIX funds for the title XXI Medicaid Expansion Demonstration Group. This request must be submitted at least 90 days prior to the date on which the state anticipates their title XXI allotment will be exhausted, and must include:

(A) An updated budget neutrality assessment that adds Medicaid Expansion children to budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that removes Medicaid Expansion children.

(4) Once the title XXI allotment is again available, the state will claim title XXI funding for the title XXI children in this demonstration. To access this funding, the state shall submit for approval a written request to CMS, referencing this STC, to access title XXI funds for the title XXI Medicaid Expansion Demonstration Group, which includes a request to update the STCs related to claiming. This formal request must be submitted prior to the change in funding source and include:

(A) An updated budget neutrality assessment that removes Medicaid Expansion children from budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that adds Medicaid Expansion children.

(5) During periods in which the state is claiming title XIX funds for Title XXI Medicaid Expansion demonstration population children, the member months attributable to this demonstration population will count toward calculation of the budget neutrality expenditure limit, using the per member per month (PMPM) amounts for "EG8 Med Exp Child." The expenditures will be considered expenditures subject to the budget neutrality expenditure limit, so that the state is not fully at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

g. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to:

(1) All TennCare title XIX expenditures on behalf of individuals who are enrolled in this demonstration (excluding the services specified in paragraph 30 *Medicaid Benefits Carved Out Of the TennCare II Demonstration*), including all service expenditures and applicable administrative costs (see subparagraph h, below) net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse), and

(2) All expenditures described in paragraph 54(d) through (i) *(Extent of Federal Financial Participation for the Demonstration)*.

All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver, with the exception of those described in h) below.

h. **Administrative Costs.** In general, administrative costs are not included in the budget neutrality expenditure limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. Administrative costs subject to budget neutrality (see below) must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, according to the EGs for which the expenditure was made (following the list in (e)(1) through (e)(8) above). Other administrative costs not subject to budget neutrality will not be broken out by EG, and will be reported under waiver name "TennCare II."

In accordance with Federal regulations at 42 CFR 438.812(b)(2), during the periods that services are provided in accordance with MCO, pharmacy benefit manager, or dental benefit manager non-risk contracts, the portion of the state's payments that is for reimbursement of the non-risk contractors' administrative services can only be claimed by the state as an administration cost at the Federal matching rates available for the costs of administration of the Medicaid program. The administrative services portion of the amounts paid by the state to compensate any non-risk contractors for their administration costs incurred in accordance with non-risk contracts are costs of the demonstration waiver that are subject to the budget neutrality expenditure limit explained in Section XI of these STCs.

i. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.

**51. Reporting Member Months.** The following describes the reporting of member months for TennCare Medicaid and TennCare Standard enrollees:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 44 *(Quarterly Progress Report)* of these STCs, the actual number of eligible member months for all TennCare Medicaid and TennCare Standard Eligibility Groups (EGs) defined in paragraph 52 *(Assignment of Expenditures and Member Months to EGs)*. The state must submit a statement accompanying the quarterly report, which recognizes the accuracy of this information. Member months should be reported only for individuals who are included in TennCare, as defined in paragraph 17 *(Eligibility)*. Persons for whom Medicaid only pays for services carved out of TennCare (as described in paragraph 30 *Medicaid Benefits Carved Out Of the TennCare II Demonstration*) are not enrolled in TennCare (e.g., QMBs, SLMBs).

b. A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for Type 1 and Type 2 eligibles (as defined in paragraph 63 *Eligibility Groups (EGs) Subject to Budget Neutrality Agreement*) are reported in section VIIIA of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for Type 3 demonstration expansion populations and for title XXI Medicaid Expansion demonstration eligibles are reported in section VIIIB of the template, and are not used to calculate the budget neutrality expenditure limit. Detailed instructions for

assigning member months to Types and to EGs are provided in paragraphs 52 *(Assignment of Expenditures and Member Months to EGs)* and 63 *(Eligibility Groups (EGs) Subject to Budget Neutrality Agreement)*.

c. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the state must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

d. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

e. The state will ensure that eligible member month totals reported to CMS for the TennCare II demonstration from July 1, 2002, forward conform to the EG definitions contained in paragraph 52 *(Assignment of Expenditures and Member Months to EGs)*.

**52. Assignment of Expenditures and Member Months to EGs:** The following rules govern the:

- Reporting of expenditures subject to the budget neutrality expenditure limit on separate waiver forms by EG, as described in paragraph 53(e) *(Reporting Expenditures in the Demonstration)* above, for the period beginning July 1, 2007, through the end of the TennCare II demonstration, and
- Reporting of eligible member months for the TennCare II demonstration from July 1, 2002, forward.

Beginning July 1, 2007, the quarterly progress report template in Attachment A, Part VIII should be used to report separate member month totals for Type 1, Type 2, and Type 3 eligibles, and for other subgroups as specified below.

a. **Title XIX State Plan Mandatory or Optional Groups (including members of the CHOICES 1 and CHOICES 2 Carryover Group and PACE Carryover Group who are SSI recipients) (Type 1 Eligibles)– TennCare Medicaid:**

(i) For persons who are Medicare beneficiaries report under **EG5 Duals.**

Note: Between July 1, 2002, and December 31, 2005, Medicare-Medicaid dual eligibles were served outside of TennCare II through a separate 1915(b) waiver program, so no member months should

be reported under TennCare II for this group during that period.

Note: EG5 Duals MEG does not include members of the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group.

(ii) For persons who are not described by (i) and who qualified for Medicaid on the basis of disability, report under **EG1 Disabled.**

(iii) For persons not described by (i) or (ii) and who are age 18 or younger, report under **EG3 Children.**

(iv) For persons who are not described by (i) or (ii) and are age 65 or older, report under **EG2 Over 65.**

(v) For persons not described by (i) through (iv), report under **EG4 Adults.**

b. **Title XIX Demonstration Eligible Groups, and members of the CHOICES 1 and CHOICES 2 Carryover Group and PACE Carryover Group who are not SSI recipients (Type 3 Eligibles)**

(A) For persons who belong to any of the following groups, report expenditures and member months under **EG6E Expan Adult** (Type 3 eligibles) those persons who are adult Standard Spend Down demonstration eligibles.

(B) For persons who belong to the following group, report expenditures and member months under **EG7E Expan Child** (Type 3 eligibles) those persons who have incomes 200 percent or more of the Federal poverty level (medically eligible (uninsurable) demonstration children).

(C) For persons in the CHOICES 1 and 2 Carryover Group and PACE Carryover Group who are not SSI recipients, report expenditures and member months under **EG12E Carryover** (Type 3 eligibles).

(ii) For Medicaid Expansion Optional Targeted Low Income Children eligible for TennCare Standard from July 1, 2007, forward, for periods in which the state is not claiming title XXI enhanced FMAP (see paragraph 53(f) *Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population*), report expenditures and member months under **EG8 Med Exp Child** (type 2 eligibles).

(iii) For persons who are not described in (i) or (ii) above, and who are Medicare beneficiaries, report expenditures and member months for July

1, 2010 and thereafter under **EG 11 H-Duals** (Type 2 eligibles); specifically, persons who:

(1) Are members of CHOICES 217-Like HCBS Group,
OR
(2) Are members of the "At Risk" Demonstration Group.

(iv) For persons who are not described in (i), (ii), or (iii) above, report expenditures and member months prior to July 1, 2010 under **EG1 Disabled** (Type 2 eligibles), and on July 1, 2010 and thereafter under **EG 9 H-Disabled** (Type 2 eligibles), those persons who:
(1) have been determined by the state or Federal Government to be disabled, and are medically needy rollovers, if age 19 and older,
OR
(2) are members of CHOICES 217-Like HCBS Group that are not dual eligibles,.
OR
(3) are members of the "At Risk" Demonstration Group.

Prior to July 1, 2007, member months for TennCare Standard Medicaid Expansion children with income up to 200 percent of the FPL who are classified as disabled are reported here. Starting July 1, 2007, expenditures for these optional targeted low-income children will be matched at the title XXI enhanced FMAP rate, and reporting expenditures and member months is governed by(c) below.

(v) For persons who are not described in (i) through (iv) above who are age 18 or younger, report member months under **EG3 Children** (Type 2 eligibles).
Note: This group consists exclusively of TennCare Standard Medicaid Expansion children with incomes up to 200 percent of FPL who are not classified as disabled, for periods of eligibility prior to July 1, 2007.

(vi) For persons not described by (i) through (iv) above, report expenditures and member months prior to July 1, 2010 under **EG2 Over 65** (Type 2 eligibles), and on July 1, 2010 and thereafter under **EG 10 H-Over 65** (Type 2 eligibles), those persons who:
(1) are age 65 or older, and are medically needy rollovers, OR
(2) are members of CHOICES 217-Like HCBS Group.

(vii) For persons not described by (i) through (iv) above, report expenditures and member months under **EG4 Adults** (Type 2 eligibles) those persons who:
(1) are between 19 and 64 years old, and
(2) are medically needy rollovers.

c. Expenditures for title XXI Medicaid Expansion children matched at the title XXI enhanced FMAP should be reported on Forms 64.21U Waiver/64.21UP Waiver, using waiver name "Med Exp Child." Report member months for quarterly reporting using Attachment A, Part VIII. For periods in which the state claims title XIX FMAP for this population (paragraph 53(f) *Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population*), follow the instructions in (b)(ii) above.

d. Type 2 eligibles can be identified as disabled for reporting purposes (see (b)(iii) above) if information exists in their enrollment record that would result in a capitation rate for disabled populations being paid on their behalf.

**53. Standard Funding Process.**

a. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

b. **Standard CHIP Funding Process.** The standard CHIP funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the allotment neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit quarterly CHIP expenditure reports as described in paragraph 53(f) *(Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population)*, showing CHIP expenditures made in the quarter just ended. CMS shall reconcile expenditures with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

**54. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding (see Section IX, paragraph

59 *Sources of Non-Federal Share*), CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in section X of these STCs.

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities.

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

d. **Graduate Medical Education (GME) Pool.** Actual cash disbursements, up to $50 million in total computable expenditures for each demonstration year, paid by the state from a supplemental pool to pay for GME costs in accordance with the pool distribution methodology described below. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology, authorized by the demonstration's expenditure authorities. Should CMS promulgate new regulations, the TennCare GME program must come into compliance in accordance with the effective date of the new regulations.

   *GME Pool Methodology***:** GME Pool payments will be made to the following medical universities that operate graduate physician medical education programs. These payments are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics: East Tennessee State University, Meharry Medical College, University of Tennessee at Memphis, and Vanderbilt University. The annual GME Pool funds will be allocated based on the annual ratio derived by dividing each hospital's average of its Primary Care Position Allocation and its Total Filled Positions Allocation by the aggregate of the medical hospitals' averages. The Primary Care Position Allocation is computed by taking each hospital's total number of primary care residents in years 1 through 4 of residency and dividing it by the total of all primary care residents in the medical hospitals in years 1 through 4 of residency. The Total Filled Positions Allocation is computed by taking each hospital's total number of residents in years 1 through 4 of residency and dividing it by the total of the medical hospitals' number of residents in years 1 through 4 of residency. This annual ratio is applied to the total GME Pool funding to be allocated. The annual GME Pool funds will be disbursed quarterly. The state must make these payments directly to the universities, and not through any third party or intermediary.

e. **Essential Access Hospital (EAH) Pool.** Actual cash disbursements paid each quarter from a $25 million quarterly supplemental pool to pay for the

uncompensated costs of the designated EAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and appropriate charity care patients in accordance with the pool distribution methodology described below. The purpose of this pool is to address the uncompensated care situation of high volume and charity hospitals that serve a disproportionate number of low-income patients with special needs. Hospitals designated as Critical Access Hospitals (CAHs) or as state mental health institutes do not participate in this pool. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR 447.10.

For FFYs 2008 and beyond, EAH Pool payments will be assumed to pertain to the FFY during which the payments were made. To the extent required by Federal law, EAH Pool payments made during a given FFY shall be reduced on a dollar for dollar basis by the amount of DSH payments made under the DSH allotment for that FFY.

*EAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Essential Access Hospitals.

*Qualifications* -- Hospitals eligible to receive EAH Pool payments include all hospitals licensed to operate in the State of Tennessee excluding the five (5) state mental health institutes and the CAHs. The four regional mental health institutes are Memphis Mental Health Institute, Moccasin Bend Mental Health Institute, Western Mental Health Institute, and Middle Tennessee Mental Health Institute. The CAHs receive cost-based reimbursement from the TennCare program subject to limitations outlined in subsection (f) of this paragraph.

- All hospitals, with the exception of free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program.
- The free standing psychiatric hospitals must be a contracted provider with at least one of the Managed Care Organizations in the TennCare program and at least 30% of its total adjusted days must be covered by TennCare.
- All acute care hospitals must have either of the following: (i) at least 13.5% or more of its total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days.
- All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare Cost.

*Allocation of the EAH Pool to Segments of Hospitals* -- The $25 million Pool should be segmented into 4 distinct parts as follows:

- Essential Service Safety Net – $12.5 Million -- These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved.
- Children's Safety Net – $1.25 Million -- These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children in Tennessee under the age of 21.
- Free Standing Psychiatric Hospitals - $0.5 Million -- These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health for the provision of psychiatric hospital services in Tennessee, excluding the state mental health institutes.
- Other Essential Acute Care – $10.75 Million -- These hospitals include all other hospitals licensed by the Tennessee Department of Health to provide services in Tennessee, excluding the Critical Access Hospitals.

*Quarterly Reports* – The state must include in its Quarterly Progress Reports a list of the current hospitals in each of the above categories (see Attachment A).

*Data* -- Calculation of the quarterly payment amounts will be based on the most recently completed Joint Annual Report of Hospitals at the time of the first quarterly payment for a given fiscal year.

*Allocation will be based on an assignment of points for*:

- TennCare adjusted days expressed as a percent of total adjusted patient days; and
- Charity, medically indigent care, and bad debt expressed as a percent of total expenses.

*Calculation of Points*

**(1)** TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:

- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the critical access, pediatric and safety net providers;
- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 34.5%;
- 3 points – greater that 34.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

**(2)** Bad Debt, Charity and Medically Indigent – BDCHMI costs as a percent of total expenses

- 0 points - less than 4.5%
- 1 point - greater than or equal to 4.5% and less than 9.5%

- 2 points - greater than or equal to 9.5% and less than 14.5%
- 3 points - greater than or equal to 14.5%

*Calculation of Amounts of Pool Payments for Hospitals* -- These points will then be used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate included all inpatient costs (operating, capital, direct education) but excluded add-ons (indirect education, MDSA, return on equity). The GHR for Safety Net Hospitals is $908.52. The GHR for Other Essential Access Hospitals is $674.11. The points for each qualifying hospital will be summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each of the 4 pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initially calculated amount will then be adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. For example, if the sum of the initial calculated amounts for the pediatric group is $9 million and the total pool for children's hospitals is $5 million, each hospital's initial calculated amount will be multiplied by $5 million / $9 million.

*Pool Payments* -- Hospitals will be paid on a quarterly basis following the end of each quarter. The initial payment will include all quarters that have ended at the time that the payment is made. All subsequent quarterly payments will be made following the end of the quarter. In order to receive a payment for the quarter, all hospitals, with the exception of the free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, with at least one Managed Care Organization, and must have contracted with TennCare Select for the entire quarter that the payment represents. In order for a free standing psychiatric hospital to receive a payment for the quarter, it must be a contracted provider with at least one of the Managed Care Organizations.

f. **Critical Access Hospital (CAH) Pool.** Actual cash disbursements, of up to $10 million per demonstration year, paid from a supplemental pool to pay for the uncompensated costs of the designated CAHs' TennCare covered inpatient and

outpatient services for the TennCare enrollees and the appropriate charity care patients in accordance with the pool distribution methodology that has been given CMS prior approval. CAHs are designated by the Tennessee Department of Health, and they are typically small, rural hospitals that are part of a rural health network. CAHs allow communities to maintain access to primary care and emergency care when the maintenance of a full-service acute care hospital is no longer feasible. The purpose of this pool is to address the uncompensated care situation of CAHs in serving a disproportionate number of low-income patients in rural areas who have special needs. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The state must make these payments directly to the providers of the services as specified in 42 CFR 447.10.

*CAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Critical Access Hospitals.

*Qualifications* -- To qualify for payment as a Critical Access Hospital, a hospital must meet the following criteria:

- The hospital is an acute care hospital located and licensed in the state of Tennessee;
- The hospital has been designated a Critical Access Hospital by the Tennessee Department of Health; and
- The hospital contracts with a managed care organization participating in TennCare.

*Reimbursement* -- TennCare will provide reimbursement to Critical Access Hospitals under the following terms. Reimbursement to hospitals will be limited to specific annual legislative appropriation. In any state fiscal year that reimbursable TennCare costs incurred by Critical Access Hospitals exceed annual appropriations, equitable adjustments will be made to the rates described below, in order to cap reimbursement at the annual appropriation.

***Inpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare inpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly with interim per diem rates and will be cost-settled at year-end. Using the Joint Annual Reports filed for the most recent year available, interim per diem rates for TennCare inpatient services will be determined with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs. Inpatient Critical Access Hospital services will not include more than 15 acute inpatient beds. An exception to the 15 bed requirement is made for swing bed hospitals. Critical Access Hospitals are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that not more than 15 beds are used at any one time for acute care.

***Outpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare outpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly based on a percentage of charges with year-end cost settlements. Using the Joint Annual Reports filed for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges, with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs.

**Cost Settlements** -- Cost settlements are determined from provider submitted Medicare cost reports that include the title XIX schedules based on 100 percent (100%) of TennCare reasonable costs. The term "reasonable costs" is defined for this purpose as total reimbursable costs under Medicare principles of cost reimbursement for Critical Access Hospitals.

*New Designations of Critical Access Hospitals* -- For new hospitals that qualify after July 1, 2002, the state will begin reimbursement at the rates established by this part on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its Critical Access Hospital designation. At that time, interim rates will be established according to this part and the designation will be confirmed with the Tennessee Department of Health.

*Audit Trail and Audit Requirements* -- Each CAH is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than 5 years from the date of the submission of the Joint Annual Report, and the provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint Annual Reports are subject to audit at any time by Federal and state auditors, including the Comptroller of the Treasury and the Bureau of TennCare, or their designated representative.

g. **Meharry Medical College (Meharry) Pool.** Actual cash disbursements paid from a $10 million supplemental pool per demonstration year to pay for the uncompensated costs of the two Medicaid clinics operated by the Meharry Medical College for TennCare covered services provided to TennCare enrollees and the appropriate charity care patients. The Meharry Pool payments will be limited to the uncompensated costs of the care as determined by an independent audit each year and subject to the review and approval by the CMS staff. Before paying the annual pool amount to the providers, the state will provide CMS with a copy of the annual independent audit report. The state must make these payments directly to the providers of the services as specified in 42 CFR 447.10.

h. **Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (CPE).** Actual costs incurred by government operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients are eligible as CPE. The state must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital from the following sources: the MCOs; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds). With regard only to hospital CPE, the state will report actual CPE within 12 months after the end of each fiscal year. At that time, the state will revise its FFP claim to reconcile actual CPEs with the CPE estimates used during the preceding fiscal year (FY).

**State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the state of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

**CPE Methodology and Protocol.** The state must follow the CPE protocol, as contained in Attachment F of these STCs, which was approved by CMS for use beginning July 1, 2008.

i. **Disproportionate Share Hospital (DSH) Payments.** The Tax Relief and Health Care Act of 2006 (TRHCA 2006) established a DSH allotment for Tennessee for FFY 2007, as described at section 1923(f)(6) of the Act. The relationship between DSH payments made by Tennessee under TRHCA 2006 and payments from the EAH Pool is further specified in the second paragraph of subparagraph (e) above. If Congress should establish a DSH allotment for Tennessee for any subsequent Federal fiscal year, the state may make DSH payments to hospitals on the basis of a state plan amendment approved by CMS. Depending on the specifics of the legislation establishing the DSH allotment, modifications to the budget neutrality expenditure limit may be required, in the manner specified in paragraph 4(a) (*Impact on Demonstration of Changes in Federal Law, Regulation, and Policy)*. Unless otherwise specified by law, DSH payments shall be considered payments made under the demonstration and subject to the budget neutrality expenditure limit and the limit described in subparagraph (j) below. When determining hospital-specific DSH limits and DSH payments, the state must take into account all Medicaid payments under the Medicaid state plan and demonstration projects including amounts paid to hospitals through the GME, EAH, Meharry Medical College, UHC, PHSP, and CAH Pools, as well as any payments by or on behalf of individuals with no source of third party coverage. The state must make these payments directly to the providers of the services as specified at section 1923(i) of the Social Security Act.

j. Beginning in DY 6 (state fiscal year 2008), the combined total of the payments to hospitals listed in (1) below shall not exceed annual limits described in (2). Any unused amount from the annual cap for one DY may not be rolled over and added to the annual cap for any subsequent DY.

(1) The following payments are subject to the limit in DY 6 through 9:
- EAH Pool payments for the four quarters of the DY (see 57(e));
- CAH Pool payments for the DY (see 57(f));
- Meharry Pool payments for the DY (see 57(g));
- One-quarter of DSH payments (see 57(i)) subject to the allotment for the FFY ending during the DY;
- Three-quarters of DSH payments (see 57(i)) subject to the allotment for the FFY beginning during the DY;
- Hospital CPE (see 57(h)).

(2) The following payments are subject to the limit in DY 10:
- EAH Pool payments for the four quarters of the DY (see 57(e));
- CAH Pool payments for the DY (see 57(f);
- Meharry Pool payments for the DY (see 57(g));
- One-quarter of the DHS payments (see 57(i)) subject to the allotment for the FFY 2011;
- Additional DSH payments equal to the DSH allotment for the first quarter of FFY 2012;
- Hospital CPE (see 57(h)).

(3) The following payments are subject to the limit in DY 11:
- EAH Pool payments for the four quarters of the DY (see 57(e));
- CAH Pool payments for the DY (see 57(f));
- Meharry Pool payments for the DY (see 57(g));
- Hospital CPE (see 57(h)).

(4) The annual limit for DY 6 – DY 11 shall be $540 million (total computable).

k. **Unreimbursed Hospital Cost (UHC) Pool.** Actual costs incurred by eligible Tennessee hospitals that are unreimbursed by TennCare. The total amount of funds to be distributed to hospitals each DY from the pool will be determined annually, in a manner defined by the Tennessee General Assembly's Annual Coverage Assessment Act and this subparagraph, but in no event may exceed the limit defined below. For any demonstration year in which it elects to make payments under the UHC Pool authority described in this paragraph, the state may not implement a reduction in benefits or elimination of coverage for any of the following services: physical therapy, occupational therapy, speech therapy, inpatient hospital, lab and x-ray, non-emergency outpatient hospital, physician,

podiatrist, certified nurse practitioner, or physician assistant services; or implement any co-payment for non-emergency medical transportation. (Nothing in this paragraph is intended to limit the state's ability to manage utilization of these services through changes to prior authorization requirements or other managed care practices).

***Eligible Hospitals.*** Hospitals eligible to receive a pool payment include all hospitals licensed to operate in the State of Tennessee, except the following groups:

- Critical Access Hospitals;
- Public hospitals eligible to certify public expenditures, including state mental health institutes;
- Rehabilitation and long term care hospitals; and
- Pediatric research hospitals that limit patients to those that meet research protocols.

Any hospitals that have closed between 2008 and the time that the amounts of the payments are calculated are not eligible to receive payments.

***Minimum Qualifications.*** In order to receive a payment, the hospital must be contracted with at least one TennCare MCO and must have unreimbursed TennCare costs, unless the hospital is capitated and accepts the capitation from TennCare as full reimbursement for services to TennCare patients.

***Data Source.*** The Joint Annual Report (JAR) of Hospitals, which is a report containing data that each licensed hospital in the state is required to file annually in accordance with T.C.A. 68-11-310. This law says:

> All hospitals that submit a joint annual report to the department of health as designated in this section also shall submit to the department, at the same time they send the signed paper copy of the report, a notarized statement from their chief financial officer stating that the financial data reported on the joint annual report is consistent with the audited financials for the hospitals for that reporting year. The notarized statement shall also be attested to by the chief executive officer of the hospital.

Reports are submitted to the Tennessee Department of Health (DOH), edited by DOH, corrected by the hospital and placed in a final data file for that year by DOH. The instructions for completing the form require the hospitals to use the same accounting method required for the Medicare cost reports.

Payment amounts for each DY will be based on the final JAR from 3 years prior to the DY.

***Calculation.*** TennCare costs shall be determined by multiplying TennCare charges for hospital inpatient and outpatient services reported by the hospital by

the ratio of reported total expenses to reported total charges (cost to charge ratio). Unreimbursed TennCare Costs are calculated as the difference between the calculated TennCare costs and the TennCare revenue as reported on the JAR.

Each hospital shall receive an annual payment each DY equal to a percentage of its Unreimbursed TennCare Costs, using the same percentage to calculate each hospital's payment.

***Funding.*** TennCare shall adjust payments if necessary to ensure no hospital receives supplemental payments in excess of unreimbursed TennCare costs. Payments may be prorated subject to available appropriations.

***Payments.*** The annual payment to each hospital shall be made in four equal quarterly payments.

***Annual Limit:*** The total amount of UHC Pool payments made each DY may not exceed $500 million total computable.

l. **Public Hospital Supplemental Payment (PHSP) Pool.** Actual cash disbursements paid from a $70 million (total computable) supplemental pool per demonstration year to selected public hospitals. The amount paid each DY to each hospital must not exceed the hospital's uncompensated cost of TennCare covered services provided to TennCare enrollees and uninsured patients. The state must make these payments directly to the providers of the services as specified in 42 CFR 447.10. PHSP Pool payments may be made to the following hospitals:

- Regional Medical Center at Memphis,
- Nashville General Hospital at Meharry.

**55. Medicare Part D Drugs.** No FFP is available under this demonstration for Medicare Part D drugs.

**56. Sources of Non-Federal Share.** The state certifies that the matching non-Federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-Federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding.

c. Under all circumstances, health care providers must retain 100 percent of the TennCare II reimbursement amounts claimed by the state as a demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

**57. Monitoring the Demonstration.** The state shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

## XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

**58. Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, with an aggregate adjustment for projected disproportionate share hospital payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section X, paragraph 53 *(Reporting Expenditures in the Demonstration).*

**59. Risk.** Tennessee shall be at risk for the per capita cost (as determined by the method described below in this Section) for Type 1 and Type 2 TennCare enrollees in the eligibility groups (EGs) described in paragraph 63 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)* under this budget neutrality agreement, but not for the number of demonstration eligibles in each of the groups. By providing FFP for all Type 1 and Type 2 TennCare enrollees in the specified EGs, Tennessee shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Tennessee at risk for the per capita costs for TennCare enrollees in each of the EGs under this agreement, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration. Tennessee will be at risk for both per capita costs and enrollment for Type 3 TennCare eligibles.

**60. Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement.** Individuals who are eligible under TennCare and whose expenditures are funded at title XIX matching rates will be one of three types:

a. Type 1 - are currently eligible under Tennessee's Medicaid state plan (Title XIX state plan mandatory or optional eligible population) - counted in the "with" and "without" waiver calculations;

b. Type 2 - could be eligible under Tennessee's Medicaid state plan if Tennessee amended its state plan or could be eligible for a Section 1915(c) waiver for aged and disabled adults pursuant to 42 C.F.R. 435.217 (Title XIX demonstration-eligible hypothetical population) or is eligible under the At Risk Demonstration Group for the Interim CHOICES 3 program - counted in the "with" and "without" waiver calculations (the state cannot generate savings from these populations); and

c. Type 3 – are only eligible with section 1115 demonstration authority (Title XIX demonstration-eligible expansion population) - counted only in the "with" waiver calculations.

**61. Budget Neutrality Ceiling.** The following describes the method for calculating the budget neutrality expenditure limit:

a. For each DY of the budget neutrality agreement, an annual target is calculated as the sum of two components:

(1) The sum of six sub-components calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the state in accordance with paragraph 54 *Reporting Member Months*) for Type 1 and Type 2 eligibles claimed under title XIX for the following six EGs: EG1 Disabled, EG2 Over 65, EG3 Children, EG4 Adults, EG5 Duals, and EG8 Med Exp Child (when title XXI allotment is exhausted); and

(2) A Disproportionate Share Hospital (DSH) adjustment for the year described in (d) below.

b. Member months for the following populations are not used for calculation of the budget neutrality expenditure limit:

(1) EG6E Expan Adult and EG7E Expan Child Type 3 eligibles

(2) Med Exp Child: Medicaid Expansion children funded at the title XXI enhanced FMAP.

c. The following tables give the projected PMPM costs for the calculation described in paragraph 64(a) (*Budget Neutrality Ceiling*) by DY. The PMPM costs for DY 8 and earlier are calculated following Attachment B of the November 14, 2006 Special Terms and Conditions and paragraph 64(c) of the July 22, 2009 STCs.

*Optional Targeted Low Income Children funded using title XIX
** Includes EG 9 H-Disabled
*** Includes EG-10 H-Over 65

**Table 8 – Projected PMPM Costs After CHOICES Implementation**

| | Trend | DY 12 | DY 13 | DY 14 |
|---|---|---|---|---|
| **EG1 Disabled**** | 5.1% | $1,561.46 | $1,641.09 | $1,724.79 |
| **EG2 Over 65***** | 4.6% | $1,022.17 | $1,069.19 | $1,118.37 |
| **EG3 Children** | 3.4% | $468.46 | $484.39 | $500.86 |
| **EG4 Adults** | 4.9% | $917.79 | $962.76 | $1,009.94 |
| **EG5 Duals** | 4.6% | $652.99 | $683.02 | $714.44 |
| **EG8 Med Exp Child*** | 3.4% | $468.46 | $484.39 | $500.86 |

*Optional Targeted Low Income Children funded using title XIX
** Includes EG 9 H-Disabled
*** Includes EG10 H-Over 65

d. The DSH adjustment is based upon Tennessee's DSH allotment for 1992 and calculated in accordance with current law.

i. For the purpose of this subparagraph, the Average FMAP (AFMAP) for each DY is defined as 0.25 times the FMAP applicable to DSH expenditures for the Federal fiscal year that ends during that DY, plus 0.75 times the FMAP applicable to DSH expenditures for the Federal fiscal year that begins during that DY.

ii. A DSH allotment has been established for Tennessee under provisions of TRHCA 2006 (and extended through subsequent legislation). Beginning with DY 5, the DSH adjustment will be based on the DSH allotments established for Tennessee, following section 1923(f)(6)(A)(i) of the Act, which are published in the *Federal Register*. The Federal share of the DSH adjustment for each DY will be equal to one quarter of the DSH allotment for the FFY ending during the DY, plus three quarters of the

DSH allotment for the FFY beginning during the DY. A total computable equivalent for each DSH adjustment can be calculated as the DSH adjustment divided by the AFMAP for that DY. For DY 5, the figure $305,541,928 will be used to compute the Federal share of the DSH adjustment in place of the FFY 2006 DSH allotment.

iii. The calculation of the DSH adjustment will be appropriately altered if legislation is enacted that impacts the calculation of DSH allotments, including any law that would affect the calculation of the DSH allotment for Tennessee.

iv. Table 10 gives the DSH adjustments for DY 1 through DY 11, and shows both total computable and Federal share. These totals reflect changes to the calculation of DSH allotments resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the temporary increase in DSH allotments provided under section 5002 of the American Recovery and Reinvestment Act of 2009. Some of the figures are labeled "preliminary" because the final DSH allotments needed to calculate them have not yet been published in the *Federal Register,* and are best estimates based on current law.

**Table 10 – DSH Adjustments for DY 1 Through DY 14**

| | **DSH Adjustment (total computable)** | **DSH Adjustment (Federal share)** |
|---|---|---|
| **DY 1** | $413,700,907 | $268,409,148 |
| **DY 2** | $479,893,052 | $310,106,890 |
| **DY 3** | $479,893,052 | $310,538,794 |
| **DY 4** | $479,893,052 | $308,091,339 |
| **DY 5** | $479,356,649 | $305,451,928 |
| **DY 6** | $479,657,638 | $305,451,928 |
| **DY 7** | $485,299,094 | $311,270,839 |
| **DY 8** | $488,969,517 | $319,052,610 |
| **DY 9** | $470,369,327 | $309,408,043 |
| **DY 10** | $463,996,853 | $305,451,928 |
| **DY 11** | $463,996,853 | $305,451,928 |
| **DY 12 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 13 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 14 (preliminary)** | $463,996,853 | $305,451,928 |

e. The budget neutrality expenditure limit is the Federal share of the annual PMPM limits for the demonstration period, plus DSH adjustments, for DY 1 through 11, and represents the maximum amount of FFP that the state may receive for title XIX expenditures during the demonstration period, as described in paragraph

53(g) *(Reporting Expenditures in the Demonstration)*. The budget neutrality expenditure limit is equal to (1) the sum of all of the subcomponents described in (a)(1) above for all DYs, times the Composite Federal Share (defined in (f) below), plus (2) the sum of the Federal shares to the DSH adjustments for all DYs, as defined in (d) above.

f. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional demonstration expenditures or offsets such as, but not limited to, premium collections and administrative costs subject to budget neutrality under paragraph 53(h) *(Reporting Expenditures in the Demonstration: Administrative Costs)*) by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for DSH payments made under the Medicaid state plan must be subtracted from the numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

**62. Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under TennCare II. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

**63. Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

| DY | Cumulative Target Definition | Percentage |
|---|---|---|
| Years 1 through 6 | Cumulative budget neutrality cap plus: | 0.5 percent |
| Years 1 through 7 | Cumulative budget neutrality cap plus: | 0.25 percent |
| Years 1 through 14 | Cumulative budget neutrality cap plus: | 0 percent |

**64. Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end of this demonstration period, the excess Federal funds shall be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

## XII. EVALUATION OF THE DEMONSTRATION

**65. Submission of a Draft Evaluation Plan.** The state shall submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after CMS approval of the demonstration extension. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design shall identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

As part of its draft evaluation plan, the state shall propose data collection and reporting measures designed to assess the ongoing need for retroactive Medicaid eligibility after changes specified in the Affordable Care Act are effectuated. In addition, the state shall propose data collection and reporting measures designed to assess the ongoing need for payments to compensate hospitals for providing care to the uninsured after changes specified in the Affordable Care Act are effectuated.

**66. Inclusion of CHOICES Special Study Components.** Suggested special study topics from which the state may choose for its Evaluation Plan include, but are not limited to, the following:

a. The rebalancing of the long-term care system including impacts on outcomes, utilization and cost;

b. Implementation lessons, successes and evolution of the Single Point of Entry and streamlined eligibility processes;

c. The expansion and development of a more robust HCBS infrastructure under managed care;

d. Implementation of Consumer Directed options under manage care;

e. Enrollee satisfaction, based on surveys that include feedback on assessment and care planning processes, quality of care coordination, actual service delivery, and (when relevant) the appeals process; and

f. Provider satisfaction from surveys.

When developing its research approach, CMS encourages Tennessee to consider adapting research questions and methodologies from the CMS sponsored Evaluation of the Money Follows the Person (MFP) Grant Program. MFP and CHOICES share many of the same goals, and by using a common study approach, the Tennessee's planned reforms can be viewed within a national context. CMS staff will be available to provide technical assistance in this regard.

**67. Evaluation of Eligibility and Enrollment Systems.** The interim evaluation report required in paragraph 8 should contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid and the Exchange. CMS may issue further guidance to the state on the specific performance measures. The state may include the following areas of interest in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other relevant data.

a. Evaluation of eligibility determinations by type, e.g. application, redetermination, transfer to the Exchange.

b. Evaluation of Medicaid denial and termination reasons.

c. Evaluation of average application processing times and timeliness.

d. Evaluation of reasons for disenrollment and internal churn.

e. Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable.

**68. Evaluation of Uncompensated Care Costs for the Uninsured.** The state should provide documentation demonstrating cost expended for uncompensated care in relation to the number of uninsured individuals that receive care during the current approval period. CMS may issue further guidance to the state on specific data collection and tracking mechanisms. The state may include the following areas of interest in its interim evaluation report. This list is not all inclusive and the state may include any other relevant data.

a. Evaluation of uninsured patient cost and dates of service.

b. Evaluation of cost for medical services to charities and the indigent.

c. Evaluation of amounts expended for services to hospitals that serve a disproportionate number of low-income patients.

**69. Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of

§1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

**70. Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation plan within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports. The state shall submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

**71. Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

## XIII. TENNCARE ELIGIBILITY REDETERMINATION AND DISENROLLMENT AND RIGHTS; APPEALS PROCESS FOR CHANGES IN BENEFITS; AND ENROLLMENT IN STANDARD SPEND DOWN

The state will follow these procedures throughout the demonstration approval period unless modified through an approved demonstration amendment.

### PART I: MEDICALLY NEEDY AND TENNCARE STANDARD ELIGIBILITY REDETERMINATION AND DISENROLLMENT PROCESS

This Part summarizes the process Tennessee will use, in accordance with paragraph 21a *(Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category)*, of these STCs, to: (i) redetermine eligibility and terminate the adult (non-pregnant) Medically Needy; and (ii) disenroll adults who are TennCare/Medicare dual eligible, uninsured, and Medically Eligible. This process was approved as an amendment to the TennCare II demonstration on March 24, 2005. It is used for redetermining the eligibility of those enrollees whose eligibility is ending, including when their period of eligibility has ended or the category in which they have been enrolled is being closed. The state will continue to follow this process for all redeterminations and terminations of eligibility throughout the demonstration approval period unless modified through an approved demonstration amendment.

**Termination of Adult Non-Pregnant Medically Needy**

**1. Ex Parte Review**

A. The state will conduct a data match of the Social Security numbers of individuals classified as adult non-pregnant Medically Needy in its InterChange Information System (which contains information on TennCare enrollees) with Social Security Administration (SSA) data to determine whether the individual has lost supplemental security income (SSI) eligibility for reasons that would qualify them as Medicaid eligible.[1]

B. The state will conduct a data match of the Social Security numbers (SSNs) of individuals classified as adult non-pregnant Medically Needy in InterChange with individuals classified as participants in its Food Stamps or Families First (TANF) program in its ACCENT system (a database maintained by the Department of Human Services (DHS)). In all instances in which there is a match between an adult Medically Needy individual with an individual with an open Food Stamps or Families First record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

[1] Such reasons include (i) they lost SSI eligibility because of Social Security cost of living adjustment(s) ("COLA(s)") but would be SSI eligible if the COLA(s) was/were disregarded ("Passalong" eligibles); or (ii) they lost SSI eligibility for some reason other than a Social Security COLA, but would be eligible for SSI if the COLA(s) received since their SSI termination was/were disregarded ("Pickle" eligibles).

## 2. Request for Information

A. At least 30 days prior to the end of the individual's current eligibility period, the state will send notification (Request for Information) to those adult non-pregnant Medically Needy enrollees who have not been identified through the ex parte review process as eligible for open categories of TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for Medicaid is ending, and that they will only remain eligible for TennCare Medicaid if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for a Medicaid category that is not ending (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for open Medicaid categories. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for Medicaid and the enrollee will receive an advance notice that will provide appeal rights.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be fair hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with Limited English Proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as Seriously and/or Persistently Mentally Ill (SPMI). Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package—i.e., elimination of pharmacy coverage for adult non-institutionalized non-pregnant Medically Needy) until

DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a "Verification Request." Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package). If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain TennCare Medicaid coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), enrollees will retain Medicaid coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. The state will make the determination that enrollees are not eligible for open TennCare Medicaid categories in the following two scenarios: (i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or (ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Expiration Notice**

A. Upon making a determination that enrollees are no longer eligible for TennCare Medicaid, the state will provide a notice (Expiration Notice) to enrollees at least 20 days in advance of the end date of the enrollees' eligibility period.

B. Expiration Notices will:

i. Inform enrollees that they will be terminated from Medicaid as of a date specified in the notice because their current eligibility period has ended, their category of TennCare Medicaid is closed and they have not proven their eligibility for other open categories of TennCare Medicaid.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Expiration Notice to request a hearing for factual disputes related to the termination and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing prior to the date of termination specified in the Notice, Medicaid benefits for non-pregnant Medically Needy (subject to changes in the benefit package) will continue until the appeal has been resolved.

C. If enrollees submit information to qualify for Medicaid prior to their termination, enrollees will continue to be eligible for TennCare Medicaid for non-pregnant Medically Needy (subject to changes in the TennCare Medicaid benefit package) pending the determination as to whether the individual is eligible for other open TennCare Medicaid categories.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Expiration Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the termination. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. Valid factual disputes include:

i. Enrollees received the Expiration Notice in error (i.e., they are currently enrolled in other categories of TennCare Medicaid including Medically Needy pregnant women or enrollees under 21 years of age);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Request for Information but failed to extend the time;

iv. Enrollees requested assistance because of a health, mental health, learning problem, or disability but the state failed to provide this assistance; or

v. The state sent the Expiration Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the request for a hearing is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of termination identified in the Expiration Notice, TennCare Medicaid benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute as described above, or the appeal is resolved.

E. If the enrollee does not request a hearing prior to the date of termination identified in the Expiration Notice, the enrollee will be disenrolled from TennCare Medicaid.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## II. Disenrollment of Adult Medicare/TennCare Dual Eligible, Uninsured, Medically Eligible

### 1. Ex Parte Review

A. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in InterChange (which contains information on TennCare enrollees) with SSA data to determine whether the individual has lost SSI eligibility for reasons that would qualify them as Medicaid eligible.[2]

B. The state will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in Interchange with individuals classified as participants in the state's TANF program in DHS' ACCENT system. In all instances when there is a match between an adult member of these demonstration populations with an individual with an open TANF record, the state will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

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[2] See footnote 1

## 2. Request for Information

A. At least 30 days prior to disenrollment, the state will send a Request for Information to all adult Medicare/TennCare Dual Eligible, Uninsured, and Medically Eligible enrollees not identified through the ex parte review process as eligible for TennCare Medicaid.

B. The Request for Information will:

   i. Inform enrollees that their eligibility category for TennCare Standard is ending and that they will only maintain coverage if they qualify for open Medicaid categories.

   ii. Provide enrollees with 30 days from the date of the Request for Information to provide the state with all of the necessary information for DHS to determine whether the individual is eligible for Medicaid (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for TennCare Medicaid. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

   iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for TennCare Medicaid and the enrollee will receive a Disenrollment Notice prior to disenrollment from TennCare Standard.

   iv. Inform enrollees that the state will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with limited English proficiency. Upon request, the state will also make special accommodations for individuals with qualifying assessments in the previous 12 months as SPMI. Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the state's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Standard until DHS determines that the individual does not qualify for open categories of Medicaid (and proper disenrollment and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the state will send these enrollees a Verification Request. Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid. If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper disenrollment and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), the enrollee will retain coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the state makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in an appropriate TennCare Medicaid category. The state will make the determination that enrollees are no longer eligible for TennCare in the following two scenarios:

(i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or

(ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Termination Notice**

A. Upon determination or confirming that enrollees are not eligible for TennCare Medicaid, the state will provide a Termination Notice to enrollees 20 days in advance of the date upon which the coverage will be terminated.

B. Termination Notices will:

i. Inform enrollees that they will be disenrolled from TennCare as of the date specified in the Notice (20 days after the date of the Notice) because their category of TennCare Standard is ending and they have not proven their eligibility for open TennCare Medicaid categories.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the notice to appeal factual disputes related to the action of disenrollment and inform enrollees how they may request a hearing.

iii. Inform enrollees that if prior to the date of disenrollment specified in the Termination

Notice, an enrollee appeals the action of disenrollment, he or she will not lose eligibility for TennCare until the state determines that the enrollee has not raised a valid factual dispute or the appeal is resolved.

iv. Inform enrollees that they may submit new information to demonstrate Medicaid eligibility at any time before or after disenrollment. Such information will be treated as a new application for Medicaid. The enrollee will not continue benefits pending the state's review and processing of this information.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice.

B. The state will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:

i. Enrollee received the Termination Notice in error (e.g., he or she is currently enrolled in Medicaid or in a TennCare Standard category that is not ending);

ii. The state failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The state granted a "good cause" extension of time to reply to the Termination Notice but failed to extend the time;

iv. Enrollee requested assistance because of a health, mental health, learning problem, or disability, but the state failed to provide this assistance; or

v. The state sent the Termination Notice to the wrong address as defined under state law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the appeal is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

ii. If the appellant submits additional information during this 10-day period and such

information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of disenrollment as identified in the Termination Notice, TennCare Standard benefits will continue either until the state determines that the enrollee has not raised a valid factual dispute, or the appeal is resolved.

E. If the enrollee does not appeal prior to the date of disenrollment as identified in the Termination Notice, the enrollee will be disenrolled from TennCare Standard.

F. If the enrollee is granted a hearing and the hearing decision sustains the state's action, the state reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## PART II: NOTICE AND APPEALS PROCESS FOR CHANGES IN COVERAGE OF TENNCARE BENEFITS

This Part summarizes the process Tennessee will use upon and after the implementation of changes in coverage of TennCare benefits. These procedures were approved as an amendment to the TennCare II demonstration on March 31, 2006. This detailed process is used by the state to implement benefit changes, specifically benefit limits. It is used daily with enrollees who are subject to pharmacy benefit limits when they reach their monthly maximum. With this process, Tennessee provides one notice per month when benefit limits have been reached. The state will continue to follow this process with enrollees who are subject to pharmacy or other benefit limits throughout the Demonstration approval period unless modified through an approved Demonstration amendment. To change benefits covered under the Demonstration, the state must submit a Demonstration amendment in accordance with paragraphs 6 and 7 regarding amendments of these STCs.

### I. Implementation of Changes in Coverage Policies

### 1. Initial Notice

A. At least 30 days prior to the effective date of changes in coverage of TennCare benefits (e.g., implementation of pharmacy benefit limits and elimination of covered services), the state shall provide a notice (Benefit Notice) to enrollees who are impacted by such changes in coverage of TennCare benefits.

B. Benefit Notices will:

i. Inform enrollees of how changes in coverage of TennCare benefits will apply to enrollees.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Benefit Notice to request a hearing for valid factual disputes related to the changes in coverage and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing for a valid factual dispute prior to the effective date of the change in coverage of TennCare benefits, benefits will be continued at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the level for Non-Institutionalized Medicaid Adults (Default Level). The state will apply the Default Level of benefits until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary. (The resolution of an appeal, for purposes of this Part, is defined as when the appeal is dismissed or resolved prior to a hearing or when a decision is rendered at or after the hearing.)

## 2. Appeals Process

A. An enrollee will have the opportunity to request a state fair hearing for 40 days (inclusive of mail time) from the date of the Benefit Notice.

B. The state will grant state fair hearings only for those enrollees raising valid factual disputes related to the changes in coverage. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to a different level of TennCare benefits than that identified in the Benefit Notice. Valid factual disputes include when an enrollee claims to have received the Benefit Notice in error (e.g., he or she is already in a TennCare category that is not subject to the particular changes in coverage).

C. When an enrollee requests a hearing prior to the effective date of changes in coverage as identified in the Benefit Notice, the enrollee shall continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the Default Level. The state will apply the Default Level until the appeal has been resolved, unless the state subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary.

D. If the enrollee appeals, the changes in coverage in dispute shall become effective upon resolution of the appeal.

E. If the enrollee does not appeal prior to the effective date of changes in coverage as identified in the Benefit Notice, such changes in benefits will become effective, as applied to the enrollee, upon this date.

F. If the enrollee appeals and:

(i) The appeal is dismissed because the enrollee has not asserted a valid factual dispute; or

(ii) The enrollee is granted a hearing and the hearing decision sustains the state's action,

The state reserves its right to recover from the enrollee the cost of services provided as a result of the appeal.

## II. Post-Implementation Appeals from Denials of Prior Authorization for Pharmacy Products

1. Prior Authorization Requirements

A. Any prescription of a branded drug may be subjected to a prior authorization requirement by the state; and prior authorization will be required as a condition of coverage for branded prescription drugs that are not included on the state's Preferred Drug List.

B. Physicians (or other providers with prescribing authority) participating in TennCare will be responsible for requesting prior authorization, according to procedures to be established by the state.

2. Notice of Prior Authorization Denial

A. Requests for prior authorization of covered outpatient drugs shall be transmitted to and acted upon by appropriate staff of the Pharmacy Benefit Manager (PBM) Clinical Call Center.

B. Written notice of denial of a request for prior authorization shall be mailed by the PBM on behalf of the state to the enrollee and transmitted by facsimile to the prescribing physician. Such Notice will inform the enrollee that the request for prior authorization of the prescribed drug has been denied and that TennCare does not cover the drug absent prior authorization, briefly state the reason or reasons for denial of the request, explain the procedures that are available to the enrollee to appeal from that decision, and inform the enrollee that TennCare will not cover the cost of the prescribed medication during the pendency of any appeal. The state's failure to act on a request for prior authorization within a 24-hour period after receiving a submission that complies with the state's requirements for a completed prior authorization request may be deemed a denial from which the enrollee can appeal.

3. Procedures for Filing and Pursuing an Appeal

A. Appeals of denials of requests for prior authorization may be initiated within 20 days of the Notice of denial of prior authorization, at the option of the enrollee, by the enrollee (or an individual appointed or otherwise authorized under state law to act as the enrollee's representative) submitting to the TennCare Solutions Unit via hand delivery, mail, or facsimile, a written statement of intent to appeal on a form prescribed by the state. Such form will be available on the PBM Web site, and the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's managed care organization (MCO), or from the TennCare Solutions Unit. Undue delay by the state in deciding a prior authorization request (i.e., delay in excess of the 24-hour period permitted for such decisions) will be considered a denial of prior authorization for purposes of appeal.

B. The state will dismiss any appeal that does not raise a valid factual dispute without a hearing, and will retain the authority to determine whether an appeal raises a valid factual dispute relating to denial of a prior authorization request or

the state's failure to act on a request for prior authorization within a 24-hour period after such request. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the prescribed drug. A dispute concerning whether a particular drug or dosage is medically necessary for the enrollee, will be considered a valid factual dispute.

C. An initial determination on appeals involving issues of medical necessity will be made by appropriately qualified medical professionals on the staff of the TennCare Solutions Unit as promptly as possible after the enrollee's submission of the appeal. After submission of the appeal, the TennCare Solutions Unit may seek additional information or documentation in support of the appeal, before any initial determination is made.

D. Upon initially deciding an appeal, the state shall send a letter communicating its decision to the enrollee and stating the reasons for that decision, and shall also communicate any decision granting prior authorization to the enrollee and/or the prescribing physician by the fastest means practicable. A letter initially denying an appeal shall also inform the enrollee of his or her opportunity to request a state fair hearing, and the procedures that must be followed to pursue such further appeal.

4. Benefits During the Pendency of an Appeal

A. During the pendency of any appeal from denial of a pharmacy service due to the lack of required prior authorization, the enrollee will continue to be eligible for pharmacy benefits within applicable pharmacy service limits, but will not have any right to receive on a covered basis the drug that is the subject of the appeal.

B. If the enrollee chooses to purchase the unauthorized, prescribed drug at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the drug upon prevailing in his or her appeal, but only to the extent that applicable, monthly pharmacy benefit limits would not thereby be exceeded.

## III. Post Implementation Appeals of Application of Benefit Limits

### 1. Initial Notice

A. Pharmacists will be required to verify TennCare coverage for all prescriptions presented by enrollees through an electronic database maintained by the PBM. If, through the database, the PBM denies coverage of a prescription because the enrollee has reached or exceeded the monthly pharmacy benefit limit ("the pharmacy limit"), the PBM on behalf of the state will mail a written notice of the denial to the enrollee (Service Notice). Service Notice shall be provided only upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five prescription limit, and/or upon the first denial in that month of a pharmacy service sought by the enrollee that exceeds the two prescriptions limit on branded drugs. (For

purposes of this Part, "the pharmacy limit" is defined as a five prescription limit per month, of which no more than two prescriptions or refills could be for branded drugs and at least three out of any five prescriptions or refills in the same month must be for generic drugs.)

B. If a pharmacist fills a prescription in excess of the pharmacy limit and submits a claim for such service, the PBM will deny payment for the claim. Upon denial of payment for such claim, the PBM on behalf of the state will mail a written notice (Notice of Limit) to enrollees.

C. If a provider denies a non-pharmacy service or charges the enrollee for the service because the enrollee has reached or exceeded a benefit limit, the provider need not give specific notice of appeal rights to the enrollee but must direct the enrollee to the responsible arm of the managed care contractor (MCC).

D. If a provider renders a non-pharmacy service in excess of a non-pharmacy benefit limit and the provider or the enrollee submits a claim for such service, the MCC will deny payment for the claim. Upon denial of payment for such claims, the MCC, on behalf of the state, will mail a Notice of Limit to enrollees. A Notice of Limit shall be provided only upon the first denial of coverage of a non-pharmacy service sought by the enrollee that exceeds the applicable limit for the kind and number of services during a given time period specified in the state's program.

E. The Notice of Limit and Service Notice will:

i. Inform an enrollee that he or she has reached or exceeded the applicable benefit limit.

ii. Provide enrollees with at least 20 days from the Notice of Limit or Service Notice to request a hearing for valid factual disputes related to the benefit limit and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing, they will not receive continuation of benefits (i.e., services in excess of the applicable limit) during the pendency of their appeal.

iv. Remind enrollees of any exceptions to the limits and inform them how to obtain more information about such exceptions.

**2. Appeals Process**

A. Enrollees will have the opportunity to request a state fair hearing for at least 20 days from the date of the Notice of Limit or Service Notice.

B. The enrollee will be required to submit a designated form in order to request a state fair hearing. The form, which must be signed by the enrollee (or an individual

appointed or otherwise authorized to act as the enrollee's representative under state law), would include the basis for the appeal and the enrollee must attest, under penalty of perjury, that his contention is true to the best of his knowledge and is made in good faith. Enrollees may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its discretion of an exemption from a signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or by an individual authorized under state law to act as the enrollee's representative.

C. The state will grant a state fair hearing only for those enrollees raising valid factual disputes related to the benefit limit. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the service that was denied because the enrollee had reached or exceeded the applicable benefit limit. Valid factual disputes include:

i. An administrative error was allegedly made and the enrollee has not yet reached the relevant benefit limit.

ii. The enrollee alleges that his or her circumstances have changed and he or she has been re-classified in a TennCare eligibility category that is not subject to the benefit limit the state has applied. The state, however, shall not grant a hearing to individuals who allege solely that they are not subject to the benefit limit without further alleging a change of circumstances that has been reported to TennCare and has resulted in a change in their eligibility category. These enrollees will be granted a hearing because they did not have the opportunity to appeal the application of the benefit limit to them in connection with the Benefit Notice.

iii. The enrollee alleges an administrative error in the processing of a request for a special exemption to the benefit limit (i.e., the enrollee's physician submitted the required attestation necessary to obtain a special exemption from the benefit limit and the prescribed drug is on the special exemption list but coverage for the drug was nonetheless denied).

D. The enrollee shall not receive continuation of benefits when appealing a denial of services based on the application of a benefit limit. This policy shall apply even for items or services that have been previously authorized as medically necessary to the extent that the denial of services is based on the application of a benefit limit.

E. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal with respect to those benefits.

F. If the enrollee does not request a hearing, the benefit limit deemed applicable by the state will continue to apply to the enrollee.

G. Providers will be permitted to bill enrollees for services that were provided in excess of the benefit limits.

**IV. Post Implementation Appeals of Elimination of Coverage for Certain Services**

1. Neither the state nor the MCC will provide notification in addition to the Benefit Notice described above with respect to services that are eliminated from TennCare coverage as those services are no longer covered by TennCare.

2. Upon denial of non-covered services, TennCare enrollees will have the opportunity to request a state fair hearing. The enrollee will be required to submit a designated form in order to request a hearing. Such form would include a statement, which must be signed by the enrollee, or an individual appointed or otherwise authorized to act as the enrollee's representative under state law that sets out or describes the factual contention on which the appeal is based, and attests, under penalty of perjury, that the contention is true to the best of the signatory's knowledge and is made in good faith. Enrollees or their representatives may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the state at its discretion of an exemption from the signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or his/her authorized representative.

3. The state will grant a state fair hearing only for those enrollees who raise valid factual disputes related to the elimination of coverage. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to coverage of the disputed service. In the context of excluded services, valid factual disputes are limited to when an enrollee claims that he or she is already in a TennCare category that is entitled to coverage of the particular service at issue. Appeals that do not raise a valid factual dispute will be dismissed without a hearing.

4. If the request for a hearing is granted, the enrollee will not receive continuation of the benefits in dispute pending the appeal.

5. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee may be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal.

**PART III: ENROLLMENT IN TENNCARE STANDARD SPEND DOWN**

TennCare Standard Spend Down (SSD) is open people who are not currently eligible for Medicaid and who meet the criteria for the new SSD program. Financial eligibility criteria for

SSD will be based on criteria that apply to medically needy pregnant women and children eligible under the state Plan.

Applicants will be enrolled only through a single toll-free telephone point of entry (the Call-In Line) initiated in periods of open enrollment. In each open enrollment period, the state will determine a specified number of calls that it will accept through the Call-In Line based on the number of Category 1 applications that the state estimates it can process within federal timeliness standards. The state will not accept or track calls received outside of open enrollment periods.

Once the state has reached its targeted enrollment of 100,000 persons, new open enrollment periods will be scheduled when enrollment in the SSD program drops to 90 percent of target enrollment. Any subsequent open enrollment periods will remain open until a pre-determined number of calls to the Call-In Line have been received. The number of calls to be received will be established based on the state's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the state estimates it can process in a timely manner in accordance with federal standards. The state's decision to open or close enrollment is a policy decision that is within the state's discretion and the state is not required to provide fair hearings for challenges to these decisions.

Callers to the Call-In Line will be asked for basic demographic information and will be assigned a unique identifier. After conducting a match to verify that callers are not already enrolled in TennCare Medicaid as state plan eligibles, the state will send each non-enrolled caller a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within 30 days. (Those callers who are already enrolled in TennCare Medicaid as state plan eligibles will be sent letters advising them that they currently have benefits and need not apply.)

Completed signed applications received by the state by the 30-day deadline established by the state will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will still be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the state. If the individual does not mail back an application by the deadline, the state will send the individual a letter advising him or her that since no application was received, the state will not make an eligibility determination for him or her, but the individual is free to apply for SSD during any subsequent open enrollment period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he or she did submit a signed, written application within the deadline. Since all SSD applications received during an open enrollment period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open enrollment period will be carried forward to future open enrollment periods. The state will determine SSD eligibility within the timeframes specified by Federal regulations at 42 CFR 435.911; such timeframes will begin on the date a signed written application is received by the state.

The effective date of SSD eligibility for individuals whose enrollment is originally initiated through the Call-In Line and who submit a timely signed application will be the later of: 1) the date that their call was received by the Call-In Line; or 2) the date spend down is met (which must be no later than the end of the 1-month budget period -- in this case, the end of the month of the original call to the Call-In Line). The effective date provisions contained herein only apply to SSD eligibility and do not apply to other categories of TennCare eligibility. All enrollees in the SSD demonstration category will have an eligibility period of 12 months from the effective date of the determination. At the end of the 12-month period the enrollee will need to have his eligibility status redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for TennCare Medicaid.

## XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

| | | |
|---|---|---|
| **Monthly Deliverables** | | |
| Monthly | Monitoring Call | 46 |
| **Quarterly Deliverables** | | |
| 60 days after end of each quarter | Quarterly progress reports | 45(d)(iv), 44, 54 |
| Per Sections 2500 & 2115 of State Medicaid Manual, or upon request | Quarterly expenditure, budget neutrality, member month reports | 43, 44, Sections X and XI |
| **Annual Deliverables** | | |
| 120 days after end of each Demonstration year | Annual Progress Report | 45 |
| Dec. 31st of each year | Annual CHIP Report entered into CHIP Annual Report Template System (SARTS) | 45 |
| Sept. of each Demonstration year | Annual beneficiary survey report | 49 |
| **Other Deliverables** | | |
| 12 months before expiration of Demonstration | Request for extension | 8 |
| 12 months prior to suspending or terminating the Demonstration | Phase-out plan | 9 |
| 12 months before expiration of Demonstration | Interim evaluation report. | 8, 71 |
| 120 days after expiration of Demonstration | Draft Final Evaluation Report | 50, 71, 72 |
| 60 days after receipt of CMS comments on Draft Final Evaluation Report | Final Evaluation Report | 71, 72 |
| Implementation of compliance plan by January 1, 2013. | Enrollee notification and implementation of the new cost-sharing requirements | 37 |
| At least annually | MEQC plan proposal and report on findings | 25 |

| | | |
|---|---|---|
| Upon receipt by state | Financial audits and quality assessment reviews of participating health plans, and other managed care and HCBS requirements | 14, 42, 45 |
| Upon receipt by state | Fraud and abuse and program integrity reports related to 1115 Demonstration beneficiaries and providers | |
| As required by CMS | Corrective Action Plans and findings | |
| Upon submission to Regional Office | Courtesy copy of all state plan amendments to be sent to the CMS Project Officer | 7(d) |
| 60 days advance notice | Modification of CHOICES benefits defined in Attachment D | 7(c) |
| No later than 120 days prior to planned implementation and may not be implemented until approved | Demonstration amendments, including requests for services not defined in Attachment D | 6 and 7 |
| 30 days advance notice | Notice on increases in CHOICES Enrollment Targets within allowable range | 32 |
| 3 months after each point in time. i.e. September 30 of each demonstration year | Submission of CHOICES baseline data | 45(d) |
| Annually | Integrated Quality Improvement Strategy Update | 45(c) |
| Subject to CMS approval prior to implementation | Final MCO contracts developed for CMS approval | 14, 39 |
| When issued or amended by state | Procedural manuals or operating protocols related to the 1115 Demonstration | |
| *All Reports Required by Sections 2500 and 2115 of the State Medicaid Manual* | | |

## ATTACHMENT A

Under Section IX, paragraph 44 *(Quarterly Progress Report)* of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

**NARRATIVE REPORT FORMAT:**

**Title Line One** – TennCare II

**Title Line Two -** Section 1115 Quarterly Report

**Demonstration/Quarter Reporting Period:**
*Example: Demonstration Year: 6 (7/1/2007 – 6/30/2008)*
*Federal Fiscal Quarter: 1/2008 (10/07 - 12/07)*

**Footer:** Approval Period July 1, 2013 – June 30, 2016

### I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

### II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to TennCare eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any Demonstration amendments related to eligibility or benefits.
    - Progress on implementing TennCare Standard Spend Down.
    - Progress on phasing out the closed eligibility categories.
    - Other

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

**Enrollment Counts for Quarter**

Note: Enrollment counts should be person counts, not member months

| Demonstration Populations | Total No. TennCare Enrollees in current Quarter |
|---|---|
| **EG1 Disabled, Type 1 state plan eligibles** | |
| **EG1 Disabled and EG 9 H-Disabled, Type 2 Demonstration Population** | |
| **EG2 Over 65, Type 1 state plan eligibles** | |
| **EG2 Over 65 and EG-10 H-Over 65, Type 2 Demonstration Population** | |
| **EG3 Children, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 1 state plan eligibles** | |
| **EG4 Adults, Type 2 Demonstration Population** | |
| **EG5 Duals, Type 1 state plan eligibles and EG-11 H-Duals 65, Type 2 Demonstration Population** | |
| **EG6E Expan Adult, Type 3 Demonstration Population** | |
| **EG7E Expan Child, Type 3 Demonstration Population** | |
| **EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX** | |
| **Med Exp Child, Title XXI Demonstration Population** | |
| **EG12E Carryover, Type 3, Demonstration Population** | |

**III. Outreach/Innovative Activities to Assure Access**

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for TennCare enrollees or potential eligibles.

**IV. Collection and Verification of Encounter Data and Enrollment Data**

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

**V. Operational/Policy/Systems/Fiscal Developments/Issues**

Identify all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

**VI. Action Plans for Addressing Any Issues Identified**

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration.

**VII. Financial/Budget Neutrality Development/Issues**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

## VIII. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

### A. For Use in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| **EG1 Disabled, Type 1 state plan eligibles (paragraph 52(a)(ii))** | | | | |
| **EG1 Disabled, Type 2 Demonstration Population (paragraph 52(b)(iv))** | | | | |
| **EG9 H-Disabled, Type 2 Demonstration Population (paragraph 52(b)(iv))** | | | | |
| **EG2 Over 65, Type 1 state plan eligibles (paragraph 52(a)(iv))** | | | | |
| **EG2 Over 65, Type 2 Demonstration Population (paragraph 52(b)(vi))** | | | | |
| **EG10 H-Over 65, Type 2 Demonstration Population (paragraph 52(b)(vi))** | | | | |
| **EG3 Children, Type 1 state plan eligibles (paragraph 52(a)(iii))** | | | | |
| **EG4 Adults, Type 1 state plan eligibles (paragraph 52(a)(v))** | | | | |
| **EG4 Adults, Type 2 Demonstration Population (paragraph 52(b)(vii))** | | | | |
| **EG5 Duals, Type 1 state plan eligibles (paragraph 52(a)(i))** | | | | |
| **EG11 H-Duals, Type 2 Demonstration Population (paragraph 52(b)(iii))** | | | | |
| **EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX (paragraph 52(b)(ii))** | | | | |

**B. Not Used in Budget Neutrality Calculations**

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| **EG6E Expan Adult, Type 3, Demonstration Population (paragraph 52(b)(i)(A))** | | | | |
| **EG7E Expan Child, Type 3, Demonstration Population (paragraph 52(b)(i)(B))** | | | | |
| **Med Exp Child, Title XXI Demonstration Population (paragraph 52(c))** | | | | |
| **EG12E Carryover, Type 3, Demonstration Population (paragraph 52(b)(i)(C))** | | | | |

## IX. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

## X. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

## XI. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

## XII. Essential Access Hospital Pool

List the Essential Access Hospitals and specify their type from the following:
Essential Service Safety Net
Children's Safety Net
Free Standing Psychiatric Hospitals
Other Essential Acute Care

## XIII. Graduate Medical Education (GME) Hospitals

List the GME hospitals and their affiliated teaching universities.

## XIV. Critical Access Hospitals

List the Critical Access Hospitals.

## Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

**State Contact(s)**
Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

**Date Submitted to CMS**

## Attachment B

## Limitations on Home Health Services

Home health services are delivered in accordance with 42 CFR 440.70. Prior authorization may be required. Definitions and coverage limitations used by the state are as follows:

1. Home health services shall include any of the following services ordered by a treating physician and provided by a licensed home health agency pursuant to a plan of care at an enrollee's place of residence.

    a. Part-time or intermittent nursing services.

        (1) To be considered "part-time and intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, AND no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide care combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. The above limits may be exceeded when medically necessary for children under the age of 21.

        (2) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on an as needed basis. Part-time or skilled nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.

    b. Home health aide services.

        (1) Home health aide care must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

        (2) The above limits may be exceeded when medically necessary for children under the age of 21.

    c. Physical therapy, occupational therapy, speech pathology and audiology services.

d. Medical supplies, equipment, and appliances ordered by a treating physician and suitable for use at an enrollee's place of residence.

2. Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, or preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:

   a. The child is non-ambulatory; and

   b. The child has no or extremely limited ability to interact with caregivers; and

   c. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and

   d. No other children shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult.

## Attachment C

## Limitations on Private Duty Nursing Services

Private duty nursing services are delivered in accordance with 42 CFR 440.80. Prior approval may be required. Definitions and coverage limitations used by the state are as follows:

PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period. A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members.

1. If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home that determines whether the nursing services are continuous or intermittent.

2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:

    a. Have a demonstrated understanding, ability, and commitment to the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration, and feeding, as applicable; and

    b. Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and

    c. Are willing and available as needed to meet the recipient's non-nursing support needs.

3. Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:

    a. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

    b. Has a functioning tracheostomy

(1) Requiring suctioning, AND

(2) Oxygen supplementation, AND

(3) Receiving nebulizer treatments or requiring the use of Cough Assist/inexsufflator devices.

(4) In addition, for persons with a functioning tracheostomy, at least one from each of the following (I and II) must be met:

(I) Medication

(a) Receiving medication via a gastrostomy tube (G-tube), OR

(b) Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port. AND

(II) Nutrition

(a) Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube), OR

(b) Receiving total parenteral nutrition.

4. Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.

5. A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period, or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of Subparagraph (a) may receive medically necessary nursing care as an intermittent service under home health.

6. General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have other non-medical caregiving needs which must be met, to the extent that private duty nursing services are provided to a person under 18 years of age, a responsible adult (other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

a. The child is non-ambulatory; and

b. The child has no or extremely limited ability to interact with caregivers; and

c. The child would not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse would be present in the home without the presence of another responsible adult; and

d. No other children will be present in the home during the time the private duty nurse would be present in the home without the presence of another responsible adult.

## Attachment D
## Glossary of Terms for the TennCare CHOICES

**Adult day care.** Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day provided pursuant to an individualized plan of care by a licensed provider not related to the participating adult.

**Adult care homes.** A state-licensed community-based residential alternative which offers 24-hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet nursing facility level of care, but who would prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-basis is living in the home with the individuals for whom they are providing care.

**Assisted care living facility services**. Community-based residential alternative to nursing home care in a licensed Assisted Care Living Facility that provides and/or arranges for daily meals, personal, homemaker and other supportive services or health care including medication oversight (to the extent permitted under state law), in a home-like environment to persons who need assistance with activities of daily living. Coverage shall not include the costs of room and board.

**Assistive technology.** Assistive device, adaptive aids, controls or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive or control their environment. Examples include, but are not limited to, 'grabbers' to pick objectives off the floor, strobe light to signify the smoke alarm has been activated, etc.

**At-Risk.** As it relates to the CHOICES program, SSI eligible adults age 65+ or age 21+ with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined by the state in administrative rule, such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As is relates to Interim CHOICES 3, open for enrollment starting on July 1, 2012 and closed to enrollment on December 31, 2013, "at risk" is defined as adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meeting nursing facility financial eligibility criteria, and also meet the nursing facility level of care in effect on June 30, 2012.

**Attendant care.** Hands-on assistance, safety monitoring and supervision for an enrollee who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visits (more than four (4) hours per visit or visits at intervals of less than four (4) hours between visits). This may include assistance with activities of daily living (ADLs) such as bathing, dressing and personal hygiene,

eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, attendant care may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home, or continuous monitoring and supervision because there is no household member, relative, caregiver, or volunteer to meet the specified need. Attendant care shall not be provided for enrollees who do not require hands-on assistance with ADLs.

Attendant care does not include:

1) Care or assistance including meal preparation or household tasks for other residents of the same household;
2) Yard work; or
3) Care of non-service related pets and animals.

Only for persons who require homemaker services in addition to hands-on assistance with ADLs, the annual benefit shall be up to 1400 hours per full calendar year.

**Community-based residential alternatives to institutional care (Community-based residential alternatives).** Residential services which offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, assisted care living facilities, adult care homes, and companion care.

**Companion care.** A consumer-directed residential model in which a CHOICES member may choose to select, employ, supervise and pay, utilizing the services of a fiscal intermediary, on a daily, weekly, or monthly basis, as applicable, a live-in companion who will be present in the member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration. Such model will be available only for a CHOICES member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with activities of daily living or supervision and monitoring for extended periods of time that cannot be met more cost-effectively with other non-residential services. A CHOICES member who requires assistance in order to direct his or her companion care may designate a representative to assume consumer direction of companion care services on his/her behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.

**Consumer direction of HCBS.** The opportunity for a member assessed to need specified types of HCBS including attendant care, personal care, homemaker services (provided only as part of attendant care or personal care visits), in-home respite, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the

hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed service(s).

**Electronic visit verification (EVV) system**. An electronic system in which caregivers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of HCBS and which may also be utilized for submission of claims.

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

**Homemaker services.** Effective July 1, 2012, homemaker services are only available as part of attendant care or personal care visits for individuals who need hands-on assistance with ADLs. Services covered include general household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the member, changing the member's linens, making the member's bed, washing the member's dishes, doing the member's personal laundry, ironing, or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the member, assistance with maintenance of safe environment, and errands such as grocery shopping and having the member's prescriptions filled. Homemaker services are to be provided only for the member (and not for other household members) and only when the member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the member.

**In-home respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in the individual's place of residence, because of the absence or need for relief of those persons normally providing the care.

**In-patient respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in a licensed nursing facility or licensed community-based residential alternative, because of the absence or need for relief of those persons normally providing the care.

**Minor home modifications.** Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered

improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

**Nursing facility care.** See Social Security Act, section 1919(a).

**Personal emergency response system (PERS).** An electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. The individual may also wear a portable 'help' button to allow for mobility. The system is programmed to signal a response center once the 'help' button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed.

PERS services are limited to those individuals who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time, such that the individual's safety would be compromised without access to a PERS.

**Personal care visits.** Intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance to an enrollee who, due to age and/or physical disability, needs help with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, personal care visits may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need.

Personal care visits do not include:

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

**Pest control.** The use of sprays, poisons and traps, as appropriate, in the enrollee's residence (excluding NF, ACLF) to regulate or eliminate the intrusion of roaches, wasps, mice, rats and other species of pests into the household environment thereby removing an

environmental issue that could be detrimental to a frail elderly or disabled enrollee's health and physical well-being.

**Reserve capacity.** The state's right to maintain some capacity within an established enrollment target to enroll individuals into HCBS under certain circumstances. These circumstances could include, but are not limited to: accommodation of a phased in implementation of the CHOICES program; discharge from a nursing facility; discharge from an acute care setting where institutional placement is otherwise imminent, or other circumstances which the state may establish from time to time in accord with these STCs.

**Room and board.** Refers to lodging, meals, and utilities. The kinds of items that are considered "room and board" and are therefore not reimbursable by Medicaid include:

- Rent, or, if the individual owns his home, mortgage payments, depreciation, or mortgage interest
- Property taxes
- Insurance (title, mortgage, property and casualty)
- Building and/or grounds maintenance costs
- Resident "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included)
- Household supplies necessary for the room and board of the individual
- Furnishings used by the resident
- Utilities (electricity, water and sewer, gas)
- Resident telephone
- Resident cable television

**Short Term Nursing Facility Care.** The provision of nursing facility care for up to no more than 90 days to a CHOICES 2 or CHOICES 3 participant who was receiving home and community based services upon admission and who requires temporary placement in a nursing facility—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 90 days. Such CHOICES 2 or CHOICES 3 member must meet the nursing facility level of care upon admission (which for CHOICES 3 participants is anticipated to be due to a short-term condition), and in such case, while receiving short-term nursing facility care may continue enrollment in CHOICES 2 or CHOICES 3, as applicable, pending discharge from the nursing facility within no more than 90 days or until such time it is determined that discharge within 90 days from admission is not likely to occur, at which time the person shall be transitioned to CHOICES 1, as appropriate. The community personal needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

**Transition Allowance.** A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of a managed care organization, be provided as a cost-effective alternative to continued institutional care for a CHOICES

member in order to facilitate transition from a nursing facility to the community when such member will, upon transition, receive more cost-effective non-residential home and community based services or companion care. Items which may be purchased or reimbursed are only those items that the member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

**Attachment E**
**Best Practices Guidance Regarding**
**Consumer Direction of Home and Community Based Services**

The state will define services that eligible members may elect to direct. Members determined, as a part of the needs assessment and plan of care processes, to require such services will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e. consumer direction of HCBS).

All eligible members requiring these services will be offered the option to participate in consumer direction of HCBS.

i. Upon enrollment in HCBS and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.

ii. Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at anytime, service by service, without affecting their enrollment in HCBS. Only the state can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare.

iii. A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or be a member's paid worker.

iv. The state will utilize a fiscal employer agency (FEA) to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services rendered; and withholding, filing and paying applicable Federal, state and local income and employment taxes for workers) and to provide supports broker assistance.

v. The plan of care process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports, contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.

vi. Members will have the flexibility to hire persons close to them, including family members but excluding spouses, to serve as their workers. All workers must meet the state specified qualifications for providers of comparable non-consumer directed services and must sign a service agreement.

vii. Members will have flexibility in establishing payment rates that do not exceed the state specified ceiling for each service.

viii. Members and/or representatives must receive training prior to participating in consumer direction of HCBS and re-enrolling in consumer direction of HCBS. Ongoing training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.

ix. Workers must receive training, as a condition for hire, which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.

x. A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care, and the adequacy of payment rates.

**Attachment F**
**Certified Public Expenditures Protocol**

## Preamble

This protocol governs the use of certified public expenditures to furnish the non-Federal share of expenditures claimed for Federal participation under the Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (paragraph 54(h)). The protocol is based on the following elements:

1) Units of government, including governmentally operated health care providers, may certify that costs have been incurred for providing services to TennCare and uninsured individuals. The CPE process contained in this attachment is in accordance with Federal regulations and CMS guidance or policy.

   i. Units of government have been determined by the state as eligible to certify public expenditures.

   ii. Certification must be supported by cost documentation, which represents both the Federal and non-Federal share of funds (i.e., total computable expenditures) under the Demonstration. Federal matching funds are available as a percentage of such eligible costs.

2) To the extent the state continues to utilize certified public expenditures (CPEs) as the funding mechanism for title XIX and XXI (or under section 1115 authority) payments beyond the date defined in this section, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs as eligible under title XIX or XXI (or under section 1115 authority) for purposes of certifying public expenditures.

3) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the state the amount of such tax revenue (state or local) appropriated to the non-governmental provider used to satisfy Demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the state's claim for Federal match. Federal matching funds will be available as a percentage of such eligible costs.

## I. Cost Computation

### A. TN CPE 1115 – Medicaid Fee-For-Service

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552)

covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P)routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from MMIS for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the

cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

**B. <u>TN CPE 1115 – Medicaid Managed Care</u>**

For the state payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P)routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not

be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

## C. TN CPE 1115 – Hospital Uninsured Care

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently as-filed Medicare cost report (CMS 2552), as-filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the as-filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospital's audited financial statements and other auditable documentation. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospital's actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term services and supports are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of Uninsured care usable organs to total usable organs. This is determined by dividing the number of Uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible Uninsured care costs are determined by adding the Uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual Uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

## II. <u>Payments and recoveries</u>

All payments and recoveries, from MCO's; BHO's; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds) including any related patient co-payments, or payments from other non-state payers will be offset against the costs computed in Section I above. Payments to the hospital from uninsured individuals for their care for the fiscal year are identified from the hospital's records. Such uninsured data must be supported by auditable documentation.

## III. Interim Reconciliation

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3

Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5

Actual Medicaid paid days and charges from MMIS paid claims data for services furnished during the payment year are used.

Step 6

Organ acquisition costs and total usable organs from the as-filed CMS 2552 cost report for the payment year are used.

## IV. Final Reconciliation

Upon finalization of the CMS-2552 by the Medicare fiscal intermediary, the methodologies as prescribed above will be used to determine final Medicaid FFS cost, Medicaid managed care cost, and uninsured cost. The routine per diems and ancillary cost-to-charge ratios will be determined using cost, day and charge data from the finalized cost report. The Medicaid FFS, Medicaid managed care, and uninsured days, charges, and payment offsets will be updated with the latest MMIS reports and other auditable financial records.

Cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include:

1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS data to the per diem amount;

2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and

3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly except for Medicaid.

If, at the end of the reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Recoveries are updated and offset to cost as calculated per Steps above.

For hospitals whose cost report year is different from the state's fiscal year, the state will proportionally allocate to the state plan rate year the costs of two cost report periods encompassing the state Plan payment year. To do so, the state will obtain the actual Medicaid FFS, Medicaid managed care, and uninsured days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS, Medicaid managed care, and uninsured costs for the reporting periods; these costs will then be proportionally allocated to the state plan rate year. All allocations will be made based upon number of months. (For example, a hospital's cost reporting period ending 12/31/07 encompasses three-fourths of the state plan rate year ending 9/30/2007, and one-fourth of the state plan rate year ending 9/30/2008. To fulfill reconciliation requirements for state plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2006, to the state plan rate year.) The state will ensure that the total costs claimed in a state plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Center for Medicaid and CHIP Services**

June 15, 2012

Mr. Darin Gordon
Director
Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

The Centers for Medicare and Medicaid Services (CMS) has approved Amendments #14 and #16 for Tennessee's section 1115 Medicaid demonstration, TennCare II (11-W-00151/4). Amendment #14 authorizes an increase to the enrollment targets for the CHOICES 2 program, which was formerly requested as Amendment #13, and approves the rebalancing of the CHOICES managed long-term care program and the creation of *Interim* CHOICES 3. Amendment #14 is effective as of July 1, 2012. Approval of Amendment #16 fully responds to the State's request to remove the DSH allotment from the existing hospital pool to implement Tennessee's DSH allotment authorized under the Affordable Care Act and to ensure that other obligations to hospitals can be fulfilled. Amendment #16 is effective as of the date of this letter. Furthermore, CMS is no longer considering Amendment #12, as modified by the State on May 5, 2011 to impose a $2 copayment on non-emergency medical transportation, as under active review.

In addition to the above, the following technical changes are made to the STCs:

- Corrects a cross-reference in Table 2a of STC paragraph 30.
- Replaces a specific State statutory citation with a general reference to the annual legislation that authorizes allocations to the Unreimbursed Hospital (UHC) Pool in STC paragraph 57(k).
- Incorporates modifications to the service definitions for attendant care, homemaker services, and personal care visits in Attachment D as approved on May 8, 2012.
- Updates the list of waivers in "Table 1a – TennCare Eligibility Groups" to remove references to waivers that were eliminated in Amendment #11.

The approval is conditioned upon compliance with the enclosed STCs, and is subject to our receiving your acknowledgement of the award and the acceptance of the STCs, waiver list, and expenditure authorities within 30 days of the date of this letter.

Your project officer is Mr. Paul Boben. He is available to answer questions concerning this demonstration project and may be contacted as follows:

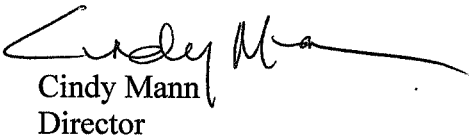
Mr. Paul Boben
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mailstop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-6629
Facsimile: (410) 786-5882
Email: Paul.Boben@cms.hhs.gov

Official communications regarding program matters should be submitted simultaneously to Ms. Kaufman, and to Ms. Jackie Glaze, Associate Regional Administrator in our Atlanta Regional Office. Ms. Glaze's address is:

Ms. Jackie Glaze
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional concerns regarding CMS oversight of this demonstration or questions, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, at (410) 786-5647.

Sincerely,



Cindy Mann
Director

Enclosures

cc: Jackie Glaze, Associate Regional Administrator, Atlanta Regional Office
Kenni Howard, State Coordinator for Tennessee, Atlanta Regional Office
Paul Boben, Technical Director, Center for Medicaid and CHIP Services

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**WAIVER LIST**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or specified as not applicable in the following list, shall apply to all TennCare II populations identified in paragraph 17 *(Eligibility)* of the Special Terms and Conditions.

The TennCare II Demonstration will operate under these waiver authorities and those provisions specified as "not applicable" beginning with the approval date for Amendment #7. The waiver authorities and the provisions specified as "not applicable" will continue through June 30, 2013, unless otherwise stated.

The following waivers shall enable Tennessee to implement the TennCare II Medicaid section 1115 Demonstration.

**WAIVERS OF TITLE XIX REQUIREMENTS FOR TENNCARE MEDICAID TITLE XIX STATE PLAN GROUPS**

**1. Statewideness/Uniformity** **Section 1902(a)(1)**
**42 CFR 431.50**

To the extent necessary to enable the State to provide managed care plans or certain types of managed care plans only in certain geographical areas of the State. Certain managed care plans or certain types of managed care plans (e.g., risk-based plans) are only available in certain areas of the State.

To the extent necessary to limit the implementation of CHOICES to certain geographic areas of the State during a phase-in period.

**2. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR 438.52**

To the extent necessary to permit the State to have only one pharmacy benefits manager and one dental benefits manager to provide services in a region of the State or statewide.

**3. Proper and Efficient Administration** **Section 1902(a)(4)(A)**
**42 CFR 435.831**

To the extent necessary to enable Tennessee to use streamlined eligibility procedures that provide for coverage of optional Medically Needy children and pregnant women and the Standard Spend Down Demonstration population for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. In accord with the Code of Federal Regulations, the "budget period" is the period of time used by the State to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

**4. Reasonable Promptness** **Section 1902(a)(8)**

To the extent necessary to enable the State to limit enrollment in CHOICES 2 and 3 to the enrollment target(s) established by the State, as authorized under 34(e) (*Enrollment Targets for TennCare CHOICES)* of the Special Terms and Conditions, and to allow the State to require applicants for long-term care services to complete a person-centered assessment and options counseling process.

**5. Access to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Benefits** **Section 1902(a)(10)**
**42 CFR 440.210 and 440.220**

To the extent necessary to enable the State to permit managed care contractors to limit coverage of FQHC and RHC services, so long as access to care is assured from other providers.

**6. Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B)**
**42 CFR 440 Subpart B**

To the extent necessary to enable the State to offer a reduced benefit package, a different benefit package, or cost-effective alternative benefit packages to different populations under the Demonstration (except for individuals specified in section 1902(l)(4) of the Act), to the extent authorized under section V of the Special Terms and Conditions.

**7. Comparability and Amount Duration and Scope** **Sections 1902(a)(17) and 1902(a)(10)(B)**

Should the State change the level of care criteria for admission to nursing facilities, to the extent necessary to enable the State to determine whether an individual has a continuing need for nursing facility services, PACE services, or home and community-based services for the elderly and disabled, based on the criteria in use when the individual first was determined to need the service.

**8. Freedom of Choice** **Section 1902(a)(23)**
**42 CFR 431.51**

To enable the State to restrict freedom of choice of provider, through the use of mandatory enrollment in managed care plans or TennCare Select for the receipt of TennCare II and TennCare CHOICES covered services, including for individuals specified at section 1932(a)(2) of the Social Security Act (the Act).

**9. Retroactive Eligibility** **Section 1902(a)(34)**
**42 CFR 435.914**

To enable the State not to extend eligibility prior to the date that an application for assistance is made.

**10. Payment for Outpatient Drugs** **Section 1902(a)(54)**
**42 CFR 440.120,**
**447.331-447.334,**
**and 456 Subpart K**

To the extent necessary to enable the State to establish a drug formulary that does not comply with the requirements of section 1927(d)(4) of the Act.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

**NUMBER:** **No. 11-W-00151/4 Title XIX**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this Demonstration extension, be regarded as expenditures under the State's Medicaid title XIX State plan.

The following expenditure authorities shall enable Tennessee to implement the Medicaid section 1115 Demonstration (TennCare II).

**1. Expenditures Related to MCO Enrollment and Disenrollment**

Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Tennessee managed care plans will be required to meet all requirements of section 1903(m) except the following:

- Section 1903(m)(2)(A)(vi) of the Act, Federal regulations at 42 CFR 438.56, to the extent that the rules in section 1932(a)(4) are inconsistent with the enrollment and disenrollment rules contained in paragraph 41 *(Plan Enrollment and Disenrollment)* of the Demonstration's Special Terms and Conditions (STCs), such as restricting an enrollee's right to disenroll within 90 days of enrollment in a new managed care organization (MCO). Enrollees may change MCOs without cause within 45 days of enrollment in an MCO. After 45 days, enrollees may disenroll from an MCO with cause at any time.

**2. Expenditures Related to Expansion of Existing Eligibility Groups**

To enable Tennessee to use streamlined eligibility procedures and include eligibility standards and requirements that differ from those required by law.

a. Expenditures for Medical Assistance furnished to State plan optional Medically Needy children and pregnant women for the remainder of a 12-month eligibility period after the 1-month budget period used for determining eligibility. The "budget period" is the period of time used by the State to determine whether an individual has "spent down" enough to meet the Medically Needy Income Standard.

b. Expenditures for Medical Assistance furnished to mandatory State plan Transitional Medical Assistance beneficiaries, who are eligible in accordance with section 1931(c)(1) of the Act, for the remainder of a 12-month eligibility period after the 4-month period specified in the statute.

**3. Expenditures for Expanded Benefits and Coverage of Cost-Effective Alternative Services**

a. Expenditures for TennCare Medicaid and TennCare Standard child enrollees for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR 438 *et seq*. and paragraph 31 *(Cost-Effective Alternatives)* of the Demonstration's STCs.

b. Expenditures for TennCare Medicaid and TennCare Standard adult enrollees for optional services not covered under Tennessee's State plan or beyond the State plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR 438 *et seq*., paragraph 30 *(TennCare Benefits)*, and paragraph 31 *(Cost-Effective Alternatives)* of the Demonstration's STC.

**4. Expenditures for Pool Payments**

Expenditures for Graduate Medical Education, Essential Access Hospital, Critical Access Hospital, Meharry Medical College, Unreimbursed Public Hospital Costs for Certified Public Expenditures, Unreimbursed Hospital Cost, and Public Hospital Supplemental Payment pool payments to the extent specified in paragraph 57(d) through (h) and (j) through (l) *(Extent of Federal Financial Participation for the Demonstration)* of the Demonstration's STCs.

**5. Indirect Payment of Graduate Medical Education**

Expenditures, up to $50 million in total computable expenditures for each Demonstration year, for payments to universities that operate graduate physician medical education programs, which are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics.

**6. Payments for Non-Risk Contractor**

Payments to the TennCare Select prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor more than what Medical Assistance would have paid fee-for-service under the State plan in accordance with the upper limits at 42 CFR 447.362.

**7. Expenditures Related to Eligibility Expansion**

Expenditures to provide Medical Assistance coverage to the following Demonstration populations that are not covered under the Medicaid State plan and are enrolled in TennCare Standard (or TennCare Medicaid – Transition Group):

a. **Medically Eligible Demonstration Population Children, Not CHIP Eligible**
Uninsured children under age 19 who lose eligibility in TennCare Medicaid, have been determined to be "medically eligible" (uninsurable), have family income at or above 200 percent of the Federal poverty level (FPL), and do not meet the definition of an optional targeted low-income child.

b. **Adult Demonstration Population Eligibles**

i) **Transition Group Adults:** Non-pregnant, non-postpartum adults aged 21 or older who were covered under the Medicaid State plan on July 1, 2007, as medically needy caretaker relatives or aged, blind, or disabled individuals (see paragraph 22, *Transition Group – Adult Medicaid State Plan* of the STCs). Individuals eligible under the State plan as of the Demonstration extension's approval date shall be transferred to this Demonstration population until their eligibility redetermination for other Medicaid State plan and Demonstration eligibility groups is completed in accordance with Section XIII of the Demonstration's STCs. If determined not eligible in any other group, the individual shall be disenrolled from the Transition Group. An individual's transition coverage shall continue until all appeals from the eligibility redetermination are exhausted.

ii) **Standard Spend Down (SSD):** Non-pregnant, non-postpartum adults aged 21 or older who have been determined to meet criteria patterned after the State plan Medically Needy requirements (see paragraph 21, *Standard Spend Down (SSD) – Adult Non-State Plan Demonstration* of the STCs), comprising:

- Aged, blind, or disabled individuals; or
- Caretaker relatives.

iii) **Discontinued Demonstration Group:** Uninsured and/or "medically eligible" (uninsurable) adults aged 19 or older who were enrolled in TennCare II and who have not yet been disenrolled or determined eligible in an active Medicaid category (see paragraph 23, *Discontinued Demonstration Group – Adult Demonstration Populations Discontinued Through March 24, 2005 Demonstration Amendment* of the STCs).

**8. CHIP-Related Medicaid Expansion Demonstration Population Children**

Expenditures to provide Medical Assistance coverage to uninsured children who lose eligibility under TennCare, meet the definition of optional targeted low-income child, and have family income up to 200 percent of the FPL.

**9. The CHOICES 217-Like HCBS Group.**

Expenditures for TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities and who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under TennCare CHOICES were provided under a HCBS waiver granted to the State under section 1915(c) of the Act, as of the initial approval date of the TennCare CHOICES component of this demonstration. This includes the application of the spousal impoverishment eligibility rules. These expenditures are limited to those necessary to provide:

a. Services as presented in Table 2a of the STCs;

b. Home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs, net of beneficiary regular and spousal impoverishment post-eligibility responsibility for the cost of care, and with post-eligibility treatment of income for individuals receiving short-term Nursing Facility care calculated as if they were receiving HCBS in the community.

**10. HCBS Services for SSI-Eligibles.**

Expenditures (as of the initial approval date of the TennCare CHOICES component of this demonstration and subject to limits as described in the STCs), for the provision of home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs that are not described in section 1905(a) of the Act and not otherwise available under the approved State plan but could be provided under the authority of section 1915(c) waivers, that are furnished to TennCare CHOICES enrollees who are age 65 and older and adults age 21 and older with disabilities with income at 100 percent of the Supplemental Security Income/Federal Benefit Rate and resources at or below $2,000 who either:

a. Meet the nursing facility institutional level of care; or

b. Do not meet the nursing facility institutional level of care but who, in the absence of TennCare CHOICES services, are "at risk" of institutionalization.

**11. The At Risk Demonstration Group.**

Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open to enrollment starting July 1, 2012.

Expenditures for these individuals are:

a. Services as presented in Table 2a of the STCs.

b. Home and community-based waiver-like services as specified in Table 2b and Attachment D of the STCs, net of beneficiary post-eligibility responsibility for the cost of care (including application of spousal impoverishment rules), and with post-eligibility treatment of income for individuals receiving short-term. Nursing Facility care calculated as if they were receiving HCBS in the community.

**12. Continuing Receipt of Nursing Facility Care.**

Should the State change the level of care criteria for admission to nursing facilities, expenditures for CHOICES-enrolled nursing facility residents who do not meet the nursing facility level of care criteria, but continue to meet the level of care criteria in place at the time of admission/enrollment.

**13. Continuing Receipt of Home and Community-Based Services.**
Should the State change the level of care criteria for admission to nursing facilities, expenditures for CHOICES-enrolled individuals receiving nursing facility or home and community-based waiver-like services for the disabled and elderly who do not meet the nursing facility level of care criteria, but continue to meet the level of care criteria in place at the time of admission/enrollment.

**14. Continuing Receipt of Program of All-Inclusive Care for the Elderly (PACE) Services.**
Should the State change the level of care criteria for admission to nursing facilities, expenditures for PACE-enrolled individuals, who upon redetermination do not meet the current nursing facility level of care criteria, but continue to meet the level of care criteria in place at the time of admission/enrollment. For purposes of this Demonstration, individuals meeting these criteria constitute the PACE Carryover Group.

**15. LTC Partnership.**
Expenditures for individuals in CHOICES 2 to participate in the Long Term Care Partnership Program.

**REQUIREMENTS NOT APPLICABLE TO TENNCARE STANDARD TITLE XIX DEMONSTRATION ELIGIBLE GROUPS**

All Title XIX requirements that are waived for the TennCare Medicaid Groups are also not applicable to the TennCare Standard Title XIX Demonstration Eligible Groups. In addition, the following is not applicable to the Title XIX Demonstration Eligible Groups.

| | |
|---|---|
| **Cost Sharing** | **Section 1902(a)(14) and Section 1916**<br>**42 CFR 447.51 – 447.56** |

To enable the State to charge cost sharing beyond applicable Medicaid limits to TennCare Standard Demonstration populations, with cost-sharing subject to an aggregate cap of 5 percent of family income for children.

# CENTERS FOR MEDICARE & MEDICAID SERVICES
# SPECIAL TERMS AND CONDITIONS (STCs)

**NUMBER:** **11-W-00151/4 (Title XIX)**

**TITLE:** **TennCare II**

**AWARDEE:** **Tennessee Department of Finance and Administration**

**DEMONSTRATION EXTENSION PERIOD:** **July 1, 2010 through June 30, 2013**

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**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS**

**NUMBER:** **Title XIX No. 11-W-00151/4**

**TITLE:** **TennCare II Medicaid Section 1115 Demonstration**

**AWARDEE:** **Tennessee Department of Finance and Administration**

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for Tennessee's TennCare II section 1115(a) Medicaid Demonstration extension (hereinafter referred to as "Demonstration"). The parties to this agreement are the Tennessee Department of Finance and Administration, Bureau of TennCare ("State") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the Demonstration project. The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective as of the approval letter's date, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This Demonstration extension is approved through June 30, 2013.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits; CHOICES Enrollment and Implementation, Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality for the Demonstration; Evaluation of the Demonstration; TennCare Eligibility Redetermination and Disenrollment and Rights; Appeals Process for Changes in Benefits; Enrollment in Standard Spend Down; and the Schedule of State Deliverables During the Demonstration Extension.

## II. PROGRAM DESCRIPTION AND OBJECTIVES

TennCare II is a continuation of the State's Demonstration, funded through titles XIX and XXI of the Social Security Act (the Act). TennCare began as an 1115(a) Demonstration project in January 1994. A 3-year extension was approved for 1999-2001, and a 1-year extension was approved early in 2002. A new TennCare II 1115(a) Demonstration was approved by CMS on May 30, 2002, and initiated on July 1, 2002, for a 5-year period. On October 5, 2007, an extension was granted under section 1115(a) through June 30, 2010, with revised waiver and expenditure authorities and STCs. (Note: Temporary extensions under the existing TennCare II STCs were granted for the July 1 through October 5, 2007 period, in order to provide additional time to conclude discussions on a longer extension.) The current extension, granted in December 2009 under the authority of section 1115(e) of the Act, will be in effect from July 1, 2010 through June 30, 2013. As of June 2009, the TennCare II program had 1.236 million enrollees, about half of whom were children. All mandatory and optional populations eligible under Tennessee's State plan are enrolled in TennCare II, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only").

There are three components to the TennCare II Demonstration program. **TennCare Medicaid** is the component that serves enrollees who are Medicaid-eligible under Tennessee's title XIX State plan. **TennCare Standard** is the component that serves title XIX Medicaid enrollees who are eligible only through the Demonstration's expenditure authorities**.** Title XXI Medicaid expansion children are also served under TennCare Standard, with a more extensive benefits package and different service delivery system than the children served under the title XXI stand-alone Children's Health Insurance Program (CHIP). Both TennCare Medicaid and TennCare Standard deliver all Medicaid services, except for services specified at paragraphs 30 *(TennCare Benefits)* and 32 *(Medicaid Benefits Carved Out of TennCare II Demonstration)* as excluded from the TennCare benefits package for specified populations.

The **CHOICES** Program is the newest component. CHOICES utilizes the existing for-risk, Medicaid managed care organizations to provide eligible individuals with nursing facility services or home and community based services. Prior to implementation of this amendment as set forth in STC 34(c) *(Regional Rollout of 1115 and Concurrent Ending of the 1915(c) Waiver – Implementation)*, Tennessee operated a Home and Community Based Services (HCBS) Program through a section 1915(c) Medicaid waiver (control number 0381.R01), and provided Medicaid funding for nursing facility services on a fee-for-service basis. With the implementation of the CHOICES program, home and community based services and nursing facility services are added to the existing TennCare II benefit package of primary, acute, and behavioral health services for qualifying State Plan and Demonstration eligible individuals. This provides participating individuals with an integrated package of acute and long-term care service benefits, through a managed care delivery system. The CHOICES program will be implemented in stages over time in different geographic areas of the State. Current HCBS participants and nursing facility residents are assured continuation of services, in accord with the medical necessity criteria in place at the time of admission. All expenditures for nursing facility, 1915(c) HCBS, and

CHOICES services are subject to the budget neutrality limit for TennCare II on a statewide basis as of the initial implementation of CHOICES in the Middle Tennessee Grand Region, which occurred on March 1, 2010. (See also paragraph 34(c)(i) *Regional Rollout of 1115 and Concurrent Ending of 1915(c) Waivers – Implementation.*)

The goals of TennCare and TennCare CHOICES are the following:

- Use a managed care approach to provide services to Medicaid State plan and Demonstration enrollees at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.
- Assure appropriate access to care for enrollees.
- Provide quality care to enrollees.
- Assure enrollees' satisfaction with services.
- Improve health care for program enrollees.
- Assure that participating health plans maintain stability and viability, while meeting all contract and program requirements.
- Provide appropriate, and cost-effective home and community based services that will improve the quality of life for persons who qualify for Nursing Facility care, as well as for persons who do not qualify for Nursing Facility care but are "at risk" of institutional placement.

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as

amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below *(Amendment Process)*.

**7. Amendment Process.** Requests to amend the Demonstration, including but not limited to TennCare II or CHOICES benefits, must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved.

a. Amendment requests must include, but are not limited to, the following:

i. An explanation of the public process used by the State, consistent with the requirements of paragraph 15 *(Public Notice and Consultation with Interested Parties)*, to reach a decision regarding the requested amendment;

ii. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

iii. An up-to-date CHIP allotment neutrality worksheet, if necessary;

iv. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

v. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

b. Changes to TennCare II benefits described in the State plan shall be made by State plan amendment. Changes to TennCare II benefits not described in the State plan shall be made by amendment to the Demonstration. Changes in benefits shall be implemented in accordance with the process set forth in Section XIII of these STCs.

c. Additions or Changes to CHOICES Benefits. All requests for changes in coverage of CHOICES benefits are subject to CMS approval. Changes in benefits

defined in Attachment D must be submitted to CMS for approval at least 60 days in advance of the State's desired implementation date. Requests for services that are not defined in Attachment D must be submitted by the State to CMS as a request to amend the demonstration.

d. The State must send a courtesy copy of all Medicaid State plan amendment requests to the Project Officer. This requirement is in addition to the submissions that the State must make as part of the usual State plan amendment process, and is not meant to substitute for or supplant that process in any way.

**8. Extension of the Demonstration.** No later than 12 months prior to the expiration date of the Demonstration, the State must submit to CMS either a Demonstration extension request and proposal, or a Demonstration phase-out plan. The State's extension proposal must be compliant with CMS written guidance on Demonstration extensions, and in addition, must include the elements described in paragraph 45(e)(i) regarding the Affordable Care Act. The State's phase-out plan must be consistent with the requirements of paragraph 9, and in addition, must include the elements described in paragraph 45(e)(ii).

**9. Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least six (6) months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10 *(Enrollment Limitation During Demonstration Phase-Out)* a phase-out plan shall not be shorter than six (6) months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

**10. Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9 *(Demonstration Phase-Out)*, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

**11. CMS Right to Terminate or Suspend**. CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

15. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6 *(Changes Subject to the Amendment Process)* are proposed by the State.

16. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

## IV. ELIGIBILITY

**17. Eligibility.** Tennessee includes in the TennCare II Demonstration all of the mandatory and optional populations eligible under the Tennessee Medicaid State plan, except for Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries who are not Medicaid eligible or who do not receive Medicaid ("QMB-only" and "SLMB-only"). Also included in TennCare II are several title XIX Demonstration-only eligible populations and one title XXI Medicaid Expansion Demonstration population. Medicaid State plan-eligible individuals and the Demonstration-eligible Transition Group (see paragraph 22 *Transition Group – Adult Medicaid State Plan Eligibility Categories for Which Enrollment is Closed*) are served in the component of the program called TennCare Medicaid. Other Demonstration-only eligible populations are served in the component called TennCare Standard.

The mandatory and optional Medicaid State plan populations described below derive their eligibility through the Medicaid State plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the Demonstration to generate savings for covering the Expansion populations, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.

The title XXI Medicaid Expansion Demonstration population is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State plan, except as otherwise listed as not applicable.

Under the TennCare II Demonstration, Tennessee is not required to extend eligibility for medical assistance prior to the date that an application for assistance is made; however, the State may provide retroactive coverage for up to 3 months for class members in *Daniels, et al. v. Tenn. Dept. of Health and Env't., et al.*, (1) who have been terminated from TennCare on or before March 31, 2010, for failure to respond to a Request for Information and Expiration Notice in accordance with the process approved in the Federal court order dated January 8, 2009; (2) who subsequently complete a Request for Information within 60 days of termination; and (3) who are determined to have been eligible at the time of termination. The State must notify the Project Officer by letter if it intends to extend retroactive eligibility to Daniels class members as described above.

Any changes to eligibility must be submitted to CMS as an amendment request, subject to the process set forth in paragraphs 6 (*Changes to the Amendment Process)* and 7 *(Amendment Process)* of these STCs.

The criteria for TennCare eligibility groups are as follows (Table 1a).

**Table 1a – TennCare Eligibility Groups**

Note: This table does not change the State plan requirements.

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **Title XIX State Plan Mandatory Groups – TennCare Medicaid** | | |
| 1931 recipients including:<br>• Children younger than 18/19<br>• Caretaker relatives<br>• Pregnant women with no other eligible children (coverage for third trimester) | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Transitional Medical Assistance – Medicaid Extension for families who lose TANF benefits due to:<br>• income from employment or work hours or loss of "income disregard"<br>• increased child or spousal support collections | 6 initial months + 6 months continued coverage<br>4 months continued coverage *and expenditure authority for 8 additional months* | 1, 2, 5, 6, 8, 9, 10 |
| Individuals who are ineligible for AFDC benefits solely due to requirements that are prohibited under Medicaid, including AFDC time limits | Income up to and including 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Poverty level pregnant & postpartum women | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level newborns under age 1 | Income up to and including 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 1-5 | Income up to and including 133% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Poverty level children 6-18 | Income up to and including 100% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Deemed categorically eligible newborns: born to & living with a woman who was eligible and received Medicaid on the date of the child's birth | Eligible for 1 year as long as mother is eligible or would be if pregnant | 1, 2, 5, 8, , 10 |
| Pregnant woman who would otherwise lose eligibility because of an increase in income remains eligible through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Woman who was eligible while pregnant continues eligibility through the postpartum period | | 1, 2, 5, 8, 9, 10 |
| Title IV-E eligible children in adoption subsidy or foster care | AFDC income standard | 1, 2, 5, 6, 8, 9, 10 |
| SSI cash recipients: aged, blind or disabled (may or may not be receiving CHOICES benefits) | | 1, 2, 4, 5, 6, 7, 8, 9, 10, |
| Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87 | | 1, 2, 5, 6, 8, 9, 10 |
| "DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits. | | 1, 2, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| SSI cash ineligible for reasons prohibited by Title XIX. | | 1, 2, 5, 6, 8, 9, 10 |
| "Pickle" SSA Beneficiaries who lost SSI cash benefits due to cost of living adjustment (COLA) increase in Title II OASDI benefits | | 1, 2, 5, 6, 8, 9, 10 |
| "DWB" Disabled widow/widower who lost SSI or state supplement due to early receipt of OASDI benefits. | | 1, 2, 5, 6, 8, 9, 10 |
| **Title XIX State Plan Optional Groups – TennCare Medicaid** | | |
| Presumptively eligible pregnant & postpartum women | Income up to 185% FPL; no resource test | 1, 2, 5, 8, 9, 10 |
| Children under 21 who meet AFDC income & resource criteria—children in State custody, foster care, subsidized adoptions, institutionalized | Income up to 185% of Consolidated Standard of Need; resources $2000 | 1, 2, 5, 6, 8, 9, 10 |
| Persons who would be eligible for AFDC or SSI cash assistance except for their institutional status | | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Special income level group: individuals who are in a medical institution at least 30 consecutive days with income that does not exceed 300% of SSI income standard under 1902(a)(10)(ii)(V) of the Act. | Income no more than 300% of SSI rate; resources $2000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| Categorically needy individuals under the State plan who are receiving home and community based services in accordance with 42 CFR 435.217. After the full implementation of CHOICES, this group will consist solely of enrollees in the MR waivers). | ` | 1, 2, 5, 6, 8, 9, 10 |
| Non-IV-E children with special medical needs who receive a state adoption subsidy payment | | 1, 2, 5, 6, 8, 9, 10 |
| Women under 65 who need treatment for breast or cervical cancer, and are not otherwise eligible for Medicaid. State utilizes presumptive eligibility for this population. | | 1, 2, 5, 6, 8, 9, 10 |
| Medically needy children under 21 *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |
| Medically needy pregnant or postpartum women *(expenditure authority for 12-month coverage based on 1-month budget period)* | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **Title XIX Demonstration Group – TennCare Medicaid** | | |
| **Transition Group**: Non-pregnant, non-postpartum adults 21 or older enrolled as medically needy as of July 1, 2007, who have not yet been assessed for transition to the Standard Spend Down Demonstration population for non-pregnant adults 21 or older (covered under expenditure authority during the transition) [See paragraph 22 *Transition Group – Adult Medicaid State Plan Eligibility Categories for Which Enrollment Is Closed*]. | Medically needy spend-down level ($241 for 1, etc.) | 1, 2, 3, 5, 6, 8, 9, 10 |
| **Title XIX Demonstration Eligible Groups– Carryover** | | |
| **CHOICES 1 and 2 Carryover Group:** Individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the State's modification of its nursing facility level of care criteria. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **PACE Carryover Group:** Individuals who were enrolled in a PACE program as of June 30, 2012, but who upon redetermination no longer qualify for enrollment due solely to the State's modification of its nursing facility level of care criteria. | As required under the State plan. | |
| **Title XIX Demonstration Eligible Groups – TennCare Standard** | | |
| **Medically Eligible Children:** uninsured children under 19 who have been determined to be "medically eligible" (uninsurable) (category is currently closed to new enrollment except for Medicaid rollovers [as defined in paragraph 20 *Rollover Definition*] who are not otherwise eligible for TennCare [See paragraph 19 *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*]. | Income 200% FPL or higher without limit; no resource test | 1, 2, 5, 6, 8, 9, 10 and cost sharing "not applicable" |
| **Standard Spend Down (SSD):** non-pregnant/postpartum adults 21 or older who have been determined to meet criteria patterned after the medically needy requirements *(enrollment target: 100,000)*<br>• aged, blind, or disabled<br>• caretaker relatives<br>CMS approved an amendment to add this expansion population in Nov. 2006.<br>Implementation of the SSD amendment will begin within 1 month of the date that the State is notified of the approval of the waiver extension. The Transition Group will move into this category over a year. This category also will be opened to new enrollment.<br>(expenditure authority for 12-month coverage based on 1-month budget period)<br>[See paragraph 21(a) *Standard Spend Down (SSD) – Adult Non-State Plan Demonstration Population Category*] | Medically needy spend-down level ($241 for 1, etc.); resources $2000 | 1, 2,, 3, 5, 6, 8, 9, 10 and cost sharing "not applicable" |

| Description | Income Limit | Provisions of the Act Waived or Made Not Applicable (see Waiver List) |
|---|---|---|
| **Discontinued Demonstration Group** (as defined in paragraph 23 *Discontinued Demonstration Group – Adult Demonstration Populations Discontinued Through March 24, 2005 Demonstration Amendment*) | Income up to 200% FPL for uninsured; no resource test<br><br>No income or resource test for Medically Eligible individuals | 1, 2, 5, 6, 8, 9, 10, and cost sharing "not applicable" |
| **Title XIX Demonstration Eligible Groups – CHOICES** | | |
| **CHOICES 217-Like HCBS Group:** Aged and / or disabled categorically needy adults who meet the CHOICES NF level of care requirement, are receiving home and community based services and who would be eligible in the same manner as specified under 42 CFR 435.217, 435.236, and 435.726 of the Federal regulations and section 1924 of the Social Security Act, if the home and community based services were provided under a 1915 (c) waiver. This group exists only in regions of the State where the CHOICES program has been implemented, and is subject to the enrollment target for CHOICES 2 in paragraph 34(e) *(Enrollment Targets for TennCare CHOICES)*. | Income no more than 300% SSI/FBR; resources $2,000 | 1, 2, 4, 5, 6, 7, 8, 9, 10 |
| **At Risk Demonstration Group:** Elderly adults and adults age 21 and older with physical disabilities who have not been determined eligible for Medicaid or TennCare under any other category and who (1) meet the financial eligibility standards for the special income level group; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the criteria in place on July 1, 2012; and (3) in the absence of the TennCare Interim Choices 3 services, are "at risk" of institutionalization. The At Risk Demonstration Group is open to enrollment starting July 1, 2012. | Income no more than 300% SSI/FBR; resources $2,000 | 1,2,4,5,6,7,8,9,10 |
| **Title XXI Medicaid Expansion Demonstration Eligible Group – TennCare Standard** | | |
| Optional Targeted Low-Income Children: uninsured children under 19 who:<br>• have lost Medicaid eligibility under the approved Medicaid State plan and who do not have access to insurance or<br>• were uninsured and enrolled in this category in the original TennCare Demonstration as of 12/31/01, even if they had access to insurance, and have been continuously enrolled in this category since 12/31/01<br>[See paragraph 19 *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*] | Income up to 200% FPL | 1, 2, 5, 6, 8, 9, 10, and cost sharing "not applicable" |

## 18. TennCare CHOICES Eligibility Groups.

As further set forth in paragraph 34 *(Operations of the TennCare CHOICES Program)*, eligibility for enrollment in TennCare CHOICES depends on (a) the individual's TennCare Eligibility Group, (b) the Nursing Facility (NF) (or "At Risk," as applicable) level-of-care (LOC) criteria as established by the State, and (c) the type of long-term care services to be provided.

There are two principal eligibility groups for TennCare CHOICES. CHOICES 1 is for individuals receiving NF services. CHOICES 2 is for individuals who meet the NF LOC that are receiving HCBS as an alternative to NF care.

Should the State elect to change the level of care that is medically necessary for admission to a NF, CHOICES 3 will serve SSI eligibles enrolled after the implementation of such change who do not meet the new LOC standard but who are "at risk" of institutionalization. If the LOC is not changed, there will be no CHOICES 3 eligibility group. If the State changes the LOC standard for admission to a NF, individuals in CHOICES 1 and CHOICES 2 who continue to meet the standard in place at the time of the individual's admission/enrollment will continue to qualify for those services.

From July 1, 2012, through the end of the demonstration approval period, the State will open Interim CHOICES 3 to serve SSI eligibles and other adults who meet the LOC standard and financial eligibility requirements in place prior to the change, allowing the State to abide by the "Maintenance of Effort" (MOE) requirements as specified by the Affordable Care Act, Section 2001.

Table 1b summarizes the CHOICES Eligibility Groups and addresses how a change in LOC criteria will be taken into account in determining eligibility for each group, at such time as the State may elect to change its LOC standard.

**Table 1b – TennCare + CHOICES Eligibility Groups**

Note: This table does not change the State plan requirements. CHOICES 1, CHOICES 2, CHOICES 3, and Interim CHOICES 3 are defined in paragraph 34 *(Operations of the TennCare CHOICES Program).*

| CHOICES Groups | Description | TennCare Medicaid | TennCare Standard |
|---|---|---|---|
| CHOICES 1 | • Nursing facility residents who meet the NF LOC in place at the time of admission* | Yes | No |
| CHOICES 2 | • Meet NF LOC in place at the time of HCBS enrollment (or NF admission if transitioning)<br>• Receive HCBS as alternative<br>• Age 65+ or 21+ and disabled<br>• SSI recipient or "CHOICES 217-Like HCBS Group" | Yes, SSI only | Yes, CHOICES 217-Like HCBS Group |

| | | | |
|---|---|---|---|
| CHOICES 3 | • "At risk" for institutionalization (as defined in Attachment D)<br>• Do not meet NF LOC, but meet At-Risk LOC<br>• Age 65+ or age 21+ and disabled<br>• SSI recipient in TennCare Medicaid | Yes, SSI only | No |
| INTERIM CHOICES 3 (open to enrollment starting July 1, 2012) | • Same as CHOICES 3, but not limited to SSI recipients<br>• Must meet nursing facility financial eligibility criteria | Yes, SSI only | Yes, At Risk Demonstration Group |

***** The State may grant an exception for persons in the community seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely be met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of NF admission when such person has transitioned to the community and requires readmission to the NF.

**19. Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed.** The State has closed enrollment into the following Demonstration categories, except for "rollovers" (as defined in paragraph 20 *Rollover Definition*). Therefore, children are only eligible for a non-State plan Demonstration population as a "rollover." If children lose Medicaid State plan eligibility, they may qualify for one of these Demonstration-only groups rather than for the standalone title XXI CHIP program.

- Title XIX Medically Eligible Children: Individuals who are under age 19, are uninsured, have income that is 200 percent of the FPL or higher without limit, are not otherwise eligible for TennCare, and meet the State-defined criteria of "medically eligible" as having medical conditions that make them uninsurable. (There is no income or resource limit for this group.)

- Title XXI Medicaid Expansion Children: Individuals under age 19 who are uninsured, have family income less than 200 percent of the FPL, and meet the definition of an optional targeted low-income child. (There is no resource limit for this group.)

Individuals under age 19 who lose eligibility for a Medicaid category may continue to roll over into a TennCare Standard category if they meet the criteria for the category.

**20. Rollover Definition.**

a. Rollover. For the purpose of this Demonstration, a "rollover" eligible is an individual who qualifies for continued coverage through a TennCare Standard Demonstration category upon losing Medicaid eligibility under any category included in Tennessee's title XIX State plan.

b. Medically Needy Rollover. A rollover eligible, except for an individual rolling over into Standard Spend Down (SSD) eligibility from Medicaid eligibility, is termed a "medically needy rollover" and included in Type 2 for budget neutrality purposes if the individual is (1) age 19 or older and (2) the individual's prior Medicaid State plan eligibility was in a medically needy eligibility group (see paragraph 55b *Title XIX Demonstration Eligible Groups – TennCare Standard (Types 2 and 3 Eligibles, Other Than Transition Group Eligibles*).

**21. Adult Non-State Plan Demonstration Population Categories.**

a. **Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category.** The SSD eligibility category is open to non-pregnant/postpartum adults ages 21 or older who are Caretaker Relatives or Aged, Blind, or Disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the State plan. The SSD Demonstration eligibility group has an enrollment cap of 105,000, with a target enrollment of 100,000. The State shall establish eligibility and enroll individuals into the SSD group in accordance with the process set forth in Section XIII of these STCs.

b. **CHOICES 217-Like HCBS Group**. This group consists of persons aged 65 and older or persons aged 21+ and who are disabled who: (1) Meet the CHOICES NF level of care requirement; (2) Are receiving home and community-based services; and (3) Would be eligible in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 of the Federal Regulations and section 1924 of the Social Security Act, if the home and community based services were provided under a 1915(c) waiver. Paragraph 18 *(TennCare CHOICES Eligibility Groups)* and paragraph 34(b) *(Eligibility for TennCare CHOICES Benefits)* describe how the NF LOC requirements shall be determined for individuals in this group in the event the State elects to change the LOC criteria for admission to nursing facilities. The State retains the discretion to apply an enrollment target as described in paragraph 34(e) *( Enrollment Targets for TennCare CHOICES)*.

c. **At Risk Demonstration Group.** As of July 1, 2012, this group consists of elderly adults and adults age 21 and older with physical disabilities who (1) meet nursing facility financial eligibility; (2) meet the nursing facility level of care criteria in place on June 30, 2012, but not the nursing facility level of care criteria in place on July 1, 2012; and (3) in the absence of TennCare Interim CHOICES 3 services, are "at risk" of institutionalization.

d. **CHOICES 1 and 2 Carryover Group.** This group consists of individuals who were enrolled in CHOICES 1 or CHOICES 2 as of June 30, 2012, but who no longer qualify for CHOICES enrollment due solely to the State's modification of its nursing facility level of care criteria. Individuals in this group will continue to

be eligible for enrollment in CHOICES 1 or CHOICES 2 if they (1) continue to meet the criteria for nursing facility level of care employed by the State at the time they were enrolled, (2) meet all the eligibility requirements for a CHOICES program; and (3) remain continuously enrolled in CHOICES 1 and/or 2, as specified below:

i. Persons enrolled in CHOICES 1 can continue in CHOICES 1 or transition to CHOICES 2, and persons enrolled in CHOICES 2 can continue in CHOICES 2; and

ii. The State may grant an exception to (i) for persons in CHOICES 2 seeking NF admission who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely be met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of NF admission when such person has transitioned to the community and requires readmission to the NF.

e. **PACE Carryover Group.** This group consists of individuals who were enrolled in PACE as of June 30, 2012, but who no longer qualify for enrollment due solely to the State's modification of its nursing facility level of care criteria. Individuals in this group will continue to be eligible for enrollment in PACE if they (1) continue to meet the criteria for nursing facility level of care employed by the State at the time they were enrolled, and (2) meet all other eligibility requirements for PACE in the Medicaid State plan. PACE remains under the Medicaid State plan.

**22. Transition Group--Adult Medicaid State Plan Eligibility Categories for Which Enrollment Is Closed.** Pursuant to waiver authority granted on March 24, 2005 at the State's request, the TennCare II Demonstration closed enrollment for the Medicaid State plan medically needy eligibility categories of non-pregnant, non-postpartum adults aged 21 or older who were either Aged, Blind, or Disabled, or Caretaker Relatives. As of October 5, 2007, all adults who were enrolled in these eligibility categories at the time they were closed or who had applications in process at that time that were subsequently approved, and who were still enrolled as medically needy as of October 5, 2007, began receiving TennCare coverage as members of the Transition Group. The waivers granted on March 24, 2005 to allow these groups to be closed to new enrollment were rescinded, effective October 5, 2007. Subsequently, Tennessee submitted a State plan amendment to remove these medically needy groups from the Medicaid State plan, which was approved with an effective date of October 5, 2007.

TennCare Medicaid coverage for individuals in the Transition Group shall continue as if they were still covered under the State plan, until they are determined eligible for another State plan eligibility category or for the SSD Demonstration group or, if not, have

exhausted all appeal rights and been disenrolled. The State must assess eligibility and disenroll individuals during the transition, in accordance with the process set forth in Section XIII of these STCs.

Nothing herein shall prejudice any individual from fully exercising his or her rights to appeal an eligibility determination. The State shall continue to provide TennCare Medicaid coverage to members of the Transition Group under the 1115 Demonstration's expenditure authority during the appeal process.

**23. Discontinued Demonstration Group--Adult Demonstration Populations Discontinued Through March 24, 2005 Demonstration Amendment.** The Demonstration eligibility groups of uninsured and/or medically eligible (i.e., uninsurable) adults aged 19 or older were terminated by the State. The State requested an amendment to the TennCare II Demonstration, which was approved by CMS on March 24, 2005. Authority to provide services to this group must terminate upon final resolution of their eligibility redetermination and appeals. The termination of coverage and the disenrollment process shall be in accordance with the process set forth in Section XIII of these STCs.

**24. Medically Needy Eligibility Period.** Financial eligibility for State plan medically needy pregnant women and children and for Standard Spend Down adults is based on a 1-month budget period described in the State plan. Those determined eligible remain eligible for up to 1 year from the effective date of eligibility.

**25. Quality Review of Eligibility**. At least annually, the State shall submit a plan for a Medicaid Eligibility Quality Control (MEQC) pilot project to the CMS Regional Office for approval. When each pilot is complete, the State shall send a report to the CMS Regional Office for approval, and shall submit a plan for the next pilot project. The MEQC pilots must be conducted in accordance with Federal law, regulations, and policy.

**26. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.**

a. Except as specified in paragraph 26(b), below, in determining eligibility for institutionalized individuals, the State must use the rules specified in the currently approved Medicaid State plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 CFR Section 435.725 of the Federal regulations.

b. For an individual in CHOICES 2 or CHOICES 3 who is admitted for short-term nursing facility care (as defined in Attachment D), in order to ensure that the individual can maintain a community residence for transition back to the community, the post-eligibility calculation shall be performed as if the individual is continuing to receive HCBS. After 90 days, or as soon as it appears that the

inpatient stay will not be short-term, whichever comes first, the person will be transitioned to CHOICES 1 and the institutional post-eligibility calculation shall apply.

27. **Eligibility/Post-Eligibility Treatment of Income and Resources for the CHOICES 217-Like HCBS Group and At Risk Demonstration Group,.** For individuals receiving 1915(c) like services in CHOICES 217-Like HCBS Group or the At Risk Demonstration Group, the State must use institutional eligibility and post-eligibility rules for individuals who would be eligible in the same manner as specified under 42 CFR 435.217, 435.236 and 435.726 of the Federal regulations and section 1924 of the Social Security Act, if the home and community based services were provided under a section 1915(c) waiver.

28. **Post-Eligibility and Patient Liability for CHOICES 217-Like HCBS Group and At Risk Demonstration Group.** The State assures that, individuals receiving 1915(c) like services, under the post-eligibility process, the State must have a method to carve out / identify the cost of the 1915(c) like services from the cost of other Medicaid services so that the individual's patient liability is applied only to the cost of the 1915(c) like services.

29. **Non-Payment of Patient Liability.** A provider (including an MCO) may decline to continue to provide services to an individual who fails to pay his or her patient liability. If an enrollee who has failed to pay patient liability is unable to find another provider or MCO who is willing to provide LTC services, then the individual may be disenrolled from the CHOICES program. If the beneficiary's eligibility for TennCare is dependent on the receipt of long-term institutional or HCBS through TennCare CHOICES, as would be the case if an enrollee is a member of the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group, such individual may be disenrolled from TennCare if he or she is no longer able to receive such services, unless he/she qualifies in another Medicaid category. The consequences for failing to pay patient liability must be clearly explained to members upon enrollment in CHOICES. Nothing herein shall prejudice any individual from fully exercising his or her rights to reapply for Medicaid eligibility.

## V. BENEFITS

**30. TennCare Benefits.** With the implementation of the CHOICES program, TennCare covers physical, behavioral, and long-term care benefits provided through managed care delivery systems.

a. All mandatory and optional Medicaid State plan eligible adults aged 21 or older, and the Transition Group (see paragraph 22 *Transition Group – Adult Medicaid State Plan Eligibility Categories For Which Enrollment Is Closed*), are enrolled in TennCare Medicaid, and receive all services covered under Tennessee's State plan according to the limitations specified in the State plan, including the services identified in paragraph 32 *(Medicaid Benefits Carved Out Of The TennCare II Demonstration)* as appropriate. Additional TennCare benefits are provided as specified in Table 2a and paragraph 31 *(Cost-Effective Alternatives)*.

b. Persons enrolled in the Elderly and Disabled 1915(c) waiver program receive HCBS as specified in the 1915(c) waiver. After the implementation of CHOICES, these individuals become members of CHOICES 2, and receive the associated HCBS benefits as specified in Table 2b below.

Members of the Choices 217-Like HCBS Group or the At Risk Demonstration Group, both of which are Demonstration-only groups, are enrolled in TennCare Standard, but receive all benefits described in (a) above. In addition, individuals in the CHOICES 217-Like HCBS Group are members of CHOICES 2 and members of the At Risk Demonstration Group are members of Interim CHOICES 3.

c. Demonstration-only eligible adults who are members of the Standard Spend Down population (see paragraph 21(a) *Standard Spend Down (SSD) – Adult Non-State Plan Demonstration Population Category*) are enrolled in TennCare Standard and receive all State plan services, plus additional TennCare benefits as specified in Table 2a and paragraph 31 *(Cost-Effective Alternatives)* as appropriate, except that they do not have access to the services discussed in Table 2b or Table 3. Medicare Parts A and B premiums and Medicare co-payments and deductibles are covered in accordance with paragraphs 32(b) and (c). Demonstration-only eligible adults who are members of the Discontinued Demonstration Group (see paragraph 23 *Discontinued Demonstration Group – Adult Demonstration Populations Discontinued Through March 24, 2005 Demonstration Amendment)*) are enrolled in TennCare Standard and receive all State plan services except pharmacy, plus additional TennCare benefits as specified in Table 2a and paragraph 31 *(Cost-Effective Alternatives)*, except that they do not have access to the services discussed in Table 2b or Table 3. Medicare premiums, co-payments and deductibles are not covered.

d. All mandatory and optional Medicaid State plan eligible children younger than 21 years old enrolled in TennCare Medicaid receive all State plan and EPSDT covered services.

e. The Demonstration-only eligible children enrolled in TennCare Standard receive the same benefits as the State plan eligible children enrolled in TennCare Medicaid, except as specified in paragraph 32 *(Medicaid Benefits Carved Out Of The TennCare II Demonstration).*

f. The Medicaid State plan mandatory and optional eligibility categories for poverty level pregnant or postpartum women are covered for all TennCare Medicaid benefits, because the State considers that all of these services are pregnancy-related services.

g. The following table (Table 2a) lists benefits for TennCare Medicaid and TennCare Standard adults aged 21 and older that are different from those identified in the State plan. All benefits are limited by medical necessity as defined by the State. "State Plan Coverage for Adults" is provided for informational purposes only, and does not supersede the approved Medicaid State plan. CMS will issue an updated version of Table 2a in the event that future SPAs cause the Medicaid State plan to be in conflict with what appears in Table 2a.

**Table 2a—TennCare Medicaid and TennCare Standard Benefits for Adults Aged 21 and Older That Are Different Than State Plan Covered Services and Limitations**

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Diagnostic services not included in other service categories | Covered as medically necessary. | Not covered. |
| Home health | Covered as medically necessary, and in accordance with the definitions and limitations included in Attachment B. | Coverage limited to 60 visits per enrollee per State fiscal year. |
| Hospice care | Covered as medically necessary. | Coverage limited to 210 days per enrollee per State fiscal year. |
| Inpatient and outpatient substance abuse services | Covered as medically necessary, with a lifetime limitation of 10 detox days and $30,000 in lifetime benefits; effective January 1, 2010, covered as medically | Not covered. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| | necessary. | |
| Inpatient hospital services | Covered as medically necessary. | Coverage limited to 43 days for heart transplants, 67 days for liver transplants, and 40 days for bone marrow transplants, per enrollee, per State fiscal year. |
| Lab and X-ray services | Covered as medically necessary. | Coverage limited to 30 occasions per enrollee per State fiscal year. |
| Medicare premiums and cost-sharing | • Not covered for the Discontinued Demonstration Group.<br>• Covered for State plan eligibles, SSD enrollees, members of the CHOICES 217-Like HCBS Group, and members of the At Risk Demonstration Group, in accordance with paragraphs 32(b) and 32(c). | Covered for Medicare beneficiaries who are dually eligible for Medicaid according to their classification under the State plan (QMB, SLMB, Other Medicaid/Medicare Duals, etc.) |
| Mental health case management services | Covered as medically necessary. | Coverage limited to Targeted Case Management for persons who are Severely and/or Persistently Mentally Ill. |
| Occupational therapy | Covered as medically necessary. | Not covered. |
| Organ and tissue transplants | Covered as medically necessary, except that experimental or investigational transplants are not covered. | Coverage limited to renal, heart, liver, corneal, and bone marrow transplants. |
| Outpatient hospital services | Covered as medically necessary. | Coverage limited to 30 visits per enrollee per fiscal year. |
| Outpatient rehabilitation services | Covered as medically necessary. | Coverage limited to mental health services provided by Community Mental Health Agencies. |
| Pharmacy services | • Not covered for the Discontinued Demonstration Group.<br>• Covered for State plan | Coverage as specified in State plan. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| | and Transition Group eligibles in accordance with the State plan.<br>• Covered for non-dual SSD eligibles and non-dual At Risk Demonstration Group members, with the co-payments specified in Table 6 of paragraph 36 *(Co-Payments)*.<br>• Covered for CHOICES 217-Like HCBS Group enrollees in accordance with the State plan for Medicaid enrollees. | |
| Physical therapy services | Covered as medically necessary. | Not covered. |
| Physicians' services (including medical and surgical services furnished by a dentist) | Outpatient services: Covered as medically necessary.<br><br>Inpatient services: Covered as medically necessary. | Outpatient services: Coverage limited to 24 outpatient office visits per year, which includes 2 office visits for podiatrists and 4 office visits for optometrists.<br><br>Inpatient services: Coverage limited to 20 visits per enrollee per State fiscal year for services other than heart, liver, and bone marrow transplants, which are limited to 43, 67, and 40 days, respectively. |
| Preventive services | Covered as medically necessary. | Not covered. |
| Private duty nursing services | Covered when medically necessary to support the use of ventilator equipment or other life-sustaining technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Definitions and limitations applicable to this service are contained in Attachment C. | Not covered. |

| Service | TennCare Medicaid and TennCare Standard Coverage for Adults | State Plan Coverage for Adults |
|---|---|---|
| Psychiatric residential treatment services (outside of an IMD) | Covered as medically necessary. | Not covered. |
| Screening services | Covered as medically necessary. | Not covered. |
| Speech, hearing, and language services | Covered as medically necessary. | Not covered. |
| Vision services | Covered for the first pair of cataract glasses following cataract surgery. | Not covered. |

h. The following table (Table 2b) lists HCBS benefits for TennCare Medicaid enrollees and CHOICES Demonstration eligibles who are enrolled in the designated CHOICES groups (specified in paragraph 34(a) *Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group*). These benefits are in addition to the benefits that are available to them through the regular TennCare program. In addition, the following rules apply to the CHOICES benefit.

i. The cost of medical assistance provided to an eligible participant in CHOICES 2 is limited to the amount calculated in the individual cost-neutrality test used in section 1915(c) waivers as set forth in section 1915(c)(4)(A). The State may delegate implementation of the cost neutrality test to the MCOs.

ii. For purposes of determining capitation rates, the cost of room and board, as defined in Attachment D, is not included in non-institutional care costs.

iii. For persons in CHOICES 3 or Interim CHOICES 3, in addition to the service limits stated in Table 2b, the total cost of the HCBS identified in Table 2b shall not exceed $15,000 per calendar year, excluding the cost of minor home modifications.

iv. Definitions for CHOICES benefits are provided in Attachment D of these STCs.

**Table 2b Benefits for Persons Enrolled in the CHOICES Program**

| **Benefit** (Definitions provided in Attachment D) | **CHOICES 1** | **CHOICES 2** | **CHOICES 3*** |
|---|---|---|---|
| Nursing facility care | X | Short-term only | Short-term only |
| Community-based residential alternatives | | X | |
| Personal care visits (up to 2 visits per day) | | X | X |
| Attendant care (up to 1080 hours per calendar year) | | X | X |
| Homemaker services (up to 3 visits per week) | | X | X |
| Home-delivered meals (up to 1 meal per day) | | X | X |
| Personal Emergency Response Systems | | X | X |
| Adult day care (up to 2080 hours per calendar year) | | X | X |
| In-home respite care (up to 216 hours per calendar year) | | X | X |
| In-patient respite care (up to 9 days per calendar year) | | X | X |
| Assistive technology (up to $900 per calendar year) | | X | X |
| Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) | | X | X |
| Pest control (up to 9 units per calendar year) | | X | X |

*Subject to the limitations in 30(h)(iii).

**31. Cost-Effective Alternatives.** TennCare MCOs and TennCare Select may provide services not listed in, or exceeding the individual service limits in, the Medicaid State plan or paragraph 30 (TennCare Benefits) of these STCs as allowed under their contracts with the TennCare program. Provision of these services is at the sole discretion of the MCO and TennCare Select. Capitation for the MCOs must be certified as actuarially sound (in accord with 42 CFR section 438.6), and comply with the Federal managed care regulations at 42 CFR 438 et seq. TennCare Select must demonstrate to the State that a service not listed as covered in the Medicaid State plan or in paragraph 30 (TennCare Benefits) is a cost-effective alternative, in order for the State to reimburse TennCare Select for the service. The State must demonstrate to CMS annually as part of the annual report described in paragraph 48 (Annual Report) that utilization of these services by the MCOs and TennCare Select is cost-effective and is reimbursed in compliance with the Federal managed care regulations at 42 CFR 438 et seq. Under the CHOICES program, cost-effective alternatives may include a Transition Allowance, as defined in Attachment D.

**32. Medicaid Benefits Carved Out Of the TennCare II Demonstration.**

a. **"Base" Medicaid State plan services.** Base services are services carved out of TennCare II, and are provided, in accordance with the provisions of the Medicaid State plan, only to the mandatory and optional State plan eligibles, Transition Group eligibles, members of the CHOICES 217-Like HCBS Group, and members of Interim CHOICES 3. The other TennCare II Demonstration-only populations,

which are eligible through the Demonstration's expenditure authorities and enrolled in TennCare Standard, are not eligible for any of the services listed in Table 3. Expenditures for these "Base" services are not Demonstration expenditures (see paragraph 53(a) *Tracking Expenditures*), are not included in the Demonstration's budget neutrality, and should, therefore, be reported on the "Base" reporting schedules of the Form CMS-64 reports (or in the case of 1915(c) waiver services, the appropriate 1915(c) waiver schedule). Some carved out services become carved in as of the initial implementation of CHOICES (i.e., March 1, 2010), however, as indicated in Table 3, and must from that point forward be reported as TennCare II Demonstration expenditures.

**Table 3: Base Services**

| Services Carved Out of TennCare II | Before Initial Implementation of CHOICES | After Initial Implementation of CHOICES |
|---|---|---|
| Nursing facility services | Base | Demonstration |
| Services in an intermediate care facility for the mentally retarded (ICF/MR) | Base | Base |
| State Plan targeted case management services | Base | Base |
| Program of All Inclusive Care for the Elderly (PACE) | Base | Base |
| Services covered by the home and community-based services waiver for the elderly and disabled under section 1915(c) of the Social Security Act. | Base | Demonstration* |
| Services covered by the home and community-based services waiver for persons with mental retardation under 1915(c) of the Social Security Act. | Base | Base |
| Services covered through the State's agreement under Title V of the Social Security Act | Base | Base |

*Following the initial implementation of CHOICES, HCBS for the elderly and disabled are provided under section 1915(c) authority in regions where CHOICES has not yet been implemented; expenditures for these services must be reported as demonstration expenditures for budget neutrality purposes. In regions where CHOICES is implemented, HCBS for the elderly and disabled will be a CHOICES benefit under the Demonstration.

b. Medicare Parts A and B Buy-In Premiums: Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, the At Risk Demonstration

Group, or Standard Spend Down group, but not described in section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare Buy-In premiums are covered for dually eligible Medicaid State plan eligibles as permitted in section 1902(a)(10)(E) of the Act and 42 CFR 431.625, for all dually eligible members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals), dually eligible members of the At Risk Demonstration Group (QMBs/SLMBs and Demo Duals), and for all dually eligible members of the Standard Spend Down group (QMBs/SLMBs and Demo Duals).

ii. Medicare premiums paid on behalf of Demo Duals are Demonstration expenditures, and must be reported on an appropriate Form CMS-64.9 or 9p Waiver, as described in paragraph 53(e).

iii. Medicare premium payments for other beneficiaries are excluded from TennCare II and must be reported as "Base" Medicaid expenditures on the CMS-64 reports.

iv. Records in CMS's Master Billing Record for Demo Duals and all buy-in transactions for Demo Duals must be identified using a specific Buy-In Eligibility Code (BIEC) value as agreed upon between the State and the Project Officer.

c. Medicare Co-payments and Deductibles (i.e., Medicare crossover claims): Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group or Standard Spend Down group, but not described in section 1902(a)(10)(E) of the Act, are referred to as "Demo Duals."

i. Medicare crossover claims are covered for dually eligible Medicaid State plan eligibles, CHOICES 217-Like HCBS Group, At Risk Demonstration Group (QMBs/SLMBs and Demo Duals), and for Standard Spend Down enrollees (QMBs/SLMBs and Demo Duals). The SSD population, the CHOICES 217-Like HCBS Group, and the At Risk Demonstration Group are the only demonstration populations for whom the State pays Medicare cost-sharing.

ii. For TennCare Medicaid enrollees, members of the CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals), and members of the At Risk Demonstration Group who are dually eligible for Medicare, these expenditures are not Demonstration expenditures and are not included in the budget neutrality calculations, so report these as "Base" Medicaid expenditures on the CMS-64 reports.

iii. For dually eligible SSD enrollees (QMBs/SLMBs and Demo Duals), these expenditures are included as Demonstration expenditures that are subject to budget neutrality, so report these Demonstration expenditures as "EG6E Expan Adult" on the CMS-64 reports. Medicare cost-sharing for SSD dual eligibles is covered in the same manner as Medicare cost-sharing would be covered for Medically Needy aged, blind, or disabled individuals and caretaker relatives, had these groups been included in the Medicaid State Plan. .

**33. Additional Provisions Related to Institutions for Mental Diseases (**IMDs).
Expenditures for services rendered to TennCare II enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.

## VI. CHOICES ENROLLMENT AND IMPLEMENTATION

### 34. Operations of the TennCare CHOICES Program.

a. **Determination of CHOICES Benefits by Designation into a TennCare CHOICES Group.** The CHOICES Program provides long-term care benefits as identified in Table 2b to three groups of people, as defined below:

i. **CHOICES 1.** This group consists of persons who are receiving Medicaid-reimbursed care in a Nursing Facility (NF).

ii. **CHOICES 2.** Persons age 65 and older and adults age 21 and older with physical disabilities who meet the NF level of care (LOC), who qualify either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to NF care. The demonstration population includes persons who could have been eligible under 42 CFR 435.217 had the State continued its 1915(c) HCBS waiver for persons who are elderly and/or physically disabled.

iii. **CHOICES 3.** Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles, who do not meet the NF LOC, but who, in the absence of HCBS, are "at risk" for institutionalization, as defined by the State.

iv. **Interim CHOICES 3 (open to enrollment starting July 1, 2012).** Elderly adults and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of the At Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012.

Should the State elect to change the level of care that is medically necessary for admission to a nursing facility, prior to implementation of the CHOICES 3 group, the State must provide to CMS the operational procedures for determining individuals "at risk" for institutionalization. Thereafter, modifications to the procedures must be included in the Quarterly Report.

b. **Eligibility for TennCare CHOICES Benefits.** Individuals can be eligible for one of the four TennCare CHOICES groups defined in (a) above depending upon their medical and / or functional needs, their TennCare eligibility group, and the ability of the State to provide them with safe, appropriate, and cost-effective LTC services.

i. Medical and / or functional needs are assessed according to LOC criteria published by the State in State rules. There will be one set of LOC criteria

for NF care, which will be used in assessing eligibility for CHOICES 1 and CHOICES 2. Should the State elect to amend its LOC criteria for NF admission, the State may open enrollment in CHOICES 3, which will be subject to a separate set of criteria to determine the "At-Risk" population. At such time as the State determines to change the LOC, for the purposes of redetermining whether a recipient of NF services (CHOICES 1) continues to require the LOC provided in a NF, the State must use criteria consistent with those used to make the initial LOC determination for that individual at the time of NF admission. For the purposes of determining whether a recipient of HCBS for elderly and disabled (CHOICES 2) continues to require the LOC provided in a NF, the State must use criteria consistent with those used to make the initial level of care determination for that individual at the time of HCBS enrollment, or for persons transitioning from a NF, at the time of NF admission. For purposes of admission to a NF, the State may grant an exception for persons in the community who continue to meet the NF LOC in place at the time of HCBS enrollment, but whose needs can no longer be safely be met in the community at a cost that does not exceed NF care, or for persons who continue to meet the NF LOC in place at the time of initial NF admission when such person has transitioned to the community and requires readmission to the NF.

ii. Financial eligibility:

(A) Financial eligibility for CHOICES 1 is established according to the Medicaid State plan.

(B) In order to be financially eligible for CHOICES 2, an individual must be eligible for TennCare as an SSI recipient or meet the criteria for the CHOICES 217-Like HCBS Group, individuals who qualify under institutional income and resource rules, and who are receiving home and community-based services and would be eligible in the same manner as specified under 42 CFR 435.217, 435.726, and 435.236 of the Federal regulations and section 1924 of the Act, if the home and community based services were provided under a 1915(c) waiver.

(C) In order to be financially eligible for CHOICES 3, an individual must be eligible for TennCare as an SSI recipient.

(D) In order to be financially eligible for Interim CHOICES 3, an individual must be eligible for TennCare as an SSI recipient or as a member of the At Risk Demonstration Group. Members of the At

Risk Demonstration Group must meet institutional income and resource criteria.

iii. The State's ability to provide applicants with appropriate home and community based services is determined by the availability of slots under an established enrollment target (see paragraph 34(e) *Enrollment Targets for TennCare CHOICES*) and, for persons in CHOICES 2, the determination by the MCO that the individual can be served appropriately at a cost that does not exceed the cost neutrality test (see paragraph 30(h)(i) *TennCare Benefits*), and for persons in CHOICES 3 and Interim CHOICES 3, the determination by the MCO that the cost of HCBS will not exceed the limit in paragraph 30(h)(iii) (*TennCare Benefits*). There is no enrollment target for Interim CHOICES 3.

c. **Regional Rollout of 1115 and Concurrent Ending of the 1915(c) Waiver - Implementation.** Over the 12-month time period during which the CHOICES managed care program is implemented statewide, the State will:

i. Implement the program in the Middle Tennessee region on or about six months after the date of CMS approval, the East Tennessee region on or about 12 months after the date of CMS approval, and the West Tennessee region on or about 18 months after the date of CMS approval (with the implementation date in the Middle Tennessee region (March 1, 2010) representing the date of the initial implementation of CHOICES);

ii. Incorporate the LTC benefits listed in Table 2b of paragraph 30 *(TennCare Benefits)* into the TennCare benefit package provided through the MCOs in that region;

iii. Provide notice to all individuals currently enrolled in the 1915(c) HCBS "statewide" waiver, control number 0381.R01. Persons who are enrolled in the 1915(c) waiver at the time that the CHOICES Program is implemented in that region must move automatically into CHOICES 2;

iv. Encumber reserve capacity CHOICES 2 slots, in accord with subparagraph 34(e)(iii)(A) *(Reserve Capacity)*, so that all current enrollees in the 1915(c) waiver can be moved into the CHOICES program when the program is implemented in each region;

v. Maintain the 1915(c) waiver in those regions where the CHOICES program has not been implemented; and

vi. Per an amendment and phase-out schedule for the 1915(c) waiver, simultaneously cease operation of the 1915(c) waiver for persons who are

elderly and/or disabled in the region in which the CHOICES program is being implemented, in accordance with established requirements.

d. **Enrollment in TennCare CHOICES.** The effective date of enrollment in TennCare CHOICES must be established by the State based on a determination that an applicant is eligible for and must begin receiving LTC services. Enrollment procedures differ depending upon whether or not the person is already enrolled in TennCare Medicaid.

i. **Persons Not Already Enrolled in TennCare.** Persons not already enrolled in TennCare who wish to enroll in TennCare CHOICES must enroll through the State's Single Point of Entry (SPOE). The SPOE must provide counseling and assistance in evaluating long-term care options, screening and intake for long-term care programs offered by the State (TennCare CHOICES as well as other programs), assistance in evaluating the individual's functional LOC for LTC, and facilitation of Medicaid eligibility determination by the State.

(A) Individuals who are determined to be both medically and financially eligible for NF placement will always be allowed to receive TennCare CHOICES services in a NF as members of CHOICES 1, if they choose.

(B) Those individuals, who meet the criteria for CHOICES 2 and, subject to the limitations set out in these STCs, will be allowed to choose HCBS as an alternative to NF placement if the determination is made that the individual can be served appropriately in CHOICES 2 at a cost that does not exceed the cost neutrality test (see paragraph 30(h)(i) *TennCare Benefits*).

ii. **Persons Already Enrolled in TennCare.**

(A) **Nursing Facility Residents at the time CHOICES is Implemented in Their Region.** Persons residing in a nursing facility and covered by Medicaid at the time that the CHOICES program is implemented in their region will be allowed to remain in a nursing facility as members of CHOICES 1 as long as their need for NF care continues to be medically necessary based on the criteria in use at the time of admission, and they continue to be financially eligible. MCOs will conduct an assessment of NF residents who wish to move to HCBS to determine if they can be served appropriately in the community at a cost that does not exceed the cost neutrality test set forth in Section 1915(c)(4)(A), as individually applied. Even if an enrollment target has been

reached for CHOICES 2, an MCO may transition persons from CHOICES 1 to CHOICES 2 in accord with subparagraph 34(e)(iii)(C) *(Transition from CHOICES 1 to CHOICES 2)*.

(B) **Participants in the Current HCBS Program for the Elderly and Disabled at the Time the CHOICES Program is Implemented in Their Region.** Persons participating in the current HCBS program for the elderly and disabled will be moved to CHOICES 2 at the time the program is implemented in their region. They will be allowed to remain in CHOICES 2 as long as (a) their care continues to be medically necessary based on the nursing facility level of care criteria in use at the time of HCBS enrollment, (b) they can be served appropriately at a cost that does not exceed the cost neutrality test set forth in paragraph 30(h)(i) *(TennCare Benefits)*, and (c) they remain financially eligible. The State will furnish the MCO with a copy of the Plan of Care for each individual at the time of enrollment with the MCO.

(C) **Other TennCare Enrollees.** Other TennCare enrollees who are not already participating in CHOICES may request enrollment in CHOICES through their MCOs, or they may be identified through other mechanisms that would trigger an assessment of their need for LTC by the MCO. The MCO will provide counseling and assistance in evaluating long-term care options, and assistance in evaluating the individual's functional LOC eligibility for LTC. The functional LOC determination for LTC will be made by the Bureau of TennCare, using criteria published in State rules. Once individuals have established LOC and financial eligibility for LTC, they can be enrolled in CHOICES in accordance with paragraph 34(e) *(Enrollment Targets for TennCare CHOICES*).

e. **Enrollment Targets for TennCare CHOICES.** The State may establish enrollment targets for CHOICES 2 and CHOICES 3. (There will be no enrollment target for CHOICES 1 or Interim CHOICES 3.) The purpose of the targets is to permit the CHOICES program to grow in a controlled manner, while assuring that the persons enrolled in the program are served appropriately, and cost effectively within available State and Federal resources. Information on enrollment for each 1915(c) and CHOICES Groups targets and enrollment numbers must be supplied to CMS in the Quarterly Progress Report as set forth in paragraphs 47 *(Quarterly Progress Reports)*, 51 *(Enrollment Reporting)* and Attachment A.

i. The State may establish an enrollment target for CHOICES 2, consistent with the upper and lower limits shown in the table below; with the actual

target number to be published in State rules. The State may adjust the target as appropriate from time to time upon notification to CMS at least 30 days prior to the desired effective date of the change. Except as set forth in paragraph 34(e)(ii) *(Enrollment Targets for TennCare CHOICES),* an increase in the enrollment target above the upper limit appropriate to the DY or a decrease below the lower limit will require an approved waiver amendment prior to implementation.

**Table 4 – Enrollment Targets for Demonstration Years 8 Through 11**

| Demonstration Year | Lower Limit | Upper Limit |
|---|---|---|
| DY 8 | 6,000 | 8,000 |
| DY 9 | 7,500 | 9,500 |
| DY 10 | 8,500 | 11,000 |
| DY 11 | 11,000 | 15,000 |

ii. The State may also establish an enrollment target for CHOICES 3, if this group is established after a change in the level of care criteria. At a minimum, this target will be set at 10% of the enrollment target for CHOICES 2. In the event that there is not a change in the level of care that would warrant opening CHOICES 3, the State may at its discretion exceed the maximum enrollment target described in paragraph 34(e)(i) *(Enrollment Targets for TennCare CHOICES)* for CHOICES 2 by 10%. There will be no enrollment target for Interim CHOICES 3.

iii. If the enrollment target established by the State for CHOICES 2 or CHOICES 3 is reached or exceeded, the State shall not enroll additional persons in CHOICES 2 or CHOICES 3, except as indicated below. The State may also establish a waiting list for CHOICES, subject to the following:

(A) **Reserve Capacity.** The State may reserve slots in CHOICES 2 for the phased-in implementation of the CHOICES Program across the State. In addition, the State may reserve slots in CHOICES 2 for individuals being discharged from a NF and for individuals being discharged from an acute care setting who, are in imminent risk of being placed in a nursing facility setting absent the provision of home and community-based services. A copy of the operational procedures for determining individuals for whom the slots will be reserved, as submitted to CMS by the State on February 2, 2010, must be included as an attachment to the Annual Report for DY 8 (see paragraph 48), and each Annual Report thereafter. The State may establish additional criteria or modify procedures for allocating reserve slots upon 30 day advance written notification to CMS; the operational procedure documents included as

attachments to subsequent Annual Reports must reflect any such changes. In each Quarterly Progress Report, the State must provide an accounting of their management of the reserve capacity, including a summary (as of the last day of the quarter) that states the total enrollment target for CHOICES 2 and 3, the number enrolled in each CHOICES group, and the numbers of slots being held in reserve for various purposes.

(B) **HCBS as a Cost-Effective Alternative.** An MCO with a TennCare enrollee who meets the criteria for CHOICES 2, but who cannot enroll the individual in CHOICES 2 because the enrollment target for CHOICES 2 has been met, has the option, at its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care, in accordance with paragraph 31 *(Cost Effective Alternatives)*. (Consistent with paragraph 34(e)(iii)(C), this person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available). The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. The State may require the MCO to provide documentation of its cost-effective alternative determination and assurance of provider capacity to meet the member's needs prior to enrollment in CHOICES.

(C) **Transition from CHOICES 1 to CHOICES 2.** An enrollee being served in CHOICES 1 who meets the requirements to enroll in CHOICES 2 can enroll in CHOICES 2 at any time such a transition can be accomplished, even if an enrollment target for CHOICES 2 has been reached. This person would be served in CHOICES 2 outside the enrollment target but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.

f. **Waiting Lists for TennCare CHOICES.** The use of enrollment targets as described in paragraph 34(e) *(Enrollment Targets for TennCare CHOICES*) may mean that there will be waiting lists for CHOICES 2 and/or 3. (There will be no waiting list for CHOICES 1.) These lists must be managed on a statewide basis using a standardized assessment tool and in accord with criteria to be established by the State. Waiting list policies must be based on objective criteria and applied consistently in all geographic areas served. The State may use separate criteria for prioritization of services under CHOICES 2 and CHOICES 3, and may revise these upon notification to CMS. There shall not be any enrollment target or

waiting list for the Interim CHOICES 3 Group that is open to enrollment starting July 1, 2012.

g. **Consumer Direction.** CHOICES members who have been determined by a care coordinator, as a part of the needs assessment and plan of care processes, to require attendant care, personal care, homemaker, in-home respite services, companion care or other services specified by the State as eligible for consumer direction, will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e., consumer direction of HCBS). The State will notify CMS in advance of any changes to the list of services eligible for consumer direction. All CHOICES members requiring these services will be offered the option to participate in consumer direction of HCBS. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E.

h. **Miscellaneous Provisions Related to CHOICES Enrollment and Implementation**

i. **Priority for Access to New Community-Based Residential Alternatives (CBRA):** When a new CBRA service becomes available through CHOICES, current CHOICES members must be notified promptly. This notice may be provided using the communication processes set forth in the Contractor Risk Agreement, such as member handbooks and member newsletters, and ongoing communications between members and their Care Coordinators. To the extent that persons enrolled in CHOICES need a particular type of CBRA service and are waiting for such service in an area of the State, and there is an applicant that can only be enrolled into CHOICES once the same CBRA is available in that area of the State, the State may not proceed with enrollment of the new applicant into CHOICES utilizing newly developed capacity until such time that the needs of the currently enrolled CHOICES member have been met. An exception may be made for a new applicant currently residing in the CBRA at the point of Medicaid application. To ensure continuity of services, a person residing in a CBRA at the time of CHOICES application need not be displaced by denying his enrollment into CHOICES in order to make that placement available to someone else already enrolled in CHOICES.

ii. The State will maintain an electronic visit verification system (as defined in Attachment D) as part of the quality program.

iii. The State must ensure that the Care Plan is considered part of the medical record of a CHOICES participant, subject to all associated requirements and protections, and available for review by the State upon request.

i. **Readiness Review.** CMS must approve the MCO contract amendments and certify the provider network for CHOICES before the State begins to enroll or deliver services under CHOICES. Except as permitted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), the State may not begin to exchange Health Information prior to CMS certifying the CHOICES provider network. CMS and the State may discuss opportunities for additional activities through which CMS may participate with the State in a mutually agreeable fashion in reviewing the readiness of the transition, enrollment and health delivery under CHOICES.

## VII. COST SHARING

### 35. Cost Sharing.

a. For Medicaid mandatory and optional State plan eligible adults and children and the Transition Group eligibles, cost-sharing must be in accordance with the Medicaid State plan.

b. The Demonstration-only eligible adults enrolled in the SSD category (see paragraph 21(a) *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*) and the At Risk Demonstration Group (see paragraph 21(c) *At Risk Demonstration Group*) are subject to all cost sharing to which non-pregnant, non-institutionalized adults are subject under the Medicaid State plan, including co-pays for pharmacy services (see Table 6 below).

c. Cost-sharing for TennCare Standard children must be limited to the amounts specified in paragraph 36(a), Table 5 (*TennCare Non-Pharmacy Co-Pays for Demonstration-Only Eligible Groups in TennCare Standard, Excluding SSD and the CHOICES 217-Like HCBS Group*) and paragraph 36(b), Table 6 *(Nominal Co-Pays on Pharmacy For Demonstration-Only Eligible Groups in TennCare Standard, Including SSD and for CHOICES 1 and CHOICES 2 Participants).*

d. Individuals participating in CHOICES 1 and CHOICES 2 are exempt from all cost sharing.

**36. Co-Payments.** For Demonstration-only eligible children in TennCare Standard (title XXI Medicaid Expansion children and medically eligible title XIX children) (see paragraph 19 *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*) and adults in the Discontinued Demonstration Group (see paragraph 23 *Discontinued Demonstration Group – Adult Demonstration Populations Discontinued Through March 24, 2005 Demonstration Amendment*), co-payments are collected by the provider when services are rendered. The requirements at section 1916A of the Act and at 42 CFR 447.50, 57, 58, and 62 through 82 will apply to cost sharing for these Demonstration-only groups.

a. **Non-Pharmacy Co-pays.** For Demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children) (see paragraph 19 *Child Non-State Plan Demonstration Population Categories For Which Enrollment is Closed*) and adults in the Discontinued Demonstration Group (see paragraph 23 *Discontinued Demonstration Group – Adult Demonstration Populations Discontinued Through March 24, 2005 Demonstration Amendment*), the non-pharmacy co-pay amounts are presented in Table 5 (*TennCare Non-Pharmacy Co-Pays for Demonstration-Only Eligible Groups in TennCare Standard, Excluding SSD, the CHOICES 217-Like HCBS Group, and the At Risk*

*Demonstration Group*). The SSD Demonstration population is not charged co-payments for non-pharmacy services. The CHOICES 217-Like HCBS Group is not charged co-payments for pharmacy or non-pharmacy services. The At Risk Demonstration Group is not charged co-payments for non-pharmacy services. Other CHOICES participants are Medicaid eligible and are subject to co-payments and limitations in accordance with paragraph 35a *(Cost Sharing)*.

**Table 5 - TennCare Non-Pharmacy Co-pays For Demonstration-Only Eligible Groups in TennCare Standard, Excluding SSD, the CHOICES 217-Like HCBS Group, and the At Risk Demonstration Group.**

| Poverty Level | Co-payment Amounts |
|---|---|
| 0%-99% | $0.00 |
| 100% - 199% | $10.00 Hospital Emergency Room (waived if admitted)<br><br>$5.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care<br><br>$5.00 Physician Specialists (including Psychiatrists)<br><br>$5.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |
| 200% and above | $50.00 Hospital Emergency Room (waived if admitted)<br><br>$10.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care (The State may increase this amount to $15.00 upon completion of the compliance plan required in paragraph 37.)<br><br>$20.00 Physician Specialists (including Psychiatrists)<br><br>$100.00 Inpatient Hospital Admission (waived if readmitted within 48 hours for the same episode) |

b. **Co-Pays on Pharmacy.** For Demonstration-only eligible children (title XXI Medicaid Expansion children and medically eligible title XIX children) (see paragraph 19 *Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed*), adults in the Discontinued Demonstration Group (see paragraph 23 *Discontinued Demonstration Group--Adult Demonstration Populations Discontinued Through March 24, 2005 Demonstration Amendment*), and adults in the Standard Spend Down Demonstration Group (see paragraph 21(a) *Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category*), and persons in the At Risk Demonstration Group, co-pays on outpatient pharmacy services are presented in Table 6 (*Co-Pays on Pharmacy For Demonstration-Only Eligible Groups in TennCare Standard, Including SSD and for CHOICESParticipants*). Persons in CHOICES 1 and CHOICES 2 do not

have co-pays on pharmacy. However, persons in CHOICES 3 (who are Medicaid eligible) and persons in Interim CHOICES 3 have the same pharmacy co-pays as other Medicaid-eligible adults.

**Table 6 –Co-Pays on Pharmacy For Demonstration-Only Eligible Groups in TennCare Standard, Including SSD and for CHOICES Participants**

| Demonstration Population | Covered outpatient brand name drugs or refills | Covered outpatient generic drugs or refills |
|---|---|---|
| TennCare Standard under age 21 with incomes below 100% FPL | $0 | $0 |
| TennCare Standard under age 21 with incomes at or above 100% FPL | $3.00 | $0 |
| TennCare Standard aged 21 and older -- other than enrollees in the SSD program | Not applicable (outpatient pharmacy services are not covered for this group) | Not applicable (outpatient pharmacy services are not covered for this group) |
| TennCare Standard aged 21 and older -- SSD enrollees | $3.00 | $0 |
| CHOICES 1 and CHOICES 2 Participants | $0 | $0 |
| Interim CHOICES 3 | $3.00 | $0 |

**37. Compliance of TennCare Standard Cost Sharing With Federal Regulations.** By October 1, 2010, the State must submit a plan (subject to CMS approval) for ensuring that cost sharing for TennCare Standard complies with the statutory and regulatory requirements listed in paragraph 36, including the implementation of an aggregate cost sharing cap as described in 42 CFR 447.78 The plan must address the applicable requirements enumerated in the regulations. The State must come into compliance by July 1, 2011, or six months after the date of notification by CMS of approval of the compliance plan, whichever is later.

## VIII. DELIVERY SYSTEMS

**38. Managed Care Entities.** TennCare II operates totally in a managed care environment and uses various types of managed care entities for delivering covered services to TennCare enrollees. The types of managed care entities used are listed in Table 7 below, with the reimbursement and rate-setting methodologies for each one. Title XXI Medicaid Expansion Demonstration population children use the same delivery systems as other enrollees.

**Table 7– Types of Managed Care Entities**

| Type of Entity | BBA Definition | Description of Services Covered | Reimbursement and Rate-Setting Methodology |
|---|---|---|---|
| Managed Care Organizations (MCOs)—at full risk | MCO | All TennCare physical health, behavioral health, and long-term care services | MCO rates are actuarially certified by an independent third party actuary |
| TennCare Select—non-risk or partial risk | Prepaid Inpatient Health Plan (PIHP) | All TennCare physical health, behavioral health, and long-term care services for enrollees selected for participation in TennCare Select rather than enrolled in MCOs (see paragraph 40 *TennCare Select*) | Provider payment rates negotiated between the PIHP and providers; administrative fee, approved by CMS, paid to the PIHP |
| Dental Benefits Manager (DBM)—non-risk | Prepaid Ambulatory Health Plan (PAHP) | Dental benefits for all TennCare enrollees with this coverage | Provider payment rates are established within DBM contract as approved by CMS; administrative fee, approved by CMS, is paid to the DBM |
| Pharmacy Benefits Manager (PBM)—non-risk (may be renegotiated as at risk) | PAHP | Pharmacy benefits for all TennCare enrollees with this coverage. | Provider payment rates are established in accordance with the State plan; administrative fee, approved by CMS, is paid to the PBM |

**39. Enrollment in Managed Care Organizations (MCOs).** With the exception of individuals enrolled in TennCare Select, all individuals eligible for TennCare (TennCare Medicaid or TennCare Standard), including those dually eligible for Medicare, shall be enrolled in a managed care organization providing the benefits described in paragraphs 30 *(TennCare Benefits)* and 31 *(Cost-Effective Alternatives)* of these STCs. In addition to the managed care organization, enrollees are enrolled with a Pharmacy Benefits Manager for covered pharmacy services and a Dental Benefits Manager for covered dental

services. The Pharmacy Benefits Manager administers the pharmacy benefits program, using a preferred drug list that is established by the State (in consultation with a Pharmacy Advisory Committee), taking into account the cost, therapeutic equivalency, and clinical efficacy in accordance with waiver authority.

**40. TennCare Select.** TennCare Select is a prepaid inpatient health plan (PIHP) (as defined in 42 CFR 438.2) which operates in all areas of the State and covers the same services as the MCOs. The State's TennCare Select contractor is reimbursed on a non-risk, non-capitated basis or a partial risk basis for services rendered to covered populations, and in addition receives fees from the State to offset administrative costs.

a. The TennCare Medicaid and TennCare Standard populations included in the TennCare Select delivery system and the services provided to these populations by the TennCare Select contractor are as follows:

i. Children who are eligible for Supplemental Security Income. TennCare Select provides medical case management and all MCO covered services.

ii. Children in State custody and children leaving State custody for 6 months post-custody as long as the child remains eligible. TennCare Select provides medical case management, all MCO covered services, and coordination with the Department of Children's Services (DCS) around medical and behavioral services.

iii. Children who are receiving care in a Nursing Facility or an Intermediate Care Facility for the Mentally Retarded. For children and adults in a Home and Community Based Services 1915(c) waiver for individuals with mental retardation, current enrollees may opt-in to receive services through TennCare Select, and new participants may opt-out of TennCare Select in order to receive services through another MCO. TennCare Select provides medical case management and all MCO covered services.

iv . Enrollees living in areas where there is insufficient capacity to service them. TennCare Select provides medical case management and all MCO covered services.

After being assigned to TennCare Select, persons in categories (a) and (c) above may choose to disenroll from TennCare Select and enroll in an MCO if one is available. Persons in categories (b) and (d) must remain in TennCare Select. The State must request a demonstration amendment (as described in paragraphs 6 (*Changes Subject to the Amendment Process* and 7 *Amendment Process*) in order to change the list of populations included in TennCare Select. TennCare Select is not open to voluntary selection by TennCare enrollees.

b. TennCare Select also provides the following functions:

i. It is the back-up plan should one of the MCOs have to leave the TennCare program unexpectedly. For TennCare enrollees previously enrolled with the MCO, TennCare Select provides medical case management and all MCO covered services.

ii. It is the only entity responsible for payment of the services described in 42 CFR 431.52 (services provided to residents temporarily absent from the State), and provides all MCO covered services (primarily emergency services).

iii. It is also the only entity responsible for payment of the services described in 42 CFR 440.255 (emergency services for aliens), and is responsible for payment of emergency medical services only. TennCare Select is paid an administrative fee for processing these claims.

Processes for Payment of Emergency Medical Services for Illegal or Ineligible Aliens

1. An alien receives services, for example in an emergency room or birthing center or as an inpatient in a hospital.

2. The individual applies for Medicaid coverage of the emergency medical services. A full Medicaid application is completed. Medical records and other verifications are provided as required for the eligibility determination.

3. The State conducts a full eligibility determination in accordance with the requirements in the Medicaid State plan and Federal statute and regulations. If the individual is approved by the State as eligible for this limited Medicaid coverage based on meeting all financial and technical eligibility requirements except having an eligible alien status (and providing or applying for a Social Security number), the individual is entered on the State's Medicaid Management Information System (MMIS) with the State's eligibility code for illegal/ineligible aliens. This category is limited by MMIS edits to payments for emergency medical services, to achieve compliance with section 1903(v) of the Social Security Act. The alien's eligibility period is based on the service dates of the emergency medical services.

4. The State enrolls the individual in TennCare Select as the managed care entity responsible for payment of the emergency medical services covered for illegal or ineligible aliens.

5. The provider bills TennCare Select.

6. TennCare Select pays the provider at the rate negotiated by TennCare Select with that provider for the type of service received by the alien (not at the rate or according to the methodology in the State plan for that service). This rate is part of TennCare Select's agreement with that provider, and is the same rate that TennCare Select pays for any other enrollee for the same service. TennCare Select does not provide any managed care services for the alien and does not limit the alien's access to emergency medical services. It operates like a fiscal intermediary to pay for the covered services received by the alien.

7. TennCare Select is reimbursed by the State for that payment. It is paid as a non-risk plan for what it paid out, as well as an administrative fee. This transaction is conducted in accordance with the State's contract with TennCare Select (approved by the CMS Regional Office), which covers all of the populations enrolled in TennCare Select by the State.

8. The State reports that payment, along with all other service and administrative payments to TennCare Select on the appropriate lines on Forms CMS-64.9 Waiver and 64.9P Waiver, as instructed in Section IX. The State does not report separately the payments for illegal/ineligible aliens for emergency medical services.

9. Expenditures and member months for the illegal/ineligible aliens are reflected in both the "with" and "without" waiver calculations for budget neutrality. Expenditures and member months for illegal/ineligible aliens are included in the base year "without" waiver per member-per month cost calculations, and are trended forward as the budget neutrality expenditure limit, along with expenditures for all other Type 1 categories reported by eligibility group (EG). For the "with" waiver calculations, expenditures for illegal/ineligible aliens are included as reported on the CMS-64 by EG, based on the instructions in paragraph 55 *(Assignment of Expenditures and Member Months to EGs)*. Member months are reported for the aliens according to their EG (following paragraph 55 *(Assignment of Expenditures and Member Months to EGs*), based on the length of their approved coverage for emergency medical services (usually 1 month, but longer if the from and thru dates of the emergency medical services span another month(s)).

**41. Plan Enrollment and Disenrollment.** The State maintains a managed care enrollment and disenrollment process that must comply with 42 CFR Part 438, except that, in accordance with waiver authority, TennCare participants have 45 days in which to

disenroll from an MCO without cause. After 45 days, a participant may disenroll from an MCO only for cause, as set forth in 42 CFR 438.56(d)(2). The "other reasons" that will be considered cause under 42 CFR 438.56(d)(2)(iv) do not include the following:

- The enrollee is unhappy with the current plan or primary care provider (PCP), but there is no hardship medical situation (as defined by the State);
- The enrollee claims lack of access to services but the plan meets the State's access standards;
- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- The enrollee is concerned that a current provider might drop out of the plan in the future; and
- The enrollee is a Medicare recipient who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation.
- The enrollee's Primary Care Provider (PCP) is no longer in the MCO's network, the enrollee wants to continue to see the current PCP, and has refused alternative PCP or provider choices offered by the MCO.

In the event that a CHOICES member is determined, based on an assessment of needs, to require a long term care service that is not currently available under the MCO in which he is currently enrolled, but that is available through another MCO, the State shall work with the current MCO to arrange for the provision of the required services, which may involve providing such services out-of-network. It shall be considered to be cause for disenrollment only if the current MCO, after working with the State, is unable to provide the required services. In such cases, the MCO that is unable to provide the required services after working with the State may be subject to sanctions.

**42. Contracts.** The following subparagraphs provide additional requirements pertaining to contracts awarded by the State for the provision of health care services under TennCare II.

a. Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS approval prior to implementation.

b. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

c. With respect to CHOICES, the State will establish minimum guidelines regarding the person-centered service plan, the processes for the development of the plan, and the monitoring of its implementation. These expectations must be reflected in

the MCO contract. The State must submit a draft of the contract requirements related to the subjects enumerated below to CMS for review prior to executing a contract amendment with an MCO. CMS will respond within 15 working days of receipt of the draft. The required subject areas are as follows:

i. The individuals who develop the person-centered service plan (and their requisite qualifications);

ii. The individuals who are expected to participate in the plan development process;

iii. Timing of the plan, how and when it is updated, including mechanisms to address changing circumstances and needs (and expectations regarding scheduling and location of meetings to accommodate individuals receiving services);

iv. Types of assessments that are conducted as a part of the service plan development process;

v. How participants are informed of the services available to them;

vi. How the process ensures that the service plan addresses the participants' desired outcomes, needs and preferences;

vii. The plans' responsibilities for implementing and monitoring the plan of care.

d. In addition to paragraph 42(c) above, the State will include the following additional requirements in their MCO contracts.

i. The State will require the MCOs to develop and maintain emergency/contingency plans in the event that a large provider of services collapses or is otherwise unable to provide needed services. These contingency plans will be available for inspection by State officials upon request.

e. The State will monitor loss ratios of the managed care plans.

## IX. GENERAL REPORTING REQUIREMENTS

**43. General Financial Requirements.** The State shall comply with all general financial requirements under title XIX and title XXI set forth in these STCs.

**44. Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in this agreement. The State must submit any corrected budget and/or allotment neutrality data upon request.

**45. Additional Reporting Requirements.**

a. **Compliance with Managed Care Reporting Requirements.** The State shall comply with all managed care reporting regulations at 42 CFR 438 *et seq.*

b. **Compliance with Specified HCBS Requirements.** The following regulations, which govern the provision of HCBS under section 1915(c) waivers, shall apply to the HCBS program authorized under section 1115 and provided through CHOICES:

- 42 CFR 440.180(a);
- 42 CFR 441.302;
  - (a),
  - (c) (insofar as it relates to NF level of care, and applying only to CHOICES 2),
  - (d) (consistent with a waiver of section 1902(a)(23) of the Act),
  - (g) (applies only to CHOICES 2), and
  - (j);
- 42 CFR 441.303
  - (a),
  - (c) (except that the requirements following the semi-colon in (c)(2) do not apply to CHOICES 3 or Interim CHOICES 3),
  - (d) (consistent with Table 2b, paragraph 30), and
  - (e); and
- 42 CFR 441.310.

Any conflict between the regulations listed in this subparagraph and these STCs shall be resolved in favor of the STCs. The State shall include a description of the steps taken to ensure compliance with these regulations as part of the Annual Report discussed in paragraph 48.

c. **Quality Improvement Strategy for the CHOICES Program.** The State must submit to CMS an integrated quality improvement (QI) strategy which builds on

existing managed care quality requirements as defined in 42 CFR 438, Subpart E, and incorporates applicable 1915(c) Home and Community-Based Services waiver regulatory assurances as discussed in paragraph 45(b).

The State must identify: 1) measures of process, health outcomes, functional status, quality of life, member choice, autonomy, satisfaction, and TennCare and CHOICES system performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

The MCOs must be required to establish methods for discovery, remediation and systems improvement and, per State prescribed timeframes, regularly report on outcomes associated with continuous quality improvements.

The State must clearly demonstrate its oversight of the process.

The QI strategy must be submitted to CMS for approval prior to implementation.

No less frequently than annually, the State must provide to CMS information regarding QI activities which must include evidence regarding system performance based on identified objectives and measures, and which demonstrates efficacy in implementing the quality strategy, including but not limited to external quality review, discovery, remediation and systems improvement activities.

d. **CHOICES Data.** The State and Federal governments will collaborate to establish the baseline long-term care data appropriate for monitoring programmatic and beneficiary trends under long-term care reform in the CHOICES Program.

i. **Baseline Data Plan.** The State will collect and submit baseline data to CMS, including the following data elements:

(A) Numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services at a point in time,

(B) Unduplicated numbers of persons receiving HCBS and unduplicated numbers of persons receiving NF services during a 12 month period,

(C) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period,

(D) HCBS expenditures and NF expenditures on the elderly and disabled population during a 12 month period as a percentage of

total long-term care expenditures (excluding expenditures on the population of persons with mental retardation),

(E) Average per person HCBS expenditures and NF expenditures on the elderly and disabled populations during a 12 month period,

(F) Average length of stay in HCBS during a 12 month period,

(G) Percent of new long-term care recipients admitted to NF during a 12 month period,

(H) Average length of stay in NFs during a 12 month period,

(I) Number of persons transitioned from NFs to HCBS during a 12 month period.

"Point in time" refers to February 28, 2010 (day before CHOICES implementation in Middle Tennessee), July 31, 2010 (day before CHOICES implementation in East and West Tennessee), June 30, 2011, and June 30 of each year thereafter. The 12 month periods referenced above are the 12 months period ending February 28, 2010 (the date prior to initial CHOICES implementation), DY 9, and each DY thereafter.

ii. **Electronic Collection of Choices Data.** The systems must be in place to record the requisite data elements within 30 days prior to the implementation of the CHOICES Program.

iii. **Submission of CHOICES Data.** An electronic copy of the actual baseline data must be submitted to CMS within 18 months of the last day of the 12-month period prior to CHOICES implementation, within a year of the last day of each DY thereafter, and within 3 months of each point in time.

iv. **CHOICES Data Reporting.** The State must report to CMS, in the Quarterly and Annual Progress Reports, on data and trends of the designated CHOICES data elements.

e. **Requirements Related to the Affordable Care Act.** Subparagraphs (i) and (ii) describe elements that must be included in an extension proposal or phase-out plan, as discussed in paragraph 8.

i. **Affordable Care Act Transition Plan For Extension.** The extension proposal must include a Transition Plan consistent with the provisions of the Affordable Care Act and CMS regulations for any individuals enrolled

in Demonstration Eligible Groups (as defined in paragraph 17, Table 1a) who will be eligible for coverage under the state plan as of January 1, 2014, including under the new Medicaid eligibility group identified in Section 1902(a)(10)(A)(i)(VIII) of the Act, or who elect to move to an Exchange plan. Persons who are Demonstration eligibles at the time of transition will continue to receive Demonstration benefits as long as they are enrolled in a Medicaid category and they continue to meet the criteria for their particular Demonstration program. The Transition Plan will include procedures for ensuring that these individuals transition to their new eligibility status without interruption in coverage to the maximum extent possible.

ii. **Demonstration Phase-Out and Affordable Care Act Transition.** As part of a phase-out plan submitted under paragraph 8, the State must include a plan for using information already in its possession on members of Demonstration Eligible Groups to make advance determinations of eligibility for TennCare under its Medicaid State plan on January 1, 2014, consistent with guidance to be issued by CMS.

**46.** **Monthly Calls.** CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment (including the State's progress on enrolling individuals into the TennCare Standard Spend Down Demonstration Group), cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, title XXI allotment neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

**47.** **Quarterly Progress Reports.** The State must submit progress reports in the format outlined below (see also Attachment A), no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

a. An updated budget neutrality monitoring spreadsheet;

b. An updated CHIP allotment neutrality monitoring spreadsheet;

c. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with

new plans; progress on implementation and/or enrollment progress of the TennCare Standard Spend Down Demonstration Group; benefits; enrollment and disenrollment; grievances; quality of care; access; health plan contract compliance and financial performance that is relevant to the Demonstration; pertinent legislative or litigation activity; and other operational issues;

d. Action plans for addressing any policy, administrative, or budget issues identified;

e. Quarterly enrollment reports for Demonstration eligibles that include the member months for each Demonstration population;

f. Quarterly enrollment reports for individuals that would otherwise be eligible for *Interim* CHOICES 3 but meet the modified institutional level of care, and whether CHOICES 1 or CHOICES 2 was selected by the individual;

g. Evaluation activities and interim findings; and

h. Other reports as indicated in these STCs.

**48.** **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each Demonstration Year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The State shall also submit the title XXI annual State report for its Medicaid Expansion children in the Demonstration, by December 31 of each year.

**49.** **Beneficiary Survey.** The State shall conduct a beneficiary survey each Demonstration year for a statistically valid sample of all TennCare enrollees. The survey shall measure satisfaction, enrollee efforts to secure out-of-network care, average waiting time for physician office visits, and enrollee efforts to change plans, along with reasons for requesting plan changes. Results of the survey must be provided to CMS by September in each Demonstration year.

**50.** **Final Evaluation Report.** The State shall submit a Final Evaluation Report pursuant to the requirements of section 1115 of the Act and as specified in Section XII of these STCs.

**51. Enrollment Reporting.**

a. Each quarter the State will provide CMS with an enrollment report for the title XXI Medicaid Expansion Demonstration population and for title XIX Medicaid children, showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered by the State into the Statistical Enrollment Data System (SEDS) within 30 days after the end of each quarter. SEDS reporting is required for any title XXI-funded population, including Medicaid Expansions, and is also required for title XIX Medicaid child enrollment.

b. Enrollment reporting in the Quarterly and Annual Reports (see paragraphs 47 *Quarterly Progress Reports* and 48 *Annual Report*) is required by Eligibility Group (EG) and Type for the TennCare title XIX and XXI State Plan and Demonstration populations.

## X. GENERAL FINANCIAL REQUIREMENTS

**52.** **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports (QERs) using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the Demonstration under section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period and pool payments and certified public expenditures made for the Demonstration period. CMS shall provide Federal financial participation (FFP) for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section X of these Terms and Conditions.

**53.** **Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures.** In order to track expenditures under this Demonstration, Tennessee must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and section 2115 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the Demonstration Year (DY) in which services were rendered or for which capitation payments were made. For this purpose, Demonstration Year 1 (DY 1) is defined as the year beginning July 1, 2002, and ending June 30, 2003. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not Demonstration expenditures should be reported on Forms CMS-64.9 Base/64.9P Base.

Expenditures for Medicaid Expansion children claimed under the authority of title XXI of the Act shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

b. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the Demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by Demonstration Year on the Form CMS-64 Narrative, and divided into subtotals corresponding to the eligibility groups (EGs) from which collections were made

(see paragraph 55 *Assignment of Expenditures and Member Months to EGs*). In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to Demonstration populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.

c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. **Pharmacy Rebates.** Pharmacy rebates must be reported on Forms CMS-64.9 Waiver or 64.9P Waiver schedules, and allocated to forms named for the different EGs described in (e)(1) through (e)(8) below as appropriate. In the calculation of expenditures subject to the budget neutrality expenditure limit, pharmacy rebate collections applicable to Demonstration populations shall be offset against expenditures.

e. **Use of Forms**. The following separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the Demonstration and title XIX expenditures made in other payment categories as follows. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system. The terms "EG1" through "EG10" refer to the Demonstration Eligibility Groups defined in paragraph 55 *(Assignment of Expenditures and Member Months to EGs)* of these STCs.

(1) "EG1 Disabled" expenditures (see paragraph 55(a)(ii) and (b)(iv))

(2) "EG2 Over 65" expenditures (see paragraph 55(a)(iv) and (b)(vi))

(3) "EG3 Children" expenditures (see paragraph 55(a)(iii) and (b)(v))

(4) "EG4 Adults" expenditures (see paragraph 55(a)(v) and (b)(vii))

(5) "EG5 Duals" expenditures (see paragraph 55(a)(i))

(6) "EG6E Expan Adult" expenditures (see paragraph 55(b)(i)(A))

(7) "EG7E Expan Child" expenditures (see paragraph 55(b)(i)(B))

(8) "EG8 Med Exp Child" expenditures (see paragraph 55(b)(ii))

(9) "EG9 H-Disabled" expenditures (see paragraph 55(a)(ii) and (b)(iv))

(10) "EG10 H-Over 65" expenditures (see paragraph 55(a)(iv) and (b)(vi))

(11) "EG11 H-Duals" expenditures (see paragraph 55(b)(iii))

(12) "CAH Pool" (Critical Access Hospital Pool) (see paragraph 57f)

(12) "EAH Pool" (Essential Access Hospital Pool) (see paragraph 57e)

(13) "Meharry Pool" (see paragraph 57g)

(14) "GME" (Graduate Medical Education) (see paragraph 57d)

(15) "CPE" (Certified Public Expenditures) for Unreimbursed Public Hospital Costs Pool (see paragraph 57h)

(16) "DSH" (Disproportionate Share Hospital Payments) (see paragraph 57i)

(17) "UHC Pool" (Unreimbursed Hospital Cost Pool) (see paragraph 57k)

(18) "PHSP Pool" (Public Hospital Supplemental Payment Pool) (see paragraph 57l)

(19) "EG12E Carryover" expenditures (see paragraph 55(b)(i)(C)).

f. **Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population.**

(1) **Expenditures Subject to the Allotment Neutrality Limit.** The State will be subject to a limit on the amount of Federal title XXI funding that the State may receive on Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including available reallocated funds published in the *Federal Register*. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of Demonstration until the next allotment becomes available.

(2) The State is eligible to receive title XXI funds for expenditures for TennCare Medicaid Expansion children described on the last row of Table 1a in Section IV, paragraph 17 *(Eligibility)*, up to the amount of its title XXI allotment. Waiver expenditures for these children under title XXI must be reported as a Medicaid expansion population on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver, in accordance with the instructions in section 2115 of the State Medicaid Manual, under waiver name "Med Exp Child," identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the Demonstration Year (DY) in which services were rendered or for which capitation payments were made. They are reported in Column C for the enhanced match under title XXI.

(3) If the State exhausts its title XXI allotment, title XIX funds are available for title XXI children in this demonstration. To access this funding, the State must submit for approval a written request to CMS, referencing this STC, to access title XIX funds for the title XXI Medicaid Expansion Demonstration Group. This request must be submitted at least 90 days prior to the date on which the State anticipates their title XXI allotment will be exhausted, and must include:

(A) An updated budget neutrality assessment that adds Medicaid Expansion children to budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that removes Medicaid Expansion children.

(4) Once the title XXI allotment is again available, the State will claim title XXI funding for the title XXI children in this Demonstration. To access this funding, the State shall submit for approval a written request to CMS, referencing this STC, to access title XXI funds for the title XXI Medicaid Expansion Demonstration Group, which includes a request to update the STCs related to claiming. This formal request must be submitted prior to the change in funding source and include:

(A) An updated budget neutrality assessment that removes Medicaid Expansion children from budget neutrality and includes a data analysis which identifies the specific "with waiver" impact of the proposed change on the current budget neutrality expenditure limit. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change; and

(B) An updated CHIP allotment neutrality worksheet that adds Medicaid Expansion children.

(5) During periods in which the State is claiming title XIX funds for Title XXI Medicaid Expansion Demonstration Population children, the member months attributable to this Demonstration population will count toward calculation of the budget neutrality expenditure limit, using the per member per month (PMPM) amounts for "EG-8 Med Exp Child." The expenditures will be considered expenditures subject to the budget neutrality expenditure limit, so that the State is not fully at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

g. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to:

(1) All TennCare title XIX expenditures on behalf of individuals who are enrolled in this Demonstration (excluding the services specified in paragraph 32 *Medicaid Benefits Carved Out Of the TennCare II Demonstration*), including all service expenditures and applicable administrative costs (see subparagraph h, below) net of premium collections and other offsetting collections (e.g., pharmacy rebates, fraud and abuse), and

(2) All expenditures described in paragraph 57(d) through (i) *(Extent of Federal Financial Participation for the Demonstration)*.

All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered Demonstration expenditures and must be reported on Forms

CMS-64.9 Waiver and/or CMS-64.9P Waiver, with the exception of those described in h) below.

h. **Administrative Costs.** In general, administrative costs are not included in the budget neutrality expenditure limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All attributable administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. Administrative costs subject to budget neutrality (see below) must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, according to the EGs for which the expenditure was made (following the list in (e)(1) through (e)(8) above). Other administrative costs not subject to budget neutrality will not be broken out by EG, and will be reported under waiver name "TennCare II."

In accordance to Federal regulations at 42 CFR 438.812(b)(2), during the periods that services are provided in accordance with MCO, pharmacy benefit manager, or dental benefit manager non-risk contracts, the portion of the State's payments that is for reimbursement of the non-risk contractors' administrative services can only be claimed by the State as an administration cost at the Federal matching rates available for the costs of administration of the Medicaid program. The administrative services portion of the amounts paid by the State to compensate any non-risk contractors for their administration costs incurred in accordance with non-risk contracts are costs of the Demonstration waiver that are subject to the budget neutrality expenditure limit explained in Section XI of these STCs.

i. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the section 1115 Demonstration, in order to account for these expenditures properly to determine budget neutrality.

**54. Reporting Member Months.** The following describes the reporting of member months for TennCare Medicaid and TennCare Standard enrollees:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 47 *(Quarterly Progress Report)* of these STCs, the actual number of eligible member months for all TennCare Medicaid and TennCare Standard Eligibility Groups (EGs) defined in paragraph 55 *(Assignment*

*of Expenditures and Member Months to EGs)*. The State must submit a statement accompanying the quarterly report, which recognizes the accuracy of this information. Member months should be reported only for individuals who are included in TennCare, as defined in paragraph 17 *(Eligibility)*. Persons for whom Medicaid only pays for services carved out of TennCare (as described in paragraph 32 *Medicaid Benefits Carved Out Of the TennCare II Demonstration*) are not enrolled in TennCare (e.g., QMBs, SLMBs).

b. A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for Type 1 and Type 2 eligibles (as defined in paragraph 63 *Eligibility Groups (EGs) Subject to Budget Neutrality Agreement*) are reported in section VIIIA of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for Type 3 Demonstration expansion populations and for title XXI Medicaid Expansion Demonstration eligibles are reported in section VIIIB of the template, and are not used to calculate the budget neutrality expenditure limit. Detailed instructions for assigning member months to Types and to EGs are provided in paragraphs 55 *(Assignment of Expenditures and Member Months to EGs)* and 63 *(Eligibility Groups (EGs) Subject to Budget Neutrality Agreement)*.

c. To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the State must report a new table with revised member month totals indicating the quarter for which the member month report is superseded.

d. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

e. The State will ensure that eligible member month totals reported to CMS for the TennCare II Demonstration from July 1, 2002, forward conform to the EG definitions contained in paragraph 55 *(Assignment of Expenditures and Member Months to EGs)*. As part of the first quarterly report submitted to CMS in DY 6, the State must report actual member months for DY 5.

f. At the implementation of CHOICES, Tennessee must distinguish between member months that occurred before March 1, 2010 (CHOICES initial implementation date) from those occurring on or after March 1, 2010, and provide separate subtotals by period if necessary.

**55. Assignment of Expenditures and Member Months to EGs:** The following rules govern the:

- Reporting of expenditures subject the budget neutrality expenditure limit on separate waiver forms by EG, as described in paragraph 53(e) *(Reporting Expenditures in the Demonstration)* above, for the period beginning July 1, 2007, through the end of the TennCare II Demonstration, and
- Reporting of eligible member months for the TennCare II Demonstration from July 1, 2002, forward.

Beginning July 1, 2007, the quarterly progress report template in Attachment A, Part VIII should be used to report separate member month totals for Type 1, Type 2, and Type 3 eligibles, and for other subgroups as specified below.

a. **Title XIX State Plan Mandatory or Optional Groups (including members of the CHOICES 1 and CHOICES 2 Carryover Group and PACE Carryover Group who are SSI recipients) (Type 1 Eligibles) and Transition Group (Type 2 Eligibles) – TennCare Medicaid:**

(i) For persons who are Medicare beneficiaries report under **EG5 Duals.**

Note: Between July 1, 2002, and December 31, 2005, Medicare-Medicaid dual eligibles were served outside of TennCare II through a separate 1915(b) waiver program, so no member months should be reported under TennCare II for this group during that period.

Note: EG5 Duals MEG does not include members of the CHOICES 217-Like HCBS Group or the At Risk Demonstration Group.

(ii) For persons who are not described by (i) and who qualified for Medicaid on the basis of disability, report under **EG1 Disabled.**

(iii) For persons not described by (i) or (ii) and who are age 18 or younger, report under **EG3 Children.**

(iv) For persons who are not described by (i) or (ii) and are age 65 or older, report under **EG2 Over 65.**

(v) For persons not described by (i) through (iv), report under **EG4 Adults.**

b. **Title XIX Demonstration Eligible Groups Other Than Transition Group Eligibles (Types 2 and 3 Eligibles), and members of the CHOICES 1 and**

**CHOICES 2 Carryover Group and PACE Carryover Group who are not SSI recipients (Type 3 Eligibles)**

(i) (A) For persons who belong to any of the following groups, report expenditures and member months under **EG6E Expan Adult** (Type 3 eligibles) those persons who:

(1) are adult grandfathered Medicare beneficiaries (duals),

(2) are adult Standard Spend Down Demonstration eligibles,

(3) are eligible for the TennCare Standard Discontinued Demonstration Group as uninsured low-income adults (age 19 or older) and are not medically needy rollovers (see Section IV, paragraphs 20 *Rollover Definition* and 23 *Discontinued Demonstration Group – Adult Demonstration Populations Discontinued Through March 24, 2005*), or

(4) were enrolled in TennCare as adult dislocated workers on June 30, 2002.

(B) For persons who belong to the following group, report expenditures and member months under **EG7E Expan Child** (Type 3 eligibles) those persons who:

- have incomes 200 percent or more of the Federal poverty level (medically eligible (uninsurable) Demonstration children).

(C) For persons in the CHOICES 1 and CHOICES 2 Carryover Group and PACE Carryover Group who are not SSI recipients, report expenditures and member months under **EG12E Carryover** (Type 3 eligibles).

(ii) For Medicaid Expansion Optional Targeted Low Income Children eligible for TennCare Standard from July 1, 2007, forward, for periods in which the State is not claiming title XXI enhanced FMAP (see paragraph 53(f) *Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population*), report expenditures and member months under **EG8 Med Exp Child** (type 2 eligibles).

(iii) For persons who are not described in (i) or (ii) above, and who are Medicare beneficiaries, report expenditures and member months for July 1, 2010 and thereafter under **EG 11 H-Duals** (Type 2 eligibles); specifically, persons who:

(1) are members of CHOICES 217-Like HCBS Group, OR

(2) are members of the "At Risk" Demonstration Group.

(iv) For persons who are not described in (i), (ii), or (iii) above, report expenditures and member months prior to July 1, 2010 under **EG1 Disabled** (Type 2 eligibles), and on July 1, 2010 and thereafter under **EG 9 H-Disabled** (Type 2 eligibles), those persons who:

(1) have been determined by the State or Federal Government to be disabled, and are medically needy rollovers, if age 19 and older,
OR

(2) are members of CHOICES 217-Like HCBS Group that are not dual eligibles,.
OR

(3) are members of the "At Risk" Demonstration Group.

Prior to July 1, 2007, member months for TennCare Standard Medicaid Expansion children with income up to 200 percent of the FPL who are classified as disabled are reported here. Starting July 1, 2007, expenditures for these optional targeted low-income children will be matched at the title XXI enhanced FMAP rate, and reporting expenditures and member months is governed by(c) below.

(v) For persons who are not described in (i) through (iv) above who are age 18 or younger, report member months under **EG3 Children** (Type 2 eligibles).
Note: This group consists exclusively of TennCare Standard Medicaid Expansion children with incomes up to 200 percent of FPL who are not classified as disabled, for periods of eligibility prior to July 1, 2007.

(vi) For persons not described by (i) through (iv) above, report expenditures and member months prior to July 1, 2010 under **EG2 Over 65** (Type 2 eligibles), and on July 1, 2010 and thereafter under **EG 10 H-Over 65** (Type 2 eligibles), those persons who:

(1) are age 65 or older, and are medically needy rollovers, OR

(2) are members of CHOICES 217-Like HCBS Group.

(vii) For persons not described by (i) through (iv) above, report expenditures and member months under **EG4 Adults** (Type 2 eligibles) those persons who:

(1) are between 19 and 64 years old, and

(2) are medically needy rollovers.

c. Expenditures for title XXI Medicaid Expansion children matched at the title XXI enhanced FMAP should be reported on Forms 64.21U Waiver/64.21UP Waiver,

using waiver name "Med Exp Child." Report member months for quarterly reporting using Attachment A, Part VIII. For periods in which the State claims title XIX FMAP for this population (paragraph 53(f) *Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population*), follow the instructions in (b)(ii) above.

d. Type 2 eligibles can be identified as disabled for reporting purposes (see (b)(iii) above) if information exists in their enrollment record that would result in a capitation rate for disabled populations being paid on their behalf.

e. When the Transition Group (see paragraph 22 *Transition Group – Adult Medicaid State Plan Eligibility Categories for Which Enrollment Is Closed*) is redetermined for SSD eligibility (see paragraph 21 *Standard Spend Down (SSD) – Adult Non-State Plan Demonstration Population Category*), the State must track and report expenditures and member months in accordance with (b) above. Expenditures and member months for the Transition Group must be reported as Type 1 (State plan eligibles) for budget neutrality and counted in both the "with" and "without" waiver calculations. Expenditures and member months for the SSD population must be reported as Type 3 (Demonstration expansion eligibles) for budget neutrality and counted only in the "with" waiver calculations.

**56. Standard Funding Process.**

a. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

b. **Standard CHIP Funding Process.** The standard CHIP funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the allotment neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as

approved by CMS. Within 30 days after the end of each quarter, the State must submit quarterly CHIP expenditure reports as described in paragraph 53(f) *(Specific Reporting Requirements for the Title XXI Medicaid Expansion Demonstration Population)*, showing CHIP expenditures made in the quarter just ended. CMS shall reconcile expenditures with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

**57. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding (see Section IX, paragraph 59 *Sources of Non-Federal Share*), CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the budget neutrality limits described in section X of these STCs.

a. Administrative costs, including those associated with the administration of the Demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan and waiver authorities.

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration.

d. **Graduate Medical Education (GME) Pool.** Actual cash disbursements, up to $50 million in total computable expenditures for each Demonstration year, paid by the State from a supplemental pool to pay for GME costs in accordance with the pool distribution methodology described below. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology, authorized by the Demonstration's expenditure authorities. Should CMS promulgate new regulations, the TennCare GME program must come into compliance in accordance with the effective date of the new regulations.

*GME Pool Methodology*: GME Pool payments will be made to the following medical universities that operate graduate physician medical education programs. These payments are restricted for use by those universities to fund graduate medical education activities of associated teaching hospitals or clinics: East Tennessee State University, Meharry Medical College, University of Tennessee at Memphis, and Vanderbilt University. The annual GME Pool funds will be allocated based on the annual ratio derived by dividing each hospital's average of its Primary Care Position Allocation and its Total Filled Positions Allocation by the aggregate of the medical hospitals' averages. The Primary Care Position Allocation is computed by taking each hospital's total number of primary care

residents in years 1 through 4 of residency and dividing it by the total of all primary care residents in the medical hospitals in years 1 through 4 of residency. The Total Filled Positions Allocation is computed by taking each hospital's total number of residents in years 1 through 4 of residency and dividing it by the total of the medical hospitals' number of residents in years 1 through 4 of residency. This annual ratio is applied to the total GME Pool funding to be allocated. The annual GME Pool funds will be disbursed quarterly. The State must make these payments directly to the universities, and not through any third party or intermediary.

e. **Essential Access Hospital (EAH) Pool.** Actual cash disbursements paid each quarter from a $25 million quarterly supplemental pool to pay for the uncompensated costs of the designated EAHs' TennCare covered inpatient and outpatient services for TennCare enrollees and appropriate charity care patients in accordance with the pool distribution methodology described below. The purpose of this pool is to address the uncompensated care situation of high volume and charity hospitals that serve a disproportionate number of low-income patients with special needs. Hospitals designated as Critical Access Hospitals (CAHs) or as State mental health institutes do not participate in this pool. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The State must make these payments directly to the providers of the services as specified in 42 CFR 447.10.

In order to enforce provisions of section 1923(f)(6)(A)(iv) of the Act, the first $25 million (total computable) of EAH Pool payments made by Tennessee for Demonstration Year (DY) 5 will be considered to have been made for Federal fiscal year (FFY) 2006. All EAH Pool payments for DY 5 beyond the first $25 million, plus all EAH Pool payments made in the quarter ending September 30, 2007, will be considered to have been made for FFY 2007. For FFYs 2008 and beyond, EAH Pool payments will be assumed to pertain to the FFY during which the payments were made. To the extent required by Federal law, EAH Pool payments made during a given FFY shall be reduced on a dollar for dollar basis by the amount of DSH payments made under the DSH allotment for that FFY.

*EAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Essential Access Hospitals.

*Qualifications* -- Hospitals eligible to receive EAH Pool payments include all hospitals licensed to operate in the State of Tennessee excluding the five (5) State mental health institutes and the CAHs. The four regional mental health institutes are Memphis Mental Health Institute, Moccasin Bend Mental Health Institute, Western Mental Health Institute, and Middle Tennessee Mental Health Institute. The CAHs receive cost-based reimbursement from the

TennCare program subject to limitations outlined in subsection (f) of this paragraph.

- All hospitals, with the exception of free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, at least one Managed Care Organization in the TennCare program.
- The free standing psychiatric hospitals must be a contracted provider with at least one of the Managed Care Organizations in the TennCare program and at least 30% of its total adjusted days must be covered by TennCare.
- All acute care hospitals must have either of the following: (i) at least 13.5% or more of its total adjusted days covered by TennCare; or (ii) 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days.
- All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare Cost.

*Allocation of the EAH Pool to Segments of Hospitals* -- The $25 million Pool should be segmented into 4 distinct parts as follows:

- Essential Service Safety Net – $12.5 Million -- These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically underserved.
- Children's Safety Net – $1.25 Million -- These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children in Tennessee under the age of 21.
- Free Standing Psychiatric Hospitals - $0.5 Million -- These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health for the provision of psychiatric hospital services in Tennessee, excluding the State mental health institutes.
- Other Essential Acute Care – $10.75 Million -- These hospitals include all other hospitals licensed by the Tennessee Department of Health to provide services in Tennessee, excluding the Critical Access Hospitals.

*Quarterly Reports* – The State must include in its Quarterly Progress Reports a list of the current hospitals in each of the above categories (see Attachment A).

*Data* -- Calculation of the quarterly payment amounts will be based on the most recently completed Joint Annual Report of Hospitals at the time of the first quarterly payment for a given fiscal year.

*Allocation will be based on an assignment of points for*:

- TennCare adjusted days expressed as a percent of total adjusted patient days; and
- Charity, medically indigent care, and bad debt expressed as a percent of total expenses.

*Calculation of Points*

**(1)** TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:

- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the critical access, pediatric and safety net providers;
- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 34.5%;
- 3 points – greater that 34.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

**(2)** Bad Debt, Charity and Medically Indigent – BDCHMI costs as a percent of total expenses

- 0 points - less than 4.5%
- 1 point - greater than or equal to 4.5% and less than 9.5%
- 2 points - greater than or equal to 9.5% and less than 14.5%
- 3 points - greater than or equal to 14.5%

*Calculation of Amounts of Pool Payments for Hospitals* -- These points will then be used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate included all inpatient costs (operating, capital, direct education) but excluded add-ons (indirect education, MDSA, return on equity). The GHR for Safety Net Hospitals is $908.52. The GHR for Other Essential Access Hospitals is $674.11. The points for each qualifying hospital will be summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each of the 4 pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by

the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initially calculated amount will then be adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. For example, if the sum of the initial calculated amounts for the pediatric group is $9 million and the total pool for children's hospitals is $5 million, each hospital's initial calculated amount will be multiplied by $5 million / $9 million.

*Pool Payments* -- Hospitals will be paid on a quarterly basis following the end of each quarter. The initial payment will include all quarters that have ended at the time that the payment is made. All subsequent quarterly payments will be made following the end of the quarter. In order to receive a payment for the quarter, all hospitals, with the exception of the free standing psychiatric hospitals, must be a contracted provider with TennCare Select and, where available, with at least one Managed Care Organization, and must have contracted with TennCare Select for the entire quarter that the payment represents. In order for a free standing psychiatric hospital to receive a payment for the quarter, it must be a contracted provider with at least one of the Managed Care Organizations.

f. **Critical Access Hospital (CAH) Pool.** Actual cash disbursements, of up to $10 million per Demonstration Year, paid from a supplemental pool to pay for the uncompensated costs of the designated CAHs' TennCare covered inpatient and outpatient services for the TennCare enrollees and the appropriate charity care patients in accordance with the pool distribution methodology that has been given CMS prior approval. CAHs are designated by the Tennessee Department of Health, and they are typically small, rural hospitals that are part of a rural health network. CAHs allow communities to maintain access to primary care and emergency care when the maintenance of a full-service acute care hospital is no longer feasible. The purpose of this pool is to address the uncompensated care situation of CAHs in serving a disproportionate number of low-income patients in rural areas who have special needs. CMS will only approve FFP for supplemental pool payments made in accordance with the following approved pool distribution methodology. The State must make these payments directly to the providers of the services as specified in 42 CFR 447.10.

*CAH Pool Methodology*: TennCare will make pool payments to certain hospitals designated as Critical Access Hospitals.

*Qualifications* -- To qualify for payment as a Critical Access Hospital, a hospital must meet the following criteria:

- The hospital is an acute care hospital located and licensed in the State

of Tennessee;

- The hospital has been designated a Critical Access Hospital by the Tennessee Department of Health; and
- The hospital contracts with a managed care organization participating in TennCare.

*Reimbursement* -- TennCare will provide reimbursement to Critical Access Hospitals under the following terms. Reimbursement to hospitals will be limited to specific annual legislative appropriation. In any State fiscal year that reimbursable TennCare costs incurred by Critical Access Hospitals exceed annual appropriations, equitable adjustments will be made to the rates described below, in order to cap reimbursement at the annual appropriation.

***Inpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare inpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly with interim per diem rates and will be cost-settled at year-end. Using the Joint Annual Reports filed for the most recent year available, interim per diem rates for TennCare inpatient services will be determined with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs. Inpatient Critical Access Hospital services will not include more than 15 acute inpatient beds. An exception to the 15 bed requirement is made for swing bed hospitals. Critical Access Hospitals are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that not more than 15 beds are used at any one time for acute care.

***Outpatient Services*** -- Effective for dates of service beginning July 1, 2002, TennCare outpatient services that are furnished by Critical Access Hospitals will be reimbursed quarterly based on a percentage of charges with year-end cost settlements. Using the Joint Annual Reports filed for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges, with consideration for payments of TennCare services to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95 percent (95%) of TennCare reasonable costs.

**Cost Settlements** -- Cost settlements are determined from provider submitted Medicare cost reports that include the title XIX schedules based on 100 percent (100%) of TennCare reasonable costs. The term “reasonable costs” is defined for this purpose as total reimbursable costs under Medicare principles of cost reimbursement for Critical Access Hospitals.

*New Designations of Critical Access Hospitals* -- For new hospitals that qualify after July 1, 2002, the State will begin reimbursement at the rates established by this part on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its Critical Access Hospital designation. At that time, interim rates will be established according to this part and the designation will be confirmed with the Tennessee Department of Health.

*Audit Trail and Audit Requirements* -- Each CAH is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than 5 years from the date of the submission of the Joint Annual Report, and the provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint Annual Reports are subject to audit at any time by Federal and State auditors, including the Comptroller of the Treasury and the Bureau of TennCare, or their designated representative.

g. **Meharry Medical College (Meharry) Pool.** Actual cash disbursements paid from a $10 million supplemental pool per Demonstration Year to pay for the uncompensated costs of the two Medicaid clinics operated by the Meharry Medical College for TennCare covered services provided to TennCare enrollees and the appropriate charity care patients. The Meharry Pool payments will be limited to the uncompensated costs of the care as determined by an independent audit each year and subject to the review and approval by the CMS staff. Before paying the annual pool amount to the providers, the State will provide CMS with a copy of the annual independent audit report. The State must make these payments directly to the providers of the services as specified in 42 CFR 447.10.

h. **Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (CPE).** Actual costs incurred by government operated hospitals for the provision of inpatient and outpatient TennCare services for TennCare enrollees and uninsured patients are eligible as CPE. The State must be able to document that the applicable hospitals had actual unreimbursed costs for providing those TennCare covered hospital inpatient and outpatient services, which exceeded the amounts paid to the hospital from the following sources: the MCOs; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds). With regard only to hospital CPE, the State will report actual CPE within 12 months after the end of each fiscal year. At that time, the State will revise its FFP claim to reconcile actual CPEs with the CPE estimates used during the preceding fiscal year (FY).

**State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the State of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

**CPE Methodology and Protocol.** The State must follow the CPE protocol, as contained in Attachment F of these STCs, which was approved by CMS for use beginning July 1, 2008.

i. **Disproportionate Share Hospital (DSH) Payments.** The Tax Relief and Health Care Act of 2006 (TRHCA 2006) established a DSH allotment for Tennessee for FFY 2007, as described at section 1923(f)(6) of the Act. The relationship between DSH payments made by Tennessee under TRHCA 2006 and payments from the EAH Pool is further specified in the second paragraph of subparagraph (e) above. If Congress should establish a DSH allotment for Tennessee for any subsequent Federal fiscal year, the State may make DSH payments to hospitals on the basis of a State plan amendment approved by CMS. Depending on the specifics of the legislation establishing the DSH allotment, modifications to the budget neutrality expenditure limit may be required, in the manner specified in paragraph 4(a) (*Impact on Demonstration of Changes in Federal Law, Regulation, and Policy).* Unless otherwise specified by law, DSH payments shall be considered payments made under the Demonstration and subject to the budget neutrality expenditure limit and the limit described in subparagraph (j) below. When determining hospital-specific DSH limits and DSH payments, the State must take into account all Medicaid payments under the Medicaid State plan and demonstration projects including amounts paid to hospitals through the GME, EAH, Meharry Medical College, UHC, PHSP, and CAH Pools, as well as any payments by or on behalf of individuals with no source of third party coverage. The State must make these payments directly to the providers of the services as specified at section 1923(i) of the Social Security Act.

j. Beginning in DY 6 (State fiscal year 2008), the combined total of the payments to hospitals listed in (1) below shall not exceed annual limits described in (2). Any unused amount from the annual cap for one DY may not be rolled over and added to the annual cap for any subsequent DY.

(1) The following payments are subject to the limit in DY 6 through 9:

- EAH Pool payments for the four quarters of the DY (see 57(e));
- CAH Pool payments for the DY (see 57(f));
- Meharry Pool payments for the DY (see 57(g));
- One-quarter of DSH payments (see 57(i)) subject to the allotment for the FFY ending during the DY;

- Three-quarters of DSH payments (see 57(i)) subject to the allotment for the FFY beginning during the DY;
- Hospital CPE (see 57(h)).

(2) The following payments are subject to the limit in DY 10:
- EAH Pool payments for the four quarters of the DY (see 57(e));
- CAH Pool payments for the DY (see 57(f);
- Meharry Pool payments for the DY (see 57(g));
- One-quarter of the DHS payments (see 57(i)) subject to the allotment for the FFY 2011;
- Additional DSH payments equal to the DSH allotment for the first quarter of FFY 2012;
- Hospital CPE (see 57(h)).

(3) The following payments are subject to the limit in DY 11:
- EAH Pool payments for the four quarters of the DY (see 57(e));
- CAH Pool payments for the DY (see 57(f));
- Meharry Pool payments for the DY (see 57(g));
- Hospital CPE (see 57(h)).

(4) The annual limit for DY 6 – DY 11 shall be $540 million (total computable).

k. **Unreimbursed Hospital Cost (UHC) Pool.** Actual costs incurred by eligible Tennessee hospitals that are unreimbursed by TennCare. The total amount of funds to be distributed to hospitals each DY from the pool will be determined annually, in a manner defined by the Tennessee General Assembly's Annual Coverage Assessment Act and this subparagraph, but in no event may exceed the limit defined below. For any demonstration year in which it elects to make payments under the UHC Pool authority described in this paragraph, the State may not implement a reduction in benefits or elimination of coverage for any of the following services: physical therapy, occupational therapy, speech therapy, inpatient hospital, lab and x-ray, non-emergency outpatient hospital, physician, podiatrist, certified nurse practitioner, or physician assistant services; or implement any co-payment for non-emergency medical transportation. (Nothing in this paragraph is intended to limit the State's ability to manage utilization of these services through changes to prior authorization requirements or other managed care practices).

***Eligible Hospitals.*** Hospitals eligible to receive a pool payment include all hospitals licensed to operate in the State of Tennessee, except the following groups:
- Critical Access Hospitals;

- Public hospitals eligible to certify public expenditures, including State mental health institutes;
- Rehabilitation and long term care hospitals; and
- Pediatric research hospitals that limit patients to those that meet research protocols.

Any hospitals that have closed between 2008 and the time that the amounts of the payments are calculated are not eligible to receive payments.

***Minimum Qualifications.*** In order to receive a payment, the hospital must be contracted with at least one TennCare MCO and must have unreimbursed TennCare costs, unless the hospital is capitated and accepts the capitation from TennCare as full reimbursement for services to TennCare patients.

***Data Source.*** The Joint Annual Report (JAR) of Hospitals, which is a report containing data that each licensed hospital in the State is required to file annually in accordance with T.C.A. 68-11-310. This law says:

> All hospitals that submit a joint annual report to the Department of Health as designated in this section also shall submit to the department, at the same time they send the signed paper copy of the report, a notarized statement from their chief financial officer stating that the financial data reported on the joint annual report are consistent with the audited financials for the hospitals for that reporting year. The notarized statement shall also be attested to by the chief executive officer of the hospital.

Reports are submitted to the Tennessee Department of Health (DOH), edited by DOH, corrected by the hospital and placed in a final data file for that year by DOH. The instructions for completing the form require the hospitals to use the same accounting method required for the Medicare cost reports.

Payment amounts for each DY will be based on the final JAR from 3 years prior to the DY.

***Calculation.*** TennCare costs shall be determined by multiplying TennCare charges for hospital inpatient and outpatient services reported by the hospital by the ratio of reported total expenses to reported total charges (cost to charge ratio). Unreimbursed TennCare Costs are calculated as the difference between the calculated TennCare costs and the TennCare revenue as reported on the JAR.

Each hospital shall receive an annual payment each DY equal to a percentage of its Unreimbursed TennCare Costs, using the same percentage to calculate each hospital's payment.

***Funding.*** TennCare shall adjust payments if necessary to ensure no hospital receives supplemental payments in excess of unreimbursed TennCare costs. Payments may be prorated subject to available appropriations.

***Payments.*** The annual payment to each hospital shall be made in four equal quarterly payments.

***Annual Limit:*** The total amount of UHC Pool payments made each DY may not exceed $500 million total computable.

l. **Public Hospital Supplemental Payment (PHSP) Pool.** Actual cash disbursements paid from a $70 million (total computable) supplemental pool per Demonstration Year to selected public hospitals. The amount paid each DY to each hospital must not exceed the hospital's uncompensated cost of TennCare covered services provided to TennCare enrollees and uninsured patients. The State must make these payments directly to the providers of the services as specified in 42 CFR 447.10. PHSP Pool payments may be made to the following hospitals:

- Regional Medical Center at Memphis,
- Nashville General Hospital at Meharry.

**58. Medicare Part D Drugs.** No FFP is available under this Demonstration for Medicare Part D drugs.

**59. Sources of Non-Federal Share.** The State certifies that the matching non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

c. Under all circumstances, health care providers must retain 100 percent of the TennCare II reimbursement amounts claimed by the State as a Demonstration expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation

of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

**60. Monitoring the Demonstration.** The State shall provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable timeframe.

## XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

**61. Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, with an aggregate adjustment for projected disproportionate share hospital payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in Section X, paragraph 53 *(Reporting Expenditures in the Demonstration).*

**62. Risk.** Tennessee shall be at risk for the per capita cost (as determined by the method described below in this Section) for Type 1 and Type 2 TennCare enrollees in the eligibility groups (EGs) described in paragraph 63 *(Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement)* under this budget neutrality agreement, but not for the number of Demonstration eligibles in each of the groups. By providing FFP for all Type 1 and Type 2 TennCare enrollees in the specified EGs, Tennessee shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Tennessee at risk for the per capita costs for TennCare enrollees in each of the EGs under this agreement, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration. Tennessee will be at risk for both per capita costs and enrollment for Type 3 TennCare eligibles.

**63. Eligibility Groups (EGs) Subject to the Budget Neutrality Agreement.** Individuals who are eligible under TennCare and whose expenditures are funded at title XIX matching rates will be one of three types:

a. Type 1 - are currently eligible under Tennessee's Medicaid State plan (Title XIX State plan mandatory or optional eligible population) - counted in the "with" and "without" waiver calculations;

b. Type 2 - could be eligible under Tennessee's Medicaid State plan if Tennessee amended its State plan or could be eligible for a Section 1915(c) waiver for aged and disabled adults pursuant to 42 C.F.R. 435.217 (Title XIX Demonstration-eligible hypothetical population) or is eligible under the At Risk Demonstration Group for the Interim CHOICES 3 program - counted in the "with" and "without" waiver calculations (the State cannot generate savings from these populations); and

c. Type 3 – are only eligible with section 1115 Demonstration authority (Title XIX Demonstration-eligible expansion population) - counted only in the "with" waiver calculations.

**64. Budget Neutrality Ceiling.** The following describes the method for calculating the budget neutrality expenditure limit:

a. For each DY of the budget neutrality agreement, an annual target is calculated as the sum of two components:

(1) The sum of six sub-components calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the State in accordance with paragraph 54 *Reporting Member Months*) for Type 1 and Type 2 eligibles claimed under title XIX for the following six EGs: EG1 Disabled, EG2 Over 65, EG3 Children, EG4 Adults, EG5 Duals, and EG8 Med Exp Child (when title XXI allotment is exhausted); and

(2) A Disproportionate Share Hospital (DSH) adjustment for the year described in (d) below.

b. Member months for the following populations are not used for calculation of the budget neutrality expenditure limit:

(1) EG6E Expan Adult and EG7E Expan Child Type 3 eligibles

(2) Med Exp Child: Medicaid Expansion children funded at the title XXI enhanced FMAP.

c. The following tables give the projected PMPM costs for the calculation described in paragraph 64(a) (*Budget Neutrality Ceiling*) by DY. The PMPM costs for DY 8 and earlier are calculated following Attachment B of the November 14, 2006 Special Terms and Conditions and paragraph 64(c) of the July 22, 2009 STCs. Table 8 gives PMPM costs to be used for months occurring before the initial implementation of CHOICES on March 1, 2010, and Table 9 gives PMPM costs to be used for months occurring after the initial implementation of CHOICES.

**Table 8 – Projected PMPM Costs Before CHOICES Implementation**

| | Trend | DY 8 | DY 9 | DY 10 | DY 11 |
|---|---|---|---|---|---|
| **EG1 Disabled**** | 5.82% | $1,206.16 | $1,276.36 | $1,350.64 | $1,429.25 |
| **EG2 Over 65***** | 5.01% | $483.31 | $507.52 | $532.95 | $559.65 |
| **EG3 Children** | 6.24% | $377.81 | $401.39 | $426.44 | $453.05 |
| **EG4 Adults** | 6.05% | $733.29 | $777.65 | $824.70 | $874.59 |
| **EG5 Duals** | 5.54% | $109.02 | $115.06 | $121.43 | $128.16 |
| **EG8 Med Exp Child*** | 6.24% | $377.81 | $401.39 | $426.44 | $453.05 |

*Optional Targeted Low Income Children funded using title XIX
** Includes EG 9 H-Disabled
*** Includes EG-10 H-Over 65

**Table 9 – Projected PMPM Costs After CHOICES Implementation**

| | Trend | DY 8 | DY 9 | DY 10 | DY 11 |
|---|---|---|---|---|---|
| **EG1 Disabled**** | 5.82% | $1,253.79 | $1,326.76 | $1,403.98 | $1,485.69 |
| **EG2 Over 65***** | 5.01% | $843.92 | $886.20 | $930.60 | $977.22 |
| **EG3 Children** | 6.24% | $377.82 | $401.40 | $426.45 | $453.06 |
| **EG4 Adults** | 6.05% | $733.56 | $777.94 | $825.01 | $874.92 |
| **EG5 Duals** | 5.54% | $531.03 | $560.45 | $591.50 | $624.27 |
| **EG8 Med Exp Child*** | 6.24% | $377.82 | $401.40 | $426.45 | $453.06 |

*Optional Targeted Low Income Children funded using title XIX
** Includes EG 9 H-Disabled
*** Includes EG-10 H-Over 65

d. The DSH adjustment is based upon Tennessee's DSH allotment for 1992 and calculated in accordance with current law.

i. For the purpose of this subparagraph, the Average FMAP (AFMAP) for each DY is defined as 0.25 times the FMAP applicable to DSH expenditures for the Federal fiscal year that ends during that DY, plus 0.75 times the FMAP applicable to DSH expenditures for the Federal fiscal year that begins during that DY.

ii. A DSH allotment has been established for Tennessee under provisions of TRHCA 2006 (and extended through subsequent legislation), beginning with DY 5, the DSH adjustment will be based on the DSH allotments established for Tennessee, following section 1923(f)(6)(A)(i) of the Act, which are published in the *Federal Register*. The Federal share of the

DSH adjustment for each DY will be equal to one quarter of the DSH allotment for the FFY ending during the DY, plus three quarters of the DSH allotment for the FFY beginning during the DY. A total computable equivalent for each DSH adjustment can be calculated as the DSH adjustment divided by the AFMAP for that DY. For DY 5, the figure $305,541,928 will be used to compute the Federal share of the DSH adjustment in place of the FFY 2006 DSH allotment.

iii. The calculation of the DSH adjustment will be appropriately altered if legislation is enacted that impacts the calculation of DSH allotments, including any law that would affect the calculation of the DSH allotment for Tennessee.

iv. Table 10 gives the DSH adjustments for DY 1 through DY 11, and shows both total computable and Federal share. These totals reflect changes to the calculation of DSH allotments resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the temporary increase in DSH allotments provided under section 5002 of the American Recovery and Reinvestment Act of 2009. Some of the figures are labeled "preliminary" because the final DSH allotments needed to calculate them have not yet been published in the *Federal Register,* and are best estimates based on current law.

**Table 10 – DSH Adjustments for DY 1 Through DY 11**

| | **DSH Adjustment (total computable)** | **DSH Adjustment (Federal share)** |
|---|---|---|
| **DY 1** | $413,700,907 | $268,409,148 |
| **DY 2** | $479,893,052 | $310,106,890 |
| **DY 3** | $479,893,052 | $310,538,794 |
| **DY 4** | $479,893,052 | $308,091,339 |
| **DY 5** | $479,356,649 | $305,451,928 |
| **DY 6 (preliminary)** | $479,657,658 | $305,451,928 |
| **DY 7 (preliminary)** | $485,299,094 | $311,270,839 |
| **DY 8 (preliminary)** | $488,969,517 | $319,052,610 |
| **DY 9 (preliminary)** | $470,369,327 | $309,408,943 |
| **DY 10 (preliminary)** | $463,996,853 | $305,451,928 |
| **DY 11 (preliminary)** | $463,996,853 | $305,451,928 |

e. The budget neutrality expenditure limit is the Federal share of the annual PMPM limits for the Demonstration period, plus DSH adjustments, for DY 1 through 11, and represents the maximum amount of FFP that the State may receive for title XIX expenditures during the Demonstration period, as described in paragraph 53(g) *(Reporting Expenditures in the Demonstration)*. The budget neutrality expenditure limit is equal to (1) the sum of all of the subcomponents described in (a)(1) above for all DYs, times the Composite Federal Share (defined in (f) below), plus (2) the sum of the Federal shares to the DSH adjustments for all DYs, as defined in (d) above.

f. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional demonstration expenditures or offsets such as, but not limited to, premium collections and administrative costs subject to budget neutrality under paragraph 53(h) *(Reporting Expenditures in the Demonstration: Administrative Costs)*) by total computable Demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for DSH payments made under the Medicaid State plan must be subtracted from the numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

**65. Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under TennCare II. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this Demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

**66. Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval.

| DY | Cumulative Target Definition | Percentage |
|---|---|---|
| Years 1 through 6 | Cumulative budget neutrality cap plus: | 0.5 percent |

| DY | Cumulative Target Definition | Percentage |
|---|---|---|
| Years 1 through 7 | Cumulative budget neutrality cap plus: | 0.25 percent |
| Years 1 through 8 | Cumulative budget neutrality cap plus: | 0 percent |

**67. Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end of this Demonstration period, the excess Federal funds shall be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

## XII. EVALUATION OF THE DEMONSTRATION

**68.** **Submission of a Draft Evaluation Plan.** The State shall submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after CMS approval of the Demonstration extension. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

**69.** **Inclusion of CHOICES Special Study Components.** The State shall submit to CMS for approval an amendment to the Evaluation Plan referenced in paragraph 68 *(Submission of a Draft Evaluation Plan)* no later than 120 days after CMS's approval of the CHOICES program. Suggested special study topics from which the State may choose for its amendment to the Evaluation Plan include, but are not limited to, the following:

a. The rebalancing of the long-term care system including impacts on outcomes, utilization and cost;

b. Implementation lessons, successes and evolution of the Single Point of Entry and streamlined eligibility processes;

c. The expansion and development of a more robust HCBS infrastructure under managed care;

d. Implementation of Consumer Directed options under manage care;

e. Enrollee satisfaction, based on surveys that include feedback on assessment and care planning processes, quality of care coordination, actual service delivery, and (when relevant) the appeals process; and

f. Provider satisfaction from surveys.

**70.** When developing its research approach, CMS encourages Tennessee to consider adapting research questions and methodologies from the CMS sponsored Evaluation of the Money Follows the Person (MFP) Grant Program. MFP and CHOICES share many of the same goals, and by using a common study approach, the Tennessee's planned reforms can be viewed within a national context. CMS staff will be available to provide technical assistance in this regard.

**71.** **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

**72.** **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation plan within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports. The State shall submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS shall provide comments within 60 days after receipt of the report. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

**73.** **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

## XIII. TENNCARE ELIGIBILITY REDETERMINATION AND DISENROLLMENT AND RIGHTS; APPEALS PROCESS FOR CHANGES IN BENEFITS; AND ENROLLMENT IN STANDARD SPEND DOWN

This Section describes several operational processes that were approved as amendments to the TennCare II Demonstration in 2005 and 2006. The State will continue to follow these procedures throughout the Demonstration approval period unless modified through an approved Demonstration amendment.

### PART I: MEDICALLY NEEDY AND TENNCARE STANDARD ELIGIBILITY REDETERMINATION AND DISENROLLMENT PROCESS

This Part summarizes the process Tennessee will use, in accordance with paragraph 21a *(Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category)*, paragraph 22 *(Transition Group--Adult Medicaid State Plan Eligibility Categories for Which Enrollment Is Closed)*, and paragraph 23 *(Discontinued Demonstration Group--Adult Demonstration Populations Discontinued Through March 24, 2005 Demonstration Amendment)* of these STCs, to: (i) redetermine eligibility and terminate the adult (non-pregnant) Medically Needy; and (ii) disenroll adults who are TennCare/Medicare dual eligible, uninsured, and Medically Eligible. This process was approved as an amendment to the TennCare II Demonstration on March 24, 2005. It is used for redetermining the eligibility of those enrollees whose eligibility is ending, including when their period of eligibility has ended or the category in which they have been enrolled is being closed. The State will continue to follow this process for all redeterminations and terminations of eligibility throughout the Demonstration approval period unless modified through an approved Demonstration amendment.

**Termination of Adult Non-Pregnant Medically Needy**

**1. Ex Parte Review**

A. The State will conduct a data match of the Social Security numbers of individuals classified as adult non-pregnant Medically Needy in its InterChange Information System (which contains information on TennCare enrollees) with Social Security Administration (SSA) data to determine whether the individual has lost supplemental security income (SSI) eligibility for reasons that would qualify them as Medicaid eligible.[1]

B. The State will conduct a data match of the Social Security numbers (SSNs) of individuals classified as adult non-pregnant Medically Needy in InterChange with individuals

[1] Such reasons include (i) they lost SSI eligibility because of Social Security cost of living adjustment(s) ("COLA(s)") but would be SSI eligible if the COLA(s) was/were disregarded ("Passalong" eligibles); or (ii) they lost SSI eligibility for some reason other than a Social Security COLA, but would be eligible for SSI if the COLA(s) received since their SSI termination was/were disregarded ("Pickle" eligibles).

classified as participants in its Food Stamps or Families First (TANF) program in its ACCENT system (a database maintained by the Department of Human Services (DHS)). In all instances in which there is a match between an adult Medically Needy individual with an individual with an open Food Stamps or Families First record, the State will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

**2. <u>Request for Information</u>**

A. At least 30 days prior to the end of the individual's current eligibility period, the State will send notification (Request for Information) to those adult non-pregnant Medically Needy enrollees who have not been identified through the ex parte review process as eligible for open categories of TennCare Medicaid.

B. The Request for Information will:

i. Inform enrollees that their eligibility category for Medicaid is ending, and that they will only remain eligible for TennCare Medicaid if they qualify for open Medicaid categories.

ii. Provide enrollees with 30 days from the date of the Request for Information to provide the State with all of the necessary information for DHS to determine whether the individual is eligible for a Medicaid category that is not ending (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for open Medicaid categories. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for Medicaid and the enrollee will receive an advance notice that will provide appeal rights.

iv. Inform enrollees that the State will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be fair hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with Limited English Proficiency. Upon request, the State

will also make special accommodations for individuals with qualifying assessments in the previous 12 months as Seriously and/or Persistently Mentally Ill (SPMI). Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the State's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package—i.e., elimination of pharmacy coverage for adult non-institutionalized non-pregnant Medically Needy) until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the State will send these enrollees a "Verification Request." Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid (subject to applicable changes in the TennCare Medicaid benefit package). If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain TennCare Medicaid coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper termination and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), enrollees will retain Medicaid coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the State makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate TennCare Medicaid category. The State will make the determination that enrollees are not eligible for open TennCare Medicaid categories in the following two scenarios: (i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or (ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Expiration Notice**

A. Upon making a determination that enrollees are no longer eligible for TennCare Medicaid, the State will provide a notice (Expiration Notice) to enrollees at least 20 days in advance of the end date of the enrollees' eligibility period.

B. Expiration Notices will:

i. Inform enrollees that they will be terminated from Medicaid as of a date specified in the notice because their current eligibility period has ended, their category of TennCare Medicaid is closed and they have not proven their eligibility for other open categories of TennCare Medicaid.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Expiration Notice to request a hearing for factual disputes related to the termination and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing prior to the date of termination specified in the Notice, Medicaid benefits for non-pregnant Medically Needy (subject to changes in the benefit package) will continue until the appeal has been resolved.

C. If enrollees submit information to qualify for Medicaid prior to their termination, enrollees will continue to be eligible for TennCare Medicaid for non-pregnant Medically Needy (subject to changes in the TennCare Medicaid benefit package) pending the determination as to whether the individual is eligible for other open TennCare Medicaid categories.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Expiration Notice.

B. The State will grant hearings only for those enrollees raising valid factual disputes related to the termination. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. Valid factual disputes include:

i. Enrollees received the Expiration Notice in error (i.e., they are currently enrolled in other categories of TennCare Medicaid including Medically Needy pregnant women or enrollees under 21 years of age);

ii. The State failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The State granted a "good cause" extension of time to reply to the Request for Information but failed to extend the time;

iv. Enrollees requested assistance because of a health, mental health, learning problem, or disability but the State failed to provide this assistance; or

v. The State sent the Expiration Notice to the wrong address as defined under State law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the request for a hearing is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of termination identified in the Expiration Notice, TennCare Medicaid benefits will continue either until the State determines that the enrollee has not raised a valid factual dispute as described above, or the appeal is resolved.

E. If the enrollee does not request a hearing prior to the date of termination identified in the Expiration Notice, the enrollee will be disenrolled from TennCare Medicaid.

F. If the enrollee is granted a hearing and the hearing decision sustains the State's action, the State reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## II. Disenrollment of Adult Medicare/TennCare Dual Eligible, Uninsured, Medically Eligible

### 1. Ex Parte Review

A. The State will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in InterChange (which contains information on TennCare enrollees) with SSA data to determine whether the individual has lost SSI eligibility for reasons that would qualify them as Medicaid eligible.[2]

B. The State will conduct a data match of the SSNs of individuals classified as adult Medicare/TennCare Dual Eligible, Uninsured or Medically Eligible enrollees in Interchange with individuals classified as participants in the State's TANF program in DHS' ACCENT system. In all instances when there is a match between an adult member of these demonstration populations with an individual with an open TANF record, the State will evaluate the individual's information to determine whether they qualify for any open TennCare Medicaid categories.

**2. <u>Request for Information</u>**

A. At least 30 days prior to disenrollment, the State will send a Request for Information to all adult Medicare/TennCare Dual Eligible, Uninsured, and Medically Eligible enrollees not identified through the ex parte review process as eligible for TennCare Medicaid.

B. The Request for Information will:

i. Inform enrollees that their eligibility category for TennCare Standard is ending and that they will only maintain coverage if they qualify for open Medicaid categories.

ii. Provide enrollees with 30 days from the date of the Request for Information to provide the State with all of the necessary information for DHS to determine whether the individual is eligible for Medicaid (i.e., completion of an attached form and verifications). The Request for Information will inform enrollees of the ways in which they may qualify for TennCare Medicaid. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.

iii. Inform enrollees that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find the enrollee eligible for TennCare Medicaid and the enrollee will receive a Disenrollment Notice prior to disenrollment from TennCare Standard.

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[2] See footnote 1

iv. Inform enrollees that the State will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS' decisions on granting good cause exceptions will not themselves be fair hearable.

C. Enrollees with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with limited English proficiency. Upon request, the State will also make special accommodations for individuals with qualifying assessments in the previous 12 months as SPMI. Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the State's policies and procedures.

D. If enrollees submit the requisite information during the 30-day time period following the Request for Information, they will retain their eligibility for TennCare Standard until DHS determines that the individual does not qualify for open categories of Medicaid (and proper disenrollment and appeal processes have been completed).

E. If enrollees provide some but not all of the necessary information to DHS to determine whether enrollees qualify for open categories of TennCare Medicaid during the 30-day period following the Request for Information, the State will send these enrollees a Verification Request. Verification Requests will inform enrollees that they must submit the missing information to DHS within 10 days from the date of the Verification Request in order for DHS to determine whether enrollees qualify for open categories of TennCare Medicaid. If enrollees submit all of the remaining requested information during this 10-day time period, enrollees will retain coverage until DHS determines that the individual does not qualify for open categories of TennCare Medicaid (and proper disenrollment and appeal processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), the enrollee will retain coverage while DHS reviews the information the enrollee has previously provided and makes an eligibility determination.

F. If the State makes a determination that an enrollee is eligible for Medicaid, DHS will so notify the enrollee and the enrollee will be enrolled in appropriate TennCare Medicaid category. The State will make the determination that enrollees are no longer eligible for TennCare in the following two scenarios:

(i) if enrollees submit information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review, DHS determines that the enrollees do not qualify for open categories of TennCare Medicaid; or

(ii) if enrollees do not submit the requisite information during the 30-day period following the Request for Information.

3. **Termination Notice**

A. Upon determination or confirming that enrollees are not eligible for TennCare Medicaid, the State will provide a Termination Notice to enrollees 20 days in advance of the date upon which the coverage will be terminated.

B. Termination Notices will:

i. Inform enrollees that they will be disenrolled from TennCare as of the date specified in the Notice (20 days after the date of the Notice) because their category of TennCare Standard is ending and they have not proven their eligibility for open TennCare Medicaid categories.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the notice to appeal factual disputes related to the action of disenrollment and inform enrollees how they may request a hearing.

iii. Inform enrollees that if prior to the date of disenrollment specified in the Termination Notice, an enrollee appeals the action of disenrollment, he or she will not lose eligibility for TennCare until the State determines that the enrollee has not raised a valid factual dispute or the appeal is resolved.

iv. Inform enrollees that they may submit new information to demonstrate Medicaid eligibility at any time before or after disenrollment. Such information will be treated as a new application for Medicaid. The enrollee will not continue benefits pending the State's review and processing of this information.

4. **Appeals Process**

A. Enrollees will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice.

B. The State will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:

i. Enrollee received the Termination Notice in error (e.g., he or she is currently enrolled in Medicaid or in a TennCare Standard category that is not ending);

ii. The State failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;

iii. The State granted a "good cause" extension of time to reply to the Termination Notice but failed to extend the time;

iv. Enrollee requested assistance because of a health, mental health, learning problem, or disability, but the State failed to provide this assistance; or

v. The State sent the Termination Notice to the wrong address as defined under State law.

C. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the appeal is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute on which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.

i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney's initial determination that there is no valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be disenrolled.

iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to a hearing.

D. When an enrollee requests a hearing prior to the date of disenrollment as identified in the Termination Notice, TennCare Standard benefits will continue either until the State determines that the enrollee has not raised a valid factual dispute, or the appeal is resolved.

E. If the enrollee does not appeal prior to the date of disenrollment as identified in the Termination Notice, the enrollee will be disenrolled from TennCare Standard.

F. If the enrollee is granted a hearing and the hearing decision sustains the State's action, the State reserves its right to recover from the enrollee the cost of services provided during the hearing process.

## PART II: NOTICE AND APPEALS PROCESS FOR CHANGES IN COVERAGE OF TENNCARE BENEFITS

This Part summarizes the process Tennessee will use upon and after the implementation of changes in coverage of TennCare benefits. These procedures were approved as an amendment to the TennCare II Demonstration on March 31, 2006. This detailed process is used by the State to implement benefit changes, specifically benefit limits. It is used daily with enrollees who are subject to pharmacy benefit limits when they reach their monthly maximum. With this process, Tennessee provides one notice per month when benefit limits have been reached. The State will continue to follow this process with enrollees who are subject to pharmacy or other benefit limits throughout the Demonstration approval period unless modified through an approved Demonstration amendment. To change benefits covered under the Demonstration, the State must submit a Demonstration amendment in accordance with paragraphs 6 *(Changes Subject to the Amendment Process)* and 7 *(Demonstration Amendment Process)* of these STCs.

### I. Implementation of Changes in Coverage Policies

#### 1. Initial Notice

A. At least 30 days prior to the effective date of changes in coverage of TennCare benefits (e.g., implementation of pharmacy benefit limits and elimination of covered services), the State shall provide a notice (Benefit Notice) to enrollees who are impacted by such changes in coverage of TennCare benefits.

B. Benefit Notices will:

i. Inform enrollees of how changes in coverage of TennCare benefits will apply to enrollees.

ii. Provide enrollees with 40 days (inclusive of mail time) from the date of the Benefit Notice to request a hearing for valid factual disputes related to the changes in coverage and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing for a valid factual dispute prior to the effective date of the change in coverage of TennCare benefits, benefits will be continued at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the level for Non-Institutionalized Medicaid Adults (Default Level). The State will apply the Default Level of benefits until the appeal has been resolved, unless the State subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary. (The resolution of an appeal, for purposes of this Part, is

defined as when the appeal is dismissed or resolved prior to a hearing or when a decision is rendered at or after the hearing.)

**2. <u>Appeals Process</u>**

A. An enrollee will have the opportunity to request a State fair hearing for 40 days (inclusive of mail time) from the date of the Benefit Notice.

B. The State will grant State fair hearings only for those enrollees raising valid factual disputes related to the changes in coverage. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to a different level of TennCare benefits than that identified in the Benefit Notice. Valid factual disputes include when an enrollee claims to have received the Benefit Notice in error (e.g., he or she is already in a TennCare category that is not subject to the particular changes in coverage).

C. When an enrollee requests a hearing prior to the effective date of changes in coverage as identified in the Benefit Notice, the enrollee shall continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable until the appeal has been resolved. If the alleged eligibility category is not immediately apparent, the enrollee's benefits will be continued at the Default Level. The State will apply the Default Level until the appeal has been resolved, unless the State subsequently determines that the enrollee is alleging that a different eligibility category is currently applicable at which time the enrollee's level of benefits will be adjusted as necessary.

D. If the enrollee appeals, the changes in coverage in dispute shall become effective upon resolution of the appeal.

E. If the enrollee does not appeal prior to the effective date of changes in coverage as identified in the Benefit Notice, such changes in benefits will become effective, as applied to the enrollee, upon this date.

F. If the enrollee appeals and:

(i) The appeal is dismissed because the enrollee has not asserted a valid factual dispute; or

(ii) The enrollee is granted a hearing and the hearing decision sustains the State's action, the State reserves its right to recover from the enrollee the cost of services provided as a result of the appeal.

## II. <u>Post-Implementation Appeals from Denials of Prior Authorization for Pharmacy Products</u>

1. Prior Authorization Requirements

   A. Any prescription of a branded drug may be subjected to a prior authorization requirement by the State; and prior authorization will be required as a condition of coverage for branded prescription drugs that are not included on the State's Preferred Drug List.

   B. Physicians (or other providers with prescribing authority) participating in TennCare will be responsible for requesting prior authorization, according to procedures to be established by the State.

2. Notice of Prior Authorization Denial

   A. Requests for prior authorization of covered outpatient drugs shall be transmitted to and acted upon by appropriate staff of the Pharmacy Benefit Manager (PBM) Clinical Call Center.

   B. Written notice of denial of a request for prior authorization shall be mailed by the PBM on behalf of the State to the enrollee and transmitted by facsimile to the prescribing physician. Such Notice will inform the enrollee that the request for prior authorization of the prescribed drug has been denied and that TennCare does not cover the drug absent prior authorization, briefly state the reason or reasons for denial of the request, explain the procedures that are available to the enrollee to appeal from that decision, and inform the enrollee that TennCare will not cover the cost of the prescribed medication during the pendency of any appeal. The State's failure to act on a request for prior authorization within a 24-hour period after receiving a submission that complies with the State's requirements for a completed prior authorization request may be deemed a denial from which the enrollee can appeal.

3. Procedures for Filing and Pursuing an Appeal

   A. Appeals of denials of requests for prior authorization may be initiated within 20 days of the Notice of denial of prior authorization, at the option of the enrollee, by the enrollee (or an individual appointed or otherwise authorized under State law to act as the enrollee's representative) submitting to the TennCare Solutions Unit via hand delivery, mail, or facsimile, a written statement of intent to appeal on a form prescribed by the State. Such form will be available on the PBM Web site, and the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's managed care organization (MCO), or from the TennCare Solutions Unit. Undue delay by the State in deciding a prior authorization request (i.e., delay in excess of the 24-hour period

permitted for such decisions) will be considered a denial of prior authorization for purposes of appeal.

B. The State will dismiss any appeal that does not raise a valid factual dispute without a hearing, and will retain the authority to determine whether an appeal raises a valid factual dispute relating to denial of a prior authorization request or the State's failure to act on a request for prior authorization within a 24-hour period after such request. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the prescribed drug. A dispute concerning whether a particular drug or dosage is medically necessary for the enrollee, will be considered a valid factual dispute.

C. An initial determination on appeals involving issues of medical necessity will be made by appropriately qualified medical professionals on the staff of the TennCare Solutions Unit as promptly as possible after the enrollee's submission of the appeal. After submission of the appeal, the TennCare Solutions Unit may seek additional information or documentation in support of the appeal, before any initial determination is made.

D. Upon initially deciding an appeal, the State shall send a letter communicating its decision to the enrollee and stating the reasons for that decision, and shall also communicate any decision granting prior authorization to the enrollee and/or the prescribing physician by the fastest means practicable. A letter initially denying an appeal shall also inform the enrollee of his or her opportunity to request a State fair hearing, and the procedures that must be followed to pursue such further appeal.

4. Benefits During the Pendency of an Appeal

A. During the pendency of any appeal from denial of a pharmacy service due to the lack of required prior authorization, the enrollee will continue to be eligible for pharmacy benefits within applicable pharmacy service limits, but will not have any right to receive on a covered basis the drug that is the subject of the appeal.

B. If the enrollee chooses to purchase the unauthorized, prescribed drug at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the drug upon prevailing in his or her appeal, but only to the extent that applicable, monthly pharmacy benefit limits would not thereby be exceeded.

## III. Post Implementation Appeals of Application of Benefit Limits

### 1. Initial Notice

A. Pharmacists will be required to verify TennCare coverage for all prescriptions presented by enrollees through an electronic database maintained by the PBM. If, through the database, the PBM denies coverage of a prescription because the enrollee has reached or exceeded the monthly pharmacy benefit limit ("the pharmacy limit"), the PBM on behalf of the State will mail a written notice of the denial to the enrollee (Service Notice). Service Notice shall be provided only upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five prescription limit, and/or upon the first denial in that month of a pharmacy service sought by the enrollee that exceeds the two prescriptions limit on branded drugs. (For purposes of this Part, "the pharmacy limit" is defined as a five prescription limit per month, of which no more than two prescriptions or refills could be for branded drugs and at least three out of any five prescriptions or refills in the same month must be for generic drugs.)

B. If a pharmacist fills a prescription in excess of the pharmacy limit and submits a claim for such service, the PBM will deny payment for the claim. Upon denial of payment for such claim, the PBM on behalf of the State will mail a written notice (Notice of Limit) to enrollees.

C. If a provider denies a non-pharmacy service or charges the enrollee for the service because the enrollee has reached or exceeded a benefit limit, the provider need not give specific notice of appeal rights to the enrollee but must direct the enrollee to the responsible arm of the managed care contractor (MCC).

D. If a provider renders a non-pharmacy service in excess of a non-pharmacy benefit limit and the provider or the enrollee submits a claim for such service, the MCC will deny payment for the claim. Upon denial of payment for such claims, the MCC, on behalf of the State, will mail a Notice of Limit to enrollees. A Notice of Limit shall be provided only upon the first denial of coverage of a non-pharmacy service sought by the enrollee that exceeds the applicable limit for the kind and number of services during a given time period specified in the State's program.

E. The Notice of Limit and Service Notice will:

i. Inform an enrollee that he or she has reached or exceeded the applicable benefit limit.

ii. Provide enrollees with at least 20 days from the Notice of Limit or Service Notice to request a hearing for valid factual disputes related to the benefit limit and inform enrollees how they may request a hearing.

iii. Inform enrollees that if they request a hearing, they will not receive continuation of benefits (i.e., services in excess of the applicable limit) during the pendency of their appeal.

iv. Remind enrollees of any exceptions to the limits and inform them how to obtain more information about such exceptions.

**2. Appeals Process**

A. Enrollees will have the opportunity to request a State fair hearing for at least 20 days from the date of the Notice of Limit or Service Notice.

B. The enrollee will be required to submit a designated form in order to request a State fair hearing. The form, which must be signed by the enrollee (or an individual appointed or otherwise authorized to act as the enrollee's representative under State law), would include the basis for the appeal and the enrollee must attest, under penalty of perjury, that his contention is true to the best of his knowledge and is made in good faith. Enrollees may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the State at its discretion of an exemption from a signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or by an individual authorized under State law to act as the enrollee's representative.

C. The State will grant a State fair hearing only for those enrollees raising valid factual disputes related to the benefit limit. Appeals that do not raise a valid factual dispute will be dismissed without a hearing. A valid factual dispute is a factual dispute that, if resolved in favor of the enrollee, would entitle the enrollee to coverage for the service that was denied because the enrollee had reached or exceeded the applicable benefit limit. Valid factual disputes include:

i. An administrative error was allegedly made and the enrollee has not yet reached the relevant benefit limit.

ii. The enrollee alleges that his or her circumstances have changed and he or she has been re-classified in a TennCare eligibility category that is not subject to the benefit limit the State has applied. The State, however, shall not grant a hearing to individuals who allege solely that they are not subject to the benefit limit without further alleging a change of circumstances that has been reported to TennCare and has resulted in a change in their eligibility category. These enrollees will be granted a hearing because they did not have the opportunity to appeal the application of the benefit limit to them in connection with the Benefit Notice.

iii. The enrollee alleges an administrative error in the processing of a request for a special exemption to the benefit limit (i.e., the enrollee's physician submitted

the required attestation necessary to obtain a special exemption from the benefit limit and the prescribed drug is on the special exemption list but coverage for the drug was nonetheless denied).

D. The enrollee shall not receive continuation of benefits when appealing a denial of services based on the application of a benefit limit. This policy shall apply even for items or services that have been previously authorized as medically necessary to the extent that the denial of services is based on the application of a benefit limit.

E. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee will be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal with respect to those benefits.

F. If the enrollee does not request a hearing, the benefit limit deemed applicable by the State will continue to apply to the enrollee.

G. Providers will be permitted to bill enrollees for services that were provided in excess of the benefit limits.

**IV. Post Implementation Appeals of Elimination of Coverage for Certain Services**

1. Neither the State nor the MCC will provide notification in addition to the Benefit Notice described above with respect to services that are eliminated from TennCare coverage as those services are no longer covered by TennCare.

2. Upon denial of non-covered services, TennCare enrollees will have the opportunity to request a State fair hearing. The enrollee will be required to submit a designated form in order to request a hearing. Such form would include a statement, which must be signed by the enrollee, or an individual appointed or otherwise authorized to act as the enrollee's representative under State law that sets out or describes the factual contention on which the appeal is based, and attests, under penalty of perjury, that the contention is true to the best of the signatory's knowledge and is made in good faith. Enrollees or their representatives may obtain this form on the PBM Web site, the TennCare Web site, at local Health Departments, from TennCare participating pharmacies, through member services of the enrollee's MCO, or from the TennCare Solutions Unit. Absent a grant by the State at its discretion of an exemption from the signature requirement due to special circumstances, an appeal will not be deemed to be filed unless this form has been signed by the enrollee or his/her authorized representative.

3. The State will grant a State fair hearing only for those enrollees who raise valid factual disputes related to the elimination of coverage. A valid factual dispute is a factual dispute that, if resolved in the enrollee's favor, would entitle the enrollee to coverage of the disputed service. In the context of excluded services, valid factual disputes are limited to when an enrollee claims that he or she is already in a TennCare category that is entitled to coverage of

the particular service at issue. Appeals that do not raise a valid factual dispute will be dismissed without a hearing.

4. If the request for a hearing is granted, the enrollee will not receive continuation of the benefits in dispute pending the appeal.

5. If the enrollee chooses to receive the benefits in dispute pending an appeal at his or her own expense, the enrollee may be entitled to reimbursement of the costs of the benefits in dispute upon prevailing in his or her appeal.

**PART III: ENROLLMENT IN TENNCARE STANDARD SPEND DOWN**

These procedures were approved as an amendment to the TennCare II Demonstration on November 14, 2006 and as part of paragraphs 21(a) *(Standard Spend Down (SSD) – Adult Non-State Plan Demonstration Population Category)* and 22 *(Transition Group – Adult Medicaid State Plan Eligibility Categories for Which Enrollment Is Closed)* in these STCs. This Part sets forth an enrollment process for implementation of the new TennCare Standard Spend Down (SSD) program for medically needy adults who are not Medicaid eligible under the State plan. It defines redeterminations of eligibility for the Transition Group adult medically needy individuals (see paragraph 22 *Transition Group – Adult Medicaid State Plan Eligible Categories for Which Enrollment Is Closed*), bringing in new enrollees to the SSD program, and maintaining SSD program enrollment within the approved cap. The State will continue to follow this process throughout the Demonstration approval period unless modified through an approved Demonstration amendment.

Upon implementation of the TennCare Standard Spend Down (SSD) demonstration amendment, the State will open SSD enrollment to two groups of individuals. One group (Category 1) consists of people who are not currently eligible for Medicaid and who meet the criteria for the new SSD program. The second group (Category 2) includes people who are in the Transition Group, have been found to be ineligible for any other Medicaid category, and meet the criteria for the new SSD program. Financial eligibility criteria for SSD will be based on criteria that apply to medically needy pregnant women and children eligible under the State Plan.

The State will establish separate processes for SSD enrollment for new applicants (Category 1) as compared to Transition Group eligibles (Category 2). For Category 2 individuals, the State will determine their SSD eligibility on a rolling basis in conjunction with their redeterminations, and shall reserve sufficient slots within the enrollment target to ensure that all such persons who are eligible may be enrolled. Category 1 applicants will be enrolled only through a single toll-free telephone point of entry (the Call-In Line) initiated in periods of open enrollment. In each open enrollment period, the State will determine a specified number of calls that it will accept through the Call-In Line based on the number of Category 1 applications that, together with projected pending applications from Category 2, the State estimates it can process within Federal timeliness standards. The number of calls to be accepted in open enrollment periods will also be based on the number of remaining slots available under the enrollment target and the number of

slots necessary to reserve for Transition Group eligibles. The State will not accept or track calls received outside of open enrollment periods.

Once the State has reached its targeted enrollment of 100,000 persons, new open enrollment periods will be scheduled when enrollment in the SSD program drops to 90 percent of target enrollment. Any subsequent open enrollment periods will remain open until a pre-determined number of calls to the Call-In Line have been received. The number of calls to be received will be established based on the State's determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the State estimates it can process in a timely manner in accordance with Federal standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions.

Callers to the Call-In Line will be asked for basic demographic information and will be assigned a unique identifier. After conducting a match to verify that callers are not already enrolled in TennCare Medicaid as State plan eligibles, the State will send each non-enrolled caller a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within 30 days. (Those callers who are already enrolled in TennCare Medicaid as State plan eligibles will be sent letters advising them that they currently have benefits and need not apply.)

Completed signed applications received by the State by the 30-day deadline established by the State will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will still be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the State. If the individual does not mail back an application by the deadline, the State will send the individual a letter advising him or her that since no application was received, the State will not make an eligibility determination for him or her, but the individual is free to apply for SSD during any open enrollment period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he or she did submit a signed, written application within the deadline. Since all SSD applications received during an open enrollment period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open enrollment period will be carried forward to future open enrollment periods. The State will determine SSD eligibility within the timeframes specified by Federal regulations at 42 CFR 435.911; such timeframes will begin on the date a signed written application is received by the State.

The effective date of SSD eligibility for individuals whose enrollment is originally initiated through the Call-In Line and who submit a timely signed application will be the later of: 1) the date that their call was received by the Call-In Line; or 2) the date spend down is met (which must be no later than the end of the 1-month budget period -- in this case, the end of the month of the original call to the Call-In Line). The effective date provisions contained herein only apply

to SSD eligibility and do not apply to other categories of TennCare eligibility. All enrollees in the SSD demonstration category will have an eligibility period of 12 months from the effective date of the determination. At the end of the 12-month period the enrollee will need to have his eligibility status redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for TennCare Medicaid.

## XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

| | | |
|---|---|---|
| **Monthly Deliverables** | | |
| Monthly | Monitoring Call | 46 |
| **Quarterly Deliverables** | | |
| 60 days after end of each quarter | Quarterly progress reports | 45(d)(iv), 47, 54 |
| Per Sections 2500 & 2115 of State Medicaid Manual, or upon request | Quarterly expenditure, budget neutrality, member month reports | 43, 44, Sections X and XI |
| **Annual Deliverables** | | |
| 120 days after end of each Demonstration year | Annual Progress Report | 48 |
| Dec. 31st of each year | Annual CHIP Report entered into CHIP Annual Report Template System (SARTS) | 48 |
| Sept. of each Demonstration year | Annual beneficiary survey report | 49 |
| **Other Deliverables** | | |
| 12 months before expiration of Demonstration | Request for extension | 8 |
| 12 months prior to suspending or terminating the Demonstration | Phase-out plan | 9 |
| 12 months before expiration of Demonstration | Interim evaluation report. | 8, 71 |
| 120 days after expiration of Demonstration | Draft Final Evaluation Report | 50, 71, 72 |
| 60 days after receipt of CMS comments on Draft Final Evaluation Report | Final Evaluation Report | 71, 72 |
| October 1, 2010 | Compliance plan for implementing new cost-sharing requirements | 37 |

| | | |
|---|---|---|
| Implementation of compliance plan by July 1, 2011, or six months after the date of notification by CMS of approval of the compliance plan, whichever is later | Enrollee notification and implementation of the new cost-sharing requirements | 37 |
| At least annually | MEQC plan proposal and report on findings | 25 |
| Upon receipt by State | Financial audits and quality assessment reviews of participating health plans, and other managed care and HCBS requirements | 14, 42, 45 |
| Upon receipt by State | Fraud and abuse and program integrity reports related to 1115 Demonstration beneficiaries and providers | |
| As required by CMS | Corrective Action Plans and findings | |
| Upon submission to Regional Office | Courtesy copy of all State plan amendments to be sent to the CMS Project Officer | 7(d) |
| 60 days advance notice | Modification of CHOICES benefits defined in Attachment D | 7(c) |
| No later than 120 days prior to planned implementation and may not be implemented until approved | Demonstration amendments, including requests for services not defined in Attachment D | 6 and 7 |
| 30 days advance notice | Notice on increases in CHOICES Enrollment Targets within allowable range | 34 |
| 18 months after CHOICES implementation, 12 months after end of each subsequent Demonstration Year or 3 months after each point in time | Submission of CHOICES baseline data | 45(d) |
| Annually | Annual (or more frequent) Integrated Quality Improvement Strategy Update | 45(c) |

| | | |
|---|---|---|
| Subject to CMS approval prior to implementation | Final MCO contracts developed for CMS approval | 14, 39 |
| When issued or amended by State | Procedural manuals or operating protocols related to the 1115 Demonstration | |
| Prior to implementation of the CHOICES Group 3 | Operational procedures for determining individuals "at risk" for institutionalization | 34(a) |
| July 1, 2012 | ACA Transition Plan | 45(e) |
| *All Reports Required by Sections 2500 and 2115 of the State Medicaid Manual* | | |

## ATTACHMENT A

Under Section IX, paragraph 47 *(Quarterly Progress Report)* of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

**NARRATIVE REPORT FORMAT:**

**Title Line One** – TennCare II

**Title Line Two -** Section 1115 Quarterly Report

**Demonstration/Quarter Reporting Period:**
*Example: Demonstration Year: 6 (7/1/2007 – 6/30/2008)*
*Federal Fiscal Quarter: 1/2008 (10/07 - 12/07)*

**Footer:** Approval Period July 1, 2010 – June 30, 2013

### I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

### II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to TennCare eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any Demonstration amendments related to eligibility or benefits.
    - Progress on implementing TennCare Standard Spend Down.
    - Progress on phasing out the closed eligibility categories.
    - Other

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

**Enrollment Counts for Quarter**

Note: Enrollment counts should be person counts, not member months

| Demonstration Populations | Total No. TennCare Enrollees in current Quarter |
|---|---|
| **EG1 Disabled, Type 1 State Plan eligibles** | |
| **EG1 Disabled and EG 9 H-Disabled, Type 2 Demonstration Population** | |
| **EG2 Over 65, Type 1 State Plan eligibles** | |
| **EG2 Over 65 and EG-10 H-Over 65, Type 2 Demonstration Population** | |
| **EG3 Children, Type 1 State Plan eligibles** | |
| **EG4 Adults, Type 1 State Plan eligibles** | |
| **EG4 Adults, Type 2 Demonstration Population** | |
| **EG5 Duals, Type 1 State Plan eligibles and EG-11 H-Duals 65, Type 2 Demonstration Population** | |
| **EG6E Expan Adult, Type 3 Demonstration Population** | |
| **EG7E Expan Child, Type 3 Demonstration Population** | |
| **EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX** | |
| **Med Exp Child, Title XXI Demonstration Population** | |
| **EG12E Carryover, Type 3, Demonstration Population** | |

**III. Outreach/Innovative Activities to Assure Access**

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for TennCare enrollees or potential eligibles.

**IV. Collection and Verification of Encounter Data and Enrollment Data**

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

**V. Operational/Policy/Systems/Fiscal Developments/Issues**

Identify all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

**VI. Action Plans for Addressing Any Issues Identified**

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration.

## VII. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the State's actions to address these issues.

## VIII. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

### A. For Use in Budget Neutrality Calculations

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| **EG1 Disabled, Type 1* State Plan eligibles (paragraph 55(a)(ii))** | | | | |
| **EG1 Disabled, Type 2 Demonstration Population (paragraph 55(b)(iv))** | | | | |
| **EG9 H-Disabled, Type 2 Demonstration Population (paragraph 55(b)(iv))** | | | | |
| **EG2 Over 65, Type 1* State Plan eligibles (paragraph 55(a)(iv))** | | | | |
| **EG2 Over 65, Type 2 Demonstration Population (paragraph 55(b)(vi))** | | | | |
| **EG10 H-Over 65, Type 2 Demonstration Population (paragraph 55(b)(vi))** | | | | |
| **EG3 Children, Type 1 State Plan eligibles (paragraph 55(a)(iii))** | | | | |
| **EG4 Adults, Type 1* State Plan eligibles (paragraph 55(a)(v))** | | | | |
| **EG4 Adults, Type 2 Demonstration Population (paragraph 55(b)(vii))** | | | | |
| **EG5 Duals, Type 1* State Plan eligibles (paragraph 55(a)(i))** | | | | |
| **EG11 H-Duals, Type 2 Demonstration Population (paragraph 55(b)(iii))** | | | | |
| **EG8, Med Exp Child, Type 2 Demonstration Population, Optional Targeted Low Income Children funded by Title XIX (paragraph 55(b)(ii))** | | | | |

***These groups also include Type 2 Transition Group eligibles.**

**B. Not Used in Budget Neutrality Calculations**

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| **EG6E Expan Adult, Type 3, Demonstration Population (paragraph 55(b)(i)(A))** | | | | |
| **EG7E Expan Child, Type 3, Demonstration Population (paragraph 55(b)(i)(B))** | | | | |
| **Med Exp Child, Title XXI Demonstration Population (paragraph 55(c))** | | | | |
| **EG12E Carryover, Type 3, Demonstration Population (paragraph 55(b)(i)(C))** | | | | |

## IX. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

## X. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

## XI. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

## XII. Essential Access Hospital Pool

List the Essential Access Hospitals and specify their type from the following:
Essential Service Safety Net
Children's Safety Net
Free Standing Psychiatric Hospitals
Other Essential Acute Care

## XIII. Graduate Medical Education (GME) Hospitals

List the GME hospitals and their affiliated teaching universities.

## XIV. Critical Access Hospitals

List the Critical Access Hospitals.

## Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

**State Contact(s)**
Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

**Date Submitted to CMS**

## Attachment B

## Limitations on Home Health Services

Home health services are delivered in accordance with 42 CFR 440.70. Prior authorization may be required. Definitions and coverage limitations used by the State are as follows:

1. Home health services shall include any of the following services ordered by a treating physician and provided by a licensed home health agency pursuant to a plan of care at an enrollee's place of residence.

    a. Part-time or intermittent nursing services.

        (1) To be considered "part-time and intermittent," nursing services must be provided as no more than one visit per day, with each visit lasting less than eight (8) hours, AND no more than 27 total hours of nursing care may be provided per week. In addition, nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours and the weekly total for nursing services and home health aide care combined may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care. The above limits may be exceeded when medically necessary for children under the age of 21.

        (2) Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on an as needed basis. Part-time or skilled nursing services may include medication administration; however, a nursing visit will not be extended in order to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.

    b. Home health aide services.

        (1) Home health aide care must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day. Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

(2) The above limits may be exceeded when medically necessary for children under the age of 21.

c. Physical therapy, occupational therapy, speech pathology and audiology services.

d. Medical supplies, equipment, and appliances ordered by a treating physician and suitable for use at an enrollee's place of residence.

2. Home health providers shall only provide services to the recipient that have been ordered by the treating physician and are pursuant to a plan of care and shall not provide other services such as general child care services, cleaning services, or preparation of meals, or services to other household members. Because children typically have non-medical care needs which must be met, to the extent that home health services are provided to a person under 18 years of age, a responsible adult (other than the home health care provider) must be present at all times in the home during the provision of home health services unless all of the following criteria are met:

a. The child is non-ambulatory; and

b. The child has no or extremely limited ability to interact with caregivers; and

c. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider is present in the home without the presence of another responsible adult; and

d. No other children shall be present in the home during the time the home health provider is present in the home without the presence of another responsible adult.

## Attachment C

## Limitations on Private Duty Nursing Services

Private duty nursing services are delivered in accordance with 42 CFR 440.80. Prior approval may be required. Definitions and coverage limitations used by the State are as follows:

PRIVATE DUTY NURSING SERVICES shall mean nursing services for recipients who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period. A person who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care. Skilled nursing care is provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician to the recipient and not to other household members.

1. If it is determined by the MCO to be cost-effective, non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home that determines whether the nursing services are continuous or intermittent.

2. To ensure the health, safety, and welfare of the individual, in order to receive private duty nursing services, the recipient must have family or caregivers who:

    a. Have a demonstrated understanding, ability, and commitment to the care of the individual related to ventilator management, support of other life-sustaining technology, medication administration, and feeding, as applicable; and

    b. Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and

    c. Are willing and available as needed to meet the recipient's non-nursing support needs.

3. Private duty nursing services are covered for adults aged 21 and older only when medically necessary to support the use of ventilator equipment or other life-sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. For purposes of this rule, an adult is considered to be using ventilator equipment or other life-sustaining medical technology if he:

    a. Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or

b. Has a functioning tracheostomy

(1) Requiring suctioning, AND

(2) Oxygen supplementation, AND

(3) Receiving nebulizer treatments or requiring the use of Cough Assist/inexsufflator devices.

(4) In addition, for persons with a functioning tracheostomy, at least one from each of the following (I and II) must be met:

(I) Medication

(a) Receiving medication via a gastrostomy tube (G-tube), OR

(b) Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port. AND

(II) Nutrition

(a) Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube), OR

(b) Receiving total parenteral nutrition.

4. Private duty nursing services are covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of medical necessity will continue to be made on an individualized basis.

5. A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period, or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of Subparagraph (a) may receive medically necessary nursing care as an intermittent service under home health.

6. General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by a private duty nurse. Because children typically have other non-medical caregiving needs which must be met, to the extent that private duty nursing services are provided to a person under 18 years of age, a responsible adult

(other than the private duty nurse) must be present at all times in the home during the provision of private duty nursing services unless all of the following criteria are met:

a. The child is non-ambulatory; and

b. The child has no or extremely limited ability to interact with caregivers; and

c. The child would not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the private duty nurse would be present in the home without the presence of another responsible adult; and

d. No other children will be present in the home during the time the private duty nurse would be present in the home without the presence of another responsible adult.

## Attachment D
## Glossary of Terms for the TennCare CHOICES

**Adult day care.** Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day provided pursuant to an individualized plan of care by a licensed provider not related to the participating adult.

**Adult care homes.** A State-licensed community-based residential alternative which offers 24-hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet nursing facility level of care, but who would prefer to receive care in the community in a smaller, home-like setting. The provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-basis is living in the home with the individuals for whom they are providing care.

**Assisted care living facility services**. Community-based residential alternative to nursing home care in a licensed Assisted Care Living Facility that provides and/or arranges for daily meals, personal, homemaker and other supportive services or health care including medication oversight (to the extent permitted under State law), in a home-like environment to persons who need assistance with activities of daily living. Coverage shall not include the costs of room and board.

**Assistive technology.** Assistive device, adaptive aids, controls or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive or control their environment. Examples include, but are not limited to, 'grabbers' to pick objectives off the floor, strobe light to signify the smoke alarm has been activated, etc.

**At-Risk.** As it relates to the CHOICES program, SSI eligible adults age 65+ or age 21+ with physical disabilities, who do not meet the established level of care criteria for nursing facility services, but have a lesser number or level of functional deficits in activities of daily living as defined by the State in Administrative rule, such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement. As is relates to Interim CHOICES 3, open for enrollment starting on July 1, 2012, "at risk" is defined as adults age sixty-five (65) and older or age twenty-one (21) or older with physical disabilities who receive SSI or meeting nursing facility financial eligibility criteria, and also meet the nursing facility level of care in effect on June 30, 2012.

**Attendant care.** Hands-on assistance, safety monitoring and supervision for an enrollee who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visits (more than four (4) hours per visit or

visits at intervals of less than four (4) hours between visits). This may include assistance with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, attendant care may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home, or continuous monitoring and supervision because there is no household member, relative, caregiver, or volunteer to meet the specified need. Attendant care shall not be provided for enrollees who do not require hands-on assistance with ADLs.

Attendant care does not include:

1) Care or assistance including meal preparation or household tasks for other residents of the same household;
2) Yard work; or
3) Care of non-service related pets and animals.

Only for persons who require homemaker services in addition to hands-on assistance with ADLs, the annual benefit shall be up to 1400 hours per full calendar year.

**Community-based residential alternatives to institutional care (Community-based residential alternatives).** Residential services which offer a cost-effective, community-based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes, but is not limited to, assisted care living facilities, adult care homes, and companion care.

**Companion care.** A consumer-directed residential model in which a CHOICES member may choose to select, employ, supervise and pay, utilizing the services of a fiscal intermediary, on a daily, weekly, or monthly basis, as applicable, a live-in companion who will be present in the member's home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration. Such model will be available only for a CHOICES member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with activities of daily living or supervision and monitoring for extended periods of time that cannot be met more cost-effectively with other non-residential services. A CHOICES member who requires assistance in order to direct his or her companion care may designate a representative to assume consumer direction of companion care services on his/her behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.

**Consumer direction of HCBS.** The opportunity for a member assessed to need specified types of HCBS including attendant care, personal care, homemaker (provided only as part of attendant care or personal care visits), in-home respite, companion care

and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed service(s).

**Electronic visit verification (EVV) system**. An electronic system in which caregivers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of HCBS and which may also be utilized for submission of claims.

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

**Homemaker services.** Effective July 1, 2012, homemaker services are only available as part of attendant care or personal care visits for individuals who need hands-on assistance with ADLs. Services covered include general household activities and chores such as sweeping, mopping, and dusting in areas of the home used by the member, changing the member's linens, making the member's bed, washing the member's dishes, doing the member's personal laundry, ironing, or mending, meal preparation and/or educating caregivers about preparation of nutritious meals for the member, assistance with maintenance of safe environment, and errands such as grocery shopping and having the member's prescriptions filled. Homemaker services are to be provided only for the member (and not for other household members) and only when the member is unable to perform such activities and there is no other caregiver or household member available to perform such activities for the member.

**In-home respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in the individual's place of residence, because of the absence or need for relief of those persons normally providing the care.

**In-patient respite care.** Services provided to individuals unable to care for themselves, furnished on a short-term basis in a licensed nursing facility or licensed community-based residential alternative, because of the absence or need for relief of those persons normally providing the care.

**Minor home modifications.** Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a

member's place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement or roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

**Nursing facility care.** See Social Security Act, section 1919(a).

**Personal emergency response system (PERS).** An electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. The individual may also wear a portable 'help' button to allow for mobility. The system is programmed to signal a response center once the 'help' button is activated. The response center is staffed by trained professionals who assess the nature of the emergency, and obtain assistance for the individual, as needed.

PERS services are limited to those individuals who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time, such that the individual's safety would be compromised without access to a PERS.

**Personal care visits.** Intermittent visits of limited duration not to exceed four (4) hours per visit and two (2) visits per day at intervals of no less than four (4) hours between visits to provide hands-on assistance to an enrollee who, due to age and/or physical disability, needs help with activities of daily living (ADLs) such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation. For enrollees requiring hands-on assistance with ADLs, personal care visits may also include the following homemaker services: assistance with instrumental activities of daily living (IADLs) such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home because there is no household member, relative, caregiver, or volunteer to meet the specified need.

Personal care visits do not include:

1) Companion or sitter services, including safety monitoring and supervision;
2) Care or assistance including meal preparation or household tasks for other residents of the same household;

3) Yard work; or
4) Care of non-service related pets and animals.

**Pest control.** The use of sprays, poisons and traps, as appropriate, in the enrollee's residence (excluding NF, ACLF) to regulate or eliminate the intrusion of roaches, wasps, mice, rats and other species of pests into the household environment thereby removing an environmental issue that could be detrimental to a frail elderly or disabled enrollee's health and physical well-being.

**Reserve capacity.** The State's right to maintain some capacity within an established enrollment target to enroll individuals into HCBS under certain circumstances. These circumstances could include, but are not limited to: accommodation of a phased in implementation of the CHOICES program; discharge from a nursing facility; discharge from an acute care setting where institutional placement is otherwise imminent, or other circumstances which the State may establish from time to time in accord with these STCs.

**Room and board.** Refers to lodging, meals, and utilities. The kinds of items that are considered "room and board" and are therefore not reimbursable by Medicaid include:

- Rent, or, if the individual owns his home, mortgage payments, depreciation, or mortgage interest
- Property taxes
- Insurance (title, mortgage, property and casualty)
- Building and/or grounds maintenance costs
- Resident "raw" food costs including individual special dietary needs (the cost of preparing, serving, and cleaning up after meals is not included)
- Household supplies necessary for the room and board of the individual
- Furnishings used by the resident
- Utilities (electricity, water and sewer, gas)
- Resident telephone
- Resident cable television

**Short Term Nursing Facility Care.** The provision of nursing facility care for up to no more than 90 days to a CHOICES 2 or CHOICES 3 participant who was receiving home and community based services upon admission and who requires temporary placement in a nursing facility—for example, due to the need for skilled or rehabilitative services upon hospital discharge or due to the temporary illness or absence of a primary caregiver—when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 90 days. Such CHOICES 2 or CHOICES 3 member must meet the nursing facility level of care upon admission (which for CHOICES 3 participants is anticipated to be due to a short-term condition), and in such case, while receiving short-term nursing facility care may continue enrollment in CHOICES 2 or CHOICES 3, as applicable, pending discharge from the nursing facility within no more

than 90 days or until such time it is determined that discharge within 90 days from admission is not likely to occur, at which time the person shall be transitioned to CHOICES 1, as appropriate. The community personal needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

**Transition Allowance.** A per member allotment not to exceed two thousand dollars ($2,000) per lifetime which may, at the sole discretion of a managed care organization, be provided as a cost-effective alternative to continued institutional care for a CHOICES member in order to facilitate transition from a nursing facility to the community when such member will, upon transition, receive more cost-effective non-residential home and community based services or companion care. Items which may be purchased or reimbursed are only those items that the member has no other means to obtain and which are essential in order to establish a community residence when such residence is not already established and to facilitate the person's safe and timely transition, including rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.

**Attachment E**
**Best Practices Guidance Regarding**
**Consumer Direction of Home and Community Based Services**

The State will define services that eligible members may elect to direct. Members determined, as a part of the needs assessment and plan of care processes, to require such services will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e. consumer direction of HCBS).

All eligible members requiring these services will be offered the option to participate in consumer direction of HCBS.

i. Upon enrollment in HCBS and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.

ii. Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at anytime, service by service, without affecting their enrollment in HCBS. Only the State can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare.

iii. A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or be a member's paid worker.

iv. The State will utilize a fiscal employer agency (FEA) to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services rendered; and withholding, filing and paying applicable Federal, State and local income and employment taxes for workers) and to provide supports broker assistance.

v. The plan of care process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports, contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.

vi. Members will have the flexibility to hire persons close to them, including family members but excluding spouses, to serve as their workers. All workers must meet the State specified qualifications for providers of comparable non-consumer directed services and must sign a service agreement.

vii. Members will have flexibility in establishing payment rates that do not exceed the State specified ceiling for each service.

viii. Members and/or representatives must receive training prior to participating in consumer direction of HCBS and re-enrolling in consumer direction of HCBS. Ongoing training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.

ix. Workers must receive training, as a condition for hire, which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.

x. A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care, and the adequacy of payment rates.

**Attachment F**
**Certified Public Expenditures Protocol**

## Preamble

This protocol governs the use of certified public expenditures to furnish the non-Federal share of expenditures claimed for Federal participation under the Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures (paragraph 57(h)). The protocol is based on the following elements:

1) Units of government, including governmentally operated health care providers, may certify that costs have been incurred for providing services to TennCare and uninsured individuals. The CPE process contained in this attachment is in accordance with Federal regulations and CMS guidance or policy.

   i. Units of government have been determined by the State as eligible to certify public expenditures.

   ii. Certification must be supported by cost documentation, which represents both the Federal and non-Federal share of funds (i.e., total computable expenditures) under the Demonstration. Federal matching funds are available as a percentage of such eligible costs.

2) To the extent the State continues to utilize certified public expenditures (CPEs) as the funding mechanism for title XIX and XXI (or under section 1115 authority) payments beyond the date defined in this section, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs as eligible under title XIX or XXI (or under section 1115 authority) for purposes of certifying public expenditures.

3) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the State the amount of such tax revenue (State or local) appropriated to the non-governmental provider used to satisfy Demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the State's claim for Federal match. Federal matching funds will be available as a percentage of such eligible costs.

## I. Cost Computation

### A. TN CPE 1115 – Medicaid Fee-For-Service

For the State payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P)routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid FFS inpatient routine cost center costs for the payment year, the hospital's actual inpatient Medicaid days by cost center, as obtained from MMIS for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine Medicaid FFS ancillary costs for the payment year, the hospital's actual Medicaid FFS allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. Medicaid FFS allowable charges for observation beds must be included in line 62. These Medicaid FFS allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid FFS allowable costs for each cost center. The Medicaid FFS allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid days and charges in Steps 4 and 5 above, or any Medicaid managed care or uninsured days and charges in Steps 4 and 5 of those portions of this protocol.

Step 7

The Medicaid FFS allowable costs determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.

## B. <u>TN CPE 1115 – Medicaid Managed Care</u>

For the State payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's Medicare cost report(s) (CMS 2552) covering the payment year, as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital costs for the payment year are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2

The hospital's total days for the payment year by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges for the payment year by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P)routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4

To determine the Medicaid managed care inpatient routine costs for the payment year, the hospital's actual Medicaid managed care inpatient days by cost center, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the Medicaid managed care allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine the Medicaid managed care ancillary costs for the payment year, the hospital's actual Medicaid managed care charges, as obtained from auditable hospital records and other applicable sources for the period covered by the as-filed cost report will be used. Medicaid managed care allowable charges for observation beds must be included in line 62. These Medicaid managed care allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid managed care allowable costs for each cost center. The Medicaid managed care allowable charges used should only pertain to inpatient and outpatient hospital services, and should exclude charges pertaining to any professional services, or non-hospital component services such as hospital-based providers.

Step 6

The Medicaid managed care allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid managed care usable organs as identified from provider records to the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Medicaid managed care usable organs" are counted as the number of Medicaid managed care patients (recipients) who received an organ transplant. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid managed care days and charges in Steps 4 and 5 above (or any Medicaid days or uninsured days in Steps 4 and 5 of those portions of this protocol).

Step 7

The Medicaid managed care allowable costs determined by adding the Medicaid managed care routine costs from Step 4, the Medicaid managed care ancillary costs from Step 5 and the Medicaid managed care organ acquisition costs from Step 6.

## C. TN CPE 1115 – Hospital Uninsured Care

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently as-filed Medicare cost report (CMS 2552), as-filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1

Total hospital actual costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series.

Step 2

The hospital's total actual days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total actual charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3

For each routine cost center, a per diem is calculated by dividing total actual costs from Step 1 by total actual days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total actual costs from Step 1 by the total actual charges from Step 2. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The per diems and cost to charge ratios determined through the above process (steps 1-3) for the as-filed cost report year are used to determine the hospital's actual costs for the payment year. The data sources utilized to determine eligible costs under this section must be derived from the hospital's audited financial statements and other auditable documentation. The hospital costs for care provided to those with no source of third party coverage (i.e., uninsured cost) for the payment year are determined as follows:

Step 4

To determine the uninsured routine cost center costs for the payment year, the hospitals actual inpatient days by cost center for individuals with no source of third party coverage are used. The actual uninsured days are multiplied by the inpatient per diems from Step 3 for each respective routine cost center to determine the low income uncompensated care inpatient costs for each cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

Step 5

To determine the uninsured ancillary cost center actual costs for the payment year, the hospital's inpatient and outpatient actual charges by cost center for individuals with no source of third party coverage are used. These allowable uninsured charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the uninsured allowable costs for each cost center. The uninsured care charges for the payment year should only pertain to inpatient and outpatient hospital services and should exclude charges pertaining to any professional services or non-hospital component services such as hospital-based providers.

Step 6

The uninsured care share of organ acquisition costs is determined by first finding the ratio of Uninsured care usable organs to total usable organs. This is determined by dividing the number of Uninsured usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance. A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or Steps 4 and 5 of the Medicaid (or Medicaid managed care) portion of this protocol.

Step 7

The eligible Uninsured care costs are determined by adding the Uninsured care routine costs from Step 4, uninsured ancillary costs from Step 5 and uninsured organ acquisition costs from Step 6.

Actual Uninsured data for services furnished during the payment year are used to the extent such data can be verified to be complete and accurate. The data sources utilized to determine eligible costs under this section must be derived from hospitals' audited financial statements and other auditable documentation.

## II. Payments and recoveries

All payments and recoveries, from MCO's; BHO's; the TennCare enrollees and the uninsured; TennCare supplemental pool payments; the amount of GME funds received that exceeded the hospital's Medicaid GME expenditures; any DSH payments received; and other sources (except for local government indigent care funds) including any related patient co-payments, or payments from other non-State payers will be offset against the costs computed in Section I above. Payments to the hospital from uninsured individuals for their care for the fiscal year are identified from the hospital's records. Such uninsured data must be supported by auditable documentation.

## III. Interim Reconciliation

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3

Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5

Actual Medicaid paid days and charges from MMIS paid claims data for services furnished during the payment year are used.

Step 6

Organ acquisition costs and total usable organs from the as-filed CMS 2552 cost report for the payment year are used.

## IV. Final Reconciliation

Upon finalization of the CMS-2552 by the Medicare fiscal intermediary, the methodologies as prescribed above will be used to determine final Medicaid FFS cost, Medicaid managed care cost, and uninsured cost. The routine per diems and ancillary cost-to-charge ratios will be determined using cost, day and charge data from the finalized cost report. The Medicaid FFS, Medicaid managed care, and uninsured days, charges, and payment offsets will be updated with the latest MMIS reports and other auditable financial records.

Cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include:

1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS data to the per diem amount;

2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and

3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly except for Medicaid.

If, at the end of the reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Recoveries are updated and offset to cost as calculated per Steps above.

For hospitals whose cost report year is different from the State's fiscal year, the State will proportionally allocate to the State plan rate year the costs of two cost report periods encompassing the State Plan payment year. To do so, the State will obtain the actual Medicaid FFS, Medicaid managed care, and uninsured days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS, Medicaid managed care, and uninsured costs for the reporting periods; these costs will then be proportionally allocated to the State plan rate year. All allocations will be made based upon number of months. (For example, a hospital's cost reporting period ending 12/31/07 encompasses three-fourths of the State plan rate year ending 9/30/2007, and one-fourth of the State plan rate year ending 9/30/2008. To fulfill reconciliation requirements for State plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS, Medicaid managed care, and uninsured costs from its reporting period ending 12/31/2006, to the State plan rate year.) The State will

ensure that the total costs claimed in a State plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

BILL HASLAM
GOVERNOR
STATE OF TENNESSEE

June 29, 2012

The Honorable Kathleen Sebelius
Secretary of the Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

The TennCare program in Tennessee is now in its 19th year. All Medicaid enrollees are enrolled in Managed Care Organizations, and the service delivery model is now almost fully integrated. The MCOs provide primary care, acute care, and behavioral health services to all enrollees, and long-term services and supports to adults who are elderly or who have physical disabilities. We hope to add to the model by integrating Medicare services for persons who are dually eligible for Medicare and Medicaid, and we have recently submitted a proposal to the Medicare-Medicaid Coordination Office to do just that.

TennCare is continuing to demonstrate the cost-effective provision of quality services. We are requesting a three-year extension of the current TennCare II demonstration, which expires on June 30, 2013. We are enclosing a copy of our extension request, which has been prepared in compliance with the new regulations at 42 CFR 431, Subpart G, and the Standard Terms and Conditions.

We appreciate your attention to this matter.

Sincerely,

Bill Haslam

STATE CAPITOL • NASHVILLE, TN 37243-0001 • PH: 615.741.2001 • www.tn.gov

# Bureau of TennCare
# Extension Request

# TennCare II (11-W-00151/4)

## June 29, 2012

## Overview

TennCare is one of the longest-lasting and most comprehensive Medicaid managed care programs in the country. It has been in existence since 1994. "TennCare II," the current phase of TennCare, has been in existence since 2002.

The Bureau of TennCare is seeking a three-year extension of the current TennCare II demonstration. The extension period is July 1, 2013, through June 30, 2016. The authority under which the extension is being sought is Section 1115(f) of the Social Security Act. The Bureau is not requesting any changes in the current Special Terms and Conditions, Expenditure Authorities, or Waivers, other than updating some sections that have become obsolete during the current extension period and amending tables and text to reflect operation of the TennCare II demonstration starting on July 1, 2013.

The chapter topics that follow, with the exception of Part VIII, are taken directly from 42 CFR § 431.408(c)(2). Part VIII is required by paragraph 45(3)(i) in the current Special Terms and Conditions.

TennCare has undergone a number of changes in the past 10 years. Financial challenges have called for minor and sometimes major course corrections in order to ensure that the program remains viable and continues to be able to serve as many people as the State can afford to serve. A great deal of progress has been made in strengthening the managed care structure, with Managed Care Organizations (MCOs) today being required to be NCQA[1]-accredited and to meet rigorous standards associated with financial and programmatic integrity and stability. Significant strides have been taken toward service integration, with behavioral health services and long-term services and supports (LTSS) for Nursing Facility (NF) eligible persons being brought under the managed care program. Some of the legal issues that have played such a prominent role in the program over the years have moved toward resolution, with two examples being the 2009 ruling in the *Daniels* case regarding redetermination of eligibility for persons losing SSI benefits and the 2012 order by the Federal District Court vacating the *John B.* Consent Decree.[2]

TennCare is achieving important goals. As an example, the percentage of beneficiaries expressing satisfaction with TennCare has grown by 10 percentage points, from 85 percent in 2002, the year TennCare II started, to 95 percent in 2011.[3] EPSDT screening rates have improved, as have timeliness of prenatal care, access to care, and other measures. Budget neutrality has been maintained. (See Section VI of this document.)

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[1] National Committee for Quality Assurance.
[2] This ruling is being appealed by the plaintiffs in the case.
[3] See http://cber.bus.utk.edu/tncare/tncare11.pdf, page 8.

In recent years, the Bureau has received a number of awards and types of recognition from outside groups. These include the following:

***Overall leadership:***

- **June 2008:** TennCare Director Darin Gordon was named to the 12-member Executive Committee of the National Association of State Medicaid Directors (NASMD). [4]
- **June 2010:** TennCare Director Darin Gordon was selected to participate as a Fellow in the 2011 class of the Medicaid Leadership Institute, a national initiative of the Robert Wood Johnson Foundation that is managed by the Center for Health Care Strategies.
- **January 2011:** TennCare Director Darin Gordon was elected Vice President of the National Association of Medicaid Directors (NAMD).

***Quality of care:***

- **December 2006:** Tennessee became the first state in the nation to require its Managed Care Organizations to be NCQA-accredited.
- **April 2008:** Chief Medical Officer Dr. Wendy Long was appointed to serve on the Medicaid Accreditation Advisory Committee of NCQA.
- **December 2008:** TennCare Director Darin Gordon was appointed as the chair of the Quality Technical Assistance Group (TAG) by NASMD.[5]

***Hospital services:***

- **October 2010:** TennCare Director Darin Gordon received a Community Service Award for Public Service to Tennessee from the Tennessee Hospital Association.

***Long-term services and supports:***

- **November 2010:** Tennessee was selected for the Center for Health Care Strategies' Profiles in State Innovations, in recognition of the successful design and implementation of the CHOICES managed LTSS program.

***Mental health services:***

- **December 2009:** Keith Gaither, Director of Managed Care Operations, received the President's Award from the Tennessee Association of Mental Health Organizations (TAMHO).
- **August 2010:** TennCare Medical Director Dr. Jeanne James was honored by Tennessee Voices for Children with the Innovations for Children and Families award. Tennessee Voices for Children is an entity that advocates for improved mental health services for children.

***Primary care:***

- **December 2011:** TennCare Chief Financial Officer Casey Dungan received the William V. Corr Award of Excellence from the Tennessee Primary Care Association.

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[4] NASMD became NAMD (the National Association of Medicaid Directors) in 2010.
[5] Ibid.

*Mothers and babies:*

- **March 2012:** The March of Dimes and its advocacy partner the Tennessee Initiative for Perinatal Quality Care honored three members of TennCare's executive staff for their "work to protect women and babies." These three members were Director Darin Gordon, Chief Medical Officer Dr. Wendy Long, and Medical Director Dr. Jeanne James.

*Services to women needing treatment for breast and/or cervical cancer:*

- **November 2010:** The Tennessee Breast and Cervical Cancer Program (TBCCP) presented an award to TennCare for its assistance over an eight-year period in diagnosing breast cancer in 905 women and cervical cancer abnormalities in 2,275 women.

*Information technology:*

- **June 2011:** TennCare Chief Information Officer Brent Antony was named one of 11 top executives and thought leaders in the healthcare information industry. The honor was bestowed jointly by eMids Technologies, a health care information technology (IT) and consultation company, and Healthcare Payer News, an online news source dedicated to IT, finance, and policy in the field of health.

## Part I: Historical Narrative Summary

The TennCare program has been in existence since 1994. It is a managed care program in which all enrollees participate. The purpose of TennCare is to demonstrate that the State can use managed care principles to serve Medicaid enrollees, as well as some individuals who are not Medicaid eligible, without compromising quality of care and without spending more than the State would have spent had it continued its fee-for-service Medicaid program.

### 1. Previous Waivers and Waiver Extensions.

Over the life of the TennCare program, there have been a number of previous extensions. These extensions are summarized in Table 1.

**Table 1**
**History of the TennCare 1115 Waiver and Waiver Extensions**

| Waivers and Waiver Extensions | Waiver Authority | Approval Period | Comments |
|---|---|---|---|
| | | **TennCare I** | |
| Original TennCare Waiver | Section 1115 | January 1, 1994 – December 31, 1998 | The original waiver request was quite expansive, proposing coverage for uninsured and uninsurable individuals up to a total enrollment cap of 1.775 million persons.[6] |
| First extension of TennCare I | Section 1115 | January 1, 1999 – December 31, 2001 | |
| One month extension of TennCare I | Section 1115(a) | January 1, 2002 – January 31, 2002 | The waiver was extended for one month because of ongoing discussions regarding the budget neutrality trend rate. |
| One-year extension of TennCare I | Section 1115(a) | February 1, 2002 – January 31, 2003 | Although this extension was "partially" approved through January 31, 2003, it ended when the TennCare II waiver began on July 1, 2002. |
| | | **TennCare II** | |
| TennCare II | Section 1115(a) | July 1, 2002 – June 30, 2007 | The new waiver outlined a more streamlined program. Persons already enrolled as uninsureds or uninsurables were allowed to remain on the program |

[6] "TennCare: A New Direction in Health Care" (June 1993), page 29. This was the initial waiver request.

| Waivers and Waiver Extensions | Waiver Authority | Approval Period | Comments |
|---|---|---|---|
| | | | subject to reverification, but new enrollment in these categories was extremely limited. |
| Six short extensions of TennCare II | Section 1115(a) | July 1, 2007 – October 4, 2007 | At the end of June 2007 CMS introduced a new cap on pool payments, which required additional time for discussion. |
| First formal extension of TennCare II | Section 1115(a) | October 5, 2007 – June 30, 2010 | |
| Second formal extension of TennCare II | Section 1115(e) | July 1, 2010 – June 30, 2013 | |

## 2. Developments in TennCare II.

Highlights of each Demonstration Year are provided below.

### a. Demonstration Year 1 (July 1, 2002, through June 30, 2003).

TennCare II began on July 1, 2002, with Manny Martins as TennCare Director.

Among the changes approved for TennCare II was a two-tiered program: TennCare Medicaid (for Medicaid enrollees) and TennCare Standard (for demonstration enrollees).[7] A differentiation in benefits between TennCare Medicaid and TennCare Standard was scheduled to begin on January 1, 2003, but was stopped by a decision of the Federal Court in Middle Tennessee on December 18, 2002. These changes were re-scheduled for implementation on April 1, 2003, but then postponed indefinitely due to efforts underway to reach new agreements with the plaintiffs in four lawsuits filed against the State.

A new Medicaid category was added by TennCare II—the category for women needing treatment under the federal Breast and Cervical Cancer Prevention (BCCP) program.

The TennCare Reform Act took effect on the same day that TennCare II began. It contained a number of provisions aimed at program improvement. A temporary Stabilization Plan was implemented, changing the risk-based arrangement under which

[7] A third program, TennCare Assist, which would have been a program to help low income persons purchase employer-sponsored insurance, was envisioned but never developed.

the Managed Care Organizations (MCOs) had operated previously to an Administrative Services Only (ASO) arrangement.

On October 1, 2002, dental services were carved out to a single Dental Benefits Manager (DBM), Doral Dental of Tennessee. Pharmacy benefits for dual eligibles were also carved out and managed by Consultec (ACS).

On March 27, 2003, the State submitted Amendment 1 to the TennCare demonstration. This amendment, which requested removal of the Stabilization Neutrality Cap implemented as part of the Stabilization Plan, was approved on April 29, 2003.

On June 2, 2003, the Tennessee Department of Commerce and Insurance (TDCI) filed a petition with the Davidson County Chancery Court to liquidate Xantus, a Middle Tennessee plan that had gone through several years of rehabilitation and then receivership with the Department. Effective July 31, 2003, the TennCare Bureau terminated its contract with Xantus, and enrollees were moved to TennCare Select.[8] The Court terminated the liquidation of Xantus by order effective February 6, 2009.

The Bureau's contract with Universal Care of Tennessee, another troubled Middle Tennessee plan, ended effective June 1, 2003, and enrollees were moved to TennCare Select. On June 5, 2003, TDCI filed a petition with the Davidson County Chancery Court to liquidate Universal. The Court terminated the liquidation of Universal Care by order effective March 3, 2009.[9]

**b. Demonstration Year 2 (July 1, 2003, through June 30, 2004).**

Early in the year, work began on designing a new single Preferred Drug List (PDL) that would streamline the pharmacy program for prescribers and pharmacists. The new PDL was phased in over a period of months beginning on September 15, 2003, with 10 drug classes being addressed each month.

In the latter half of 2003, a coalition of groups including BlueCross BlueShield of Tennessee, the Farm Bureau, Hospital Corporation of America, Vanderbilt University, and 22 hospitals within the Tennessee Hospital Association entered into a contract with McKinsey & Company, an international consulting company, for the purpose of conducting an independent study to assess the viability of TennCare over the next five years and to identify strategic options for improving its financial sustainability.

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[8] TennCare Select is the State's plan that serves certain special populations, including persons living in parts of the State where there is insufficient capacity to serve them. See paragraph 40 of the Special Terms and Conditions. TennCare Select is managed by Volunteer State Health Plan (VSHP), a licensed HMO affiliate of its parent company BlueCross BlueShield of Tennessee.

[9] There was one more troubled Middle Tennessee plan during this period—the Tennessee Coordinated Care Network (TCCN, also known as Access MedPlus). TennCare ended its contract with TCCN prior to the start date of TennCare II. The Court terminated the liquidation of TCCN by order effective July 23, 2009.

On December 11, 2003, McKinsey & Company issued "Achieving a Critical Mission in Difficult Times—TennCare's Financial Viability" as Part 1 of a two-part report. It included the following summary statement: "Our assessment is that, even with current and planned improvement efforts and solid program management, TennCare as it is constructed today will not be financially viable. Without additional reform, the program is projected to become so costly by fiscal year 2008 [that] the state will find it difficult, if not impossible, to both support TennCare and meet its obligations in other critical programs. TennCare's costs could grow by as much as 80 percent by fiscal year 2008, and its cost growth could represent more than 80 percent of new state revenues in each of the 4 years leading up to that date." (p. ii)

On January 1, 2004, First Health replaced Consultec (ACS) as the TennCare PBM.

On February 11, 2004, McKinsey & Company issued "Achieving a Critical Mission in Difficult Times—Illustrative Strategic Options for TennCare" as Part 2 of its report. The report included 25 potential initiatives for reducing TennCare's costs and five different combinations of those initiatives as potential approaches.

On February 17, 2004, Governor Phil Bredesen addressed the Tennessee General Assembly and announced plans to reform TennCare so that it could remain financially viable. A "TennCare Transformation Team" was assembled. State workers, providers, and advocates formed four policy teams and four organization teams to develop detailed plans for "TennCare Transformation," following the Governor's directive that coverage for children, pregnant women, and individuals with disabilities be protected to the greatest extent possible.

**c. Demonstration Year 3 (July 1, 2004, through June 30, 2005).**

On July 1, 2004, J. D. Hickey became TennCare Director. A new Office of the Inspector General was created by statute to investigate and resolve cases of potential TennCare fraud and abuse.

On August 19, 2004, a draft of a massive waiver amendment for "TennCare Transformation" was released for public comment. Presentations and "listening sessions" were conducted in various Tennessee communities. The State received over 2,000 electronic, written, or telephone comments, and on September 24, 2004, the waiver amendment was submitted to CMS.

As part of TennCare Transformation, the State had requested relief from the plaintiffs involved in several Consent Decrees affecting the TennCare program. There were a number of discussions to this effect during this period, but these discussions were ultimately unsuccessful. In light of this development and continuing budgetary

issues, the Governor announced on November 10, 2004, that he was setting in motion a process to end TennCare and return to a traditional Medicaid program.

On January 10, 2005, the Governor announced a proposal for a "third way." This approach involved retaining TennCare and doing everything possible to keep children on the program, but closing the uninsured and uninsurable categories for adults and implementing some benefit reductions.

With respect to the September 24, 2004, waiver amendment, CMS requested that the State break this up into smaller amendments, or "phases."

The proposal for "Phase 1" (also known as Amendment 2) was submitted on February 18, 2005, and approved on March 24, 2005. It involved closing enrollment in the Medically Needy category fornon-pregnant adults and closing enrollment in the uninsured and uninsurable categories for adults age 19 and older. The 323,000 adults then enrolled in the uninsured and uninsurable categories were to be reviewed for eligibility in other Medicaid categories and moved into these categories if they qualified.

On May 6, 2005, the State submitted "Phase 2" (Amendment 3). Amendment 3 proposed to implement a limit on pharmacy coverage for non-institutionalized TennCare Medicaid adults of five prescriptions or refills per month, of which no more than two could be brand name drugs. It also proposed the implementation of a nominal copay of $3.00 per brand name prescription or refill for non-exempt TennCare Medicaid adults. Pharmacy coverage was eliminated altogether for TennCare Standard adults. Finally, Amendment 3 removed the out-of-pocket maximum applied to copays paid by TennCare Standard enrollees with incomes above poverty. Very few individuals had even come close to reaching the out-of-pocket maximum.

Amendment 3 was approved by CMS on June 8, 2005.

**d. Demonstration Year 4 (July 1, 2005, through June 30, 2006).**

On July 29, 2005, the Federal District Court in Nashville issued a ruling in the *Grier* Consent Decree that allowed the State to move forward with certain benefit changes. These included the new limit on prescription drug coverage for non-institutionalized adults and the new copay requirement on brand name prescriptions for non-exempt adults. On August 1, 2005, the State implemented these changes, as well as eliminating the adult dental program and coverage of methadone clinic services for adults.

On September 1, 2005, the State submitted "Phase 3" (Amendment 4) to the TennCare demonstration. This amendment proposed to re-establish an annual MCO change period and to eliminate coverage of benzodiazepines and barbiturates for adults. Amendment 4 was approved by CMS on March 31, 2006.

Amendment 4 included a proposal that CMS declined to act on, which was a request to implement a practice of suspending persons from TennCare for one year if they had been convicted of a TennCare crime such as selling drugs obtained through TennCare.

On January 11, 2006, the State submitted Amendment 5 to the TennCare demonstration. Amendment 5 outlined a plan for opening a new demonstration category patterned after the Medically Needy category for non-pregnant adults, but with an enrollment cap. This category came to be known as the "Standard Spend Down" (SSD) category. Amendment 5 was approved on November 14, 2006.

On April 7, 2006, the Bureau of TennCare issued a Request for Proposals (RFP) for new MCOs to serve the Middle Tennessee area. This was the first time that TennCare had used a competitive bid process to recruit MCOs into the program.

In June 2006 the State submitted a request to CMS for a three year extension of TennCare II under the Section 1115(e) authority.

**e. Demonstration Year 5 (July 1, 2006, through June 30, 2007).**

On July 7, 2006, Darin Gordon was named TennCare Director.

On July 26, 2006, after the completion of a detailed procurement process, the Bureau announced that two new MCO contracts had been awarded in the Middle Tennessee Region. The two MCOs were Amerigroup and UnitedHealthcare. The model to be used by the new MCOs was an integrated model whereby behavioral health services were coordinated with physical health services. The plans formally began operations on April 1, 2007, after completion of a series of lengthy and intensive readiness activities.

In November 2006, CMS denied the State's request for an extension of the demonstration under the Section 1115(e) waiver authority and communicated that the extension would have to be accomplished under the Section 1115(a) authority. CMS and State staff spent several months rewriting the Special Terms and Conditions of the demonstration so that they were more consistent with those approved for other states.

Earlier in the year, all MCOs had been notified that the contracts of any plans failing to obtain NCQA accreditation by December 31, 2006, would be subject to termination. All MCOs completed the NCQA survey and received their ratings. Three received an "Excellent" rating, three received a "Commendable" rating, and one received a "Provisional" rating. (The plan receiving the "Provisional" rating was already scheduled to leave the program on March 31, 2007, when the two new MCOs were scheduled to "go live" in Middle Tennessee.)

On December 1, 2006, the State promulgated a new rule on Medical Necessity. Tennessee Rule 1200-13-16 established objective definitions, clear standards for prior authorization and concurrent medical review, specific criteria for medical necessity, and detailed procedures for use in determining medical necessity.

On February 1, 2007, the State implemented "soft limits" in the pharmacy program. The process, which was later re-named the "Prescriber Attestation Process," was put in place to allow enrollees who were subject to a limit on outpatient drugs to obtain additional prescriptions in urgent situations. Over 600 medications were initially identified for this process. When an enrollee had reached his benefit limit for any given month and his prescriber contacted TennCare and attested that the enrollee had an urgent need for an otherwise covered drug that was in excess of the benefit limit, TennCare would pay for it. The State already had an "Auto Exception Process," formerly called the "Short List," which included more than 500 drugs that did not count against the limit.

On June 29, 2007, CMS notified the State that a cap on pool payments was being added to the Special Terms and Conditions for the extension that was set to begin on July 1, 2007. CMS granted the State the first in a series of short extensions of the TennCare demonstration so that this issue could be discussed.

**f. Demonstration Year 6 (July 1, 2007, through June 30, 2008).**

The waiver extension was approved on October 5, 2007.

Approval of the extension enabled the State to begin to address the Medically Needy program for non-pregnant adults, which was closed on April 29, 2005.[10] Persons enrolled in this program when it closed were reviewed for eligibility in the new SSD program. By agreement with CMS, the State submitted a State Plan Amendment (SPA) to remove the Medically Needy category for non-pregnant adults from the Medicaid State Plan. SPA 07-007 was approved by CMS on November 1, 2007, with an effective date of October 5, 2007.

By 2007, only a small number of TennCare Standard enrollees had premium obligations; these were children with family incomes at or above the poverty level. TennCare made the decision to end premiums for TennCare Standard enrollees effective December 1, 2007.

TennCare continued to monitor program costs closely, and in December 2007 the Bureau began public discussions of the unsustainable growth that was being experienced with respect to two services—home health and private duty nursing. In order to implement limits on these services for adults, the State submitted Amendment

[10] The Medically Needy program for pregnant women and children continued without change.

6 to the TennCare demonstration on February 29, 2008. The amendment was revised after discussions with CMS and re-submitted on May 29, 2008. It was approved by CMS on July 22, 2008.

On January 8, 2008, the Bureau released a Request for Proposals (RFP) for health plans to offer integrated medical and behavioral services in East and West Tennessee. The successful bidders were announced on April 22, 2008, and they were BlueCross BlueShield of Tennessee and UnitedHealthcare. The anticipated start date of operations for these plans was November 1, 2008, in West Tennessee, and January 1, 2009, in East Tennessee.

In the spring of 2008, the General Assembly passed the Long-Term Community Choices Act of 2008. The Act, which passed unanimously in both houses of the General Assembly, laid out the components of a proposed re-design of the TennCare long-term care program.

**g. Demonstration Year 7 (July 1, 2008, through June 30, 2009).**

In response to the Long-Term Community Choices Act of 2008, the Bureau developed a concept paper for Amendment 7, which would bring long-term care for elderly persons and adults with physical disabilities under the managed care program and open up new opportunities for these individuals to receive Home and Community Based Services (HCBS). The concept paper was submitted to CMS on July 11, 2008, and followed by a formal submission of Amendment 7 on October 2, 2008. The new program was called CHOICES.

On October 1, 2008, SXC became the new TennCare PBM, replacing First Health.

On January 8, 2009, the Federal District Court lifted an injunction that had been in place for over 20 years in a case called *Daniels*. The issue in the case was the State's ability to properly redetermine the eligibility of individuals who had lost SSI benefits and who therefore would have to qualify in another Medicaid category in order to remain eligible for Medicaid and later TennCare. The redetermination procedures developed by the State were approved both by CMS and by the Court. As a result of this decision, the State began redetermining the eligibility of about 147,000 *Daniels* class members, some of whom had been enrolled in TennCare for years after losing SSI without having had their eligibility redetermined.

On June 15, 2009, the State requested a three-year extension of TennCare II.

**h. Demonstration Year 8 (July 1, 2009, through June 30, 2010).**

CMS approved Amendment 7 on July 22, 2009, and work began on the first phase of implementation. The State announced plans to start CHOICES in Middle Tennessee on

March 1, 2010, with implementation in the West and East Tennessee regions to occur soon after.

The benefit limits on home health and private duty nursing services for adults, which had been approved by CMS in Amendment 6, were implemented on September 8, 2009, following a 30-day advance notice to adult enrollees.

On September 23, 2009, the Bureau announced that Volunteer State Health Plan (VSHP) would take over the provision of behavioral health care for enrollees receiving services through TennCare Select. This announcement completed the integration of medical and behavioral health care in the managed care program, and there was no longer a need for Behavioral Health Organizations (BHOs).[11]

On September 28, 2009, the State submitted Amendment 8 to CMS. The purpose of Amendment 8 was to ensure compliance with the Mental Health Parity requirements of the Emergency Economic and Stabilization Act of 2009 by removing, effective January 1, 2010, the limits that were in place on inpatient and outpatient substance abuse treatment benefits for adults. Amendment 8 was approved on December 15, 2009.

On November 19, 2009, TennCare leaders made a presentation to a legislative committee outlining looming financial issues, with enrollment increasing due to challenging economic conditions (about 5,000 new enrollees were being added per month) and decreases occurring in State revenues. These developments led the State to submit Amendment 9 to the demonstration on February 3, 2010. Amendment 9 would have required new limits on benefits for most adults, effective July 1, 2010. On May 5, 2010, the Tennessee General Assembly passed the "Annual Coverage Assessment Act of 2010," which established a new one-year fee on hospitals.

The State quickly followed up on the potential availability of revenues from the new fee. On May 10, 2010, the Bureau of TennCare submitted a request to CMS for a waiver of the broad-based requirements related to tax programs on inpatient and outpatient hospital net patient revenues. On May 24, 2010, the Bureau submitted Amendment 10 to establish a new Unreimbursed Hospital Cost (UHC) Pool and a new Public Hospital Supplemental Payment (PHSP) pool. Both requests were approved by CMS on June 30, 2010, and Amendment 9 was withdrawn.

On December 15, 2009, CMS wrote to the State approving the requested waiver extension for the 2010-2013 period.

The CHOICES program was implemented in Middle Tennessee on March 1, 2010.

[11] BHOs had been part of the TennCare program since July 1, 1996.

### i. Demonstration Year 9 (July 1, 2010, through June 30, 2011).

On July 21, 2010, the Bureau submitted Amendment 11 to CMS. The purpose of Amendment 11 was to add another hospital to the PHSP. Amendment 11 was approved on December 16, 2010.

The CHOICES program was implemented in East and West Tennessee on August 1, 2010.

On October 1, 2010, a new DBM began operations. The new DBM was Delta Dental, and its TennCare product was called "TennDent."

On October 4, 2010, after completion of reviews of eligibility for persons enrolled in the Medically Needy program for non-pregnant adults when it closed, the State conducted the first open enrollment period for new enrollment in the SSD category. The call-in enrollment process for this program, which is described in Section XIII, Part III, of the Special Terms and Conditions, is a unique process designed especially for this program. The State received 2,835 calls in just over one hour. A second open enrollment period occurred on February 22, 2011. This time, the State received 3,080 calls in just over one hour.

On January 3, 2011, Tennessee was one of 11 states to launch an Electronic Health Record (EHR) Incentive program. By the end of the first three months, 943 providers had registered for the program.

On February 1, 2011, Tennessee submitted a request to the new Medicare-Medicaid Coordination Office for one of the $1 million planning grants that were to be made to 15 states to develop a proposal for integrating care for Medicare-Medicaid dual eligibles. On April 5, 2011, the State was notified that the request was approved. The contract was signed on April 26, 2011.

On April 1, 2011, TennCare launched a new initiative to improve the dental health of enrollees who were 3 to 5 years old by offering reimbursement to non-traditional providers to conduct dental screens and apply fluoride varnish to teeth. "Non-traditional providers" were defined to include primary care physicians, pediatricians, physician assistants, nurse practitioners, and public health nurses.

Since the hospital assessment fee discussed in the section on Demonstration Year 8 was a one-year fee only, the State submitted Amendment 12, a recap of Amendment 9, in case the fee was not renewed.[12] Amendment 12 was submitted on February 28, 2011.

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[12] Paragraph 7 in the Special Terms and Conditions requires that amendments to the TennCare demonstration be submitted no later than 120 days prior to the planned date of implementation. The Tennessee General Assembly usually meets from January to May, with the annual Appropriations Bill not taken up until the end of the session.

It was substantively withdrawn on May 5, 2011, after the General Assembly passed a one-year extension of the hospital assessment fee.

**j. Demonstration Year 10 (July 1, 2011, through June 30, 2012).**

A third open enrollment was held for the SSD program on September 12, 2011. This time the State received 2,793 calls in just over one hour. The fourth open enrollment, held on February 21, 2012, generated 2,934 calls in just over one hour.

Amendment 13 was submitted to CMS on December 15, 2011. The purpose of Amendment 13 was to expand the enrollment cap in the CHOICES program, effective April 1, 2012. Amendment 13 was subsequently withdrawn and consolidated with Amendment 14, which had an effective date of July 1, 2012.

On February 14, 2012, a chapter ended in the 14-year long *John B.* case regarding EPSDT services for children. The District Court in Middle Tennessee ruled that TennCare had successfully established its compliance with "all the binding provisions of the Consent Decree" and, consequently, that the Consent Decree was vacated and the case dismissed. The plaintiffs filed an appeal of the decision on March 9, 2012.

Amendment 14 was submitted to CMS on March 1, 2012. This amendment was developed after several months of conversation with CMS staff regarding strategies for changing the Level of Care (LOC) criteria for NF care without violating the Maintenance of Effort (MOE) requirements contained in the Affordable Care Act. Tennessee's current LOC are among the most lenient in the country. Amendment 14 was approved on June 15, 2012, with a July 1, 2012, effective date.

Amendment 15, which was a repeat of Amendments 9 and 12, was submitted to CMS on March 1, 2012, and withdrawn on April 3, 2012, after the General Assembly passed another one-year extension of the hospital assessment fee.

Finally, the State submitted Amendment 16 to CMS on April 13, 2012. Amendment 16 was a request to remove Disproportionate Share Hospital (DSH) payments from the cap on pool payments, since the current DSH allotment for Tennessee cannot be paid out in full under the current cap. Amendment 16 was approved on June 15, 2012, with a June 15, 2012, effective date.

**3. Program Component: Eligibility.**

TennCare covers most Medicaid groups, including:

- Section 1931 eligibles and related groups
- SSI eligibles and related groups
- Poverty level pregnant women and children
- Children in foster care and adoption assistance programs

- Medically needy pregnant women and children
- Individuals in institutional placements and receiving HCBS as alternatives to institutional care
- Women under 65 who need treatment for breast and/or cervical cancer

Table 1a in paragraph 17 of the current Special Terms and Conditions provides a full list of Medicaid categories covered by TennCare.

There are currently six categories of demonstration eligibles, with a seventh category to be implemented as part of Amendment 14. Two of the demonstration categories were established to address particular situations when the program was in transition some years ago; today, these categories no longer have any members in them. These two categories will likely be removed in the extension.

The demonstration categories are summarized in Table 2.

**Table 2**
**TennCare II Demonstration Categories**

| Group | Description | When Approved/Modified | Comments |
|---|---|---|---|
| Medically Eligible children[13] | Uninsurable children under age 19 who were already enrolled in the category or who are able to qualify as "Medicaid Rollovers"[14] when they lose Medicaid eligibility. | Amendment 2 (March 24, 2005) | |
| Uninsured children[15] | Children under age 19 who lack access to insurance and whose family incomes are below 200 percent of poverty; must be already enrolled in the category or able to qualify as "Medicaid Rollovers" when they lose Medicaid eligibility. | Amendment 2 (March 24, 2005) | |
| Transition Group | Persons who were eligible in the Medically Needy category as aged, | Amendment 2 (March 24, 2005) | There are no longer any individuals left in |

[13] At the beginning of TennCare II, the word "Uninsurable" was replaced with the term "Medically Eligible." Persons already enrolled as "Uninsurables" continued on the program as long as they continued to meet eligibility criteria. New "Medically Eligible" persons were covered with incomes below 100 percent of poverty. Amendment 2 removed coverage of Medically Eligible adults and replaced it with coverage of Medically Eligible children at any income level.

[14] A "Medicaid Rollover" is a person who moves from Medicaid to the Uninsured Children or Medically Eligible Children category.

[15] The category for newly enrolling Uninsured children was closed for many children during TennCare I. Children already enrolled who continued to meet the criteria for the category or who qualified as "Medicaid Rollovers" remained on the program.

| Group | Description | When Approved/Modified | Comments |
|---|---|---|---|
| | blind, or disabled individuals, or as caretaker relatives of Medicaid-eligible children, at the time this category was closed in April 2005. | | this category. |
| Discontinued Demonstration Group | Persons in the closed adult uninsured and uninsurable categories who were awaiting a determination that they might be eligible in a Medicaid category. | Amendment 2 (March 24, 2005) | There are no longer any individuals left in this category. |
| Standard Spend Down | Persons who meet the criteria associated with the Medically Needy category for aged, blind, or disabled individuals, or as caretaker relatives of Medicaid-eligible children, and who enroll during designated enrollment periods. | Amendment 6 (November 14, 2006) | |
| CHOICES 217-Like Group | Elderly or disabled adults who meet the Nursing Facility Level of Care (LOC), who are receiving HCBS, and who would qualify for TennCare if the HCBS they are receiving were provided under a 1915(c) waiver. | Amendment 7 (July 22, 2009) | |
| At Risk Demonstration Group | Persons who, without HCBS, are "At Risk" for Nursing Facility placement.[16] | Amendment 14 (June 15, 2012) | |

One question that is often asked is which eligibility groups are exempt from managed care. The answer is that none of them is exempt. All TennCare enrollees participate in the managed care program and have done so since the beginning of the program in 1994. There are about 325 people who participate in a PACE program, which is treated separately from the rest of the managed care program, as of this writing. Everyone else, including persons enrolled in one of the State's three HCBS waivers for persons with intellectual disabilities and including dually eligible Medicare-Medicaid beneficiaries, chooses or is assigned to an MCO. Children under 21 and adults who are not Medicare beneficiaries are assigned to the PBM. Children under 21 are also assigned to the DBM.

We anticipate the addition of a new Medicaid expansion population in January 1, 2014, as required by the Affordable Care Act. Information about this population is presented in Part VIII of this extension request.

[16] "Interim CHOICES 3" is a new category proposed in Amendment 14.

## 4. Program Component: Benefits.

TennCare covers a long list of benefits, including all mandatory Medicaid benefits and many optional benefits, such as:

- Speech, occupational, and physical therapy
- Private duty nursing services
- Psychiatric residential treatment services
- Clinic services
- Prescription drugs
- Durable medical equipment

When the CHOICES program was approved in Amendment 7, a list of HCBS was added for CHOICES participants. This list includes, for specified groups, community-based residential alternatives, personal care visits, attendant care, home-delivered meals, Personal Emergency Response Systems, adult day care, in-home and inpatient respite care, assistive technology, minor home modifications, and pest control. It appears in Table 2b in paragraph 30(h) of the current Special Terms and Conditions.

In accordance with paragraph 7(c) of the Special Terms and Conditions, TennCare has requested a change in the description of the homemaker, attendant care, and personal care benefits in Attachment D. That request was approved on May 8, 2012.

For much of its existence, TennCare has operated with very few benefit limits. There are still relatively few, with the major ones being a limit on prescription drug coverage for most adults, approved in Amendment 3, and limitations on coverage of home health and private duty nursing services for adults, approved in Amendment 8.

Two factors have been useful in making benefit decisions. One is the clarification we have provided in State rules regarding "Medical Necessity." This clarification was required by State law in 2004 and effectuated in State rules in 2006. See http://www.tn.gov/sos/rules/1200/1200-13/1200-13-16.20111128.pdf.

The other factor has been the development of a list of exclusions, meaning services that are never covered. This list was first put into State rules at the beginning of TennCare II and has been modified on several occasions since then. Although some of the items on the list appear extreme, almost all of them are items or services that have been requested from TennCare at one time or another. See Rule 1200-13-13-.10 at the following web address: http://www.tn.gov/sos/rules/1200/1200-13/1200-13-13.20120129.pdf.

## 5. Program Component: Service Delivery.

Almost all TennCare services are delivered by Managed Care Contractors (MCCs).

Table 3 presents a configuration of the current MCCs serving the TennCare program.

**Table 3**
**TennCare Managed Care Contractors (MCCs)**

| | West Tennessee | Middle Tennessee | East Tennessee |
|---|---|---|---|
| **Managed Care Organizations (MCOs)** | BlueCare[17]<br><br>UnitedHealthcare Community Plan[18]<br><br>TennCare Select[19] | Amerigroup<br><br>UnitedHealthcare Community Plan<br><br>TennCare Select | BlueCare<br><br>UnitedHealthcare Community Plan<br><br>TennCare Select |
| **Pharmacy Benefits Manager (PBM)** | SXC Health Solutions Corp. | | |
| **Dental Benefits Manager (DBM)** | TennDent[20] | | |

One of the areas of TennCare where change is most apparent is in the number of MCCs At the beginning of TennCare II, MCCs included MCOs, BHOs, and a DBM. The PBM was added across the board in 2003.[21] As is evident in Table 4, the overall number of TennCare MCCs has declined dramatically over time.

**Table 4**
**Number of Managed Care Contractors During TennCare II**

| Year | MCOs[22] | BHOs | DBM | PBM | Total |
|---|---|---|---|---|---|
| 2002 | 9 | 2 | 1 | 0 | 12 |
| 2003 | 9 | 2 | 1 | 1 | 13 |
| 2004 | 7 | 2 | 1 | 1 | 11 |
| 2005 | 7 | 2 | 1 | 1 | 11 |
| 2006 | 7 | 2 | 1 | 1 | 11 |
| 2007 | 9 | 2 | 1 | 1 | 13 |

[17] BlueCare is operated by Volunteer State Health Plan, Inc. (VSHP), which is an independent licensee of the BlueCross BlueShield Association and a licensed HMO affiliate of its parent company BlueCross BlueShield of Tennessee.
[18] UnitedHealthcare Community Plan, formerly known as "AmeriChoice," is operated by UnitedHealthcare Plan of the River Valley, Inc.
[19] TennCare Select is operated by Volunteer State Health Plan, Inc. (VSHP).
[20] TennDent is operated by DentaQuest and assumed responsibilities as TennCare's Dental Benefits Manager on October 1, 2010.
[21] Earlier, the PBM had had some responsibilities for certain populations, such as dual eligibles.
[22] One of the MCOs serving TennCare offers two plans: an at-risk plan in East and West Tennessee, and a partial risk plan known as TennCare Select.

| Year | MCOs[22] | BHOs | DBM | PBM | Total |
|---|---|---|---|---|---|
| 2008 | 7 | 2 | 1 | 1 | 11 |
| 2009 | 3 | 1 | 1 | 1 | 6 |
| 2010 | 3 | 0 | 1 | 1 | 5 |
| 2011 | 3 | 0 | 1 | 1 | 5 |
| 2012 | 3 | 0 | 1 | 1 | 5 |

Interestingly, none of the MCOs and BHOs operating in TennCare prior to 2007 was acquired through a competitive procurement process. The two BHOs were statewide, but the MCOs varied greatly in size, ranging from statewide to county-specific.

All of that began to change in 2006, when TennCare started thinking about "right-sizing" the MCOs and "re-visioning" what they could do. "Right sizing" meant that the State would contract with two MCOs to serve each of the three grand regions of the State (West, Middle, and East Tennessee). MCOs would be selected through a competitive procurement process to be managed, in part, by an outside contractor and that would involve painstaking attention to a multitude of details. The new vision for MCOs included integration of behavioral health services, thereby ending the artificial divisions that occurred when a person's mental health care was managed by one entity and his physical health care by another. BHOs were no longer needed.

The result of the MCO procurement process was that the MCOs currently providing TennCare services are strong, well-capitalized, experienced entities. During the October-December 2011 quarter, they reported a collective net worth of nearly seven times the statutorily required amount.

Once the new MCOs were chosen, a lengthy readiness review process was put in place prior to their beginning operations. The "go live" dates for the new MCOs were as follows:

- April 1, 2007: Middle Tennessee
- November 1, 2008: West Tennessee
- January 1, 2009: East Tennessee

After the last integration effort occurred in East Tennessee, there was still one BHO remaining as a partner to TennCare Select. That BHO was phased out in September 2009, when physical and behavioral health services were blended in TennCare Select just as in the other health plans.

The next target for service integration was LTSS. Beginning with the approval of the CHOICES program in Amendment 7, LTSS for adults who are elderly or physically disabled, as well as NF care for children, was brought under the MCOs. CHOICES was phased in on the following dates:

- March 1, 2010: Middle Tennessee
- August 1, 2010: East and West Tennessee

CHOICES has been instrumental in helping TennCare meet goals of rebalancing LTSS so that there is more access to HCBS for people who need them and more targeted utilization of NFs as providers of care to persons with the most acute needs.

At the inception of the TennCare program, 17 percent of all elderly persons and adults with physical disabilities receiving LTSS got their care in home and community settings, with the remaining 83 percent receiving care in an institution. As of April 2012, the percentage of members receiving care in home and community settings had nearly doubled, to 33.5 percent, with only 66.5 percent receiving care in institutions. While the vast majority of changes in enrollment are attributable to successful diversion efforts achieved through expanded access to HCBS and improved coordination of care, hundreds of TennCare members have also successfully transitioned from institutions to community-based living, both before and after the State's Money Follows the Person Rebalancing Demonstration, which is also administered by MCOs through the managed care program.

Each of the Bureau's expectations regarding MCC performance is carefully laid out in the MCC contracts, which are usually amended twice a year. All contracts are monitored closely.

As an example, there are several hundred deliverables included in the MCO contracts. The Bureau has established an electronic database for tracking these deliverables and assigned a business owner within the Bureau for each one. The system identifies when items are due and triggers reminders to business owners, as well as follow-up messages if the reminders are not acted upon. Business owners must enter their responses into the system, showing that they have followed up on the items that are their responsibility. Sometimes this process reveals that a particular report is no longer needed, in which case it may be removed from the contract the next time it is amended. The Bureau seeks to avoid requesting items from the MCOs that no one at the Bureau is reviewing or using. This electronic contract monitoring process promotes regular, systematic, and timely reports on all required deliverables and helps make sure that these items are reviewed and responded to as intended. Additional monitoring activities have been established since implementation of the CHOICES program, including specific monitoring of care coordination processes through audits and other on-site monitoring activities.

An important participant in the monitoring process is the Tennessee Department of Commerce and Insurance (TDCI). TDCI maintains a TennCare Oversight Division that carries out a number of critical functions such as collecting and analyzing MCO financial reports and assuring compliance with prompt pay requirements.

**6. Progress on Project Objectives.**

A detailed Interim Evaluation Report, which is required by paragraph 71 of the Special Terms and Conditions, is presented in Part VI of this application. This report shows improvements over time in a number of indicators such as EPSDT screening rates, child/adolescent access to PCPs, adult and adolescent well-care visits, timeliness of prenatal care, control of high blood pressure, and HbA1c (diabetes) testing. Over 90 percent of TennCare enrollees report that they

go to a doctor or clinic, rather than a hospital emergency room, when initially seeking care.[23] Satisfaction with TennCare remains extremely high at 95 percent, which is a full 10 percentage points above the level reported at the beginning of TennCare II in 2002.[24]

In addition to the positive effects on enrollee health, the TennCare program has demonstrated important outcomes of an economic nature—efficiency, stability and viability. During the course of the demonstration, budget neutrality has been successfully maintained. TennCare MCOs exhibit a high rate of claims payment accuracy and timeliness.

In the few areas where progress has lagged, measures have been taken to improve the trend. When breast cancer screening rates failed to improve, TennCare instituted pay-for-performance incentives for MCOs that hit target rates. Similar initiatives are currently being considered to improve cervical cancer screening rates as well. MCOs are required to do performance improvement projects each year, and they are currently working together in collaborative workgroups that focus on diabetes and maternity-related issues.

A major new program that is now under the demonstration's umbrella, the CHOICES LTSS program, has shown remarkable progress so far in rebalancing the system so that NF care is reserved for those with the most acute needs and those with lesser levels of need can be offered cost-effective HCBS.

Due to these favorable results, we have seen significant achievements so far in our overall demonstration goals:

- Assuring appropriate access to care for enrollees
- Providing quality care to enrollees
- Assuring enrollees' satisfaction with services
- Improving health care for enrollees
- Using a managed care approach to provide services to Medicaid State Plan and demonstration eligibles at a cost that does not exceed what would have been spent in a Medicaid fee-for-service system
- Assuring that health plans maintain stability and viability while meeting all contract and program requirements

We envision making additional progress toward these goals during the new waiver period.

## 7. Future Goals of the Program.

[23] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource).

[24] The Impact of TennCare: A Survey of Recipients, The University of Tennessee Center for Business and Economic Research (produced yearly-last report November 2011).

A major goal of the future is to continue the progress made to date on integration of benefits. The State is applying to the Medicare-Medicaid Coordination Office for a separate Section 1115 waiver to be layered on top of the TennCare demonstration. The new program, to be called TennCare PLUS, would allow the State to offer a coordinated package of TennCare and Medicare benefits to Full Benefit Dual Eligibles (FBDEs). The projected start date is January 1, 2014. Although this project is outside the TennCare demonstration, it is certainly complementary to it and dependent upon continuation of TennCare as it currently exists.

**a. Future goals and desired outcomes.**

Each year, the Bureau of TennCare goes through a process of updating program goals, objectives, and performance measures. This involves determining whether the current goals, objectives, and performance measures are still appropriate, given any program changes that have occurred during the year or are likely in the near future.

We anticipate that goals, objectives, and performance measures will remain relatively unchanged during 2013. The major addition will likely be adding/enhancing measures for the relatively new CHOICES LTSS population. We doubt we will need to make many changes to accommodate the new expansion population in 2014, however, since this population is likely to be similar to the adult 1931 population and to uninsured adult populations that we have served in the past.

**b. Plans for quality of care activities under the extension.**

TennCare currently carries on a wide variety of process-related quality of care activities, in addition to the collection and analysis of outcome measures. It is anticipated that all of these activities will continue into 2013. The process indicators that have been developed for the CHOICES LTSS population will continue to be incorporated into the quality plan. As 2014 approaches, the activities will need to be enhanced in order to encompass the Medicaid expansion population. We are now making plans for just what that enhancement will look like. For example, it is possible that TennCare's External Quality Review Organization (EQRO), Qsource, will take on additional roles and responsibilities.

**c. Plans for evaluation activities under the extension.**

We will continue with the present outcome evaluation, with a couple of additions. First, the outcome indicators for the CHOICES LTSS population will be incorporated into the evaluation. Next, an analysis plan for the Medicaid expansion in 2014 will need to be developed. Since the characteristics of this population will be different from the characteristics for our current TennCare population, targets for our current goals and objectives may need to be revised. Additional goals and objectives for the expansion population may be needed as well.

## Part II: Narrative of Changes Being Requested

The State is not requesting any changes in the current Special Terms and Conditions of the demonstration other than those mentioned below.

We are aware that certain changes will need to be made to reference the new ACA eligibility group, effective January 1, 2014. It is our intention to consult with CMS about how best to incorporate these references.

CMS may wish to update certain items in the Special Terms and Conditions that are out-of-date. These items include references to demonstration categories that are now obsolete and references to CHOICES that are obsolete now that the program has been fully implemented. See Table 5.

**Table 5**
**Major Out-of-Date Items in Current STCs**

| Out-of-Date Item | Why Out-of-Date | References |
|---|---|---|
| The "Transition Group" | This group was established as a transition group at the time Amendment 2 was approved in 2005. There are no longer any persons in the group. | Paragraph 17 (Table 1a)<br>Paragraph 22 |
| The "Discontinued Demonstration Group" | This group was established as a transition group at the time Amendment 2 was approved in 2005. There are no longer any persons in the group. | Paragraph 17 (Table 1a)<br>Paragraph 23 |
| Readiness review for implementation of CHOICES | CHOICES was implemented in 2010. | Paragraph 34(h)(ii) |
| Table 8 | This table is entitled "Projected PMPM Costs Before CHOICES Implementation." CHOICES was implemented in 2010. | Paragraph 64(c) |

Also, we want the new STCs to clarify that enrollment into the "At Risk Demonstration Group" and Interim CHOICES 3 will be closed as of December 31, 2013. The State had requested this end date in Amendment 14 and was told that it could not be approved as part of Amendment 14 because December 31, 2013, is outside the time period for the current extension, which ends on June 30, 2013. Individuals enrolled in the At Risk Demonstration Group and in Interim CHOICES 3 as of December 31, 2013, may continue to qualify in this demonstration eligibility category and in this CHOICES group so long as the following criteria are met:

- They continue to meet Nursing Facility eligibility and the Level of Care (LOC) criteria in place when they enrolled; and
- They remain continuously enrolled in the At Risk Demonstration Group and in CHOICES Group 3.

Finally, certain Special Terms and Conditions contain tables that may need to be extended. The State's proposals for extending these tables are shown below.

1. **Table 4, paragraph 34(e)(i).** Proposed continuation numbers are provided in red font.

**Table 4—Enrollment Targets**

| Demonstration Year | Lower Limit | Upper Limit |
|---|---|---|
| DY 8 | 6,000 | 8,000 |
| DY 9 | 7,500 | 9,500 |
| DY 10 | 8,500 | 11,000 |
| DY 11 | 11,000[25] | 15,000[26] |
| DY 12 | 12,000 | 16,000 |
| DY 13 | 13,500 | 17,500 |
| DY 14 | 15,000 | 18,500 |

2. **Table 9, paragraph 64(c).** Continuation numbers are provided in red font.

**Table 9—Projected PMPM Costs After CHOICES Implementation**

| | Trend | DY 8 | DY 9 | DY 10 | DY 11 |
|---|---|---|---|---|---|
| EG1 Disabled | 5.82% | $1,253.79 | $1,326.76 | $1,403.98 | $1,485.69 |
| EG2 Over 65 | 5.01% | $843.92 | $886.20 | $930.60 | $977.22 |
| EG3 Children | 6.24% | $377.82 | $401.40 | $426.45 | $453.06 |
| EG 4 Adults | 6.05% | $733.56 | $777.94 | $825.01 | $874.92 |
| EG 5 Duals | 5.54% | $531.03 | $560.45 | $591.50 | $624.27 |
| EG6 Med Exp Child | 6.24% | $377.82 | $401.40 | $426.45 | $453.06 |

| | Trend | DY 12 | DY 13 | DY 14 |
|---|---|---|---|---|
| EG1 Disabled | 5.82% | $1,572.16 | $1,663.65 | $1,760.48 |
| EG2 Over 65 | 5.01% | $1,026.18 | $1,077.58 | $1,131.57 |
| EG3 Children | 6.24% | $481.33 | $511.36 | $543.27 |
| EG 4 Adults | 6.05% | $927.85 | $983.98 | $1,043.51 |
| EG 5 Duals | 5.54% | $658.86 | $695.36 | $733.88 |
| EG6 Med Exp Child | 6.24% | $481.33 | $511.36 | $543.27 |

3. **Table 10, paragraph 64(d).** Continuation numbers are provided in red font.

[25] Lower limit requested in Amendment 14.
[26] Upper limit requested in Amendment 14.

**Table 10—DSH Adjustments for DY 1 through DY 14**

| | DSH Adjustment (total computable) | DSH Adjustment (Federal share) |
|---|---|---|
| DY 1 | $413,700,907 | $268,409,148 |
| DY 2 | $479,893,052 | $310,106,890 |
| DY 3 | $479,893,052 | $310,538,794 |
| DY 4 | $479,893,052 | $308,091,339 |
| DY 5 | $479,356,649 | $305,451,928 |
| DY 6 (preliminary) | $479,657,638 | $305,451,928 |
| DY 7 (preliminary) | $485,299,094 | $311,270,839 |
| DY 8 (preliminary) | $488,969,517 | $319,052,610 |
| DY 9 (preliminary) | $470,369,327 | $309,408,043 |
| DY 10 (preliminary) | $463,996,853 | $305,451,928 |
| DY 11 (preliminary) | $463,996,853 | $305,451,928 |
| DY 12 (preliminary) | $463,996,853 | $305,451,928 |
| DY 13 (preliminary) | $463,996,853 | $305,451,928 |
| DY 14 (preliminary) | $463,996,853 | $305,451,928 |

## Part III: Waivers and Expenditure Authorities

The State is requesting the same waiver and expenditure authorities as those approved in the current demonstration.

## Part IV: Summaries of EQRO Reports, MCO and State Quality Assurance Monitoring, and Other Documentation of the Quality of and Access to Care Provided Under the Demonstration

### 1. Overview of Reports Used to Assess Quality and Access.

#### a. The EQRO.

The Balanced Budget Act of 1997 required that an EQRO monitor TennCare's health plans. The federally mandated activities are the Annual Quality Survey (AQS), Performance Measure Validation (PMV), Performance Improvement Project (PIP) Validation, Technical Report, and an Annual Provider Network Adequacy and Benefit Delivery Review (ANA).

The other activities of the EQRO are activities requested by TennCare: EPSDT Summary Report, HEDIS/CAHPS Report, Impact Analysis Report, and Provider Data Validation.

TennCare's current EQRO contractor is Qsource. Qsource monitors the MCOs and the DBM; it does not monitor the PBM.

Reports prepared regularly by the EQRO are described in Table 6 below.

**Table 6**
**Overview of Quality Monitoring Activities in Tennessee**

**a. EQRO Reports**

| Activity | Description | Frequency |
|---|---|---|
| **Annual Provider Network Adequacy and Benefit Delivery Review (ANA)** | The EQRO completes a review of each health plan regarding the adequacy of the provider network and the completeness of the communication with enrollees and providers about TennCare-covered services. This includes credentialing and recredentialing information. The EQRO completes this report at the direction of TDCI[27] with support from TennCare. The EQRO submits an individual report for each MCO and the DBM. The reporting period is the previous calendar | Annually |

[27] Tennessee Department of Commerce and Insurance.

| Activity | Description | Frequency |
|---|---|---|
| | year (for instance, January 1- December 31, 2011 was the reporting period for the 2012 ANA).[28] | |
| **Annual Quality Survey (AQS)** | The EQRO conducts an AQS of each MCO and DBM in order to determine the extent to which each MCO and the DBM is in compliance with the following:<br>▪ Contractor Risk Agreements with the State of Tennessee, Bureau of TennCare<br>▪ 42 CFR Parts 417.106, 430, 433, 434 and 438<br>▪ Quality standards and State mandates that include the *John B. Consent Decree* and the *Grier Revised Consent Decree*<br><br>The EQRO submits an individual report for each MCO and DBM and a summary report for the MCOs. The reporting period is the previous calendar year (for instance, January 1- December 31, 2009 was the reporting period for the 2010 AQS).[29] | Annually |
| **Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Summary Report** | Using data from EPSDT-related assessments conducted through the AQS and ANA processes, the EQRO compiles this single report documenting the EPSDT-specific activities conducted during the review period (the previous calendar year).[30] | Annually |
| **Performance Improvement Project (PIP) Validation** | Based on requirements set forth in the EQRO's contract with TennCare, the EQRO validates PIP(s) for each MCO and documents the findings in individual MCO reports. The EQRO utilizes the CMS publication entitled *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities, final protocol, Version 1.0, May 1, 2002* in order to assess each PIP's compliance with the requirements set forth in 42 CFR § 438.240(b)(1).[31] | Annually |
| **Performance Measure Validation** | For each MCO, the EQRO conducts PMV(s) and submits MCO-specific reports detailing the findings. To conduct | Annually |

[28] Annual Provider Network Adequacy and Benefit Delivery Review Reports (MCC-specific), State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report May 2011, prepared by Qsource).

[29] Annual Quality Survey Reports (MCC-specific and summary reports), State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource).

[30] EPSDT Summary Report, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource).

[31] PIP Validation Reports (MCO-specific and summary reports), State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report September 2011, prepared by Qsource).

| Activity | Description | Frequency |
|---|---|---|
| **(PMV)** | the PMV, the EQRO utilizes the most current volume of the National Committee for Quality Assurance's (NCQA) *HEDIS Compliance Audit: Standards, Policies, and Procedures.*[32] | |
| **EQRO Technical Report** | CMS requires the EQRO to summarize the quality, timeliness and access to care furnished by the TennCare MCOs and the DBM. This report utilizes the guidelines and specifications set forth by CMS to summarize the results of the federally mandated EQRO activities (ANA, AQS, PIP, and PMV).[33] | Annually |
| **Provider Data Validation (PDV)** | TennCare's contract with the EQRO requires the EQRO to conduct a provider data validation survey and submit a report documenting its findings. The purpose of this activity is to determine the accuracy of the provider data files submitted by the TennCare MCOs and the DBM and to use the results as an indication of the extent to which providers are available and accessible to TennCare enrollees. The EQRO conducts this activity and develops this report under the direction of TennCare's Office of Provider Services with support from Quality Oversight.[34] | Quarterly |
| **Healthcare Effectiveness Data and Information Set (HEDIS)/Consumer Assessment of Healthplan Providers and Systems (CAHPS) Summary Report** | The EQRO summarizes the results of the HEDIS/CAHPS data reported by TennCare MCOs. In addition to the data summary, the report includes an overview of MCO performance using the calculated weighted average of scores alongside national averages and comparisons across the State's MCOs. Starting in 2011, the EQRO will also produce a HEDIS/CAHPS Report for Consumers.[35] | Annually |
| **Impact Analysis** | This report examines federal and state activity that could impact the Bureau of TennCare and inform State policy.[36] | Annually |

[32] Annual Performance Measure Validation Reports (MCO specific), State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report September 2011, prepared by Qsource).

[33] Annual EQRO Technical Report, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report September 2011, prepared by Qsource).

[34] Provider Data Validation Reports, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced quarterly-last report 2012 quarter 1, April 2012, prepared by Qsource).

[35] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource). http://www.tn.gov/tenncare/forms/hedis11.pdf.

[36] Impact Analysis Report, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report 2011).

b. **Annual Beneficiary Survey.**

| Activity | Description | Frequency |
|---|---|---|
| **The Impact of TennCare: A Survey of Recipients** | This survey is used to capture satisfaction/access data beyond what is covered by CAHPS. TennCare contracts with the University of Tennessee Center for Business and Economic Research to survey approximately 5,000 Tennesseans each year, with most questions posed to the subset of that group who are TennCare members. The survey has been conducted since 1993, thereby allowing for long-term tracking of trends.[37] | Annually |

c. **EPSDT Medical Record Review.**

| Activity | Description | Frequency |
|---|---|---|
| **Report of Annual EPSDT Medical Record Review** | All children and youth under age 21 are eligible to receive EPSDT screens, and providers have been required to carry out and document the seven components of each EPSDT screen. Nursing consultants from TennCare's Division of Quality Oversight conduct the record reviews.[38] | Annually |

d. **CMS-416 Reports.**

| Activity | Description | Frequency |
|---|---|---|
| **Annual EPSDT Participation Report Form CMS-416** | This is a report compiled by CMS for each state and the nation as a whole. Tennessee completes its form CMS-416 in excel format and e-mails it to CMS on an annual basis. CMS collects basic information on Medicaid and CHIP programs to assess the effectiveness of EPSDT. Information on the number of individuals eligible for EPSDT services is collected as well as the number of children provided screening services, the number of | Annually |

[37] The Impact of TennCare: A Survey of Recipients, The University of Tennessee Center for Business and Economic Research (produced yearly-last report November 2011) http://cber.bus.utk.edu/tncare/tncare11.pdf.

[38] Report of Annual EPSDT Medical Record Review, Bureau of TennCare Division of Quality Oversight, July 2011.

| Activity | Description | Frequency |
|---|---|---|
| | children referred for medical treatment, and the number of children receiving dental services.[39] | |

e. **CHOICES Studies.**

A new component to our Quality Improvement Strategy has been added for the CHOICES program (required by STC 45c) in addition to a CHOICES Special Study (required by STC 69).

| Activity | Description | Frequency |
|---|---|---|
| **CHOICES Quality Improvement Strategy** | A number of measures were added to the 2011 Quality Assessment and Improvement Strategy to assure quality in the CHOICES program. These measures seek to assure that CHOICES 2 members have a level of care determination indicating the need for institutional services prior to enrollment in CHOICES and receipt of HCBS; members are offered a choice between institutional services and HCBS; plans of care are reviewed/updated at least annually; providers meet minimum qualifications; CHOICES 2 members/family members receive education at least annually about how to identify and report abuse, neglect and exploitation; critical incidents are reported within timeframes specified in Contractor Risk Agreement; MCO provider agreements meet uniform requirements; members are informed of and afforded rights to request a Fair Hearing when services denied, reduced, suspended or terminated. The CHOICES 3 group will be added when the strategy is updated in 2013.[40] | Annually |

[39] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html

[40] 2011 Quality Assessment and Performance Improvement Strategy and Quality Strategy: Annual Update Report, State of Tennessee Bureau of TennCare, 2011, pgs. 14-21. Implementation of the CHOICES program occurred in 2010. Group 1 is for individuals receiving services in a NF. These individuals are enrolled in TennCare Medicaid. Group 2 is for individuals who meet the NF level-of-care and are receiving HCBS as an alternative to Medicaid, if they are eligible for SSI, or TennCare Standard, if they are not SSI eligible but would qualify in the demonstration group for persons receiving HCBS who meet institutional income standards. A waiver amendment was submitted to CMS on March 1, 2012 to make certain changes to CHOICES Group 3, for those "at-risk" of NF care. CHOICES Group 3 was approved as part of the original program design, but the State has been prohibited from implementing this group due to federal maintenance of effort provisions of the ARRA and ACA.

| Activity | Description | Frequency |
|---|---|---|
| **CHOICES Special Study** | The CHOICES Special Study seeks to answer the question: *What is the effect of CHOICES on the use of institutional versus home- and community-based care?* It looks at the rebalancing of the long-term care system including impacts on utilization and cost. The study indicators include utilization-based measures and expenditure-based measures in order to determine the share of member months and expenditures in both CHOICES 1 and CHOICES 2 and the amount of movement in between the two groups. As with the Quality Strategy, this study will be altered in 2013 to include CHOICES Group 3.[41] | Annually |

**f. Pharmacy.**

| Activity | Description | Frequency |
|---|---|---|
| **Pharmacy Audits** | In the PBM contract that went into effect October 1, 2008, TennCare included a contractual requirement for the PBM to perform regular pharmacy audits. The PBM is responsible for performing desk audits on a quarterly basis, along with 10 field audits per quarter. The goal of these audits is to identify prescriptions that are incorrectly billed or that suggest fraud or abuse. Patterns identified during the audits can then be used to create new quantity limits aimed at preventing fraud and abuse. | Quarterly |

## 2. Summaries of Reports Used to Assess Quality and Access.

See Table 7 below.

[41] CHOICES Special Study for TennCare Health Plans, TennCare Division of Quality Oversight, Revised January 26, 2011.

**Table 7**
**Summaries of Report Findings on Quality and Access**

| Report | Date of Most Recently Completed Report | Summary | Follow up by the State, if Indicated |
|---|---|---|---|
| ANA | 2011 | Network Adequacy: MCOs scored between 99.5% and 99.9%; TennDent scored 100%.<br><br>Benefit Delivery: One MCO scored 99%; all the other MCOs scored 100%; TennDent scored 80.9%. | The Bureau required a Corrective Action Plan from TennDent to address its score. |
| AQS | 2011 | No plan rated fewer than 4 out of 5 stars on any standard or activity, with 5 being the highest rating. | Less than 100% compliance necessitates corrective action plan, which all plans submitted. |
| EPSDT Summary Report | 2011 | Strengths and Areas of Need were identified for each MCC in areas that include: member communication/outreach, tracking system, and program coordination. Several strengths identified, but areas of need also noted for Amerigroup, UnitedHealthcare and TennDent | Corrective action plans submitted as part of AQS and ANA (where EPSDT Summary Report data originate). |
| PIP Validation Report | 2011 | PIPs carried out during 2010: Follow-up for children prescribed ADHD medication (Amerigroup), Behavioral health postpartum depression screening (Volunteer State Health Plan), Improving compliance with continuing treatment for major depressive disorders (UnitedHealthcare). United had a validation status of "Met," Other MCOs had validation status of "Not Met." | Those with "Not Met" status required to submit corrective action plans. MCOs also given extensive technical assistance by TennCare quality staff. |
| Performance Measure Validation | 2011 | This is a report documenting the EQRO's yearly validation of two HEDIS measures. In 2010 these measures | |

| Report | Date of Most Recently Completed Report | Summary | Follow up by the State, if Indicated |
|---|---|---|---|
| Report | | were Breast Cancer Screening and Follow-up Care for Children Prescribed ADHD Medication (initiation phase). MCOs were in full compliance with all standards. | |
| EQRO Technical Report | 2011 | This is a summary document containing information for many of the specific measures collected by the EQRO that are noted in this table. | |
| Provider Data Validation | 2012 | This quarterly report documents accuracy rate for each audited provider data element: contract status, address, whether provider credentialed, panel status (open or closed), provides services to patients under 21/21+, provides primary care services, provides prenatal care services. Overall ratings for the most recent audit (first quarter 2012) ranged from 90.6% to 99.2%. | In the case where more than 10% of listed providers had incorrect data for a particular element, damages were assessed and/or a corrective action plan was required. |
| HEDIS/CAHPS Report | 2011 | This yearly report details NCQA-specified measures (by health plan) used to assess quality and effectiveness of health services. A number of these measures are discussed in the Interim Evaluation Report, most with very positive results over time. | Indicators needing improvement may be chosen by TennCare for use in Pay-for-Performance incentive payments (e.g. breast cancer screening), MCC may do PIP or they may be the focus of MCC Collaborative (where MCCs work jointly to address particular issues). |
| Impact Analysis Report | 2011 | The most recent report focuses on three major national and state-related issues with consequences for the TennCare program: healthcare reform, EHRs and ICD-10, and disparities in | |

| Report | Date of Most Recently Completed Report | Summary | Follow up by the State, if Indicated |
|---|---|---|---|
| | | health/healthcare services. | |
| UT Beneficiary Survey | 2011 | This is a statewide, not MCC-specific yearly survey, which found, for example, high rates of beneficiary satisfaction and high rates of beneficiaries first seeking care at doctor office/clinic rather than E.R. | |
| EPSDT Medical Record Review | 2011 | This record review was conducted with a statewide sample of medical records to ascertain provider compliance with carrying out and documenting seven components of each EPSDT screen. Statewide compliance rate for 2010 was 91.27%. | Although the rate is not calculated at the level of the individual provider, TennCare quality oversight staff educates providers in the sample with regards to elements that were found to be deficient during the medical record review. Corrective action plans are required from MCOs that are two or more standard deviations below the State average for any of the required seven components. |
| CMS-416 Reports | 2012 | These CMS-generated tables show that for fiscal year 2010, the screening ratio for Tennessee (total number of screens/expected number of screens for the eligible population) is nearly perfect at 0.99. (A ratio of 1.00 means that the total number of screens are identical to the number of screens that actually occurred). In comparison, the ratio for the nation as a whole is just 0.83. | |
| CHOICES Quality Improvement | 2011 | This data is currently being analyzed by TennCare's Long Term Services and | N/A |

| Report | Date of Most Recently Completed Report | Summary | Follow up by the State, if Indicated |
|---|---|---|---|
| Strategy (contained in 2011 Quality Assessment and Performance Improvement Strategy document) | | Supports Division and Quality Oversight Division. | |
| Choices Special Study for TennCare Health Plans (methodology document) | 2011 | This data is currently being analyzed by TennCare's Long Term Services and Supports Division and Quality Oversight Division. | N/A |

## Part V: Financial Data

With respect to Budget Neutrality assumptions and projections for the waiver extension, we have largely continued the trends as defined in the current extension.

The growth rate trends for each of the five eligibility groups included in the Baseline Per Member Per Month (PMPM) calculations are continued from the current waiver, using DY 11 as the base. Member months for Demonstration Year (DY) 12 for each of the five eligibility groups in Groups I and II are projected with a 1 percent increase over the member months projected for DY 10, the current DY, with no additional change projected for DY 13 and DY 14. The funding for the Disproportionate Share (DSH) adjustment is held constant with the DY10 level across DY 12, DY 13, and DY 14.

Section 2001 of the Affordable Care Act (ACA) requires the enrollment of many new Medicaid eligibles, beginning on January 1, 2014, which is six months into the new extension period. The State has discussed this issue with CMS, and no decision has yet been reached as to when or how to show the effects of this change. At such time as CMS and the State reach a mutually agreeable decision on this issue, we will provide an update that reflects the impact of ACA implementation on our Budget Neutrality assumptions and projections.

**TennCare Budget Neutrality (2003-2016)**
**(Note: Premiums have been subtracted)**

### I. The Baseline 2003-2007

**Baseline PMPM**

| | FY 2003 | FY 2004 | FY 2005 | FY 2006 | FY 2007 |
|---|---|---|---|---|---|
| Disabled (can be any ages) | $730.05 | $787.29 | $849.01 | $915.57 | $987.35 |
| 2-Child<=18 | $230.19 | $248.56 | $268.40 | $289.82 | $312.95 |
| 3-Adult>=65 | $317.64 | $337.27 | $358.11 | $380.24 | $403.74 |
| 4-Adult<=64 | $455.09 | $490.36 | $528.36 | $569.31 | $613.43 |
| Duals(17) | | | | $83.17 | $89.82 |

**Member Months of Groups I and II**

| Groups I & II | FY 2003 | FY 2004 | FY 2005 | FY 2006 | FY 2007 |
|---|---|---|---|---|---|
| 1-Disabled (can be any ages) | 1,995,204 | 2,050,765 | 2,078,035 | 2,006,317 | 1,981,596 |
| 2-Child <=18 | 6,618,606 | 6,607,161 | 6,685,162 | 7,039,017 | 7,100,528 |
| 3-Adult >=65 | 58,522 | 53,656 | 46,049 | 34,826 | 30,648 |
| 4-Adult<=64 | 2,146,506 | 2,519,172 | 2,720,294 | 3,082,138 | 3,041,436 |
| Duals (17) | | | | 1,206,933 | 2,279,536 |
| **Total** | **10,818,838** | **11,230,754** | **11,529,540** | **13,369,231** | **14,433,744** |

**Ceiling without DSH**

| | FY 2003 | FY 2004 | FY 2005 | FY 2006 | FY 2007 |
|---|---|---|---|---|---|
| 1-Disabled (can be any ages) | $1,456,598,680 | $1,614,546,777 | $1,764,272,495 | $1,836,923,656 | $1,956,528,811 |
| 2-Child <=18 | $1,523,536,915 | $1,642,275,938 | $1,794,297,481 | $2,040,047,907 | $2,222,110,238 |
| 3-Adult >=65 | $18,588,928 | $18,096,559 | $16,490,607 | $13,242,238 | $12,373,824 |
| 4-Adult<=64 | $976,853,416 | $1,235,301,182 | $1,437,294,538 | $1,754,691,985 | $1,865,708,085 |
| Duals (17) | | | | $100,380,618 | $204,747,924 |
| **Total** | **$3,975,577,939** | **$4,510,220,456** | **$5,012,355,121** | **$5,745,286,403** | **$6,261,468,881** |

DSH

| DSH Adjustment | FY 2003 | FY 2004 | FY2005 | FY 2006 | FY 2007 |
|---|---|---|---|---|---|
| Total | $413,700,907 | $479,893,052 | $479,893,052 | $479,893,052 | $479,893,052 |

Total Ceiling

| Budget Neutrality Cap | FY 2003 | FY 2004 | FY2005 | FY 2006 | FY 2007 |
|---|---|---|---|---|---|
| Total w/DSH Adj. | $4,389,278,846 | $4,990,113,508 | $5,492,248,173 | $6,225,179,455 | $6,741,361,933 |

## I. The Baseline 2008-2010

**Note: CHOICES PMPM for Middle Region is included in FY2010 (Mar-June)**

**Baseline PMPM**

| | FY 2008 | FY 2009 | FY 2010 (July-Feb) | FY 2010 (March-June) |
|---|---|---|---|---|
| Disabled (can be any ages) | $1,055.48 | $1,128.31 | $1,206.16 | $1,253.79 |
| 2-Child<=18 | $333.23 | $354.82 | $377.81 | $377.82 |
| 3-Adult>=65 | $428.69 | $455.18 | $483.31 | $843.92 |
| 4-Adult<=64 | $651.03 | $690.94 | $733.29 | $733.56 |
| Duals(17) | $95.81 | $102.20 | $109.02 | $531.03 |

**Member Months of Groups I and II**

| Groups I & II | FY 2008 | FY 2009 | FY 2010 (July-Feb) | FY 2010 (March-June) |
|---|---|---|---|---|
| 1-Disabled (can be any ages) | 1,946,150 | 1,944,260 | 1,103,020 | 489,276 |
| 2-Child <=18 | 7,043,034 | 7,310,961 | 4,865,391 | 2,538,340 |
| 3-Adult >=65 | 23,843 | 19,148 | 8,117 | 5,103 |
| 4-Adult<=64 | 3,054,558 | 2,895,697 | 2,214,292 | 1,130,748 |
| Duals (17) | 2,351,021 | 2,367,131 | 1,341,198 | 539,186 |
| **Total** | **14,418,606** | **14,537,197** | **9,532,017** | **4,702,653** |

**Ceiling without DSH**

| | FY 2008 | FY 2009 | FY 2010 (July-Feb) | FY 2010 (March-June) |
|---|---|---|---|---|
| 1-Disabled (can be any ages) | $2,054,122,402 | $2,193,728,001 | $1,330,418,000 | $613,449,356 |
| 2-Child <=18 | $2,346,950,220 | $2,594,075,182 | $1,838,193,468 | $959,035,619 |
| 3-Adult >=65 | $10,221,256 | $8,715,787 | $3,923,027 | $4,306,524 |
| 4-Adult<=64 | $1,988,608,895 | $2,000,752,885 | $1,623,717,997 | $829,471,503 |
| Duals (17) | $225,251,322 | $241,920,788 | $146,217,351 | $286,323,942 |
| **Total** | **$6,625,154,094** | **$7,039,192,643** | **$4,942,469,844** | **$2,692,586,943** |

DSH

| DSH Adjustment | FY 2008 | FY 2009 | FY2010 |
|---|---|---|---|
| Total | $479,657,658 | $485,299,094 | $488,969,517 |

Total Ceiling

| Budget Neutrality Cap | FY 2008 | FY 2009 | FY 2010 |
|---|---|---|---|
| Total w/DSH Adj. | $7,104,811,752 | $7,524,491,737 | $8,124,026,304 |

## I. The Baseline 2011-2013

**Baseline PMPM**

| | FY 2011 | FY 2012 | FY 2012 Projected | FY 2013 Projected |
|---|---|---|---|---|
| Disabled (can be any ages) | $1,326.76 | $1,403.98 | $1,403.98 | $1,485.69 |
| 2-Child<=18 | $401.40 | $426.45 | $426.45 | $453.06 |
| 3-Adult>=65 | $886.20 | $930.60 | $930.60 | $977.22 |
| 4-Adult<=64 | $777.94 | $825.01 | $825.01 | $874.92 |
| Duals(17) | $560.45 | $591.50 | $591.50 | $624.27 |

**Member Months of Groups I and II**

| Groups I & II | FY 2011 | FY 2012 Actual | FY 2012 Projected | FY 2013 Projected |
|---|---|---|---|---|
| 1-Disabled (can be any ages) | 1,504,522 | 767,336 | 1,534,672 | 1,786,250 |
| 2-Child <=18 | 8,026,649 | 4,022,195 | 8,044,390 | 6,943,137 |
| 3-Adult >=65 | 14,895 | 7,025 | 14,050 | 5,232 |
| 4-Adult<=64 | 3,432,624 | 1,732,807 | 3,465,614 | 3,396,483 |
| Duals (17) | 1,640,349 | 821,633 | 1,643,266 | 2,557,814 |
| **Total** | **14,619,039** | **7,350,996** | **14,701,992** | **14,688,916** |

**Ceiling without DSH**

| | FY 2011 | FY 2012 Actual | FY 2012 Projected | FY 2013 Projected |
|---|---|---|---|---|
| 1-Disabled (can be any ages) | $1,996,139,609 | $1,077,324,397 | $2,154,648,795 | $2,653,813,763 |
| 2-Child <=18 | $3,221,896,909 | $1,715,265,058 | $3,430,530,116 | $3,145,657,649 |
| 3-Adult >=65 | $13,199,949 | $6,537,465 | $13,074,930 | $5,112,815 |
| 4-Adult<=64 | $2,670,375,515 | $1,429,583,103 | $2,859,166,206 | $2,971,650,906 |
| Duals (17) | $919,333,597 | $485,995,920 | $971,991,839 | $1,596,766,546 |
| **Total** | **$8,820,945,578** | **$4,714,705,943** | **$9,429,411,885** | **$10,373,001,679** |

**DSH**

| DSH Adjustment | FY 2011 | FY 2012 Actual | FY2012 Projected | FY2013 Projected |
|---|---|---|---|---|
| Total | $470,369,327 | $231,998,427 | $463,996,853 | $463,996,853 |

**Total Ceiling**

| Budget Neutrality Cap | FY 2011 | FY 2012 Actual | FY 2012 Projected | FY 2013 Projected |
|---|---|---|---|---|
| **Total w/DSH Adj.** | **$9,291,314,905** | **$4,946,704,369** | **$9,893,408,738** | **$10,836,998,532** |

## I. The Baseline 2014-2016

| Annual Trends Used in Baseline PMPM Projections, FY 2014 – FY 2016 | |
|---|---|
| Disabled (can be any ages) | 5.82% |
| 2-Child<=18 | 6.24% |
| 3-Adult>=65 | 5.01% |
| 4-Adult<=64 | 6.05% |
| Duals(17) | 5.54% |

**Baseline PMPM**

| | FY 2014 Projected | FY 2015 Projected | FY 2016 Projected |
|---|---|---|---|
| Disabled (can be any ages) | $1,572.16 | $1,663.65 | $1,760.48 |
| 2-Child<=18 | $481.33 | $511.36 | $543.27 |
| 3-Adult>=65 | $1,026.18 | $1,077.58 | $1,131.57 |
| 4-Adult<=64 | $927.85 | $983.98 | $1,043.51 |
| Duals(17) | $658.86 | $695.36 | $733.88 |

**Member Months of Groups I and II**

| Groups I & II | FY 2014 Projected | FY 2015 Projected | FY 2016 Projected |
|---|---|---|---|
| 1-Disabled (can be any ages) | 1,550,019 | 1,550,019 | 1,550,019 |
| 2-Child <=18 | 8,124,834 | 8,124,834 | 8,124,834 |
| 3-Adult >=65 | 14,191 | 14,191 | 14,191 |
| 4-Adult<=64 | 3,500,270 | 3,500,270 | 3,500,270 |
| Duals (17) | 1,659,699 | 1,659,699 | 1,659,699 |
| **Total** | **14,849,012** | **14,849,012** | **14,849,012** |

**Ceiling without DSH**

| | FY 2014 Projected | FY 2015 Projected | FY 2016 Projected |
|---|---|---|---|
| 1-Disabled (can be any ages) | $2,436,870,342 | $2,578,693,357 | $2,728,770,305 |
| 2-Child <=18 | $3,910,729,828 | $4,154,754,967 | $4,414,007,001 |
| 3-Adult >=65 | $14,561,944 | $15,291,449 | $16,057,500 |
| 4-Adult<=64 | $3,247,723,434 | $3,444,198,479 | $3,652,559,524 |
| Duals (17) | $1,093,501,604 | $1,154,083,256 | $1,218,021,225 |
| **Total** | **$10,703,387,151** | **$11,347,021,508** | **$12,029,415,555** |

**DSH**

| DSH Adjustment | FY 2014 Projected | FY 2015 Projected | FY2016 Projected |
|---|---|---|---|
| **Total** | $463,996,853 | $463,996,853 | $463,996,853 |

**Total Ceiling**

| Budget Neutrality Cap | FY 2014 Projected | FY 2015 Projected | FY 2016 Projected |
|---|---|---|---|
| **Total w/DSH Adj.** | **$11,167,384,004** | **$11,811,018,361** | **$12,493,412,408** |

## II. Actual Experience

**2003-2007**

| Schedule C Reports | FY 2003 | FY 2004 | FY 2005 | FY 2006 | FY 2007 |
|---|---|---|---|---|---|
| Schedule C - Services (including drug rebates & premiums) | $2,918,489,924 | $4,767,439,313 | $3,515,173,372 | $3,553,329,225 | $3,774,856,521 |
| Schedule C - Pool payments and Admin | $670,147,871 | $765,484,916 | $860,964,598 | $731,067,879 | $682,605,192 |
| Schedule C -- TOTAL (both FMAP and admin) | $3,588,637,795 | $5,532,924,229 | $4,376,137,970 | $4,284,397,104 | $4,457,461,713 |
| Premium Collections Reported on CMS-64 Summary, Line 9E | $51,078,297 | $37,017,558 | $28,173,531 | $10,497,520 | $5,654,183 |
| **Schedule C Net of Premium Collections, Total Computable** | **$3,537,559,498** | **$5,495,906,671** | **$4,347,964,439** | **$4,273,899,584** | **$4,451,807,530** |

**2008-2012**

| Group 1 and 2 | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 Q1-Q2 | FY 2012 |
|---|---|---|---|---|---|---|
| 1-Disabled (can be any ages) | $1,431,705,596 | $1,543,027,265 | $1,549,907,539 | $1,761,238,295 | $885,893,490 | $1,771,786,980 |
| 2-Child <=18 | $1,158,903,371 | $1,294,467,233 | $1,434,117,751 | $1,381,469,818 | $746,334,590 | $1,492,669,180 |
| 3-Adult >=65 | $9,608,405 | $9,495,474 | $43,683,766 | $36,874,554 | $14,904,570 | $29,809,140 |
| 4-Adult<=64 | $1,059,521,141 | $1,015,532,446 | $1,198,014,788 | $1,187,599,744 | $624,577,094 | $1,249,154,188 |
| Duals (17) | $331,585,163 | $389,298,464 | $507,472,557 | $1,494,242,311 | $757,243,350 | $1,514,486,700 |
| **Total** | **$3,991,323,676** | **$4,251,820,882** | **$4,733,196,401** | **$5,861,424,722** | **$3,028,953,094** | **$6,057,906,188** |

| Group 3 | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 Q1-Q2 | FY 2012 |
|---|---|---|---|---|---|---|
| 1-Disabled (can be any ages) | $0 | $0 | $0 | $0 | $0 | $0 |
| 2-Child <=18 | $11,060,683 | $3,066,409 | $3,285,240 | $3,153,048 | $2,364,001 | $4,728,002 |
| 3-Adult >=65 | $0 | $0 | $0 | $0 | $0 | $0 |
| 4-Adult<=64 | $3,278,887 | $1,859,013 | $804,766 | $1,027,139 | $425,528 | $851,056 |
| Duals (17) | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total** | **$14,339,570** | **$4,925,422** | **$4,090,006** | **$4,180,187** | **$2,789,529** | **$5,579,058** |

| Pool Payments and Admin | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 Q1-Q2 | FY 2012 |
|---|---|---|---|---|---|---|
| Total Pool Payments | $563,755,906 | $607,735,588 | $583,184,390 | $574,357,772 | $236,426,239 | $574,357,772 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Quarterly Premium Collections | $983,165.68 | $116,389.00 | $116,389.00 | | | |
| Total Net Quarterly Expenditures | $4,568,435,986 | $4,864,365,503 | $5,320,354,408 | $6,439,962,681 | $3,268,168,862 | $6,637,843,018 |

III. Surplus
2003-2007

| Surplus/ (Deficit) | FY 2003 | FY 2004 | FY 2005 | FY 2006 | FY 2007 |
|---|---|---|---|---|---|
| Surplus/ (Deficit) – per FY | $851,719,348 | ($505,793,163) | $1,144,283,734 | $1,951,279,871 | $2,289,554,403 |
| Surplus/ (Deficit) - Cumulative | N/A | $345,926,185 | $1,490,209,919 | $3,441,489,790 | $5,731,044,193 |

2008-2012

| Surplus/ (Deficit) | FY 2008 | FY 2009 | FY 2010 | FY 2011 | FY 2012 Q1-Q2 | FY 2012 |
|---|---|---|---|---|---|---|
| Surplus/ (Deficit) – per FY | $2,536,375,766 | $2,660,126,234 | $2,803,671,896 | $2,851,352,224 | $1,678,535,507 | $3,255,565,720 |
| Surplus/ (Deficit) - Cumulative | $8,267,419,959 | $10,927,546,193 | $13,731,218,089 | $16,582,570,313 | | $19,838,136,033 |

## Part VI: Interim Evaluation Report

The heart of TennCare's program evaluation involves outcome measures designed to determine whether program goals and objectives contained in the TennCare Evaluation Plan submitted to CMS and approved on March 31, 2008 have been met. Performance measures are those specified in the Quality Improvement Strategy (QIS).

We first discuss our medical and behavioral health measures. Then we discuss measures related to program efficiency, stability and viability. Finally, we speak to new measures being introduced for the TennCare CHOICES program.

### 1. Medical and behavioral health measures.

| Goals | Objectives | Progress to Date |
|---|---|---|
| 1. Assure appropriate access to care for enrollees. | 1.1 By 2013, the statewide weighted HEDIS rate for adults' access to preventive/ambulatory health services will increase to 75% for enrollees 20-44 years old and the rate for enrollees 45-64 years old will be maintained at 79% or above.[42] *(2007 baseline=70% for ages 20-44; 74% for ages 45-64)* | In 2010, the rate was 79.50% for enrollees 20-44 years old and 79.89% for enrollees 45-64 years old.<br><br>**Better than baseline**<br>**2013 objective met** |
| | 1.2 By 2013, the statewide weighted HEDIS rate for children and adolescents' access to PCPs will increase to 90% for enrollees 7-11 years old and 86% for enrollees 12-19 years old.[43] *(2007 baseline=87% for ages 7-11, 82% for ages 12-19)* | In 2010, the rate was 91.43% for enrollees 7-11 years old and 87.22% for enrollees 45-64 years old.<br><br>**Better than baseline**<br>**2013 objective met** |

[42] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource). See http://www.tn.gov/tenncare/forms/hedis11.pdf.
[43] Ibid.

| Goals | Objectives | Progress to Date |
|---|---|---|
| | 1.3 By 2013, 97% of TennCare heads of household and 98% or greater of TennCare children will go to a doctor or clinic when they are first seeking care rather than a hospital (emergency room).[44] *(2007 baseline=94% for heads of household, 97% for children)* | In 2010, the rate was 92% for heads of household and 97% for children.<br><br>**Same as baseline (children)**<br>**Not better than baseline (heads)**<br>**2013 objective not yet met** |
| 2. Provide quality care to enrollees. | 2.1 By 2013, the statewide weighted HEDIS rate for adolescent well-care visits will increase to 41%.[45] *(2007 baseline=35%)* | In 2010, the rate was 41.1%<br><br>**Better than baseline**<br>**2013 objective met** |
| | 2.2 By 2013, the statewide weighted HEDIS rate for timeliness of prenatal care will be maintained at 82% or above.[46] *(2007 baseline=78%)* | In 2010, the rate was 81.06%<br><br>**Better than baseline**<br>**2013 objective not yet met** |
| | 2.3 By 2013, the statewide weighted HEDIS rate for breast cancer screening will increase to 50%.[47] *(2007 baseline=44%)* | In 2010, the rate was 38.45%<br><br>**Not better than baseline**<br>**2013 objective not yet met** |
| | 2.4 By 2013, the statewide weighted HEDIS rate for cervical cancer screening will increase to 68%.[48] *(2007 baseline=63%)* | In 2010, the rate was 61.30%<br><br>**Not better than baseline**<br>**2013 objective not yet met** |
| | 2.5 By 2013, providers of EPSDT screening services will document the delivery of 95% of the required seven components of an EPSDT screen.[49] *(2007 baseline=89%)* | In 2010, the rate was 94%.<br><br>**Better than baseline**<br>**2013 objective not yet met** |

[44] The Impact of TennCare: A Survey of Recipients, The University of Tennessee Center for Business and Economic Research (produced yearly-last report November 2011). See http://cber.bus.utk.edu/tncare/tncare11.pdf.
[45] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource). See http://www.tn.gov/tenncare/forms/hedis11.pdf.
[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] Report of Annual EPSDT Medical Record Review, Bureau of TennCare Division of Quality Oversight, July 2011.

| Goals | Objectives | Progress to Date |
|---|---|---|
| 3. Assure enrollees' satisfaction with services. | 3.1 By 2013, 95% of TennCare enrollees will be satisfied with TennCare.[50] *(2007 baseline=90%)* | In 2010, the rate was 94%.<br><br>**Better than baseline**<br>**2013 objective not yet met** |
| | 3.2 By 2013, the statewide average for adult CAHPS getting needed care-always or usually-will increase to 82%.[51] *(2007 baseline=78%)* | In 2010, the rate was 76.6%<br><br>**Not better than baseline**<br>**2013 objective not yet met** |
| | 3.3 By 2013, the statewide average for child CAHPS getting care quickly-always or usually-will increase to 81%.[52] *(2007 baseline=79%)* | In 2010, the rate was 88.78%<br><br>**Better than baseline**<br>**2013 objective met** |
| 4. Improve health care for program enrollees. | 4.1 By 2013, the statewide weighted HEDIS rate for HbA1c testing will be maintained at 73% or above.[53] *(2007 baseline=68%)* | In 2010, the rate was 77.93%<br><br>**Better than baseline**<br>**2013 objective met** |
| | 4.2 By 2013, the statewide weighted HEDIS rate for controlling high blood pressure will increase to 55%.[54] *(2007 baseline=50%)* | In 2010, the rate was 53.67%<br><br>**Better than baseline**<br>**2013 objective not yet met** |
| | 4.3 By 2013, the statewide weighted HEDIS rate for follow-up after hospitalization for mental illness will be maintained at 51% for follow-up within 7 days of discharge and 72% for follow-up within 30 days of discharge.[55] | In 2010, the 7-day rate was 37.93% and the 30-day rate was 61.24%<br><br>**2010 is baseline**<br>**2013 objective not yet met** |

[50] The Impact of TennCare: A Survey of Recipients, The University of Tennessee Center for Business and Economic Research (produced yearly-last report November 2011). See http://cber.bus.utk.edu/tncare/tncare11.pdf.
[51] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource). See http://www.tn.gov/tenncare/forms/hedis11.pdf.
[52] Ibid.
[53] Ibid.
[54] Ibid.
[55] Ibid.

| Goals | Objectives | Progress to Date |
|---|---|---|
| | 4.4 By the end of each demonstration year, the state will achieve a total statewide EPSDT screening rate of at least 80%.[56] *(2007 baseline=77%)* | In 2010, the rate was 99%<br><br>**Better than baseline**<br>**2013 objective met** |
| | 4.5 By 2013, the statewide weighted HEDIS rate for antidepressant medication management will be maintained at 63% for acute phase and 48% for continuation phase.[57] | In 2010, the rate was 50.11% for acute phase and 32.03% for continuation phase<br><br>**2010 is baseline**<br>**2013 objective not yet met** |
| | 4.6 By 2013, the statewide weighted HEDIS rate for follow-up care for children prescribed ADHD medication will be maintained at 36% for initiation and 46% for continuation and maintenance.[58] | In 2010, the rate was 34.29 for acute phase and 44.15 for continuation phase<br><br>**2010 is baseline**<br>**2013 objective not yet met** |

## 2. Efficiency, stability and viability measures.

| Goals | Objectives | Progress to Date |
|---|---|---|
| 1. Use a managed care approach to provide services to Medicaid State Plan and Demonstration eligibles at a cost | | **During the course of the Demonstration, budget neutrality has been successfully maintained and reported in each Quarterly Report submitted to CMS in fulfillment of STC #47.** |

[56] Report of Annual EPSDT Medical Record Review, Bureau of TennCare Division of Quality Oversight, July 2011.
[57] HEDIS/CAHPS Report: Comparative Analysis of Audited Results from TennCare MCOs, State of Tennessee, Department of Finance and Administration, Bureau of TennCare (produced yearly-last report August 2011, prepared by Qsource). See http://www.tn.gov/tenncare/forms/hedis11.pdf.
[58] Ibid.

| Goals | Objectives | Progress to Date |
|---|---|---|
| that does not exceed what would have been spent in a Medicaid fee-for-service program. | | |
| 2. Assure that health plans maintain stability and viability while meeting all contract and program requirements. | 2.1 By 2013, 100% of the TennCare MCCs will have demonstrated compliance with statutory and/or contractual claims processing timeliness standards in at least 10 out of 12 months in a calendar year. *(2010 baseline=80%)* | In 2011, the rate was 83%.<br><br>**Better than baseline**<br>**2013 objective not yet met** |
| | 2.2 By 2013, the MCCs will report a compliance rate of 95% for all contractual claims payment accuracy reports. *(2010 baseline=91.5%)* | In 2011, the rate was 87.9%<br><br>**Not better than baseline***<br>**2013 objective not yet met** |

*3.6% decline in accuracy over the year appears to be a temporary phenomenon attributable to the start-up of the CHOICES program. The start-up of this program, which resulted in some early claims payment challenges, caused a short-term decline in accuracy. This has been resolved and should show improvement in the future.

**3. Evaluation for CHOICES program.**

When the CHOICES** program was added as part of the TennCare waiver, CMS requested that a CHOICES Special Study for TennCare Health Plans be added to the evaluation design. The question that the study seeks to answer, through a combination of membership, utilization and expenditure data, is this:

> *What is the effect of CHOICES on the use of institutional versus home- and community-based care?*

The first wave of data for our special study is currently being analyzed. In the table below, we list the study indicators.

**Choices Special Study**

| Study Indicators | Denominator | Numerator(a) | Numerator (b) | Numerator (c) |
|---|---|---|---|---|
| 1. Individual-level utilization-based measures (descriptive demographics) | Member months of all eligible CHOICES users at date of measurement/12 | Member months of all eligible CHOICES users in Group 1 at date of measurement/12 | Member months of all eligible CHOICES users in Group 2 at date of measurement/12 | |
| 2. Overall expenditure-based measures (evaluates population expenditures for Group 1 and 2) | Total dollar amount of CHOICES expenditures for Group 1 and 2 services rendered to CHOICES members | Dollar amount of all CHOICES expenditures for Group 1 services rendered to Group 1 members | Dollar amount of all CHOICES expenditures for Group 2 services rendered to Group 2 members | |
| 3. Individual-level utilization and expenditure-based measures combined (actual dollar amounts calculated as a figure of the number of months in the measurement period for a per-user-per month expression) | (a) member months of all eligible CHOICES users at time of measurement/12 (b) member months of eligible CHOICES users in Group 1 at date of measurement/12 (c) member months of eligible CHOICES users in Group 2 at date of measurement/12 | Total dollar amount of CHOICES expenditures for Group 1 and 2 services | Dollar amount of all CHOICES expenditures for Group 1 services rendered to Group 1 members | Dollar amount of all CHOICES expenditures for Group 2 services rendered to Group 2 members |
| 4. Transition in level of care from Group 1 to Group 2 (evaluates the number of Group 1 users who transition from Group 1 to Group 2 for a specified time frame) | Number of unique members eligible for CHOICES Group 1 during measurement period | Number of unique CHOICES members who transition from Group 1 to Group 2 | Number of CHOICES members who transition from Group 1 to Group 2 and remain in Group 2 for 90 days or longer | |
| 5. Transition in level of care from Group 2 to Group 1 (evaluates the number of Group 2 users who | Number of unique members eligible at any time for CHOICES | Number of CHOICES members who transition from | Number of CHOICES users who transition from Group 2 to | (c) Number of CHOICES users who transition from Group 2 to |

| Study Indicators | Denominator | Numerator(a) | Numerator (b) | Numerator (c) |
|---|---|---|---|---|
| transition from Group 2 to Group 1 for a specified time frame) | Group 2 during measurement period | Group 2 to Group 1 | Group 1 and remain in Group 1 for less than 90 days | Group 1 and remain in Group 1 between 90 and 179 days (d) Number of CHOICES users who transition from Group 2 to Group 1 and remain in Group 1 for 180 days or longer |

We would like to note that we already have some preliminary outcome-related data that shows the CHOICES program has been quite effective in rebalancing enrollment in favor of home- and community-based care, as shown in the table below.

**CHOICES 1 and 2 Membership****

| | February 2010 (pre-CHOICES) | April 2012 |
|---|---|---|
| CHOICES 1 (NF) | 23,076 (82.6%) | 20,763 (66.5%) |
| CHOICES 2 (HCBS) | 4,861 (17.4%) | 10,438 (33.5%) |

** Implementation of the CHOICES program occurred in the Middle Grand region on March 1, 2010, and in the East and West regions on August 1, 2010.
Initial implementation included two CHOICES groups and a recent waiver amendment request will allow the State to implement a third group, effective July 1, 2012:

Group 1 is for individuals receiving services in a nursing facility. These individuals are enrolled in TennCare Medicaid.

Group 2 is for individuals who meet the nursing facility level-of-care and are receiving home and community-based services as an alternative to Medicaid, if they are eligible for SSI, or TennCare Standard, if they are not SSI-eligible.

A waiver amendment was submitted to CMS on March 1, 2012 to make certain modifications to CHOICES Group 3, for those "at risk" of nursing facility care as well. This group was part of the original approved program design but had not been implemented due to federal maintenance of effort (MOE) provisions. These changes will allow the State to comply with MOE provisions and open CHOICES Group 2 for enrollment.

## Part VII: Documentation of the State's Compliance with the Public Notice Process

The Bureau of TennCare has used multiple mechanisms to inform interested parties about the waiver extension application and to solicit public input. These public notice and public input procedures were developed to ensure compliance with the requirements specified at 42 CFR § 431.408.

### 1. Public Notice and Input Procedures.

The State's 30-day public notice and comment period began on May 7, 2012. A comprehensive description of the extension to be submitted to CMS was made available for public review and comment on an extension-specific Web page on the TennCare Web site. An easily identifiable link on TennCare's home page was used to refer users to the extension Web page. This extension-specific Web page, which was maintained and updated throughout the public comment and review process, included all of the following:

- The physical locations and Internet address where copies of the extension request were available for public review;
- A mailing address, email address, and telephone number available for making public comments on the extension (along with instructions for requesting copies of public comments received);
- The locations, dates, and times of two public hearings to seek public comment on the extension; and
- Information about the State's public notice process, public input process, and a link to the relevant demonstration page on CMS's Web site.

Furthermore, the State developed an abbreviated public notice including a summary description of the demonstration, the locations, dates, and times of the two public hearings, and a link to the full public notice on the extension Web page. This abbreviated public notice was published in *The Tennessee Administrative Register* and in the newspapers of widest circulation in the eight Tennessee cities with 50,000 or more citizens.

The State used several additional mechanisms to inform interested parties of the waiver extension process.

- The State's Medical Care Advisory Committee discussed the waiver extension in a meeting that took place on April 11, 2012.
- On April 24, 2012, the State convened a statewide conference call with stakeholders that included information about the waiver extension. This conference call included representatives of the Tennessee Medical Association, the Tennessee Hospital Association, TennCare's current MCOs, and others.

- On May 8, 2012, the State shared information about the waiver extension and a link to the full public notice on the extension Web page via Facebook and Twitter to individuals who have elected to receive updates about the TennCare program through these media.
- On May 9, 2012, the State disseminated information about the waiver extension to representatives of more than 25 agencies and advocacy organizations, including the Tennessee Disability Coalition, the Rural Health Association of Tennessee, the Tennessee Mental Health Consumers Organization, and others through an e-mail list maintained by the State. Some of these organizations were also represented at a meeting convened by the State on May 8, 2012, during which information about the extension was shared.
- On May 10, 2012, the Bureau notified members of the Tennessee General Assembly of the waiver extension by e-mail and encouraged members to review the full public notice and draft extension request on the Bureau of TennCare's Web site.

The Bureau of TennCare held two public hearings to seek public comment on the waiver extension. The first hearing took place on May 15, 2012, at 10:00 a.m. CT at the Bordeaux Branch Library, 4000 Clarksville Pike in Nashville. The second public hearing took place on May 22, 2012, at 2:30 p.m. CT at the Ellington Agricultural Center, 440 Hogan Road in Nashville. The times, dates, and locations of both public hearings were included in the State's public notice and abbreviated public notice. Telephonic access to the May 22, 2012, hearing was available for individuals unable to attend the hearing in person. The State's public notices encouraged persons with disabilities needing special accommodations in order to participate in the hearings to contact the Bureau to ensure that appropriate accommodations could be arranged.

Tennessee has no Federally-recognized Indian tribes, Indian health programs, or urban Indian health organizations with which to consult or from which to seek advice.

Table 8 summarizes the State's public notice and public input processes for this waiver extension request.

**Table 8. Summary of Public Notice and Input Processes**

| Public Notice and Input Component | Date | Requirement |
|---|---|---|
| MCAC discussed waiver extension | April 11, 2012 | 42 CFR § 431.408(a)(2)(iii) |
| Information about waiver extension provided to stakeholders via conference call | April 24, 2012 | 42 CFR § 431.408(a)(2)(iii) |
| Abbreviated public notice sent to newspapers for publication | May 4, 2012 | 42 CFR § 431.408(a)(2)(ii) |
| Public notice and comment period began<br><br>Extension-specific Web site launched, including a comprehensive description of the waiver extension, the State's public notice and public input processes, and other required information | May 7, 2012 | 42 CFR § 431.408(a)(1)<br>42 CFR § 431.408(a)(2)(i) |

| Public Notice and Input Component | Date | Requirement |
|---|---|---|
| Abbreviated public notice appeared in the State's *Administrative Register* | May 7, 2012 | 42 CFR § 431.408(a)(2)(ii) |
| TennCare Facebook friends and Twitter followers notified of waiver extension | May 8, 2012 | 42 CFR § 431.408(a)(2)(iii) |
| Information about waiver extension provided to stakeholders at meeting of state advocacy organizations | May 8, 2012 | 42 CFR § 431.408(a)(2)(iii) |
| Information about waiver extension disseminated to stakeholders via e-mail list to state agencies and advocacy organizations | May 9, 2012 | 42 CFR § 431.408(a)(2)(iii) |
| Members of the Tennessee General Assembly notified of waiver extension | May 10, 2012 | 42 CFR § 431.408(a)(2)(iii) |
| First public hearing held | May 15, 2012 | 42 CFR § 431.408(a)(3) |
| Second public hearing held | May 22, 2012 | 42 CFR § 431.408(a)(3) |
| Public notice and comment period ends | June 7, 2012 | 42 CFR 431.408(a)(1) |

Materials documenting the State's compliance with public notice and input requirements are available upon request.

### 2. Issues Raised by the Public During the Public Notice and Input Period

The Bureau's public notice and comment period began on May 7, 2012, and lasted through June 7, 2012. During this time, the draft extension request was available for public review and comment on an extension-specific Web page. The Bureau made arrangements and was prepared to receive public comments submitted through mail, e-mail, telephone, and at the two public hearings.

The Bureau received no comments from the public on the waiver extension through mail, e-mail, or telephone. No members of the public attended the first public hearing. One individual attended the second public hearing; however, he did not offer any comments on the waiver extension.

As noted elsewhere in this document, this request seeks to extend the existing TennCare program. We believe that the lack of comments from the public—despite the multiple opportunities to provide public input—reflects the public's familiarity with the TennCare program and the principles upon which the program is organized. The Bureau will work with CMS to consider public input received during the federal public notice process.

### 3. Post-Award Public Input Process

The Bureau of TennCare will comply with all post-award public input requirements. Within six months of the renewal of the TennCare demonstration (anticipated to begin on July 1, 2013), the Bureau will hold a public forum to solicit comments on the progress of the demonstration. After this first public forum, the Bureau will convene a similar forum at least annually throughout the extension period. The Bureau will publish the date, time, and location of each

public forum on its public Web site at least 30 days prior to the forum date. Summaries of the comments provided at the public forums will be included in the appropriate quarterly reports to CMS.

## Part VIII: Affordable Care Act Transition Plan

### 1. Requirement for a Transition Plan.

Paragraph 45(e)(i) of the Special Terms and Conditions requires that the extension proposal include:

> [A] Transition Plan consistent with the provisions of the Affordable Care Act and CMS regulations for any individuals enrolled in Demonstration Eligible Groups (as defined in paragraph 17, Table 1a) who will be eligible for coverage under the State plan as of January 1, 2014, including under the new Medicaid eligibility group identified in Section 1902(a)(10)(A)(i)(VIII) of the Act, (called the Medicaid "VIII" group, for short) or who elect to move to an Exchange plan. Persons who are demonstration eligibles at the time of transition will continue to receive demonstration benefits as long as they are enrolled in a Medicaid category and they continue to meet the criteria for their particular demonstration program. The Transition Plan will include procedures for ensuring that these individuals transition to their new eligibility status without interruption in coverage to the maximum extent possible.

### 2. Demonstration Eligible Groups.

As discussed previously in this Extension Request, there are five "active" demonstration groups at the present time.

- Two of these groups are limited to children under age 19, who would not be included in the "VIII" group. Children under 6 can be eligible for Medicaid today with incomes below 133 percent of poverty, and children between the ages of 6 and 19 can be eligible with incomes below 100 percent of poverty. Therefore, the group affected by the Transition Plan would be demonstration children between the ages of 6 and 19 who have family incomes between 100 percent and 133 percent of poverty.

- Two of the active demonstration groups are LTSS-related groups. These are the 217-Like HCBS Group and the At-Risk Demonstration Group. The Medicaid final rule clarified that individuals seeking coverage based on the need for LTSS may be enrolled in an eligibility group where such services are provided, regardless of their eligibility for a MAGI-Medicaid group. For individuals already enrolled in a LTSS-related demonstration group, presumably there would be no need for them to ever be in a MAGI group.

- There is only one demonstration group left, and that is the SSD group. Some of these individuals likely have incomes that would qualify them for the "VIII" group. However, some of them have Medicare, which would disqualify them from the "VIII" group.

So, to summarize, the focus of the Transition Plan would be on the following individuals:

- Demonstration children between the ages of 6 and 19 who have family incomes between 100 percent and 133 percent of poverty
- Individuals in the SSD group who do not have Medicare and who have incomes below 133 percent of poverty

**3. Transition Planning Process.**

Given the Supreme Court decision that was announced yesterday, we need to evaluate our options with respect to inclusion of the expansion population in 2014.

We are continuing to monitor CMS guidance regarding eligibility after January 1, 2014. Should we decide to go forward with enrollment of this group, we will work with CMS to develop the specifics of a Transition Plan.

BILL HASLAM
GOVERNOR
STATE OF TENNESSEE

October 1, 2012

The Honorable Kathleen Sebelius
Secretary of the Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

On June 29, 2012, Tennessee submitted an application for a three-year extension of the TennCare demonstration, from July 1, 2013, through June 30, 2016. The authority requested was Section 1115(f) of the Social Security Act.

On September 27, 2012, the TennCare staff received a letter from Victoria Wachino, Director of the Children and Adult Health Programs Group at CMS, stating CMS's intention to renew the current demonstration only through December 31, 2013. This would be a six-month extension rather than the three-year extension we requested.

Section 1115(f)(5)(A) of the Social Security Act requires that an extension application be approved or disapproved no later than 120 days after the date of application, unless a later date is agreed to by the Chief Executive Officer of the State.

I am aware that additional discussions need to take place in order to obtain a longer term extension as originally requested. I am thereby agreeable to extending the 120 day period called for in Section 1115(f) until December 31, 2012, so that we may continue our discussions and work out all outstanding issues.

Sincerely,

Bill Haslam

STATE CAPITOL • NASHVILLE, TN 37243-0001 • PH: 615.741.2001 • www.tn.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Center for Medicaid and CHIP Services**
**Children and Adults Health Programs Group**

SEP 2 7 2012

Mr. Darin Gordon
Director
Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

This letter serves as notification from the Centers for Medicare & Medicaid Services (CMS) of our continuing review of the Special Terms and Conditions (STCs) for the current TennCare II section 1115 Demonstration (11-W-00151/4), in compliance with section 1115(f) of the Social Security Act (the Act). The next step, as outlined in the statute, is the 30-day negotiation period beginning with the date of this letter.

At this time, CMS is prepared to renew the current demonstration through December 31st, 2013, with technical changes. This extension period will give CMS and the State the opportunity to have more detailed discussions of the issues involved in a longer extension of all or part of the demonstration. For example, there would be more time to engage in discussions concerning the coordination of the demonstration with other state initiatives. We note that section 1115(f)(5)(A) of the Act allows the state to request more negotiating time before CMS makes a final decision on the demonstration, up to the expiration of the current approval period, June 30, 2013.

We have had productive discussions and look forward to reaching a mutual agreement on the authorities and terms of this demonstration. If, however, CMS and Tennessee are unable to reach an agreement on final STCs for the extension period requested, we will proceed according to section 1115(f) of the Act.

We ask that you contact your project officer, Jessica Woodard, in order to facilitate negotiations. You may contact Ms. Woodard at (410) 786-9249. We look forward to working with you on this demonstration extension.

Sincerely,

Victoria Wachino
Director

Cc: Angela Garner, CMCS
Jessica Woodard, CMCS
Jackie Glaze, CMS Atlanta Regional Office
Kenni Howard, CMS Atlanta Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Center for Medicaid and CHIP Services**
**Children and Adults Health Programs Group**

August 13, 2012

Mr. Darin Gordon
Director
Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

Thank you for your recent request to extend the State's TennCare II section 1115 demonstration (11-W-00151/4) received on June 29th, 2012.

Section 1115(f) of the Social Security Action (the Act) specifies the process under which a request for an extension of a waiver project that "is operating under an extension under subsection (e)…shall be submitted and approved or disapproved." In accordance with this section, the Centers for Medicare & Medicaid Services (CMS) acknowledges receipt of the State's extension request, which was submitted 1 year prior to the June 30, 2013 expiration date of this demonstration.

Unlike section 1115(e), section 1115(f) of the Act does not require that the extension be awarded under the same terms and conditions as the original demonstration. This means that States and CMS may negotiate new terms and conditions, including but not limited to terms regarding budget neutrality. Please be advised that all provisions of title XIX, including the amendments added by the Affordable Care Act of 2010 (ACA), apply to demonstrations extended under section 1115(f) of the Act unless specifically waived.

As required by statute, this letters serves as notification that CMS intends to review the special terms and conditions of the current demonstration, including, but not limited to, waivers and expenditure authorities. If CMS determines that any changes are necessary, we will notify you within 45 days of the date of this letter.

If you have additional questions or concerns, please contact your assigned project officer Jessica Woodard, Division of State Demonstrations and Waivers, at (410) 786-9249, or at Jessica.Woodard@cms.hhs.gov.

Sincerely,

/s/

Victoria Wachino, Director
Children and Adults Health Programs Group

cc: Allison Orris, CMCS
Jackie Glaze, ARA, CMS Atlanta Regional Office
Jessica Woodard, CMCS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Center for Medicaid and CHIP Services**
**Children and Adults Health Programs Group**

July 16, 2012

Mr. Darin Gordon
Director
Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Gordon:

Thank you for your recent request to extend the State's TennCare II section 1115 demonstration (11-W-00151/4). The Centers for Medicare & Medicaid Services (CMS) received your extension request on June 29, 2012. We have completed a preliminary review of the application, and have determined that the State's extension request has met the requirements for a complete extension request as specified under section 42 CFR 431.412(c).

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the State's extension request. The 30-day Federal comment, as required under 42 CFR 431.416(b), begins on July 17, 2012, and ends on August 16, 2012. The State's extension request is available at http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

We look forward to working with you and your staff to extend the State's Demonstration. If you have additional questions or concerns, please contact your assigned project officer Jessica Woodard, Division of State Demonstrations and Waivers, at (410) 786-9249, or at Jessica.Woodard@cms.hhs.gov.

Sincerely,

/s/

Allison Orris, Acting Director
Division of State Demonstrations and Waivers

cc: Victoria Wachino, CMCS
Jackie Glaze, ARA, CMS Atlanta Regional Office
Jessica Woodard, CMCS