

**TENNCARE II  
SECTION 1115 DEMONSTRATION  
FACT SHEET**

Last Updated February 2, 2016

**Name of Medicaid Section 1115 Demonstration:** TennCare II

**Date Initial Proposal Submitted:** February 12, 2002

**Date Initial Proposal Approved:** May 30, 2002

**Date Implemented:** July 1, 2002

**Date Expired:** June 30, 2007

**Date Renewal Proposal Submitted:** June 15, 2006

**Date Renewal Proposal Approved:** June 29, 2007

**Date Implemented:** July 1, 2007

**Date Expired:** June 30, 2010

**Date Renewal Proposal Submitted:** June 15, 2009

**Date Renewal Proposal Approved:** December 15, 2009

**Date Implemented:** July 1, 2010

**Date Expired:** June 30, 2013

**Date Renewal Proposal Submitted:** June 29, 2012

**Date Renewal Proposal Approved:** December 31, 2012

**Date Implemented:** July 1, 2013

**Date Expired:** December 15, 2016 (temporary extension)

**Date Renewal Proposal Submitted:** December 22, 2015

**Date Renewal Proposal Approved:** December 16, 2016

**Date Implemented:** December 16, 2016

**Date Expires:** June 30, 2021

**SUMMARY**

TennCare II is a continuation of the state's demonstration, funded through titles XIX and XXI of the Social Security Act. TennCare began on January 1, 1994, as an ambitious statewide health care reform program. It provided comprehensive benefits to Medicaid beneficiaries, uninsured state residents with income below specified limits, and uninsured residents at any income level if they had medical conditions that made them uninsurable. After several extensions of the original five-year demonstration, Tennessee began TennCare II on July 1, 2002, as a new five-year demonstration program.

Tennessee operates its Medicaid program through the TennCare II demonstration. All Medicaid state plan eligibles (except for those eligible only for payment of Medicare premiums) are enrolled in TennCare Medicaid and receive most of their state plan services through the

demonstration's delivery system. The program uses savings from managed care and the redirection of disproportionate share hospital payments to fund enhanced services to adult Medicaid state plan eligibles and to extend eligibility to uninsured or uninsurable demonstration eligibles through the TennCare Standard program.

In 2005, Tennessee received approval for a series of demonstration amendments that allowed the state to close selected state plan and demonstration populations to new enrollment and eventually to disenroll individuals already determined eligible. These changes would have resulted in approximately 323,000 individuals losing eligibility for coverage under TennCare. A subsequent demonstration amendment approved in 2006 authorized the creation of a new demonstration expansion population to take the place of the state plan eligibility groups that were discontinued. In 2009, TennCare implemented the CHOICES program that provides long-term care and home and community based services to aged and disabled individuals. The TennCare II demonstration, which provides Medicaid coverage to approximately 1.2 million enrollees, has been extended twice since its initial approval and is set to expire on June 30, 2016.

### **AMENDMENTS**

<b>Date Amendment #27 Submitted:</b>	June 23, 2015
<b>Date Amendment #27 Approved:</b>	February 2, 2016
<b>Date Amendment #27 Effective:</b>	February 2, 2016

Amendment #27 amends Tennessee's TennCare II demonstration by implementing the Employment and Community First CHOICES program that provides integrated managed long term services and supports (MLTSS) program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living for individuals with intellectual and developmental disabilities (IDD). Program implementation and enrollment begins on June 30, 2016.

<b>Date Amendment #28 Submitted:</b>	October 8, 2015
<b>Date Amendment #28 Approved:</b>	February 2, 2016
<b>Date Amendment #28 Effective:</b>	February 2, 2016

Amendment #28 amends Tennessee's TennCare II demonstration by phasing out the Standard Spend Down (SSD) eligibility category that was approved in 2007 as a demonstration expenditure authority population of adult Tennesseans who are aged, blind, disabled or caretaker relatives who meet spend down requirements. Individuals enrolled as of the effective date of the amendment will be allowed to remain in the category until they undergo a reverification process, at which point the state will assess their eligibility for any open category of TennCare coverage. Individuals who are not eligible for any open category will be referred to Medicare or the Marketplace.

<b>Date Amendment #32 Submitted:</b>	September 6, 2017
<b>Date Amendment #32 Approved:</b>	Under CMS Review
<b>Date Amendment #32 Effective:</b>	Under CMS Review

\*See the Additional Amendments Section for more information on other TennCare II amendments.

## **ELIGIBILITY**

**Medicaid State Plan Mandatory and Optional Eligibles**—All individuals eligible under the title XIX state plan are enrolled in TennCare II, except for those whose only coverage consists of payment for Medicare premiums.

**Uninsured or Uninsurable Demonstration Populations**—Once the planned disenrollment of uninsured or uninsurable adults aged 19 or older was complete, these demonstration expansion populations only include the following children who “rollover” into TennCare Standard coverage after losing eligibility under the Medicaid state plan:

- Title XXI optional targeted low-income children who are uninsured and younger than 19 years old with family income up to 200 percent of the federal poverty level (FPL)
- Title XIX medically eligible (uninsurable) children younger than 19 years old with family income at 200 percent of the federal poverty level or higher, without limit.

**Standard Spend Down (SSD) Demonstration Population**—On November 14, 2006, CMS authorized the state to add a new demonstration expansion population of non-pregnant adults aged 21 or older who would meet the state plan medically needy rules. To reflect the additional expansion population, the Medicaid state plan was amended to eliminate medically needy coverage for non-pregnant adults who are eligible as parents/caretaker relatives or as aged, blind, or disabled. Enrollment for this program closed on January 1, 2016 to new enrollment and the state redetermined remaining enrollees of this program for other coverage.

**TennCare CHOICES Groups**—The CHOICES component of the TennCare provides long-term care services in a nursing facility or through home and community based services to individuals in need of those services. The CHOICES program provides long-term care benefits to the three following groups:

- CHOICES 1. This group consists of persons who are receiving Medicaid-reimbursed care in a nursing facility. There is no enrollment target for this group.
- CHOICES 2. Persons age 65 and older and adults age 21 and older with physical disabilities who meet the nursing facility level of care, who qualify either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving home and community based services (HCBS) as an alternative to nursing facility care. The state has enrollment targets for CHOICES 2, and may cover up to 15,000 individuals.
- *Interim* CHOICES 3. Persons age 65 and older and adults age 21 and older with physical disabilities, who qualify either as SSI recipients or as members of the At Risk Demonstration Group, and who do not meet the nursing facility level of care, but who in the absence of HCBS are “at risk” for institutionalization, as defined by the state. *Interim* CHOICES 3 provides a more limited HCBS benefit than CHOICES 2. There is no enrollment target for *Interim* CHOICES 3. This program closed to new enrollment beginning December 31, 2013.

- CHOICES 3. Persons age 65 and older and adults age 21 and older with physical disabilities to qualify for TennCare as SSI eligible, who do not meet the NF LOC, but who, in the absence of HCBS, are “at risk” for institutionalization, as defined by the state. **This group opened for new enrollment based on a revised LOC on January 1, 2014.**
- Interim ECF CHOICES. Individuals with I/DD who are not otherwise eligible for Medicaid or TennCare who are receiving ECF CHOICES services; meet the financial eligibility standards for the ECF CHOICES 217-Like Group; meet the nursing facility level of care in place on June 30, 2012 but not the nursing facility level of care in place on July 1, 2012; and in the absence of the services offered through ECF CHOICES are “at risk” of institutionalization. Enrollment in this group will stop upon implementation of Phase 2 of ECF CHOICES. However, individuals enrolled in the Interim ECF CHOICES At-Risk Demonstration Group prior to implementation of Phase 2 may continue to be eligible through the interim group as long as they continue to meet the eligibility requirements and remain continuously enrolled in the interim group. These expenditures are limited to those necessary to provide.
- ECF CHOICES Working Disabled Demonstration Group. Beginning with Phase 2 of ECF Choices, working age individuals with I/DD who are not otherwise eligible for Medicaid or TennCare who are receiving ECF CHOICES services; meet the NF LOC criteria in place on June 30, 2012, and in the absence of ECF CHOICES are “at risk” of institutionalization, or meet the current NF LOC criteria; but for their earned income would be eligible for SSI; and have family income at or below 250% of the FPL.

### **DELIVERY SYSTEM**

The state contracts with full or partial risk managed care organizations (MCOs) to provide all health services.

### **BENEFITS**

#### **TennCare Medicaid**

##### ***State plan eligible children under age 21***

All Medicaid state plan services, including EPSDT expanded services, are covered, as well as services that managed care entities may provide as cost-effective alternatives. The following state plan covered services are carved out of TennCare: Medicare premiums and cost-sharing, targeted case management, and residential day services for children in state custody.

##### ***State plan eligible adults aged 21 or older***

All Medicaid state plan services are covered, as well as various optional services not covered under the state plan and services that managed care entities may provide as cost-effective alternatives. Service limitations either are not applicable or are less stringent than under the state plan. The following state plan covered services are carved out of TennCare: Medicare premiums and cost-sharing, targeted case management, and Program of All-Inclusive Care for the Elderly.

#### **TennCare Standard**

***Demonstration populations of uninsured or medically eligible (uninsurable) children under age 19***

Medicaid state plan services, including EPSDT expanded services, are covered, as well as services that managed care entities may provide as cost-effective alternatives. The following state plan services are not covered: targeted case management.

**TennCare CHOICES**

Individuals age 65 and older and adults age 21 and older with a demonstrated need for nursing facility level of care can participate in TennCare CHOICES and receive such services in the community rather than a nursing facility. All nursing facility and home and community based services are provided through the managed care system.

**QUALITY AND EVALUATION PLAN**

Tennessee has developed an evaluation plan with specific data and sampling methodologies that focuses on the access to and quality of care delivered to beneficiaries, satisfaction of enrollees, improved health care outcomes, and the financial stability of participating managed care plans.

**COST SHARING**

**For TennCare Medicaid:**

There are no premiums, deductibles, or out-of-pocket maximum limit. The only co-payment is a nominal \$3 co-pay for each brand name drug, and there are no co-payments for individuals receiving long-term care, family planning, pregnancy-related, emergency, or hospice services.

**For TennCare Standard:**

- There are no premiums or deductibles.
- For enrollees with income less than 100 percent of the FPL, there are no co-payments, except that the Standard Spend Down population has a nominal \$3 co-pay for each brand name drug.
- For enrollees with income from 100 to 199 percent of the FPL, the co-payments are as follows:
  - \$10 for emergency room services (waived if admitted);
  - \$3 for each brand name drug for the SSD population;
  - \$5 for outpatient physician services, \$5 for a specialist; and
  - \$5 per inpatient hospital admission (waived if readmitted within 48 hours for the same episode)
- For enrollees with income at or above 200 percent of the FPL, the co-payments are as follows:
  - \$50 for emergency room services (waived if admitted);
  - \$3 for each brand name drug for the SSD population;
  - \$15 for outpatient physician services, \$20 for a specialist; and
  - \$100 per inpatient hospital admission (waived if readmitted within 48 hours for the same episode)

- Total out-of-pocket cost sharing for TennCare Standard children is limited to 5 percent of the family income. There is no annual out-of-pocket maximum for TennCare Standard adults.

**For TennCare CHOICES:** There are no cost-sharing requirements for persons enrolled in CHOICES 1 or CHOICES 2. Persons enrolled in *Interim* CHOICES 3 have a nominal \$3 co-pay for each brand name prescription.

### **STATE FUNDING SOURCE**

The State of Tennessee certifies that state/local monies are used as matching funds for the demonstration and that such funds shall not be used as matching funds for any other federal grant or contract, except as permitted by law.

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### **ADDITIONAL AMENDMENTS**

**Date Amendment #1 Submitted:** March 27, 2003  
**Date Amendment #1 Approved:** April 29, 2004

Amendment #1 was approved to remove the Stabilization Neutrality Cap, which permitted the state to enter into non-risk contracts with managed care organizations (MCOs) in order to keep the MCOs from withdrawing from the program, and possibly causing it to collapse. When more people were found to be eligible for Medicaid than projected, the STC was removed to allow the state to increase the overall budget neutrality cap and give them more flexibility to modify the program as needed.

**Date Amendment #2 Submitted:** September 24, 2004  
**Date Amendment #2 Revised:** February 18, 2005  
**Date Amendment #2 Approved:** March 24, 2005

Amendment #2 was approved in order to allow the state to disenroll 323,000 individuals in the following groups:

- state plan categories of medically needy non-pregnant adults aged 21 and older, including parents and other caretaker relatives and individuals eligible as aged, blind, or disabled; and
- demonstration expansion population of (1) uninsured adults aged 19 and older with income below 200 percent of the federal poverty level (FPL); (2) adults aged 19 and older with medical conditions that made them uninsurable; (3) and adults with Medicare, but not Medicaid, who met criteria for TennCare as of December 31, 2001, and continued to meet the criteria that made them uninsurable (grandfathered duals).

The state also received approval to close:

- new enrollment for state plan medically needy non-pregnant adults;

- new enrollment into the demonstration expansion populations; and
- “rollover” enrollment of individuals aged 19 and older from Medicaid state plan eligibility to the demonstration expansion populations, so that rollover is now only authorized for uninsured or medically eligible (uninsurable) children.

Enrollment was closed for these groups on April 29, 2005. In May 2005, the state began the disenrollment process for demonstration expansion eligible adults. Through the use of *ex parte* eligibility reviews, the state sought to determine whether any of the affected individuals were eligible in an open Medicaid state plan category, and could, in this manner, retain eligibility for TennCare. The state later suspended disenrollment of the state plan medically needy non-pregnant adults.

<b>Date Amendment #3 Submitted:</b>	September 24, 2004
<b>Date Amendment #3 Revised:</b>	February 18, 2005
<b>Date Amendment #3 Approved:</b>	June 8, 2005

The state was granted permission to limit or eliminate coverage of certain pharmacy and other optional benefits for Medicaid state plan and demonstration expansion groups, as follows:

- elimination of pharmacy coverage for adults (aged 21 or older) who are demonstration expansion eligibles or are medically needy non-pregnant state plan eligibles, except for individuals receiving long-term care institutional or 1915(c) waiver services. However, since the approval of Amendment #3, the state received approval of a state plan Amendment, effective July 1, 2005, that authorized a monthly limit of five prescriptions, of which no more than two can be brand name drugs, for medically needy non-pregnant state plan adults (with the exception of individuals receiving long-term care services who are exempt from these limits). The state has the authority to exempt certain drugs from the monthly limit.
- reduction of pharmacy coverage for all other Medicaid state plan eligible adults (aged 21 or older) to a monthly limit of five prescriptions, of which no more than two can be brand name drugs, except for those receiving long-term care services (who continue to receive pharmacy services as medically necessary). The state has the authority to exempt certain drugs from the monthly limit.
- elimination of coverage for other-the-counter drugs (except prenatal vitamins for pregnant women), methadone clinic services, and dental services for all state plan and demonstration expansion adults (aged 21 years or older).
- additional of the benefit of private duty nursing for demonstration expansion children, while affirming previously approved authority to eliminate private duty nursing for all state plan and demonstration expansion adults. However, the state indicated in a letter dated July 13, 2005 that the state would postpone elimination of private duty nursing for adults.
- imposition of nominal co-payments of \$3.00 per brand name prescription drug or refill for all state plan eligible adults and for all other state plan or demonstration expansion enrollees with incomes at or above 100 percent of the FPL, except for individuals receiving long-term care, family planning, pregnancy-related, emergency, or hospice services.

- removal of the out-of-pocket maximum previously applied to demonstration expansion eligibles with incomes at or above 100 percent of the FPL, including children.
- affirmation of previously approved authority to limit substance abuse services to a lifetime maximum of \$30,000 for all state plan and demonstration expansion adults (aged 21 or older).
- affirmation of previously approved authority to exclude convalescent care or sitter services under TennCare II.

**Date Amendment #4 Submitted:** September 24, 2004  
**Date Amendment #4 Revised:** February 18, 2005  
September 1, 2005  
**Date Amendment #4 Approved:** March 31, 2006

Amendment #4 was approved to allow the state to proceed with several components from the demonstration amendment dated September 24, 2004, updated on February 18, 2005, and clarified on September 1, 2005. The state was granted permission to make the following benefit and related changes to the TennCare II program:

- operate one Behavioral Health Organization (BHO) statewide;
- re-establish an annual managed care organization (MCO) change period for TennCare enrollees, beginning in the fall of 2006;
- eliminate pharmacy coverage of benzodiazepines and barbiturates for all adult state plan enrollees including dual eligibles;
- implement technical corrections regarding notice and appeals to Attachment F of the Special Terms and Conditions (STCs);
- transfer individuals who are eligible for both Medicaid and Medicare from the existing section 1915(b) waiver to the section 1115 demonstration in order to enroll them in a managed care delivery system;
- make \$50 million in Special Hospital Pool payments for demonstration year 4 to compensate hospitals for unreimbursed costs of care;
- withdraw previously granted authority to eliminate coverage of private duty nursing for all TennCare adults; and
- reinstitute outpatient pharmacy coverage for medically needy non-pregnant state plan adults, with a five prescription monthly limit.

**Date Amendment #5 Submitted:** January 11, 2006  
**Date Amendment #5 Revised:** March 14, 2006  
May 21, 2006  
**Date Amendment #5 Approved:** November 14, 2006

Amendment #5 was approved to:

- add a Standard Spend Down (SSD) demonstration expansion population of non-pregnant adults aged 21 or older, capped at 105,000 enrollees, who would meet the medically needy rules in the state plan;
- authorize “soft” limits for outpatient pharmacy coverage;



- added the per member per month (PMPM) budget neutrality expenditure limit for dual eligibles; and
- deny an increase in the Meharry Medical College supplemental pool payments

**Date Amendment #6 Submitted:** February 29, 2008  
**Date Amendment #6 Revised:** May 19, 2008  
**Date Amendment #6 Approved:** July 22, 2008

Amendment #6 was approved to:

- modify the TennCare Medicaid and TennCare Standard benefits for adults aged 21 and older by clarifying that the home health benefits will be covered as medically necessary and in accordance with limitations including in state rules; and
- cover Medicaid-optional private duty nursing services 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 the equipment and patient are required.

**Date Amendment #7 Submitted:** October 4, 2008  
**Date Amendment #7 Approved:** July 22, 2009

Amendment #7 permitted the state to incorporate long-term care services (nursing facility and home and community based services) into its managed care program under the TennCare CHOICES program. The CHOICES amendment accomplished the following:

- added home and community-based services (HCBS) for the disabled and elderly populations (formerly provided through a section 1915(c) Medicaid waiver) and NF services (formerly provided on a fee-for-service basis) to the existing TennCare II benefit package of primary, acute, and behavioral health services for qualifying state plan and demonstration-eligible individuals;
- provides appropriate and cost-effective HCBS that will improve the quality of life for persons who qualify for NF care, as well as for SSI-eligible persons who do not qualify for NF care but are “at risk” of institutional placement;
- used a regional implementation (phasing-in the provision of LTC services by MCOs in different geographic areas of the state over a 12-month period) and HCBS-controlled enrollment strategies (enrollment targets for HCBS) to maintain quality while expanding the availability (quantity and array) of home and community-based options. The program was operational statewide on August 1, 2010.

**Date Amendment #8 Submitted:** September 28, 2009  
**Date Amendment #8 Approved:** December 15, 2009

At the request of the state, CMS issued a number of technical and typographical corrections to the Standard Terms and Conditions (STCs).

**Date Amendment #9 Submitted:** February 3, 2010

**Date Amendment #9 Approved:** June 30, 2010

The state submitted Amendment #9 to implement reductions in TennCare benefits to alleviate a state budget crisis. The state also requested a postponement in the implementation date for changes in cost-sharing rules for children enrolled in TennCare Standard.

**Date Amendment #10 Submitted:** May 14, 2010

**Date Amendment #10 Approved:** June 30, 2010

The state submitted Amendment #10 to request approval for new supplemental payments to private hospitals that, in conjunction with a new hospital fee, would provide additional state revenue needed to avoid the benefit cuts. The state also requested a new supplemental payment for the Regional Medical Center at Memphis, a public safety-net hospital.

**Date Amendment #11 Submitted:** July 21, 2010

**Date Amendment #11 Revised:** September 3, 2010

**Date Amendment #11 Approved:** December 16, 2010

The state submitted Amendment #11 to request an increase to the annual limit on payments from the Public Hospital Supplemental (PHSP) Pool and added Nashville General Hospital at Meharry to the list of eligible recipients of payments from the PHSP Pool. The amendment deleted the requirement to subtract certain hospital payment revenues from Unreimbursed TennCare costs prior to calculating payments under the Unreimbursed Hospital Cost (UHC) Pool. In its place, a requirement was added that UHC (and PHSP) Pool payments be taken into account when calculating the hospital-specific DSH limit for each facility.

**Date Amendment #12 Submitted:** January 28, 2011

**Date Amendment #12 Revised:** May 5, 2011

**Date Amendment #12 No Longer under  
Active CMS Review:** June 15, 2012

The state submitted Amendment #12 to limit or eliminate coverage of selected services for TennCare eligible adults, and to impose a co-payment for non-emergency transportation (NEMT) on non-pregnant, non-institutionalized adults. The changes were proposed by the state to address an anticipated budget shortfall in its 2012 fiscal year and the pending June 30, 2011 expiration of an assessment fee for private hospitals. On May 5, 2011, CMS received written notification from the state that fiscal projection had improved with the legislature's extension of the hospital assessment fee; therefore, in that same written communication, the state withdrew the proposed changes to select covered services and narrowed the amendment request to the \$2 per on-way co-payment for NEMT. As of summer 2011, the state requested that CMS hold approval of this request pending an Agency-level or Congressional decision on the Special Disability Workload cases. The CMS communicated to the state in the approval letter for Amendment 14 that this request was no longer under active review.

**Date Amendment #13 Submitted:** December 15, 2011

**Date Amendment #13 Withdrawn:** March 14, 2012

The state submitted Amendment #13 to increase the Enrollment Targets for the CHOICES 2 program as required by the Standard Terms and Conditions. The state received approval for the request to increase the upper limit for Demonstration Year (DY) 10 (7/1/11 – 6/30/12) from 11,000 to 12,500, and to increase the enrollment target range for DY 11 (7/1/12 – 6/30/2013) from 9,500 – 12,500 to 11,000 – 15,000. This request was withdrawn by the state and incorporated in Amendment #14.

<b>Date Amendment #14 Submitted:</b>	March 1, 2012
<b>Date Amendment # 14 Revised:</b>	March 13, 2012
<b>Date Amendment #14 Approved:</b>	June 15, 2012
<b>Date Amendment #14 Implemented:</b>	July 1, 2012

The state submitted Amendment #14 to rebalance the CHOICES program to ensure that beneficiaries in need of long term services and supports receive such services in the appropriate setting. The institutional level of care applicable to enrollment in CHOICES 1 and 2 was increased and an “at risk” eligibility group was created to serve individuals in the community who, in the absence of such services, would be at risk of institutionalization. The “at risk” group will be enrolled in Interim CHOICES 3, which is open to enrollment starting July 1, 2012. The amendment also increased the enrollment target for CHOICES 2 for the final year of the demonstration period.

<b>Date Amendment #15 Submitted:</b>	March 1, 2012
<b>Date Amendment #15 Withdrawn:</b>	April 3, 2012

The state submitted Amendment #15 to limit or eliminate coverage of selected services for TennCare eligible adults. The changes were proposed by the state to address an anticipated budget shortfall in its 2013 fiscal year and the pending June 30, 2012 expiration of an assessment fee for private hospitals. The hospital assessment fee was reauthorized by the state legislature and the amendment was withdrawn.

<b>Date Amendment #16 Submitted:</b>	April 13, 2012
<b>Date Amendment # 16 Approved:</b>	June 15, 2012
<b>Date Amendment #16 Implemented:</b>	June 15, 2012

The state submitted Amendment #16 to remove the Disproportional Share Hospital (DSH) allotment from the existing hospital funding pool to permit the state to make DSH expenditures authorized under the Affordable Care Act and fulfill obligations for hospital payments under the demonstration.

<b>Date Amendment #17 Submitted:</b>	February 4, 2013
<b>Date Amendment #17 Withdrawn:</b>	April 26, 2013

The state submitted Amendment #17 to limit or eliminate coverage of selected services for TennCare eligible adults. The changes were proposed by the state to address an anticipated budget shortfall in its 2013 fiscal year and the pending June 30, 2012 expiration of an assessment

fee for private hospitals. The hospital assessment fee was reauthorized by the state legislature and the amendment was withdrawn.

**Date Amendment #18 Submitted:** March 7, 2013  
**Date Amendment #18 Approved:** June 23, 2015

Amendment #18 provides Assisted Care Living Facility (ACLF) services, to CHOICES Group 3 members that are determined to need ACLF services and the services are considered to be cost effective alternatives. There is no budget impact for the addition of these benefits and will not increase the overall cost of program benefits.

**Date Amendment #19 Submitted:** April 26, 2013  
**Date Amendment #19 Approved:** July 16, 2013  
**Date Amendment #19 Implemented:** October 1, 2013

The state submitted Amendment #19 to introduce a \$1.50 co-pay for generic prescriptions for non-exempt Medicaid adults, TennCare Standard Spend Down Adults, TennCare Standard children with incomes at 100 percent of the federal poverty level and above, and the at-risk demonstration groups in the CHOICES 3 and Interim CHOICES 3 programs.

**Date Amendment #20 Submitted:** December 17, 2013  
**Date Amendment #20 Approved:** December 30, 2013  
**Date Amendment #20 Implemented:** January 1, 2014

The state submitted Amendment 20 to reopen enrollment for the Interim CHOICES 3 At-risk demonstration group that provides home and community based services to individuals who are at-risk for institutionalization without the provision of these services. New enrollment for CHOICES 3 will remain open until June 30, 2015. The state also requested to remove the Essential Access Hospital (EAH) uncompensated care pool from the group of uncompensated care pools that are subject to a \$540 million annual cap. The request also includes proposing the authority to add an additional hospital to the Public Hospital Supplemental Payment (PHSP) pool. CMS approved Amendment 20 partially, approving the state's request to reopen the Interim CHOICES 3 group to new enrollment on December 30, 2013. CMS subsequently approved the remainder of the request on March 31, 2014 to add Erlanger Medical Center to the PHSP and increasing the pool to \$100 million. The March 31, 2014 approval also increased the EAH pool to \$621.2 million for the period of April 1, 2014 to March 31, 2015.

**Date Amendment #21 Submitted:** January 27, 2014  
**Date Amendment #21 Withdrawn:** April 25, 2014

The state submitted Amendment #21 to limit or eliminate coverage of selected services for TennCare eligible adults. The changes were proposed by the state to address an anticipated budget shortfall in its 2014 fiscal year and the pending June 30, 2013 expiration of an assessment fee for private hospitals. The hospital assessment fee was reauthorized by the state legislature and the amendment was withdrawn.

**Date Amendment #22 Submitted:** May 8, 2014  
**Date Amendment #22 Approved:**

Tennessee submitted Amendment #22 to introduce maximum allowable medical copays to Medicaid beneficiaries that are not exempt from cost sharing. It also requested to charge the regulatory amount for non-emergency use of the emergency department of \$8.00. The request also sought the authority to introduce an annual cost sharing tracking methodology to replace the quarterly tracking that states are required to conduct. Also in the request, was a request to limit incontinence supplies to adults. The requests to introduce maximum cost sharing and limits on incontinence supplies were redirected to the Medicaid state plan authority and are not subject to changes in the 1115 demonstration. The request for annual cost sharing tracking is still pending.

**Date Amendment #23 Submitted:** July 28, 2014  
**Date Amendment #23 Approved:** September 5, 2014  
**Date Amendment #23 Effective:** September 5, 2014

Tennessee submitted Amendment #23 to respond to guidance received from CMS. The state requested expenditure authority under the demonstration to provide non-ambulatory services provided to pregnant women during a period of presumptive eligibility. The state considers all covered services to be “pregnancy related” and requested an update to its authorities to reflect CMS approval.

**Date Amendment #24 Submitted:** March 4, 2015  
**Date Amendment #24 Approved:** June 23, 2015  
**Date Amendment #24 Effective:** June 23, 2015

Amendment #24 revises the definition of community-based residential alternatives to institutional care by including two new service definitions in Attachment D, “Glossary of Terms for TennCare CHOICES,” in the STCs. The first new definition is for Community Living Supports (CLS) and the second is for Community Living Supports – Family Model (CLS-FM). CLS and CLS-FM services are intended to encompass a continuum of support options for up to four individuals living in a home in the community, and up to three individuals living in the home of a trained family caregiver, respectively. These services will be individualized based on the needs of the resident and specified in the person-centered plan of care. CLS and CLS-FM services may include assistance, supervision, transportation, and other supports intended to help the individual make a number of choices, including selecting and moving into a home, managing acute or chronic health conditions, and becoming aware of and effectively using transportation, police, fire, and emergency services.

**Date Amendment #26 Submitted:** April 14, 2015  
**Date Amendment #26 Approved:** December 11, 2015  
**Date Amendment #26 Effective:** January 1, 2016

Amendment #26 extends funding for Tennessee’s uncompensated care pool payments to June 30, 2016. This amendment also formalizes updated requirements for an independent evaluation of pool funding.

