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Agency*	Citation(s)	Group Covered
	B.	Optional Group Other Than the Medically Needy (continued)
42 CFR 435.217	X 4.	A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment. X PACE Enrollees.

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I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are: (See page 7 of Supplement 3 to Attachment 3.1-A). The State will apply the spousal impoverishment eligibility rules for individuals who have a community spouse.

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. ____The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver #0427.

Regular Post Eligibility

1. X SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.
1. Allowances for the needs of the:
(A) Individual (check one)
1. X The following standard included under the State plan (check one):
(a) ____SSI
(b) ____Medically Needy
(c) X The special income level for the institutionalized
(d) ____Percent of the Federal Poverty Level: _____%
(e)____ Other (specify):_____
2. _____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

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3. _____ The following formula is used to determine the needs allowance:

_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):
1. ____SSI Standard
2. ____Optional State Supplement Standard
3. ____Medically Needy Income Standard
4. ____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5. ____The following percentage of the following standard that is not greater than the standards above: _____% of ____standard.
6. ____The amount is determined using the following formula:

_____
_____
7. X Not applicable (N/A)

(C) Family (check one):
1. ____AFDC need standard
2. X Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4. ____The following percentage of the following standard that is not greater than the standards above:_____ % of _____standard.
5. ____The amount is determined using the following formula:
6. ____ Other
7. ___ Not applicable (N/A)

(b) Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

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2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____The following percentage of the following standard that is not greater than the standards above: _____ % of _____standard.
5.____The amount is determined using the following formula:
_____
_____
6.____Other
7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:

1. Individual (check one)
(A) X The following standard included under the State plan (check one):
1.____SSI
2. ____Medically Needy
3. X The special income level for the institutionalized
4. ____Percent of the Federal Poverty Level: _____%
5. ____Other (specify): ____
(B) _____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
(C)____The following formula is used to determine the needs allowance:
_____
_____

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If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____
_____
_____
_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. ____ Rates are set at a percent of fee-for-service costs
2. ____Experience-based (contractors/State's cost experience or encounter date) (please describe)
3. ____Adjusted Community Rate (please describe)
4. _X_ Other (please describe)

Description of Rate Setting Methodology

The comparison group for PACE will be CHOICES program participants residing in the region where the PACE program is located who meet nursing facility level of care, including persons enrolled in CHOICES Group 1 (receiving NF services) and persons enrolled in CHOICES Group 2 (NF LOC eligible but receiving HCBS as an alternative to NF services). The blended base capitation rate (excluding administrative load and premium tax) for dual eligible or non-dual eligible (as applicable) CHOICES Group 1 and 2 members in the Grand Region, plus monthly average Medicare cost sharing payments made by the TennCare program (applicable only for dual eligibles) is the upper payment limit for any PACE program operating in that region. The State's maximum rate for PACE will be 95% of the combined total of the blended base capitation rate (excluding administrative load and premium tax), plus monthly average Medicare cost sharing (as applicable).

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For PACE programs established *prior to* the implementation of the TennCare CHOICES in Long-Term Care Program, the initial per member per month capitation rate paid to the PACE Provider by TennCare for the provision of all Medicaid covered services and administrative and all other costs was determined by the following:

1. Calculating 95% of the weighted monthly average Medicaid per person nursing facility costs in the geographic service area; and

2. (a) For Dual Eligibles:

   Calculating 95% of the monthly statewide average Medicaid per person costs, excluding nursing facility services, for Medicare/Medicaid dual eligibles, inclusive of the following:

   - The base capitation rate (excluding administrative load and premium tax) paid by TennCare to Managed Care Organizations for Medicare/Medicaid dual eligible enrollees;
   - The base capitation rate (excluding administrative load and premium tax) paid by TennCare to Behavioral Health Organizations for dual eligible enrollees, except those classified as severely and persistently mentally ill (SPMI) or seriously emotionally disturbed (SED); and
   - One-twelfth ($1/12^{th}$) of the annual statewide average per person Medicare cost sharing (deductibles and coinsurance) paid by TennCare to providers for Medicare services delivered to dual eligible enrollees;

   (b) For Non-Dual Eligibles:

   Calculating 95% of the monthly statewide average Medicaid per person costs, excluding nursing facility services, for non-dual eligibles, inclusive of the following:

   - The base capitation rate (excluding administrative load and premium tax) paid by TennCare to Managed Care Organizations for Medicare/Medicaid non-dual eligible enrollees; and
   - The base capitation rate (excluding administrative load and premium tax) paid by TennCare to Behavioral Health Organizations for non-dual eligible enrollees, except those classified as severely and persistently mentally ill (SPMI) or seriously emotionally disturbed (SED); and

3. Adding the calculated amount from (1) above to the applicable calculated amount from (2) above to establish a dual eligible and non-dual eligible per member per month capitation rate.

Such rates shall be reviewed at least annually and may be adjusted as determined by TennCare.

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For dual eligibles, the rate shall not exceed 95% of the combined total of:

- The blended CHOICES Group 1/Group 2 dual eligible per member per month base capitation rate (excluding administrative load and premium tax) established by TennCare for contracted Managed Care Organizations operating in the region of the State where the PACE program is located; and
- One-twelfth ($1/12^{th}$) of the annual statewide average per person Medicare cost sharing (deductibles and coinsurance) paid by TennCare to providers for Medicare services delivered to dual eligible enrollees;

For non-dual eligibles, the rate shall not exceed:

- 95% of the blended CHOICES Group 1/Group 2 non-dual eligible per member per month base capitation rate (excluding administrative load and premium tax) established by TennCare for contracted Managed Care Organizations operating in the region of the State where the PACE program is located.

This new methodology is not expected to have a significant impact on the rates being paid to the State's existing PACE program prior to January 1, 2012.

For PACE programs established *after* the implementation of the TennCare CHOICES in Long Term Care Program, the initial per member per month capitation rate paid to the PACE Provider by TennCare for the provision of all Medicaid covered services and administrative and all other costs for dual eligibles shall be determined by the following, subject to the maximum rates as specified below:

1. Calculating 95% of the blended CHOICES Group 1/Group 2 dual eligible per member per month base capitation rate (excluding administrative load and premium tax) established by TennCare for contracted Managed Care Organizations operating in the region of the State where the PACE program is located.
2. Calculating 95% of the average annual per person Medicare cost sharing (deductibles and coinsurance) paid by TennCare to providers for Medicare/Medicaid dual eligibles and dividing by twelve (12).
3. Adding the calculated amount from (1) above to the calculated amount from (2) above to establish a monthly per member per month capitation rate in the region of the State where the PACE facility is located.

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For PACE programs established *after* the implementation of the TennCare CHOICES in Long Term Care Program, the initial per member per month capitation rate paid to the PACE Provider by TennCare for the provision of all Medicaid covered services and administrative and all other costs for non-dual eligibles shall be determined by the following:

Calculating 95% of the blended CHOICES Group 1/Group 2 non-dual eligible per member per month base capitation rate (excluding administrative load and premium tax) established by TennCare for contracted Managed Care Organizations operating in the region of the State where the PACE program is located.

These rates shall be reviewed at least annually and may be adjusted as determined by TennCare.

For dual eligibles, the initial and all subsequent rates shall not exceed 95% of the combined total of:

- The blended CHOICES Group 1/Group 2 dual eligible per member per month base capitation rate (excluding administrative load and premium tax) established by TennCare for contracted Managed Care Organizations operating in the region of the State where the PACE program is located; and
- One-twelfth ($1/12^{th}$) of the annual statewide average per person Medicare cost sharing (deductibles and coinsurance) paid by TennCare to providers for Medicare services delivered to dual eligible enrollees.

For non-dual eligibles, the initial and all subsequent rates shall not exceed:

- 95% of the blended CHOICES Group 1/Group 2 non-dual eligible per member per month base capitation rate (excluding administrative load and premium tax) established by TennCare for contracted Managed Care Organizations operating in the region of the State where the PACE program is located.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Rates are determined by the Bureau of TennCare, Department of Finance and Administration.

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C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.