



January 8, 2021

Stephen Smith
Director of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Smith

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain Act programs including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not “stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients.” S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115 of the Act allows the Secretary to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. In addition, section 1115 of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Tennessee’s request for a section 1115 demonstration project entitled, “TennCare III” (Project Number 11-W-00369/4), in accordance with section 1115(a) of the Act. On November 20, 2019, Tennessee submitted a request to amend its section 1115 Medicaid demonstration, TennCare II, to develop a different financing structure using an “aggregate cap” approach for most of its existing demonstration alongside requests for additional flexibilities. Per regulations at 42 CFR 431.412(c)(1), CMS has the discretion to treat an application as a new demonstration when the application includes substantial changes to the existing demonstration. CMS determined that this amendment proposed substantial changes to the state’s existing section 1115 demonstration, and the state’s amendment application met the requirements for submission of a new demonstration under CMS transparency regulations. Therefore, CMS is approving this request as a new section 1115 demonstration. With this approval, which also subsumes TennCare II under the new demonstration, the state will have a longer approval period to test this innovative financing approach, as well as reduce the future administrative burden associated with having to renew the demonstration more frequently.

This approval is effective January 8, 2021, through December 31, 2030, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS’s approval of this section 1115(a) demonstration is subject to the limitations specified in

the attached expenditure authority, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures or individuals covered by expenditure authority.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 of the Act if, in his judgment, the demonstration is likely to assist in promoting the objectives of title XIX. Under section 1901 of the Act, the Medicaid program provides federal funding to participating states, “[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” Act § 1901. As this statutory text makes clear, two Medicaid objectives are to enable states to “furnish ... medical assistance” – i.e., healthcare services – to certain vulnerable populations and to furnish those populations with rehabilitation and other services to help them “attain or retain capability for independence or self-care.” Section 1901 of the Act. Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better “enabling each [s]tate, as far as practicable under the conditions in such [s]tate”, to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need.

We are committed to supporting states that seek to test measures that are likely to increase coverage, improve the health of beneficiaries, and support the fiscal sustainability of states’ Medicaid programs. We expect that such demonstration policies will improve beneficiaries’ physical and mental health, resulting in these beneficiaries consuming fewer health care services and resources while they are enrolled in Medicaid, which will preserve Medicaid program resources, make the Medicaid program more efficient, and potentially reduce the program’s national average total annual cost per beneficiary of \$7871.¹ Such measures can promote the objectives of the Medicaid statute by enabling states to make improvements and investments “as far as practicable under the conditions in such state[s],” SSA Section 1901, in the broader Medicaid program. These measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.² By the same token, such

¹ U.S. Department of Health and Human Services 2018 Actuarial Report on the Financial Outlook for Medicaid.

² States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom their Medicaid programs will cover. Certain eligibility groups must be covered under a state’s program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders (SUDs) beyond what the statute explicitly authorizes.

measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place. To the extent that either or both of these trends results in lower costs for the state over the long-term, it may allow the state to maintain the long-term fiscal sustainability of its Medicaid program and provide medical services to more Medicaid beneficiaries.

Background

Tennessee's Medicaid program is currently operating under the 1115 demonstration program, titled "TennCare II." This new demonstration is a continuation of the state's Medicaid program funded through titles XIX and XXI of the Social Security Act (the Act), and would supplant the TennCare II demonstration. TennCare began as an 1115(a) demonstration project in January 1994. 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 provide all state plan Medicaid services, except for services specified in the attached STCs.

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

Employment and Community First (ECF) CHOICES program utilizes Medicaid managed care to provide HCBS and LTSS for beneficiaries with intellectual or developmental disabilities (I/DD). To be eligible to participate in ECF CHOICES, a person must meet the definition of intellectual disability, or the definition of developmental disability.

The "Katie Beckett" program establishes new eligibility and benefits for children through age 18 with disabilities and/or complex medical needs who are not Medicaid eligible because of their parents' income or assets. These children receive medical care in home-based settings rather than in institutions.

With this approval, the components of the TennCare II demonstration will now operate under a new section 1115 demonstration titled TennCare III, with new flexibilities and financing structure described below. Many aspects of the TennCare II will continue in the TennCare III demonstration, except the authority for payments for graduate medical education (GME) and the waiver of retroactive eligibility for pregnant women and children. In the TennCare II uncompensated care pools amendment approved on June 30, 2020, GME was not approved to be increased and will expire as scheduled on June 30, 2021. CMS is also modifying the waiver and

STCs related to retroactive eligibility to exclude pregnant women and children described in section 1902(l)(4) of the Act from the applicability of the waiver. Consistent with the provisions of this section, CMS is not authorizing a waiver of retroactive eligibility for these populations. CMS will use its enforcement discretion for 6 months to obtain notice of state budget authority and complete all necessary operations and system changes needed to provide retroactive eligibility to these populations no later than July 1, 2021.

Extent and Scope of the Demonstration

CMS recognizes that states, as administrators of their Medicaid programs, are in the best position to assess the needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes. Tennessee’s demonstration, TennCare III, builds on the state’s past successes of managing their Medicaid program efficiently, by granting the state additional administrative flexibility to implement its program in exchange for taking on some financial risk through an aggregate cap financing model based on the state’s recent historical costs and enrollment experience. This approach is described in detail below.

Financing Approach

With this approval, the state will use a budget neutrality structure bound by an aggregate cap on demonstration funding based on established recent historical state costs and enrollment for most populations covered under the demonstration. This aggregate cap approach is not a “block grant” but rather, gives the state flexibility in operating its program under a defined cap by putting expenditures at risk based on both cost and population growth and is consistent with existing CMS policy outlined in the “Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects” State Medicaid Director Letter (SMDL).³ The administrative flexibility afforded under this demonstration will allow the state to appropriately manage costs within a fixed budget. In January 2020, CMS released a SMDL outlining the “Healthy Adult Opportunity (HAO)” initiative⁴, which would give states the opportunity to receive extensive flexibility to test alternative approaches to implementing their Medicaid programs. While TennCare III is not an HAO demonstration, it provides Tennessee with some similar flexibilities in exchange for managing its program under a funding ceiling and assuming some financial risk.

The aggregate cap model places a fixed total dollar cap on most state expenditures for the demonstration for which federal matching funds can be obtained under the expenditure authority in section 1115(a)(2). The aggregate cap includes a two-sided risk corridor of +/-1 percentage point change in enrollment between the demonstration’s base year enrollment and actual enrollment, which the state would be held harmless for the increase, and the federal government will be held harmless for the decrease. We note that under the aggregate cap the state will have savings to enable it to receive federal matching on expenditures for state plan covered services furnished to state plan eligible individuals.

³ “Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects” State Medicaid Director Letter #18-009: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf>

⁴ “Healthy Adult Opportunity” State Medicaid Director Letter #20-001: <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf>

Under this financing approach, the state will also have the ability to earn and reinvest shared savings. Tennessee will be eligible to qualify for shared savings on an annual basis when it underspends the “without waiver” aggregate cap and meets quality targets. Up to 55 percent of any savings achieved may be earned by the state in the form of additional federal matching funds that can be reinvested in its state health programs. The state may not earn savings in TennCare III for populations covered in TennCare II for which budget neutrality savings could not be earned.

Flexibilities

CMS is approving this demonstration for a period of 10 years. With this longer approval period, CMS is requiring the state to rebase the “without waiver” expenditure amounts to actual expenditures after 5 years, consistent with the CMS budget neutrality policy requiring rebasing to actual expenditures every 5 years. No later than July 1, 2025, the state will provide updated actual expenditure data to CMS to recalculate the base year amount and adjust the aggregate cap to reflect actual spending during the first 5 years of the demonstration. The base year starting January 1, 2026 will be updated to reflect actual expenditures for the demonstration period of July 1, 2023 through June 30, 2024, consistent with the same time period used to for the base for demonstration year 1 of the TennCare III demonstration.

Alongside the aggregate cap financing approach, CMS will allow the state discretion to make certain changes to its program within parameters established in the STCs without additional federal approval. This administrative flexibility may allow the state to be better equipped to respond to changes in demographics, economic conditions, or emerging public health issues without time delays in order to more effectively manage their Medicaid program. Any coverage or benefit changes to existing populations covered are limited to those that are additive in nature, and the state is not authorized to make reductions to its current approved coverage or benefits package without approval of an amendment. The state also commits that a change to the current coverage or benefits package that would reduce its maintenance of effort would require a change to the aggregate cap without waiver calculation. The state is receiving approval for the following new flexibilities and authorities under this demonstration.

Administrative Flexibilities. This demonstration provides the state with flexibility to add benefits and coverage without seeking prior approval from CMS. Any additional populations must be coverable under the state plan, and new benefits must be allowable under the state plan or through authority in sections 1915(b), 1915(c), 1915(i), 1915(j), 1915(k), or 1945. This flexibility allows the state to make meaningful decisions about program management or respond to changes in demographics, economic conditions, or emerging public health issues without the need for federal advance approvals. The state has the authority to not apply reasonable promptness and comparability requirements to new coverage in order to limit the group and vary the benefit package from the state plan.

Pharmacy Flexibilities. With this approval, Tennessee will be able to collect statutory section 1927 manufacturer drug rebates and negotiate other supplemental rebates directly with drug manufacturers. With the exception of drugs for individuals eligible for Early and Periodic Screening, Diagnostic and Treatment benefits, the state will have the authority to implement a

“commercial-style” closed drug formulary, while continuing to receive statutory drug rebates for covered drugs. Specifically, the state will have authority to not cover certain medications where there is at least one drug available per therapeutic class under Essential Health Benefits (EHB) rules (with the exception of certain protected drug classes), and to exclude certain new drugs from its formulary, with an exceptions process for specialty drugs.

Uncompensated Care Pools. This demonstration will allow the state to control the amount of uncompensated care (UC) funding for hospitals and develop the distribution methodology for their virtual disproportionate share hospital (DSH) and uncompensated charity care pools, under the aggregate cap, without prior approval from CMS. The state will have the flexibility to implement a methodology that will align with moving towards a value-based model to promote value over volume of services. By allowing the state to regulate the amount of funding to hospitals for uncompensated charity care, the state will ensure that hospitals can continue to provide high quality care, serve indigent patients, increase access to care, and improve health outcomes through a value-based system. The virtual DSH will also have a maintenance of effort at the level that was in place for demonstration year 19 in TennCare II.

Designated Savings Investment Programs (DSIP). Tennessee will be eligible to qualify for shared savings on an annual basis when it underspends the “without waiver” aggregate cap and meets quality targets. The state may be eligible to receive up to 55 percent of savings as federal expenditure authority for DSIP – here forward referred to as shared savings – that provide or support the provision of health-related services that are otherwise state-funded, and are not eligible for Medicaid funding. On December 15, 2017, CMS issued a SMDL #17-005 that indicated CMS generally would not extend Designated State Health Programs (DSHP) in current demonstrations. The HAO SMDL, however provided for a new opportunity to use a portion of savings for existing state-funded health programs when quality metrics were met. We extended similar HAO policy principles to this approval for DSIP.

As described in the STCs, the state must meet or exceed targets on the set of metrics for which shared savings can be qualified – here forward referred to as the shared savings metric set. Through the *Shared Savings Quality Measures Protocol*, the state will submit for CMS approval at least 10 quality measures that will comprise the shared savings metric set. The state is eligible to spend 45 percent of savings on DSIP if the state maintains performance on the full shared savings metric set. If performance falls below maintenance as defined in the STCs, in the first year of that underperformance, the state will submit to CMS a performance improvement plan. If in a consecutive year, maintenance is not achieved for those same metrics, the state will lose 10 percentage points of the 45 percent shared savings opportunity for each such metric. Shared savings for maintenance will not to fall below 20 percent unless the state underperforms in two consecutive years on at least four of these metrics and also does not improve on the remaining metrics, in which case the state forgoes the entire 45 percent shared savings opportunity. Only if the state qualifies for any shared savings based on maintenance, the state is also eligible to spend an additional ten percentage points up to a possible total of 55 percent of the savings on DSIP as defined in the STCs; the amount of shared savings for improvement will be proportionate to the number of metrics in the shared savings metric set. If in any demonstration year, the state performs with sufficient improvement on a shared savings metric to be in the 90th percentile or higher, the metric will be retired from the shared savings metric set, and CMS and the state will

select a replacement metric. Shared savings earned can be spent in that demonstration year, or in future demonstration years through December 31, 2030. The DSIPs that support vital state health programs and are eligible for FFP are listed in the STCs. By allowing the state to receive FFP for these health-related programs, CMS is enabling the state to continue to improve health outcomes and increase the efficiency and quality of care that advance Medicaid objectives.

Fraud Penalties. The state will have the authority to suspend Medicaid eligibility for individuals who have been convicted of Medicaid fraud in state or local courts for a period of up to 12 months. The state will provide at least 10 days advance notice prior to the suspension. Beneficiary protections remain in place including their right to appeal, their right to apply for Medicaid on another basis, and access to information about other available services.

Monitoring and Evaluation

The monitoring and evaluation activities under TennCare III will focus on assessing the performance of the demonstration and whether the demonstration is effective in achieving the objectives of the program. Throughout the life-cycle of the demonstration approval period, monitoring will support tracking the state's progress towards its demonstration goals. The evaluation will focus on studying whether the TennCare III model that offers the state significant flexibilities in exchange for assuming financial risk is effective in producing the desired outcomes for beneficiaries, providers, and the Medicaid program overall.

As part of this demonstration approval, Tennessee will be required to conduct robust monitoring of the demonstration policies, including reporting on enrollment and enrollment changes over time, access to care, quality of care, and health outcomes, and for some metrics for specific subgroups of demonstration populations. The demonstration monitoring will also include reporting on the shared savings metric set, as outlined in the STCs and the state's performance relative to the CMS approved *Shared Savings Quality Measures Protocol*. The monitoring reports will describe performance progress on this metric set and the calculation of shared savings for the year, as well as how savings are spent in each demonstration year.

Per the STCs, the state will report on CMS's standard metrics for the waiver of retroactive eligibility policy, and for premiums as well as suspension, disenrollment and lock-out for non-payment of premiums under the Katie Beckett program. The state will also be expected to report metrics on suspensions for fraud, and on the number and types of drugs affected under the closed formulary policy that would apply for individuals not eligible for EPSDT benefits. The performance metrics will also reflect all other components of the state's demonstration.

Consistent with CMS requirements for all section 1115 demonstrations, the state will undertake rigorous evaluation of the demonstration policies. Where applicable, the state will be expected to adopt, with necessary adaptations, CMS's evaluation design guidance for various demonstration policy areas. The state is required to prepare a strong evaluation design that is subject to CMS approval for the entirety of the demonstration approval period, and conduct—in alignment with the evaluation design—three interim evaluations and one summative evaluation pertaining to the ten-year demonstration approval period. The key provisions under the demonstration will be tested via hypotheses and research questions approved in the state's

evaluation design. In assessing the extent to which the demonstration achieves the key policy outcomes and objectives, the state must identify, through robust statistical methods, viable in-state or out-of-state comparison populations, or use other rigorous methodological approaches, such that the impact of the demonstration can be estimated.

The state will be expected to make a significant and sustained effort to conduct a robust evaluation leveraging otherwise comparable states with or without section 1115 Medicaid demonstrations, to assess whether the TennCare III model, including its programmatic flexibilities, is successful in offering high-quality care, assuring access to health care, enhancing beneficiary satisfaction, and improving health outcomes of Tennesseans enrolled in the demonstration. It must provide a comprehensive understanding of how the state uses the shared savings and also study whether the program flexibilities with risk-sharing promote the goals of fiscal sustainability.

The evaluation will also assess insurance and health outcomes of former beneficiaries disenrolled or suspended from the program, for example, due to the non-payment of premiums under the Katie Beckett program or due to a suspension for fraud, as well as individuals who separate voluntarily from the program.

The state will also continue focusing on evaluating the effectiveness and impact on beneficiaries of the demonstration's HCBS-focused program components, including TennCare CHOICES and ECF CHOICES. For example, the evaluation will assess whether the provision of different benefit packages to individuals needing HCBS is successful in meeting beneficiary needs. The evaluation design will also include research questions focused on the effectiveness of the financial support that hospitals and safety net providers receive who serve the Medicaid and uninsured populations and provide graduate medical education.

The evaluation of the Katie Beckett program will include hypotheses focused on beneficiary compliance with premiums payments, enrollment continuity, and health status. The DSIP program and other added benefits must also be assessed in their effectiveness of addressing social determinants of health, in particular, focusing on the additional services covered and populations served. This assessment will study outcomes, such as coverage, beneficiary access to care and health outcomes, and any improvements in provider and service delivery networks. Furthermore, the evaluation will assess the impacts of the demonstration's beneficiary fraud provisions and hypotheses focused on suspensions of eligibility will examine outcomes, such as, enrollment continuity and health status (as a result of greater enrollment continuity). The closed drug formulary component will also be evaluated for its impact on beneficiary access to and the cost of prescriptions drugs.

The state will evaluate the waiver of retroactive eligibility to understand how the policy affects outcomes, such as enrollment and enrollment continuity, enrollment when people are healthy, and health status (as a result of greater enrollment continuity). The state must also investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, provider uncompensated care costs, and the impact of the DSIP program on generating net Medicaid costs or savings. In addition, the state must use hypothesis tests aligned with other demonstration

goals and cost analyses together to assess the demonstration's effects on Medicaid program sustainability.

The demonstration approval includes robust monitoring and evaluation requirements, and the demonstration may be suspended or withdrawn, if monitoring or evaluation data raise concerning evidence. Specifically, these STCs outline that CMS reserves the right to require the state to take corrective action, which could include suspending implementation of specific provisions of the demonstration, if monitoring or evaluation data indicate substantial and sustained directional change inconsistent with state targets (such as substantial and sustained trends indicating increased difficulty accessing services). CMS further has the ability to suspend implementation of part or the whole of the demonstration should corrective actions not effectively resolve these concerns in a timely manner. The STCs will aid the state and CMS in measuring and tracking the demonstration's impact, and give CMS additional tools to protect beneficiaries if necessary. Further, CMS reserves the right to withdraw expenditure authorities at any time, subject to the conditions described in the STCs, if it determines that continuing the expenditure authorities would no longer be in the beneficiaries' interest or promote the objectives of Medicaid.

Elements of the Demonstration Request that CMS is Not Approving at This Time

Tennessee requested exemption from future federal mandates regarding eligibility or benefits in the absence of an agreement to provide additional federal funding to the budget neutrality calculation. CMS cannot commit to this request at this time. The state also requested permanent approval of the demonstration and for CMS to only require amendments to receive ongoing approval from CMS. CMS is not permanently approving this demonstration. CMS is approving this demonstration for a period of 10 years to reduce administrative burden and to allow the state sufficient time to test its innovative approach. The state withdrew its requests for flexibility to receive FFP for services provided in institutions for mental diseases and regulatory requirements related to managed care.

Determination that the demonstration project is likely to assist in promoting Medicaid's objectives

For the reasons discussed below, the Secretary has determined the TennCare III demonstration is likely to assist in promoting the objectives of the Medicaid program.

The demonstration will furnish medical assistance in a manner that improves the sustainability of the safety net.

The measures being tested with this demonstration approval may have associated administrative costs, particularly at the initial stage, and CMS acknowledges that section 1115 demonstrations may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." Act § 1115(d)(1). Here, however, we anticipate that the only impacts on eligibility or enrollment will be to expand eligibility and enrollment because the state has agreed to a maintenance of effort for the currently allotted funding, ensuring that there will be no changes to the current coverage and benefit levels prior to the demonstration. The state also agrees that no changes will be made to the scope of the EPSDT benefit for children under age 21 under this demonstration. The TennCare III demonstration will implement new policies and flexibilities designed to drive

program improvement while also offering flexibility to make future changes that increase coverage and facilitate timely response to emerging public health issues as needed.

CMS believes that the flexibilities provided under this proposal will allow the state to manage its Medicaid program in ways that best meet the needs of Tennesseans, as well as afford the state the opportunity to implement additional innovative solutions within the TennCare program to address problems faced by beneficiaries. TennCare III will preserve and build on the gains that have already been achieved under the TennCare II demonstration and allow the state to pursue changes in the organization, finance, and delivery of services that will continue to improve the program in the future. By operating under this financing approach, the state is able to better manage its limited resources in such a way that may result in achieving savings, which in turn can be used to pay for expanded state health programs, subject to the parameters in the STCs. Therefore, these flexibilities and financing approach approved in TennCare III meet the objectives of the Medicaid program.

The demonstration will expand coverage and improve health outcomes.

Approval of TennCare III demonstration supports Medicaid's objectives by improving access to high-quality services and expansion of coverage. Under the demonstration, the state may only expand benefits and coverage under this demonstration authority; benefits and coverage cannot be reduced, as the state is required to maintain the level of benefits and coverage that are in place as of December 31, 2020.

CMS is approving a range of flexibilities that will help the state be more nimble in applying resources to reflect changes in emerging health care needs, including public health issues, demographic changes, and economic conditions. The state may receive up to 55 percent of savings on vital state health programs including those that address social determinants of health, which could better enable the state to advance the objectives of Medicaid by continuing to improve health outcomes and increase the efficiency and quality of care that Medicaid beneficiaries and similar populations receive.

We are committed to supporting states that seek to test measures that are likely to increase coverage and improve the health of beneficiaries, and support the fiscal sustainability of states' Medicaid programs. We expect that such demonstration policies will improve beneficiaries' physical and mental health, resulting in these beneficiaries consuming fewer health care services and resources while they are enrolled in Medicaid, which will preserve Medicaid program resources, making the Medicaid program more efficient.

Consideration of Public Comments

To increase the transparency of demonstration projects, sections 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

Section 1115(d)(2)(A) & (C) of the Act specifies that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposes no additional specific requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not necessarily provide written responses to public comments. 42 CFR 431.416(d)(2).

The federal public comment period was open from November 27, 2019 and closed December 27, 2019. CMS received 6,186 public comments during the federal comment period on the state's application. Although CMS is not legally required to provide written responses to comments, CMS is addressing some of the central issues raised by the commenters and summarizing CMS's analysis of those issues for the benefit of stakeholders. After carefully reviewing the public comments submitted during the federal comment period, CMS has concluded that the demonstration project advances the objectives of Medicaid.

General Comments

The vast majority of comments CMS received opposed Tennessee's proposed demonstration. Only a small number of comments supported the proposed demonstration or expressed mixed opinions. The opposing comments included concerns about what the commenters thought the proposed demonstration's negative effects could be on coverage and access. Commenters were specifically concerned that vulnerable populations could be adversely affected by the demonstration, and the proposed demonstration would result in decreased public transparency and federal oversight. Additional comments included concerns about the effects of proposed formulary restrictions, potential weakened/lesser coverage, and flexibility with respect to complying with regulatory requirements. CMS believes that these commenter concerns are misplaced in light of the guarantees under this demonstration concerning the state's maintenance of effort in providing coverage, and the fact that flexibilities provided on coverage pertain to expansions in coverage, as this demonstration would do generally (e.g., other expanded benefits). CMS agrees with the state that the new demonstration's policies are designed to drive program improvement while also offering flexibility to make future changes that actually would increase, or at a minimum be able to retain existing optional coverage, and facilitate timely response to emerging public health issues as needed and anticipates that the only impact on eligibility or enrollment will be to expand it. CMS addresses these themes more specifically below.

Comments on the Financing

Of the opposing comments, a major theme was on the financing aspect of the demonstration. Commenters were concerned about what they saw to be a proposal that would alter Medicaid's financing structure, including the formula that the commenters believed would change the rate at which states draw down federal Medicaid funds for state plan covered services, which they believed would require a waiver of the federal Medicaid matching rate incorporated under section 1903 of the Social Security Act, which governs how Medicaid is financed. The comments correctly note that section 1115 does not give the Secretary authority to alter the medical assistance matching rate under section 1903, stating that "...giving Tennessee a lump sum of federal funds isn't allowable." Stakeholders were also concerned that any savings the

state earned could be used in ways that may be too flexible and supplant current state spending on public health or social services — effectively making the funds it saves available for highways or tax cuts. In particular, commenters were concerned it could create powerful new incentives and opportunities for Tennessee to balance its budget by cutting TennCare.

CMS understands these concerns and is not approving the “block grant” financing approach the state described in its original application. Tennessee’s financing structure under this demonstration uses an aggregate cap budget neutrality financing approach that is consistent with existing CMS policy outlined in the “Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects” SMDL #18-009. Under this approach, the state will be subjected to a budget neutrality limit on the federal matching funds it receives under the expenditure authority under section 1115(a)(2). To the extent the state exceeds the budget neutrality limit, federal matching under section 1115(a)(2) would be disallowed for that excess amount. Conversely, to the extent the state’s expenditures turn out to be below the budget neutrality limit, the state can share in the savings achieved. Specifically, this financing approach would permit the state an opportunity to earn savings, which can be reinvested into the state’s health programs, subject to guardrails specified in the STCs limiting the types of programs and priorities on which the state may spend the savings. These savings must be reinvested in allowable health programs and cannot be diverted from critical Medicaid programs to other expenses, such as spending on highways or a tax cut, as suggested by some commenters. As described earlier, the state’s evaluation will be required to rigorously evaluate the impact these new flexibilities will have on enrollment and other beneficiary outcomes, and how the state uses the shared savings.

The demonstration will also have a two-sided risk corridor mechanism that will have the state and its federal CMS partner jointly share the risk of an increase or decrease by 1 percentage point above or below the baseline enrollment, within an eligibility group for the specific demonstration year. As long as actual enrollment is within 1 percentage point in either direction of the baseline enrollment value, the aggregate cap for a specific enrollment group will stay the same. If a particular eligibility group is above or below the 1 percentage point threshold, then an adjustment is made to the aggregate cap amount. This financing model will provide the state with flexibility to manage its program with fewer administrative burdens in exchange for the state assuming increased financial risk, but maintains critical protections, including the aforementioned safety valve, and oversight as described in the STCs.

Comments on Pharmacy Flexibilities

Comments addressing the proposed demonstration’s impact on beneficiary access to care often cited specific concerns about pharmacy benefits. Specifically, commenters expressed concern that pharmacy benefits would become less generous under Tennessee’s Medicaid program because, rather than covering all drugs offered by manufacturers with drug rebate agreements, formularies could be limited in the manner of those offered by employers, private insurance companies, Medicare Part D, and the Department of Veteran’s Affairs. Comments indicated the state’s proposal would have necessary outpatient drugs offered using a “drug formulary” that would not include every drug manufacturer’s version of a particular type of drug, such as a cholesterol-lowering statin. In commenting on the formulary component of the state’s proposal, some individuals and organizations questioned how the state intended to review pharmaceuticals

approved through the Federal Drug Administration's (FDA) accelerated pathway for potential inclusion on the TennCare III formulary. Commenters objected to the suggestion that the state would review these drugs, noting that the FDA is the standard for drug review and approval, and that the FDA has determined that drugs approved through the fast track approval process are safe and meet an urgent and unmet need. Again, as occurs in Medicare Part D, under which Medicaid beneficiaries who are eligible for Medicare receive their drug coverage, not every drug approved by FDA would be covered by the state, but every class of drug needed to treat the beneficiary would be covered, with an exception process for coverage of drugs not on the formulary.

Under this demonstration approval, CMS is granting the state many flexibilities requested. However, in light of the concerns expressed in the public comment period, the state will be subject to increased oversight and monitoring to ensure that all beneficiaries have access to needed pharmaceuticals. In addition, the state must meet the standards of Essential Health Benefit plans, which align coverage with requirements of plans in the individual market insurance Marketplace, and the standards that apply under Alternate Benefit Plans (ABPs) under section 1937 of the Social Security Act. The formulary under the demonstration must comply with new mandatory Medication Assisted Treatment drug coverage requirements, Medicare Part D rules for mental health and other protected class drugs, and comply with other protections as outlined in the STCs. Additionally, as noted above, the state is subject to increased oversight and monitoring with the increased flexibility under the new model.

CMS will require that the state's evaluation of the demonstration to assess the impact of the pharmacy benefits and formulary management strategies on beneficiary access to prescription medication and refills, including implications for health outcomes. Key informational interviews will help support the state and CMS' understanding about the implementation of the policy and any challenges therein, and beneficiary interviews could inform beneficiary understanding of and experience with the policy.

Comments on Disproportionate Impact on Vulnerable Populations

Another concern among the comments received was that the proposed demonstration could have a disproportionate impact on vulnerable populations by restricting behavioral health services to beneficiaries with serious mental illnesses. In this approval, the state is required to maintain the level of benefits and coverage that are in place as of December 31, 2020. No reductions in benefits or coverage can be made by the state without an amendment and additional public comment processes. The state may only expand benefits and coverage or pilot new health programs under this demonstration authority. These protections were designed to alleviate concerns about any potential disproportionate impact on vulnerable populations as a result of reductions in benefits for the accrual of savings.

Comments on Decreased Oversight of Tennessee's Medicaid Program

A large number of commenters suggested that the proposed demonstration would result in decreased transparency and oversight of Tennessee's Medicaid program. Commenters highlighted aspects of the proposed demonstration that would allow the state to make changes to TennCare without soliciting feedback from the public.

Under this demonstration, any proposed changes to the TennCare demonstration will continue to be subject to the existing federal notice and transparency requirements regarding 1115 demonstrations. While the demonstration provides authority for the state to make certain changes to the demonstration without prior approval by CMS, the scope of the changes are limited to what is already approvable under Medicaid authorities, and all changes must be posted for public comment in advance with no exceptions to the transparency requirements with this authority. Robust monitoring and evaluation will also be required throughout the lifecycle of the demonstration approval period with regard to enrollment, access to and quality of care, health outcomes and costs of care. CMS will gather regular monitoring data through deliverables outlined in the STCs, such as contract amendments, rates, and the quarterly and annual monitoring reports, as well as continued engagement between CMS and the state via regularly scheduled demonstration monitoring calls. Through these oversight mechanisms, CMS will work with the state to resolve any issues that arise as Tennessee works to implement the authorities approved under this demonstration.

Comments on Consequences for Fraud/Abuse

Several commenters expressed concern about the state's request to temporarily suspend or terminate the eligibility of individuals who have been convicted of Medicaid fraud. Some commenters questioned whether such a policy promotes the objectives of the Medicaid program. Others expressed concern about potential disruptions to care, especially for individuals receiving cancer treatment. Other commenters questioned whether the magnitude of member fraud experienced by Tennessee is sufficient to warrant granting such authority to the state. There was also concern that suspending any portion of these members' benefits would shift the costs of their care to providers, especially hospitals. One commenter pointed out that there are certain circumstances in which the state can already disenroll individuals who are guilty of fraud, and that additionally, TennCare is not obligated to pay for members' care if they are incarcerated for TennCare fraud. Finally, some commenters suggested that a new administrative process would be needed to make the kinds of determinations described in the state's proposal (e.g., about whether to suspend a member's benefits in whole or in part or to refer a member to substance use disorder treatment as an alternative to suspension of benefits), and expressed skepticism that Tennessee's current administrative structure could implement such processes effectively.

This demonstration provides the state with the authority to suspend beneficiary eligibility for up to 12 months for fraud convictions in state or local court. CMS understands commenters' concerns, and as result has included several guardrails to this policy. Under this demonstration, the state will provide at least 10 days advance notice of the suspension to beneficiaries, which will include information on the nature of the suspension, as well as their right to appeal, their right to apply for Medicaid on another basis, what this status means with respect to their ability to access other health insurance coverage, and what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category. This flexibility allows the state to hold beneficiaries accountable while ensuring that beneficiary protections are provided.

Comments Supporting the Demonstration

The most common theme among the supportive comments focused on the use of shared savings that would occur within the demonstration. Allowing shared savings to be earned under the demonstration had general support from commenters since it will allow the state to use the savings for health-related programs for people similar to Medicaid beneficiaries that are not otherwise eligible for FFP. CMS agrees with these supporting comments, and in addition, CMS has added some guardrails described within the STCs clarifying which programs the state can use the shared savings for as well as limiting to those programs that will support vital state health programsthat address social determinants of health. By allowing the state to receive FFP for health-related programs, CMS is enabling the state to continue to improve health outcomes and increase the efficiency and quality of care that advance Medicaid objectives.

Other Information


CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of expenditure authorities and STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receipt of your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Lorraine Nawara. She is available to answer any questions concerning your section 1115 demonstration. Ms. Nawara's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
E-mail: Lorraine.Nawara1@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Teresa DeCaro, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,



Seema Verma

Enclosure

cc: Tandra Hodges, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES WAIVER LIST

NUMBER: No. 11-W-00369/4

TITLE: TennCare III 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 for the term of this demonstration extension period as specified in the accompanying approval letter.

These waivers of specified requirements under section 1902(a) of the Social Security Act, and implementing regulations, are granted only to the extent necessary to achieve the indicated purposes, and must be exercised in accordance with the Special Terms and Conditions (STCs). These waivers are effective upon approval of the term of this extension of the demonstration through December 31, 2030 unless otherwise stated.

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

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

1. 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.

2. 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.

3. 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 STC 33.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.

To the extent necessary to enable the state to limit enrollment in each Employment and Community First (ECF) CHOICES benefit group to the enrollment target established by the state for that group, as authorized under STC 34.d. (*Enrollment Targets for ECF CHOICES*) of the STCs.

4. 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.

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

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.

To the extent necessary to allow the state to offer the applicable ECF CHOICES benefits package to an individual with intellectual or developmental disabilities (I/DD) enrolled in an ECF CHOICES benefit group.

6. 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 III, TennCare CHOICES and ECF 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.

7. Retroactive Eligibility **Section 1902(a)(34)**
42 CFR 435.915

To enable the state not to extend eligibility prior to the date that an application for assistance is made. The waiver of retroactive eligibility does not apply after June 30, 2021 to pregnant women (or during the 60-day period beginning on the last day of the pregnancy), infants under one year of age, or individuals under age 21.

8. Suspension of eligibility for State or local fraud convictions **Section 1902(a)(8) and**
1902 (a)(10)

To the extent necessary to implement suspension of eligibility as provided under STC 28 below.

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

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

TITLE: **TennCare III 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 III):

1. Expenditures Related to Demonstration Eligibility Methods for 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 and 42 CFR 435.115, for the remainder of a 12-month eligibility period after the 4-month period specified in the statute and regulation.

2. Expenditures for Expanded Benefits.

Expenditures for TennCare Medicaid and TennCare Standard enrollees for optional services in section 1905(a) of the Act but are not covered under Tennessee's state plan or beyond the state plan's service limitations as indicated in STC 29 (*TennCare Benefits*).

3. Expenditures for Hospital and Clinic Payments.

Expenditures for hospital and clinic payments to the extent specified in STC 67 (*Permissible Uncompensated Care Payments*).

4. Indirect Payment of Graduate Medical Education.

Expenditures, up to \$50 million in total computable expenditures (minus any spending for these expenditures under TennCare II in DY 19) 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, through June 30, 2021.

5. Payments for Non-Risk Contractor.

Expenditures for payments to the TennCare Select prepaid inpatient health plan (PIHP), non-risk, non-capitated contractor that exceed the upper limits at 42 CFR 447.362.

6. Medically Eligible Demonstration Population Children, Not CHIP Eligible.

Expenditures for certain uninsured children under age 19 who lose eligibility in TennCare Medicaid, have family income at or above 211 percent of the Federal poverty level (FPL), and do not meet the definition of an optional targeted low-income child.

7. Adult Demonstration Population Eligibles Standard Spend Down (SSD):

Expenditures for non-pregnant, non-postpartum adults aged 21 or older who are not eligible under the state plan, but are determined to meet criteria similar to the state plan medically needy criteria in accordance with STC 20.a. and are:

- i. Aged, blind, or disabled individuals; or
- ii. Caretaker relatives.

8. Additional Optional Coverage: Expenditures for optional coverage, not already covered by the state on December 31, 2020 to the extent that the populations could be covered under the state plan and that the coverage is otherwise consistent with sections 1902, 1903, 1905, and 1906 of the Act, current Federal regulations, and CMS policy, and STC 6.

9. Additional Benefits: Expenditures for optional benefits, not already covered by the state on December 31, 2020, to the extent that the benefits could be covered under the state plan or through authority in sections 1915(b), 1915(c), 1915(i), 1915(j), 1915(k), or 1945 and that the coverage is otherwise consistent with sections 1902, 1903, 1905, and 1906 of the Act, current Federal regulations, and CMS policy, and STC 6.

10. CHIP-Related Medicaid Expansion Demonstration Population Children.

Expenditures to provide Medical Assistance coverage to uninsured children who lose eligibility under TennCare Medicaid, who meet the definition of an optional targeted low-income child, and who have family income up to 211 percent of the FPL.

11. 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 E 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.

12. Employment and Community First (ECF) CHOICES 217-Like HCBS Group.

Expenditures for ECF CHOICES enrollees with intellectual or developmental disabilities (I/DD) who would be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) and 42 CFR 435.217, if the services they received under ECF CHOICES were provided under a Section 1915(c) waiver. This includes application of the post-eligibility and spousal impoverishment rules. These expenditures are limited to those necessary to provide:

- a. Services as presented in Table 2a of the TennCare III STCs; and
- b. ECF CHOICES services as authorized under STC 29.j. and Attachment H.

13. CHOICES HCBS Services for SSI-Eligibles.

Expenditures for the provision of home and community-based waiver-like services as specified in Table 2b and Attachment E 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 or below 100 percent of the Supplemental Security Income/Federal Benefit Rate (SSI/FBR) 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.

14. ECF CHOICES Services for SSI Eligibles.

Expenditures for the provision of home and community-based waiver-like services, as specified under STC 29.j. and Attachment H, that are not described in Section 1905(a) and not otherwise available under the approved state plan, but could be provided under Section 1915(c), that are furnished to ECF CHOICES enrollees with I/DD with income up through 100 percent of the SSI/FBR and resources at or below \$2,000 who either:

- a. Meet the nursing facility (NF) level of care (LOC) and need specialized services for I/DD, or pursuant only to STC 34.c.i., are granted an exception by the state based on transition either from the Statewide or Comprehensive Aggregate Cap Waivers or from an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) into ECF CHOICES Group 6 or ECF CHOICES Group 8; or
- b. Do not meet the NF LOC but who, and in the absence of ECF CHOICES services, are “at risk” of institutionalization.

15. The CHOICES At Risk Demonstration Group.

Elderly adults and adults age 21 and older with physical disabilities who were not otherwise determined eligible for Medicaid or TennCare under any other category and who were determined prior to July 1, 2015, to: (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; (3) be “at risk” of institutionalization in the absence of TennCare Interim CHOICES 3 services, and (4) continue to meet the nursing facility financial eligibility standards and the nursing facility level of care criteria in place on June 30, 2012, and remain continuously enrolled in the CHOICES At Risk Demonstration Group.

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 E 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.

16. Continuing Receipt of Nursing Facility Care and 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.

17. 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.

18. LTC Partnership.

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

19. Full State Plan and Demonstration Benefits for Presumptively Eligible Pregnant and Postpartum Women.

Expenditures to provide presumptively eligible pregnant and postpartum women who have incomes up to 195 percent of the FPL the following benefits: the full benefit package under the state plan for categorically needy individuals who are not enrolled in an alternative benefit plan, and demonstration benefits described in STC 29 (*TennCare Benefits*). For purposes of this expenditure authority, benefits covered by the TennCare demonstration provided to presumptively eligible pregnant and postpartum women are not limited to ambulatory services.

20. Interim ECF CHOICES At-Risk Demonstration Group.

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:

- a. Services as presented in Table 2a of the TennCare III STCs;
- b. ECF CHOICES services as authorized under STC 29.j. and Attachment H.

21. ECF CHOICES At-Risk Demonstration Group

Beginning with Phase 2 of ECF CHOICES, individuals with I/DD who are not otherwise eligible for Medicaid or TennCare who are receiving ECF CHOICES services; meet the resource limit for the ECF CHOICES 217-Like Group; have income at or below 150 percent of the FPL; meet the NF LOC criteria in place on June 30, 2012 but not the criteria in place on July 1, 2012; and in the absence of ECF CHOICES are “at risk” of institutionalization. These expenditures are limited to those necessary to provide:

- a. Services as presented in Table 2a of the TennCare III STCs;
- b. ECF CHOICES services as authorized under STC 29.j and Attachment H.

22. 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 percent of the FPL. These expenditures are limited to those necessary to provide:

- a. Services as presented in Table 2a of the TennCare III STCs;
- b. ECF CHOICES services as authorized under STC 29.j and Attachment H.

23. Katie Beckett Group (Part A)

Expenditures for children through age 18 who (1) have medical needs that are likely to last at least 12 months or result in death, and which result in severe functional limitations based on medical eligibility criteria developed specifically for children; (2) qualify for care in a medical institution; (3) but for the parents’/guardians’ income would qualify for Medicaid; and (4) meet all of the eligibility requirements specified in STC 21a. These expenditures are limited to those which are medically necessary up to \$15,000 annually of:

- a. Services as presented in Table 2e of the TennCare III STCs;
- b. Services as authorized under STC 21.

24. Medicaid Diversion Group (Part B)

Expenditures for specified services for children under age 18 who (1) have medical needs that are likely to last at least 12 months or result in death, and which result in severe functional limitations based on medical eligibility criteria developed specifically for children; (2) qualify for care in a medical institution or are at risk of institutional placement; and (3) meet all of the eligibility requirements specified in STC 21b. These expenditures are limited to those necessary to provide up to \$10,000 annually of reimbursement for specified items and services, as described in Table 2f of the TennCare III STCs.

25. Continued Eligibility Group (Part C)

Expenditures for children through age 18 who are enrolled in Medicaid, but are no longer eligible in any Medicaid category, and who meet the criteria for enrollment in Katie Beckett (Part A), but for whom there is not an available slot. These expenditures are limited to those necessary to provide all TennCare Medicaid services as presented in Table 2a of the TennCare III STCs.

26. Designated State Investment Program (DSIP)

Expenditures for cost of designated programs that provide or support the provision of health services that are otherwise state-funded as of December 31, 2020, and not eligible

for Medicaid funding. These expenditures are limited to those necessary to support vital state health programs as defined in STC 32.

27. Pharmacy

Expenditures for coverage of outpatient drugs as provided in STC 45.

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.

1. Reasonable Promptness (10)

Section 1902(a)(8) and

To the extent necessary to enable the state to limit enrollment in the Katie Beckett (Part A) and the Medicaid Diversion (Part B) groups to the enrollment target established by the state for that group, as authorized under STC 35.c. (*Enrollment Targets for Katie Beckett and Medicaid Diversion*) of the STCs.

To the extent necessary to enable the state to implement the Katie Beckett (Part A) and Medicaid Diversion (Part B) groups on different timeframes, and/or to stagger implementation of the HCBS benefits for the Katie Beckett (Part A) and/or Medicaid Diversion (Part B) group.

To the extent necessary to enable the state to suspend enrollment in Katie Beckett Part A detailed in STC 21.a for individuals who fail to pay required premiums until such time the premiums are paid in full.

To the extent necessary to enable the state to limit enrollment in state plan optional groups added in accordance with Expenditure Authority 8.

To the extent necessary to enable the state to suspend eligibility for individuals who have committed Medicaid beneficiary fraud as described in STC 28 for a period of 12 months.

2. Comparability and Provision of Medical Assistance

Sections 1902(a)(17) and 1902(a)(8)

To the extent necessary to permit the state to close enrollment in the population groups set forth in Expenditure Authorities 6 and 10, except for individuals who “rollover” from other eligibility groups in accordance with STCs 18 and 19.

To the extent necessary to allow the state to offer the applicable benefits package to an individual with disabilities enrolled in Katie Beckett (Part A), the Medicaid Diversion (Part B), and Continued Eligibility (Part C) benefit groups.

To the extent necessary to allow the state to limit enrollment in the Continued Eligibility group to children with disabilities losing Medicaid eligibility but for whom there is not an available slot in the Katie Beckett (Part A) group.

To the extent necessary to allow the state to require parents with access to private coverage for a child in the Katie Beckett (Part A) group to obtain or maintain such coverage, subject to a hardship exception

To the extent necessary to allow the state to offer the applicable benefits package to an individual enrolled in new optional state plan groups as described in Expenditure Authority 8.

3. Premiums

**Section 1902(a)(14)
insofar as it incorporates section 1916**

To the extent necessary to enable the state to require payment of monthly premiums as a condition of enrollment for Katie Beckett (Part A).

4. Freedom of Choice

**Section 902(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 Katie Beckett (Part A), Continued Eligibility (Part C), and newly added state plan optional groups described in Expenditure Authority 8. No waiver of freedom of choice is authorized for family planning providers.

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

NUMBER: Title XIX No. 11W00369/4

TITLE: TennCare III 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 III Section 1115(a) Medicaid demonstration (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 December 31, 2030.

The STCs have been arranged into the following subject areas:

- I. PREFACE**
- II. PROGRAM DESCRIPTION AND OBJECTIVES**
- III. GENERAL PROGRAM REQUIREMENTS**
- IV. ELIGIBILITY**
- V. BENEFITS**
- VI. CHOICES, ECF CHOICES, KATIE BECKETT (Part A), MEDICAID
DIVERSION (Part B) and CONTINUED ELIGIBILITY (Part C)
ENROLLMENT**
- VII. COST SHARING**
- VIII. DELIVERY SYSTEMS**
- IX. GENERAL REPORTING REQUIREMENTS**
- X. GENERAL FINANCIAL REQUIREMENTS**
- XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION**
- XII. EVALUATION OF THE DEMONSTRATION**

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Interim and Summative Evaluation Reports
- Attachment C: Limitations on Home Health Services
- Attachment D: Limitations on Private Duty Nursing Services
- Attachment E: Glossary of Terms of TennCare CHOICES
- Attachment F: Best Practices Guidance Regarding Consumer Direction of HCBS
- Attachment G: Certified Public Expenditures Protocol
- Attachment H: Employment and Community First CHOICES Service Definitions
- Attachment I: Reconciliation of Uncompensated Care Payments (reserved)
- Attachment J: Evaluation Design (reserved)
- Attachment K: COVID-19 Emergency HCBS Flexibilities
- Attachment L: Glossary of Terms for Katie Beckett Program
- Attachment M: Implementation Plan (reserved)
- Attachment N: Monitoring Protocol (reserved)
- Attachment O: Designated State Investment Programs
- Attachment P: Shared Savings Quality Measures Protocol (reserved)
- Attachment Q: DSIP Claiming Protocol (reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

TennCare began as an 1115(a) demonstration project in January 1994. The last extension was granted under the authority of Section 1115(a) of the Act and in effect from December 16, 2016, through January 7, 2021. TennCare III builds upon the success of its predecessors but realigns the financial incentives and increases the administrative flexibilities of the demonstration, giving the state increased responsibility for managing its Medicaid program.

All mandatory and optional populations eligible under Tennessee's state plan are enrolled in TennCare III, 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 four components to the TennCare III 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 provide all Medicaid services, except for services specified in the STCs, and as excluded from the TennCare Standard benefits package and provided as part of the TennCare Medicaid benefit package.

The **CHOICES** Program 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 III 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.

Employment and Community First (ECF) CHOICES utilizes Medicaid managed care to provide home and community-based long-term services and supports for individuals with intellectual or developmental disabilities. To be eligible to participate in ECF CHOICES, a person must meet the definition of intellectual disability located at T.C.A. 33-1-101(16), or the definition of developmental disability located at T.C.A. 33-1-101(11). Eligibility for ECF CHOICES will proceed in two phases. Phase 1 will commence upon implementation of ECF CHOICES and assurance of plan readiness. Phase 2 will begin 60 days after the state notifies CMS that its eligibility systems are ready to begin processing eligibility for the ECF CHOICES At-Risk Demonstration Group and the ECF CHOICES Working Disabled Demonstration Group. Benefits are the same in both phases.

Katie Beckett and Medicaid Diversion components of the TennCare III demonstration, offer services and supports to children under age 18 with disabilities and/or complex medical needs

who are not Medicaid eligible because of their parents' income or assets. There are three benefit groups.

1. Katie Beckett (Part A)
2. Medicaid Diversion (Part B)
3. Continued Eligibility (Part C)

Katie Beckett (Part A) is a "traditional" Katie Beckett model, providing full Medicaid eligibility by waiving the deeming of the parents' income and assets to the child, as well as essential wraparound home and community-based services (HCBS) to children with the most significant disabilities or complex medical needs who meet institutional level of care, and for whom the estimated amount which would be expended for medical assistance for care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution. Medicaid Diversion (Part B) is a Medicaid diversion program, offering a capped package of essential wraparound services and supports, as well as premium assistance on a sliding fee scale to a broader group of children with disabilities, including those "at risk" of institutionalization. The Continued Eligibility group (Part C) allows children to continue receiving TennCare state plan services after upon being determined to no longer qualify for Medicaid in any other eligibility category if they meet the Katie Beckett (Part A) group eligibility criteria, but a slot is not available for them at the time financial eligibility is lost.

The TennCare III demonstration is a new approach that supports goals of broad access to high quality care that leads to improved health outcomes, fiscally sustainable program administration, and innovative solutions to delivering healthcare more effectively. This demonstration allows the state significant flexibilities in exchange for assuming the financial risk. The demonstration gives the state a range of autonomy within which it can make decisions about its Medicaid program. The state may increase coverage and benefits without additional CMS approval as well as implement new flexibilities in pharmacy. The state now has a discrete set of reasonable flexibilities that will provide the ability to make meaningful decisions about program management without the need for federal advance approvals; initiate new policies designed to drive program improvement; or respond to changes in demographics, economic conditions, or emerging public health issues.

The primary goals of the TennCare program will remain unchanged and are the following:

- Provide high-quality care to enrollees
- Ensure enrollees' satisfaction with services
- Improve health outcomes for enrollees
- Support access to care at safety net health care providers in the Medicaid delivery system through targeted support of such providers
- Provide enrollees with appropriate and cost-effective HCBS within acceptable budgetary parameters
- Manage expenditures at a stable and predictable level, and at a cost that does not exceed what would have been spent in a Medicaid fee-for-service program.

As a means of advancing those goals, the demonstration project:

- Uses a managed care service delivery model that does not comply with certain statutory requirements
- Permits the state to implement certain efficiencies in operation
- Gives the state authority to provide a range of HCBS not covered by the state plan
- Provides different benefit packages to individuals needing HCBS in order to best meet their needs
- Expands eligibility to certain groups that would not be eligible under the state plan
- Provides financial support to hospitals and safety net providers who serve the Medicaid and uninsured populations

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 and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
- 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 and Regulation.** The state must, within the timeframes specified in law or regulation, come into compliance with any changes in federal law or regulation 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. In addition, CMS reserves the right to amend the STCs to reflect changes in law or regulation as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
- 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 agreement for the demonstration as necessary to comply with such change, as well as a allotment neutrality worksheet 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. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
 - b. If mandated changes in the Federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.
- 5. State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) 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 is required,

except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, 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 to the extent that such changes reduce benefits and/or coverage in place as of December 31, 2020. Changes that add allowable benefits and coverage shall not require submission of an amendment but must comply with public notice processes as specified under 42 CFR 431.408. Documentation of the state’s compliance with Federal statutes, regulations, CMS policy, and the public notice processes and tribal consultation requirements outlined in STC 12, must be submitted to CMS at least 60 days in advance of implementation. 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 no FFP of any kind, including for administrative or medical assistance expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.
- 7. Amendment Process.** State 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 according to the deadlines specified therein. 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 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
 - b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
 - c. 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;
 - d. An up to date CHIP allotment neutrality worksheet, if necessary;
 - e. If applicable, the state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual

progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

- 8. Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 CFR §431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 9.
- 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 6 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 STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
 - b. Transition and 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 redetermine Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
 - c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
 - d. Transition and Phase-out Procedures: In addition, the state must consider eligibility on all bases for all affected Medicaid beneficiaries prior to determining a beneficiary is ineligible as required under 42 CFR 435.916(f)(1).. For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all notice requirements found in 42 CFR 431.206-214 and 42 CFR 435.917. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

- e. Exemption from Public Notice Procedures at 42 CFR 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
- f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
- g. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers are suspended by the state, FFP shall be limited to normal closeout costs associated with termination or expiration of the demonstration including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

10. Withdrawal of Waiver Authority. CMS reserves the right to withdraw waivers and/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 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, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. 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.

12. Public Notice and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. 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.

In states with federally recognized tribes, the state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. Federal Financial Participation (FFP). No Federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be

available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

- 14. Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.
- 15. Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services, possible changes in or alternatives to Medicaid programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY

- 16. Eligibility and Covered Populations.** 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”) are covered by the provisions of the demonstration. Several title XIX demonstration-only eligible populations including the title XXI Medicaid Expansion demonstration population (which currently is open only for “rollover” individuals) are made eligible and covered by the demonstration. Medicaid state plan-eligible individuals are served in the component of the program called TennCare Medicaid. 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 their benefits and rights and responsibilities are set forth in the Medicaid state plan except as specified in demonstration authority. For these populations, and for populations only eligible under the demonstration, the state must comply with all applicable Medicaid laws and regulations, except as expressly waived or specified as not applicable, for the purposes specified in and consistent with these STCs. Any changes to eligibility must be submitted to CMS as an amendment request, subject to the limitations and process set forth in STCs 6 and 7. The criteria for TennCare eligibility groups are as follows (Table 1a). Note: This table does not change the state plan requirements.

Table 1a TennCare Population Groups		
Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
Title XIX State Plan Mandatory Groups – TennCare Medicaid		
Caretaker relatives: parents and caretaker relatives with dependent children living in the home	Converted AFDC income standard based on household size	1, 6, 7, 8
Transitional Medical Assistance for individuals in the MAGI categories for children, pregnant women, or caretaker relatives who lose eligibility in these categories due to increased work hours or earnings, and who were receiving benefits in the appropriate category for three of the last six months.	12 months continued coverage	1, 6, 7, 8
Extended Medicaid is available for individuals who lose eligibility in the MAGI categories for children, pregnant women, or caretaker relatives due to increased spousal support	4 months continued coverage <i>and expenditure authority for 8 additional months</i>	
Pregnant & postpartum women. State utilizes presumptive eligibility for this population.	Income up to and including 195% FPL; no resource test	1, 6, 7, 8
Newborns under age 1. State utilizes presumptive eligibility for this population.	Income up to and including 195% FPL; no resource test	1, 6, 7, 8
Children 1-5	Income up to and including 142% FPL; no resource test	1, 6, 7, 8
Children 6-18	Income up to and including 133% FPL; no resource test	1, 6, 7, 8
Deemed categorically eligible newborns: Newborn under 1 year of age, born to a woman who was eligible for and receiving Medicaid on the date of the child's birth.	No income limit; no resource test	1, 6, 8

Table 1a TennCare Population Groups		
Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
Pregnant woman who would otherwise lose eligibility because of an increase in income remains eligible through the postpartum period		1, 6, 7, 8
Woman who was eligible while pregnant continues eligibility through the postpartum period		1, 6, 7, 8
Title IV-E eligible children in adoption subsidy or foster care	No income limit; no resource test	1, 4, 6, 7, 8
Former Foster Care Children: are under age 26, were in foster care provided by the state of Tennessee and were receiving Medicaid when aging out of state custody	No income limit; no resource test.	1, 4, 6, 7, 8
SSI cash recipients: aged, blind or disabled (may or may not be receiving CHOICES or ECF CHOICES benefits)		1, 3, 4, 6, 7, 8
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, 4, 6, 7, 8
"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, 4, 6, 7, 8
SSI cash ineligible for reasons prohibited by Title XIX.		1, 4, 6, 7, 8
"Pickle" SSA Beneficiaries who lost SSI cash benefits due to cost of living adjustment (COLA) increase in Title II OASDI benefits		1,4, 6, 7, 8

Table 1a TennCare Population Groups		
Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
“DWB” Disabled widow/widower who lost SSI or state supplement due to early receipt of OASDI benefits.		1, 4, 6, 7, 8
Title XIX State Plan Optional Groups – TennCare Medicaid		
Persons who would be eligible for AFDC or SSI cash assistance except for their institutional status		1, 3, 4, 5, 6, 7, 8
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, 3, 4, 5, 6, 7, 8
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, 4, 6, 7, 8
Non-IV-E children with special medical needs who receive a state adoption subsidy payment		1, 4, 6, 7, 8
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, 4, 6, 7, 8
Medically needy children under 21 (<i>expenditure authority for 12-month coverage based on 1-month budget period</i>)	Medically needy spend-down level (\$241 for 1, etc.)	1, 2, 4, 6, 7, 8
Medically needy pregnant or postpartum women (<i>expenditure authority for 12-month coverage based on 1-month budget period</i>)	Medically needy spend-down level (\$241 for 1, etc.)	1, 2, 4, 6, 7, 8

Table 1a TennCare Population Groups		
Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
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, 4, 5, 6, 7, 8
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.	1, 4, 5, 6, 7, 8
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 STC 19, <i>Rollover Definition</i>] who are not otherwise eligible for TennCare. See STC 18. <i>Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed.</i>	Income 211% FPL or higher without limit; no resource test	1, 4, 6, 7, 8

Table 1a TennCare Population Groups		
Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
<p>Standard Spend Down (SSD): non-pregnant/postpartum adults 21 or older who have been determined to meet criteria patterned after the medically needy requirements (<i>enrollment target: 100,000</i>)</p> <ul style="list-style-type: none"> • aged, blind, or disabled • caretaker relatives <p>CMS approved an amendment to add this expansion population in Nov. 2006. (Expenditure authority for 12 month coverage based on 1-month budget period.) Effective January 1, 2016, this category is closed. See STC 20.a. <i>Standard Spend Down (SSD) Adult Non-State Plan Demonstration Population Category.</i></p>	<p>Medically needy spend-down level (\$241 for 1, etc.); resources \$2000</p>	<p>1, 2, 4, 6, 7, 8</p>
Title XIX Demonstration Eligible Groups – CHOICES, ECF CHOICES, and KATIE BECKETT		
<p>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 1902(a)(10)(A)(ii)(VI) 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 STC 33.d. (<i>Enrollment Targets for TennCare CHOICES</i>).</p>	<p>Income no more than 300% SSI/FBR; resources \$2,000</p>	<p>1, 3, 4, 5, 6, 7, 8</p>

Table 1a TennCare Population Groups		
Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
CHOICES 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 CHOICES At Risk Demonstration Group is open to enrollment starting July 1, 2012, and closed to new enrollment on June 30, 2015.	Income no more than 300% SSI/FBR; resources \$2,000	1, 3, 4, 5, 6, 7, 8
ECF CHOICES 217-Like HCBS Group: Individuals with I/DD who would be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) and 42 CFR 435.217, if the services they received under ECF CHOICES were provided under a Section 1915(c) waiver except that effective upon implementation of the Katie Becket (Part A) Group, children described in Section 1902(e)(3) shall not be eligible in this Group, unless they are already enrolled in ECF CHOICES; age 17 or older; or enrolling in or transitioning from ECF CHOICES Group 7. This group is subject to the enrollment targets for ECF CHOICES in STC 34.d. (<i>Enrollment Targets for ECF CHOICES</i>).	Income no more than 300% SSI/FBR; resources \$2,000	1, 3, 4, 5, 6, 7, 8

Table 1a TennCare Population Groups		
Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
ECF CHOICES At-Risk Demonstration Group: Upon implementation of Phase 2 of ECF CHOICES, 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 but not the criteria in place on July 1, 2012; and in the absence of ECF CHOICES are “at risk” of institutionalization. This group is subject to the enrollment targets for ECF CHOICES in STC 34.d. (<i>Enrollment Targets for ECF CHOICES</i>).	Income no more than 150% FPL; resources \$2,000	1, 3, 4, 5, 6, 7, 8
ECF CHOICES Working Disabled Group: Upon implementation of Phase 2 of ECF CHOICES, working age adults 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 and need specialized services for I/DD; have family income no more than 250% of the FPL and but for their earned income would be eligible for SSI. This group is subject to the enrollment targets for ECF CHOICES in STC 34.d. (<i>Enrollment Targets for ECF CHOICES</i>).	Income no more than 250% FPL; resources \$2,000	1, 3,4,5, 6,7,8

Table 1a TennCare Population Groups		
Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
Interim ECF CHOICES At Risk Demonstration Group: Individuals with I/DD who are not otherwise eligible for Medicaid or TennCare who: meet the financial eligibility requirements 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. New enrollment in this group will close 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 of ECF CHOICES 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. This group is subject to the enrollment targets for ECF CHOICES in STC 34.d. <i>Enrollment Targets for ECF CHOICES</i>).	Income no more than 300% SSI/FBR; resources \$2,000	1, 3,4,5, 6,7,8
Katie Beckett (Part A) Group – children described in Section 1902(e)(3) with the most significant disabilities and/or complex medical needs. This group is subject to the enrollment target for Part A. ¹	Income no more than 300% SSI/FBR; resources \$2,000 (Only the child’s income and resources are counted)	1,3,4,5,6,7,8,9

¹ Children in the Continued Eligibility Group shall not count against the enrollment target for Part A.

Table 1a TennCare Population Groups		
Description	Income Limit	Provisions of the Act Waived or Made Not Applicable (see Waiver List)
Medicaid Diversion (Part B) Group – children under age 18 with medical needs that are likely to last at least 12 months or result in death and that result in severe functional limitations based on medical eligibility developed specifically for children. This group is subject to the enrollment target for Part B.	Income no more than 300% SSI/FBR; resources \$2,000 (Only the child's income and resources are counted)	3,4,5
Continued Eligibility (Part C) Group – children who have been enrolled in Medicaid but are no longer eligible in any category, and who are described in Section 1902(e)(3) but for whom there is not an available slot in the Katie Beckett (Part A) Group	Income no more than 300% SSI/FBR; resources \$2,000 (Only the child's income and resources are counted)	1,4,5,6,8
Title XXI Medicaid Expansion Demonstration Eligible Group – TennCare Standard		
Optional Targeted Low-Income Children: uninsured children under 19 who: <ul style="list-style-type: none"> • have lost Medicaid eligibility under the approved Medicaid state plan and who do not have access to insurance or • See STC 18 (<i>Child Non-State Plan Demonstration Population Categories For Which Enrollment Is Closed</i>).	Income up to 211% FPL	1, 4, 6, 7, 8

17. TennCare CHOICES and ECF CHOICES Eligibility Groups.

a. CHOICES

As further set forth in STC 33 (*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 met 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 was subsequently 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. This table does not change the state plan requirements. CHOICES 1, CHOICES 2, CHOICES 3, and Interim CHOICES 3 are defined in STC 33. The CHOICES 1 and 2 Carryover Group and the PACE Carryover Group are defined in Table 1a of STC 16. 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.

Table 1b TennCare + CHOICES Eligibility Groups			
CHOICES Groups	Description	TennCare Medicaid	TennCare Standard
CHOICES 1	<ul style="list-style-type: none">Nursing facility residents who meet the NF LOC in place at the time of enrollment²	Yes	Yes, CHOICES 1 and 2 Carryover Group

² 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 the cost of NF care, or for persons who continue to meet the NF LOC in place at the time of enrollment into CHOICES 1 when such persons have transitioned to the community and requires readmission to the NF.

Table 1b TennCare + CHOICES Eligibility Groups			
CHOICES Groups	Description	TennCare Medicaid	TennCare Standard
CHOICES 2	<ul style="list-style-type: none"> • Meet NF LOC in place at the time of HCBS enrollment • Receive HCBS as an alternative to NF care • Age 65+ or 21+ and disabled 	Yes, SSI only	Yes, CHOICES 217-Like HCBS Group and CHOICES 1 and 2 Carryover Group
CHOICES 3	<ul style="list-style-type: none"> • “At risk” for institutionalization (as defined in Attachment E) • 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)	<ul style="list-style-type: none"> • Same as CHOICES 3, but not limited to SSI recipients • Must meet nursing facility financial eligibility criteria 	Yes, SSI only	Yes, At Risk Demonstration Group

b. ECF CHOICES

- i. TennCare eligibility groups for ECF CHOICES will be implemented in two phases. In Phase 1, a person may qualify to enroll in ECF CHOICES services in one of the following TennCare eligibility groups: SSI recipients; the ECF CHOICES 217-Like Group; and the Interim ECF CHOICES At- Risk Group. In Phase 2, a person may also qualify to enroll in ECF CHOICES in the ECF CHOICES At-Risk Group and the ECF CHOICES Working Disabled Group. Upon implementation of Phase 2, new enrollment will close for the Interim ECF CHOICES At-Risk Demonstration Group; however, individuals enrolled through that group prior to implementation of Phase 2 may continue to be eligible in the interim group as long as they continue to meet the eligibility requirements and remain continuously enrolled in the interim group. The state will provide CMS with at least 60 days’ notice in advance of implementing Phase 2 of ECF CHOICES.
- ii. As further set forth in STC 34 (*Operations of Employment and Community First (ECF) CHOICES*), eligibility for enrollment in ECF CHOICES depends on (a) the individual’s TennCare eligibility group or, for individuals not otherwise eligible, meeting the applicable financial eligibility criteria for ECF CHOICES Title XIX Demonstration Eligible Groups set forth in Table 1a; (b) the individual’s age; (c) the NF LOC (or “At Risk”, as applicable) criteria as established by the state, except as provided pursuant only to STC 34.c.i.; (d) the type of long-term services and supports (LTSS) to be provided, and (e) the individual’s

I/DD status. In order to be considered to be an individual with I/DD, a person must meet the definition of intellectual disability located at T.C.A. 33-1-101(16), or the definition of developmental disability located at T.C.A. 33-1-101(11). ECF CHOICES is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with I/DD. There are six target populations for ECF CHOICES: (1) children under age 21 with I/DD living at home with family and who meet the NF LOC, except that upon implementation of Katie Beckett (Part A), children described in Section 1902(e)(3) are not included in this target population unless they are already enrolled in ECF CHOICES, age 17 or older, or transitioning from ECF CHOICES Group 7; (2) children under age 21 with I/DD living at home with family who qualify for Medicaid under SSI deeming rules and who, in the absence of HCBS, are “at risk of NF placement”; (3) adults age 21 and older with I/DD who meet the NF LOC and need specialized services for I/DD (except as provided pursuant only to STC 34.c.i.); (4) adults age 21 and older with I/DD who, in the absence of HCBS, are “at risk of NF placement”; (5) children under age 21 with I/DD and severe co-occurring behavioral health and/or psychiatric conditions who are living at home with family or other permanent guardian(s) in a long-term family living arrangement,³ and who meet NF LOC and other criteria as defined in STC 34.a.iv or in state rule; and (6) adults age 21 and older⁴ with I/DD and severe co-occurring behavioral health and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment and who meet NF LOC and other criteria as defined in STC 34.a.v or in state rule (unless the state makes an exception pursuant to STC 34.c.i), and need and are receiving specialized services for I/DD.

Children enrolled in ECF CHOICES prior to the implementation of the Katie Beckett (Part A) Group shall continue to be eligible for ECF CHOICES, if they meet the financial criteria in place at the time of their enrollment and remain continuously eligible and enrolled.

Table 1c summarizes the ECF CHOICES Target Populations:

³ A “permanent guardian” does not mean that the person could never have full decision making rights restored, but rather than this is not expected to be a short-term guardianship arrangement. A “long-term family living arrangement” does not mean that the person could not in the future transition to community living separate from the guardian, but rather that a child enrolled in Group 7 either lives with their family or with a permanent guardian that is expected to continue to provide primary caregiving support such that a benefit targeted to improving the caregiver’s capacity to support the child is appropriate. A child in State Custody does not qualify for enrollment in Group 7.

⁴ As it relates to ECF CHOICES, “adults” generally refers to individuals no longer eligible for the EPSDT benefit, i.e., individuals age 21 and older. However, IBCTSS and enrollment into ECF CHOICES Group 8 may be permitted for emerging young adults, and on a case-by-case basis, for late adolescents with severe psychiatric or behavioral symptoms in one of the circumstances described above in order to avoid placement in DCS custody.

Table 1c TennCare + ECF CHOICES Target Populations		
Target Population Descriptions	TennCare Medicaid	TennCare Demo Standard
Children under age 21 with I/DD living at home with family and who meet the NF LOC except for children described in Section 1902(e)(3), unless they are enrolled in ECF CHOICES upon implementation of Katie Beckett (Part A), age 17 or older, or transitioning from ECF CHOICES Group 7	SSI	ECF 217-Like (Phase 1 and Phase 2) ECF Working Disabled (upon implementation of Phase 2)
Children under age 21 with I/DD living at home with family who qualify for Medicaid under SSI deeming rules and who, in the absence of HCBS, are “at risk of NF placement”	SSI	ECF At-Risk (upon implementation of Phase 2) ECF Working Disabled (upon implementation of Phase 2) Interim ECF At-Risk (open to new enrollment only during Phase 1)
Adults age 21 and older with I/DD who meet the NF LOC and need specialized services for I/DD (except as provided pursuant only to STC 34.c.i.)	SSI	ECF 217-Like (Phase 1 and Phase 2) ECF Working Disabled (upon implementation of Phase 2)
Adults age 21 and older with I/DD who, in the absence of HCBS, are “at risk of NF placement”	SSI	ECF At-Risk (upon implementation of Phase 2) ECF Working Disabled (upon implementation of Phase 2) Interim ECF At- Risk (open to
Children under age 21 with I/DD and severe co-occurring behavioral health and/or psychiatric conditions who are living at home with family or other permanent guardian(s) in a long-term family living arrangement, ⁵ guardians and who meet NF LOC and other criteria as defined in STC 33.a.iv. or in State rule.	SSI	ECF 217-Like (Phase 1 and Phase 2)

⁵ See footnote 2.

Table 1c TennCare + ECF CHOICES Target Populations		
Target Population Descriptions	TennCare Medicaid	TennCare Demo Standard
Adults age 21 and older ⁶ with I/DD and severe co-occurring behavioral health and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment and who meet NF LOC and other criteria as defined in STC 34.a.v. or in State rule (unless the state makes an exception pursuant to STC 34.c.i.), and need and are receiving specialized services for I/DD.	SSI	ECF 217-Like (Phase 1 and Phase 2) ECF Working Disabled (upon implementation of Phase 2)

18. 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 STC 19 *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. 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.

- a. **Title XIX Medically Eligible Children:** Individuals who are under age 19, are uninsured, have income that is 211 percent of the FPL or higher without limit, are not otherwise eligible for TennCare, and have a qualifying medical condition such that they meet the state-defined criteria of “medically eligible”. (There is no income or resource limit for this group.)
- b. **Title XXI Medicaid Expansion Children:** Individuals under age 19 who are uninsured, have family income less than 211 percent of the FPL, and meet the definition of an optional targeted low-income child. (There is no resource limit for this group.)

19. 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.

20. Adult Non-State Plan Demonstration Population Categories.

⁶ See footnote 3.

- 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. Effective January 1, 2016, this category is closed. Persons enrolled in the category as of that date will remain in the program until they complete the redetermination process. If they are found through the redetermination process to be eligible in another TennCare category, they will be moved to that category when they complete the redetermination process. If they are not found eligible for another category, they will be disenrolled.
- 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 1902(a)(10)(A)(ii)(VI) of the Social Security Act, if the home and community based services were provided under a 1915(c) waiver. STC 17 (*TennCare CHOICES and ECF CHOICES Eligibility Groups*) and STC 33.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 STC 33.d. (*Enrollment Targets for TennCare CHOICES*).
- c. **CHOICES 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.
- f. **ECF CHOICES 217-Like HCBS Group.** This group consists of individuals of all ages with I/DD who would be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) and 42 CFR 435.217, if the services they received under ECF CHOICES were provided under a Section 1915(c) waiver, except that after the implementation of Katie Beckett (Part A) Group, children described in Section 1902(a)(3) shall not be eligible in this Group, unless they are already enrolled in ECF CHOICES and remain continuously eligible and enrolled; age 17 or older; or enrolling in or transitioning from ECF CHOICES Group 7.
- g. **Interim ECF CHOICES At-Risk Group.** This group consists of individuals of all ages 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 under SSI deeming rules; 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; in the absence of the services offered through ECF CHOICES are "at risk" of institutionalization; and are enrolled in the group prior to implementation of Phase 2 of ECF CHOICES. The Interim ECF CHOICES At-Risk Group will close for new enrollment once the ECF CHOICES At-Risk Group and the ECF CHOICES Working Disabled Group are implemented. Individuals enrolled in the Interim ECF CHOICES At-Risk Demonstration Group prior to implementation of the ECF CHOICES At-Risk Group and the ECF CHOICES Working Disabled Group 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.
- h. The following two demonstration groups will be added in Phase 2 of ECF CHOICES:
 - i. **ECF CHOICES At-Risk Group.** This group consists of individuals with I/DD who are not otherwise eligible for Medicaid or TennCare who:
 - A. are receiving ECF CHOICES services;
 - B. meet the resource limit for the ECF CHOICES 217-Like Group ;
 - C. have income at or below 150% of the FPL;
 - D. meet the NF LOC criteria in place on June 30, 2012 but not the criteria in place on July 1, 2012; and in the absence of ECF CHOICES are "at risk" of institutionalization.
 - ii. **ECF CHOICES Working Disabled Group.** This group consists of working age adults with I/DD who are not otherwise eligible for Medicaid or TennCare who:

- A. are receiving ECF CHOICES services;
- B. 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 and need specialized services for I/DD;
- C. but for their earned income would be eligible for SSI;
- D. have family income at or below 250% of the FPL.

21. Additional Non-State Plan Demonstration Population Categories for Children

- a. **Katie Beckett (Part A).** This group consists of children under the age of 18⁷ who are not otherwise eligible for Medicaid or TennCare who:
 - i. Have medical needs that are likely to last at least twelve months or result in death;
 - ii. Result in severe functional limitations based on medical eligibility criteria developed specifically for children;
 - iii. Qualify for care in a medical institution according to criteria established for children by the state;
 - iv. The estimated amount which would be expended for medical assistance outside an institution is not greater than the estimated amount which would otherwise be expended for the individual within an institution;
 - v. Qualify for supplemental security income (SSI) due to the child’s disability—except for parents’ income and/or assets;
 - vi. Pay premiums, if family income is above 150% of the FPL; and
 - vii. Purchase and maintain minimum essential coverage private or employer-sponsored insurance or qualify for a hardship exception; however, if cost-effective, TennCare may choose to offer premium assistance for such coverage in lieu of granting a hardship exception.
- b. **Medicaid Diversion (Part B).** This group consists of children under the age of 18 who are not otherwise eligible for Medicaid or TennCare who:
 - i. Have medical needs that are likely to last at least twelve months or result in death;
 - ii. Result in severe functional limitations based on medical eligibility criteria developed specifically for children;
 - iii. Qualify for care in a medical institution; or are at-risk for institutional placement according to criteria established for children by the state; and
 - iv. Are not eligible for the Katie Beckett (Part A) Group or are not enrolled in the Katie Beckett (Part A) Group due to program enrollment caps.
- c. **Continued Eligibility (Part C)** This group consists of children under the age of 18⁸ who are enrolled in Medicaid but are no longer eligible for Medicaid, who:
 - i. Have medical needs that are likely to last at least twelve months or result in death;

⁷ While a child must be under age 18 to qualify and enroll in Katie Beckett (Part A), a child may remain enrolled in Katie Beckett (Part A) for up to 12 months following the 18th birthday.

⁸ While a child must be under age 18 to qualify and enroll in Continued Eligibility (Part C), a child may remain enrolled in Continued Eligibility (Part C) for up to 12 months following the 18th birthday.

- ii. Result in severe functional limitations based on medical eligibility criteria developed specifically for children;
- iii. Qualify for care in a medical institution according to criteria for children established by the state;
- iv. The estimated amount which would be expended for medical assistance outside an institution is not greater than the estimated amount which would otherwise be expended for the individual within an institution;
- v. Qualify for supplemental security income (SSI) due to the child's disability—except for parents' income and/or assets;
- vi. Are not enrolled in Katie Beckett (Part A) due to program enrollment caps; and
- vii. A child must remain continuously eligible and enrolled in TennCare to qualify in the Katie Beckett Continued Eligibility Group. If a child enrolled in this group loses eligibility, the child will have to reapply for Katie Beckett (Part A) subject to the availability of an open slot, and in accordance with prioritization criteria.

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

- a. Except as specified 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 E), 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.

24. Eligibility/Post-Eligibility Treatment of Income and Resources for Individuals Receiving Long Term Services and Supports. For individuals receiving state plan long term services and supports or 1915(c) like services through the demonstration, 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 Act, if the home and community based services were provided under a Section 1915(c) waiver.

25. Post-Eligibility and Patient Liability for Individuals Receiving Long Term Services and Supports. 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.

26. Non-Payment of Patient Liability. An LTSS 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 or ECF CHOICES program. If the beneficiary's eligibility for TennCare is dependent on the receipt of long-term institutional care or HCBS through TennCare CHOICES or ECF CHOICES, 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 or ECF CHOICES. Nothing herein shall prejudice any individual from fully exercising his or her rights to reapply for Medicaid coverage.

27. Additional Coverage Assurances

- 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.
- b. Transition and Phase-out Plan Requirements. The state must redetermine Medicaid or CHIP eligibility for all affected beneficiaries and consider eligibility on all bases for Medicaid beneficiaries prior to determining a beneficiary ineligible in accordance with 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). Prior to termination or suspension of eligibility or reduction, suspension or termination of benefits and services, the state must comply with all notice requirements found in 42 CFR 431.206-431.214 and 435.917. In addition, the state must assure all appeal and hearing rights are provided to demonstration beneficiaries as outlined in 42 CFR part 431 subpart E. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.
- c. Exemption from Public Notice Procedures at 42 CFR 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
- d. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP shall be limited to normal closeout costs associated with termination or expiration of the demonstration including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

28. Medicaid Beneficiary Fraud. Medicaid beneficiary fraud is defined in CFR 455.2 as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Conviction means a

judgment of conviction entered against the individual in a federal, state, or local court; a finding of guilt against the individual by a federal, state, or local court; a plea of guilty or nolo contendere by the individual that has been accepted by a federal, state, or local court; or the individual's agreement to enter into participation in a first offender, deferred adjudication, or other arrangement where judgment of conviction has been withheld.

- a. Consequences for beneficiary fraud: After a conviction for beneficiary fraud and 10-day advance notice has been provided as described in STC 28.c. below, the state may suspend an individual's Medicaid eligibility for up to 12 months.
- b. Fair hearing rights: The state will provide all beneficiaries with fair hearing rights consistent with 42 CFR 431, subpart E.
- c. Notice related to the suspension for beneficiary fraud: The state will provide at least 10 days advance notice to beneficiaries prior to suspension of eligibility for beneficiary fraud consistent with 42 C.F.R. 435.917(a) and 431.206-431.214. This notice must explain what this suspension means, including but not limited to: a statement describing the suspension, the effective and end dates of the suspension, a clear statement of the specific reasons for the suspension, and the specific regulations or authority under the demonstration that support the suspension. The notice should also include explanations of the beneficiary's right to appeal, the circumstances under which Medicaid is continued if a hearing is requested, what this status means with respect to the beneficiary's ability to access other health insurance coverage, and what the beneficiary should do if the beneficiary's circumstances change such that he/she may be eligible for coverage in another Medicaid category.
- d. Limitations: The imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for Medicaid under the plan, regardless of the relationship between that individual and such other person.

V. BENEFITS

29. 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 STC 30 (*Benefits for TennCare Medicaid Population Only that are not Included in the TennCare Standard Benefit Package*) as appropriate. Additional TennCare benefits are provided as specified in Table 2a.
- b. Members of the CHOICES 217-Like HCBS Group, the CHOICES At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, the ECF CHOICES 217-Like HCBS Group,

the ECF CHOICES At-Risk Group, the ECF CHOICES Working Disabled Group and the Interim ECF CHOICES At-Risk 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 CHOICES 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 STC 20.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 as appropriate, except that they do not have access to the services discussed in Table 2b, Table 2d, or Table 3. Medicare Parts A and B premiums and Medicare co-payments and deductibles are covered in accordance with STCs 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 STC 30 (*Benefits for TennCare Medicaid Population Only that are not Included in the TennCare Standard Benefit Package*).
- f. The Medicaid state plan mandatory and optional eligibility categories for pregnant or postpartum women receive all TennCare Medicaid benefits, because the state considers that all of these services are pregnancy-related services.
- g. Medication Therapy Management (MTM) Benefit.
Individuals enrolled in the state's patient-centered medical home (PCMH) and health home programs are eligible to receive MTM, regardless of which eligibility group the individual qualifies under. This benefit will expire three years after the implementation date of the state's MTM pilot program, not to exceed June 30, 2021, unless amended in accordance with the requirements of STC 7. The state must notify CMS in the subsequent quarterly monitoring report, as required by STC 56, when the benefit has been implemented.
- h. 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.

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	State Plan Coverage for Adults	TennCare Medicaid and TennCare Standard Coverage for Adults
Diagnostic services not included in other service categories	Not Covered.	Covered as medically necessary.
Home health	Coverage limited to 60 visits per enrollee per state fiscal year.	Covered as medically necessary, and in accordance with the definitions and limitations included in Attachment C.
Hospice care	Coverage limited to 210 days per enrollee per state fiscal year.	Covered as medically necessary.
Inpatient and outpatient substance abuse services	Not Covered.	Covered as medically necessary.
Inpatient hospital services	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.	Covered as medically necessary.
Lab and X-ray services	Coverage limited to 30 occasions per enrollee per state fiscal year.	Covered as medically necessary.
Medicare premiums and cost- sharing	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.)	Covered for state plan eligibles, and covered for dually eligible members of demonstration-only populations, in accordance with STCs 30.b. and c.
Medication therapy management (MTM)	Not covered.	Covered as part of MTM pilot for individuals who are enrolled in the state's PCMH program or the health home program.
Mental health case management services	Coverage limited to Targeted Case Management for persons who are severely and/or persistently mentally ill.	Covered as medically necessary.
Occupational therapy	Not covered.	Covered as medically necessary.

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	State Plan Coverage for Adults	TennCare Medicaid and TennCare Standard Coverage for Adults
Organ and tissue transplants	Coverage limited to renal, heart, liver, corneal and bone marrow transplants.	Covered as medically necessary, except that experimental or investigational transplants are not covered.
Outpatient hospital services	Coverage limited to 30 visits per enrollee per fiscal year.	Covered as medically necessary.
Outpatient rehabilitation services	Coverage limited to mental health services provided by Community Mental Health Agencies.	Covered as medically necessary.
Pharmacy services	Coverage as specified in state plan or 1115 demonstration.	Covered in accordance with the State Plan or 1115 demonstration for Medicaid enrollees for non-dual members of the following demonstration populations: <ul style="list-style-type: none"> • Standard Spend Down • CHOICES At-Risk Demonstration Group • ECF CHOICES At-Risk Demonstration Group • Interim ECF CHOICES At-Risk Demonstration Group • CHOICES 217-Like HCBS Group • ECF CHOICES 217-Like HCBS Group • ECF CHOICES Working Disabled Group • CHOICES 1 and 2 Carryover Group • PACE Carryover Group.
Physical therapy services	Not covered.	Covered as medically necessary.

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	State Plan Coverage for Adults	TennCare Medicaid and TennCare Standard Coverage for Adults
Physicians' services (including medical and surgical services furnished by a dentist)	<u>Outpatient Services:</u> Coverage limited to 24 outpatient office visits per year, which includes 2 office visits for podiatrists and 4 office visits for optometrists. <u>Inpatient Services:</u> Coverage limited to 20 visits per enrollee per state fiscal year for services other than heart, liver and bone marrow transplants.	<u>Outpatient services:</u> Covered as medically necessary. <u>Inpatient services:</u> Covered as medically necessary.
Preventive services	Not covered.	Covered as medically necessary.
Private duty nursing services	Not covered.	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 D.
Psychiatric residential treatment services (outside of an IMD)	Not covered.	Covered as medically necessary.
Screening services	Not covered.	Covered as medically necessary.
Speech, hearing, and language services	Not covered.	Covered as medically necessary.
Vision services	Not covered.	Covered for the first pair of cataract glasses following cataract surgery.

- i. 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 STC 33.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 E, 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 (as described in Attachment E and Table 2b).
- iv. Definitions for CHOICES benefits are provided in Attachment E of these STCs.

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

<u>Benefit</u> (Definitions provided in Attachment E)	<u>CHOICES</u> <u>1</u>	<u>CHOICES</u> <u>2</u>	<u>CHOICES</u> <u>3⁹</u>
Nursing facility care	X	Short-term only	Short-term only
Community-based residential alternatives (CBRAs)		X	X ¹⁰
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

⁹ Subject to the limitations in paragraph 29.i.iii.

¹⁰ CBRAs available in CHOICES 3 include only Assisted Care Living Facility services and Community Living Supports (CLS) and Community Living Supports – Family Model (CLS-FM) that can be provided within the limitations set forth in paragraph 28.h.iii., when the cost of such services will not exceed the cost of CHOICES HCBS that would otherwise be needed by the member to 1) safely transition from a nursing facility to the community; or 2) continue being safely served in the community and to delay or prevent nursing facility placement. Consistent with the CMS final rule defining person-centered planning and HCBS setting requirements, TennCare requires that persons receiving HCBS choose the setting in which services will be delivered.

Table 2b: Benefits for Persons Enrolled in the CHOICES Program			
<u>Benefit</u> (Definitions provided in Attachment E)	<u>CHOICES</u> <u>1</u>	<u>CHOICES</u> <u>2</u>	<u>CHOICES</u> <u>3⁹</u>
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

- j. The following tables (Tables 2c and 2d) list the HCBS benefits (and limits on those benefits) for TennCare Medicaid enrollees and demonstration eligibles who are enrolled in the ECF CHOICES benefit groups (specified in STC 34.a. *Determination of ECF CHOICES Benefits by Designation into an ECF CHOICES Benefit 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 ECF CHOICES benefits.
- i. For purposes of determining capitation rates, the cost of room and board, as defined in Attachment H, is not included in non-institutional care costs.
 - ii. Definitions for ECF CHOICES benefits are provided in Attachment H of these STCs.
 - iii. In addition to the benefits specified below and defined in Attachment H, a person enrolled in ECF CHOICES may receive short-term nursing facility care as defined in Attachment E, without being required to disenroll from their ECF CHOICES group until such time that it is determined that transition back to HCBS in ECF CHOICES will not occur within 90 days from admission.
 - iv. ECF CHOICES benefits will be subject to an annual per member expenditure cap as follows. The cost of medical assistance provided to an eligible participant in ECF CHOICES, including any exceptions to the expenditure cap granted under this STC, 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.
 - A. Individuals receiving Essential Family Supports benefits will be subject to a \$15,000 cap (on benefits), not counting the cost of minor home modifications (as described in Attachment E and Table 2b);
 - B. Individuals receiving Essential Supports for Employment and Independent Living benefits will be subject to a \$30,000 cap on benefits. The state may grant an exception to the \$30,000 cap under the following circumstances:
 - 1. The expenditure cap may be exceeded based on emergency needs by up to \$6,000 per member per year.

2. For an individual receiving Community Living Supports, the expenditure cap may be exceeded by an amount to be determined per individual based on the individual's need when necessary to permit access to Supported Employment and/or Individual Employment Support benefits.
 3. For an individual requiring a Community Stabilization and Transition rate of reimbursement for Community Living Supports, the higher cost of transitional Community Living Supports may be excluded from the individual's expenditure cap for the year in which the transitional Community Living Supports are required. This exception would be made only if the individual is expected to be safely and appropriately served within the customary expenditure cap once transition to the appropriate ongoing Community Living Supports level occurs and the transitional rate ends.
- C. Individuals receiving Comprehensive Supports for Employment and Community Living benefits will be subject to an annual expenditure cap as follows:
1. Individuals with low need as determined by the state, in accordance with the published criteria, will be subject to a \$45,000 expenditure cap.
 2. Individuals with moderate need as determined by the state, in accordance with the published criteria, will be subject to a \$67,500 expenditure cap.
 3. Individuals with high need as determined by the state, in accordance with the published criteria, will be subject to a \$88,250 expenditure cap.
 4. The state may grant exceptions to these expenditure caps on a case-by-case basis as follows:
 - a. For an individual with low, moderate, or high need (but not exceptional medical or behavioral needs) an exception may be made to the applicable expenditure cap for emergency or one-time (including transitional assessment) needs up to \$7,500 per calendar year. Any exception that may be granted would apply only for the calendar year in which the exception is approved.
 - b. For an individual with low, moderate, or high need (but not exceptional medical or behavioral needs), an exception may be made to the applicable expenditure cap when necessary to permit access to Supported Employment and/or Individual Employment Support benefits. The amount will be determined per individual based on the individual's need.
 - c. For individuals with developmental disabilities (DD) and exceptional medical/behavioral needs as determined by the state in accordance with published criteria, up to the average cost of NF plus specialized services that would be needed for persons with such needs determined appropriate for NF

placement; or for individuals with intellectual disabilities (ID) and exceptional medical/behavioral needs as determined by the state in accordance with published criteria, up to the average cost of private ICF/IID services.

5. Individuals receiving Intensive Behavioral Family Supports will be subject to an annual expenditure cap based on the comparable cost of institutional care. Behavioral health services (other than Intensive Behavioral Family-Centered Treatment Stabilization and Supports) will not be counted against the expenditure cap.
6. Individuals receiving Comprehensive Behavioral Supports for Employment and Community Living will be subject to an annual expenditure cap based on the comparable cost of institutional care. Behavioral health services (other than Intensive Behavioral Community Transition and Stabilization Services) will not be counted against the expenditure cap.

Table 2c Benefit Groups for Persons Enrolled in the ECF CHOICES Program	
Benefit Groups	Target Population
Essential Family Supports (ECF CHOICES 4)	<p>Children under age 21 with I/DD living at home with family and who meet NF LOC and who are SSI eligible or qualify in the ECF CHOICES .217-like group. Effective upon implementation of Katie Beckett (Part A), children described in Section 1902(e)(3) shall not be newly enrolled in this group unless they are age 17 or older or transitioning from ECF CHOICES Group 7.</p> <p>Children under age 21 with I/DD living at home with family who qualify for Medicaid under SSI deeming rules and who, in the absence of HCBS, are “at risk” of NF placement.</p> <p>If they are living at home with family caregivers, adults age 21 and older with I/DD who meet or are “at risk” of NF placement may also elect to be in this benefit group</p>
Essential Supports for Employment and Independent Living (ECF CHOICES 5)	Adults age 21 and older ¹¹ with I/DD who meet the NF LOC and whose needs can be safely met in this group, or who do not meet NF LOC, but who, in the absence of HCBS, are “at risk” of NF placement
Comprehensive Supports for Employment and Community Living (ECF CHOICES 6)	Adults age 21 and older ¹² with I/DD who meet NF LOC and need specialized services for I/DD

¹¹ On a case by case basis, the state may grant an exception to permit adults ages 18-20 with I/DD not living at home with family, including young adults with I/DD transitioning out of state custody, to enroll in Groups 5 and 6, if they meet eligibility criteria.

¹² See previous footnote.

Table 2c Benefit Groups for Persons Enrolled in the ECF CHOICES Program	
Benefit Groups	Target Population
Intensive Behavioral Family Supports (ECF CHOICES 7)	Children under age 21 with I/DD who are living at home with family and who meet NF LOC and other criteria as defined in STC 34.a.iv. or in State rule, including severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at imminent and significant risk of serious physical harm, significantly strain the family's ability to adequately respond to the child's needs, threaten the sustainability of the family living arrangement, and place the child at imminent and significant risk of placement outside the home.
Comprehensive Behavioral Supports for Employment and Community Living (ECF CHOICES 8)	Adults age 21 and older ¹³ with I/DD and severe co-occurring behavioral health and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment and who meet NF LOC and other criteria as defined in STC 33.a.v. or in State rule, and need and are receiving specialized services for I/DD.

Table 2d Benefits and Benefit Limits in ECF CHOICES Benefits Groups					
Benefit (Definitions provided in Attachment H)	Essential Family Supports	Essential Supports for Employment and Independent Living	Comprehensive Supports for Employment and Community Living	Intensive Behavioral Family Supports	Comprehensive Behavioral Supports for Employment and Community Living
Respite (up to 30 days per calendar year or up to 216 hours per calendar year only for persons living with unpaid family caregivers)	X	X	X		
Supportive home care (SHC)	X				
Family caregiver stipend in lieu of SHC (up to \$500 per month for children under age 18; up to \$1,000 per month for adults age 18 and older)	X				
Community integration support services (subject to limitations specified in Attachment H)	X	X	X	X	

¹³ See footnote 3.

Table 2d Benefits and Benefit Limits in ECF CHOICES Benefits Groups					
Benefit (Definitions provided in Attachment H)	Essential Family Supports	Essential Supports for Employment and Independent Living	Comprehensive Supports for Employment and Community Living	Intensive Behavioral Family Supports	Comprehensive Behavioral Supports for Employment and Community Living
Community transportation	X	X	X	X	
Independent living skills training (subject to limitations specified in Attachment H)	X	X	X	X	
Assistive technology, adaptive equipment and supplies (up to \$5,000 per calendar year)	X	X	X	X	X
Minor home modifications (up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime)	X	X	X	X	X
Community support development, organization and navigation	X			X	
Family caregiver education and training (up to \$500 per calendar year)	X			X	
Family-to-family support	X			X	
Decision making supports and options (up to \$500 per lifetime)	X	X	X	X	X
Health insurance counseling/forms assistance (up to 15 hours per calendar year)	X			X	
Personal assistance (up to 215 hours per month)		X	X		
Community living supports (CLS)		X	X		
Community living supports—family model (CLS-FM)		X	X		
Individual education and training (up to \$500 per calendar year)		X	X		X
Peer-to-peer person-centered planning, self-direction, employment and community support and navigation (up to \$1,500 per lifetime)		X	X		X

Table 2d Benefits and Benefit Limits in ECF CHOICES Benefits Groups					
Benefit (Definitions provided in Attachment H)	Essential Family Supports	Essential Supports for Employment and Independent Living	Comprehensive Supports for Employment and Community Living	Intensive Behavioral Family Supports	Comprehensive Behavioral Supports for Employment and Community Living
Specialized consultation and training (up to \$5,000 per calendar year ¹⁴)		X	X		X
Adult dental services (up to \$5,000 per calendar year; up to \$7,500 across three consecutive calendar years)	X ¹⁵	X	X		X
Employment services/supports (subject to limitations specified in Attachment H)	X	X	X	X	X

¹⁴ For adults in the Comprehensive Supports for Employment and Community Living benefit group determined to have exceptional medical and/or behavioral support needs, and for adults in the Comprehensive Behavioral Supports for Employment and Community Living benefit group, specialized consultation services are limited to \$10,000 per person per calendar year.

¹⁵ Limited to adults age 21 and older.

Table 2d Benefits and Benefit Limits in ECF CHOICES Benefits Groups					
Benefit (Definitions provided in Attachment H)	Essential Family Supports	Essential Supports for Employment and Independent Living	Comprehensive Supports for Employment and Community Living	Intensive Behavioral Family Supports	Comprehensive Behavioral Supports for Employment and Community Living
– Supported employment—individual employment support – Exploration – Benefits counseling – Discovery – Situational observation and assessment – Job development plan or self-employment plan – Job development or self-employment start up – Job coaching for individualized, integrated employment or self-employment – Co-worker supports – Career advancement	X	X	X	X	X
– Supported employment—small group supports	X	X	X	X	X
– Integrated employment path services	X	X	X	X	X
Intensive Behavioral Family-Centered Treatment, Stabilization and Supports				X	
Intensive Behavioral Community Transition and Stabilization Services					X

k. The following table (Table 2e) lists benefits for the Katie Beckett eligibility group (specified in STC 23.a. *Katie Beckett (Part A)*). These benefits are in addition to the benefits that are

available to them through the regular TennCare program. In addition to the service limits stated in Table 2e, the total cost of the HCBS identified in Table 2e shall not exceed \$15,000 per calendar year.

Table 2e Benefits and Benefit Limitations Katie Beckett (Part A) Eligibility Group	
Benefit	Amount Duration and Scope
State Plan- and EPSDT-covered services	Covered as medically necessary, no limitations
Self-directed respite and/or supportive home care	Covered as medically necessary Respite subject to limitations described in Attachments H and L
Agency-based HCBS – Respite – Supportive home care – Community integration support services – Community transportation – Decision making supports – Family to Family Support – Community Support Development, Organization and Navigation	Covered as medically necessary subject to limitations described in Attachment H and L
Assistive technology, adaptive equipment and supplies	Up to \$5,000 per calendar year
Minor home modifications	Up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime
Vehicle modifications	Up to \$10,000 per calendar year and \$20,000 per lifetime
Family caregiver education and training	Up to \$500 per calendar year
Health insurance counseling/forms assistance	Up to 15 hours per calendar year
Health insurance premium assistance (for the eligible child’s portion of the premium only)	Covered only when a hardship exception would be approved as described in Attachment L

1. The following table (Table 2f) lists benefits for the Medicaid Diversion (Part B) eligibility group (specified in STC 24). In addition to the service limits stated in Table 2f, the total cost of the services and supports identified in Table 2f shall not exceed \$10,000 per calendar year.

Table 2f Benefits and Benefit Limitations Medicaid Diversion (Part B) Eligibility Group	
Benefit	Amount Duration and Scope

Health insurance premium assistance (for the eligible child's portion of the premium only)	
Automated health care and related expenses reimbursement	
Individualized therapeutic support reimbursement	
Self-directed respite and/or supportive home care	Covered as medically necessary subject to limitations described in Attachments H and L
Agency-based HCBS – Respite – Supportive home care – Community integration support services – Community transportation – Decision making supports – Family to Family Support – Community Support Development, Organization and Navigation	Covered as medically necessary subject to limitations described in Attachments H and L
Assistive technology, adaptive equipment and supplies	up to \$5,000 per calendar year
Minor home modifications	Up to \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime
Vehicle modifications	Up to \$10,000 per calendar year and \$20,000 per lifetime
Family caregiver education and training	Up to \$500 per calendar year
Health insurance counseling/forms assistance	Up to 15 hours per calendar year

- m. The demonstration-only eligible children enrolled in the Continued Eligibility group (Part C) described in STC 25, Continued Eligibility for Children with Disabilities, will receive the same benefits as the state plan eligible children enrolled in TennCare Medicaid.

30. Benefits for TennCare Medicaid Population Only that are Not Included in the TennCare Standard Benefit package.

- a. Base services are services carved out of TennCare III, 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 services listed in Table 3 are excluded from the TennCare Standard benefit package, and, while included in the TennCare Medicaid package, are carved out of the managed care service delivery system and shall instead be furnished as specified under the state plan. Expenditures for such services shall not be counted as demonstration expenditures, and are not included in the demonstration's budget neutrality. They should 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).

<p align="center">Table 3</p> <p align="center">Services Excluded from TennCare Standard, Carved Out of TennCare Medicaid Managed Care, and Reported as Base Expenditures Under the State Plan</p>
<p>Services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID)</p> <p>State Plan targeted case management services</p> <p>Program of All Inclusive Care for the Elderly (PACE) (except for members of the PACE Carryover Group)</p> <p>Services covered by the home and community-based services waiver for individuals with intellectual disabilities under 1915(c) of the Social Security Act. , Enrollment in these waivers is closed except as specified in the approved Comprehensive Aggregate Cap (CAC) Waiver application (CMS Control #0357).¹⁶</p> <p>Services covered through the state’s agreement under Title V of the Social Security Act.</p>

- b. **Medicare Parts A and B Buy-In Premiums.** Medicare beneficiaries who are members of the CHOICES 217-Like HCBS Group, the CHOICES At Risk Demonstration Group, the ECF CHOICES 217-Like HCBS Group, the Interim ECF CHOICES At-Risk Group, and upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES Working Disabled Group and ECF CHOICES At- Risk 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 CHOICES At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),
 - D. Dually eligible members of the ECF CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals),
 - E. Dually eligible members of the Interim ECF CHOICES At-Risk Demonstration Group and, upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES At-Risk

¹⁶ This includes only persons discharged from the Harold Jordan Center following a stay of at least 90 days.

- Demonstration Group and ECF CHOICES Working Disabled Group (QMBs/SLMBs and Demo Duals),
- F. Dually eligible members of the Standard Spend Down group (QMBs/SLMBs and Demo Duals), and
 - G. 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 STC 63 (*Reporting Expenditures and Member Months*).
 - iii. Medicare premium payments for other beneficiaries are excluded from TennCare III 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, CHOICES At Risk Demonstration Group, CHOICES 1 and 2 Carryover Group, the ECF CHOICES 217-Like HCBS Group; the Interim ECF CHOICES At-Risk Demonstration Group; upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES Working Disabled Group and the ECF CHOICES At-Risk Demonstration 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 CHOICES At Risk Demonstration Group (QMBs/SLMBs and Demo Duals),
 - D. Dually eligible members of the ECF CHOICES 217-Like HCBS Group (QMBs/SLMBs and Demo Duals),
 - E. Dually eligible members of the Interim ECF CHOICES At-Risk Demonstration Group and, upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES At-Risk Demonstration Group and the ECF CHOICES Working Disabled Group (QMBs/SLMBs and Demo Duals).

F. Dually eligible members of the CHOICES 1 and 2 Carryover Group and PACE Carryover Group, and

G. Standard Spend Down enrollees (QMBs/SLMBs and Demo Duals). The SSD population, the CHOICES 217-Like HCBS Group, the CHOICES At Risk Demonstration Group, the CHOICES 1 and 2 Carryover Group, the ECF CHOICES 217-Like HCBS Group; the Interim ECF CHOICES At- Risk Demonstration Group; upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES Working Disabled Group and the ECF CHOICES At-Risk Demonstration 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 CHOICES At Risk Demonstration Group (QMBs, SLMBs, and Demo Duals), members of the CHOICES 1 and 2 Carryover Group; members of the ECF CHOICES 217-Like HCBS Group; members of the Interim ECF CHOICES At-Risk Demonstration Group; and upon implementation of Phase 2 of ECF CHOICES, members of the ECF CHOICES Working Disabled Group and the ECF CHOICES At-Risk Demonstration Group (QMBs, SLMBs, and Demo Duals); 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. Minimum Essential Coverage (MEC). Services as described in Section V, STC 24. Medicaid Diversion (Part B) are limited and, consequently, are not recognized as Minimum Essential Coverage (MEC) as outlined in section 5000A(f)(1)(A)(ii) of the Internal Revenue Code of 1986. The state shall adhere to all applicable Internal Revenue Service reporting requirements with respect to MEC for demonstration enrollees.

32. Designated State Investment Programs. The state may claim FFP for health programs, funded as of December 31, 2020 identified in Attachment O, subject to the restrictions described below unless otherwise specified. Expenditures are limited to costs not otherwise covered under the state plan, but consistent with Medicaid demonstration objectives that enable the state to continue to improve health outcomes and increase the efficiency and quality of care.

- a. The DSIPs must meet one or more of the criteria for promoting the objectives of title XIX. These criteria include:
 - i. increase and strengthen overall coverage of low-income individuals in the state;

- ii. increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
 - iii. improve health outcomes for Medicaid and other low-income populations in the state; or
 - iv. increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.
- b. Allowable Expenditures
 - i. Medicaid services for non-Medicaid eligible people.
 - ii. Non-Medicaid services for Medicaid eligible people.
 - iii. Medicaid provider stabilization payments for current Medicaid services for people at-risk for Medicaid if services are not received.
- c. Prohibited Expenditures. Allowable expenditures do not include the following.
 - i. Capital investments;
 - ii. Expenditures that are not health-related; and
 - iii. Any expenditure that is otherwise prohibited by statute or regulation.
- d. Savings achieved under the demonstration are calculated as the total computable difference between the aggregate budget neutrality cap in a given year and actual demonstration expenditures for that year. Up to 55 percent of newly accrued savings during the TennCare III demonstration period may be used as federal expenditure authority to fund DSHP contingent on meeting quality performance targets. For example, if the state's federal demonstration expenditures are \$100 million less than the aggregate budget neutrality cap for a demonstration year, the state may be eligible to draw down up to \$55 million in federal funding for approved DSIPs (provided the state has the requisite quality improvements to achieve the full 55 percent level). The total amount of federal match available to the state for approved DSIPs in a given year may be equal to, but will not exceed, the federal match on identified CNOMs.
- e. Qualifying for Savings to use on DSIP. Tennessee will be eligible to qualify for shared savings on an annual basis when it underspends the "without waiver" aggregate cap and meets quality targets. These shared savings will be available as federal funding to be used as DSIP-like CNOMs on a number of existing programs that are currently being funded with state dollars. These shared savings are available to the state for the year in which they qualify or during any subsequent year of the demonstration. Any available savings will be made available to: overages of current programs funded in the TennCare II demonstration; expenditure authorities 8 and 9 and increased UC above the December 31, 2020 expenditure amount; and then DSHP.
- f. Shared Savings Quality Measures Protocol. No later than 60 calendar days after the demonstration approval, the state will submit for CMS approval, a protocol that includes the following:

- i. At least 10 quality metrics from the Medicaid Adult, Child, and Maternity Core Sets (at least 3 applicable to each population impacted by the demonstration) to be monitored for performance measurement in order to access shared savings. These metrics will be called the Shared Savings Metric Set. The state will use CY 2019 as the baseline year, and the baseline will be recalculated in DY5. At the rebasing that occurs at DY5, the state may select a different set of 10 quality metrics from the Medicaid Adult, Child, and Maternity Core Sets (at least 3 applicable to each population impacted by the demonstration) to be monitored for the remainder of the demonstration.
 - ii. Any deviations from national measure steward technical specifications.
 - iii. A mathematical representation by which to document how shared savings are earned and spent, and commensurate with STC 32.h. Upon approving the Shared Savings Quality Measures Protocol, CMS will attach the deliverable to the STCs as Attachment P.
 - iv. Any revisions to the Shared Savings Quality Measures Protocol will submitted to CMS for approval.
- g. Reporting on Shared Savings Quality Measures. Progress on the shared savings metric set will be documented in the quarterly and annual monitoring reports, and will capture the calculation of shared savings for that year as well as how savings are spent in each demonstration year. All quality measures will be calculated based on the demonstration population as the denominator. The quality measures will represent a segment of the overall metrics reported to CMS for monitoring of the demonstration. The measures for shared savings must be reported to CMS annually, upon completion of measure validation, and in accordance with CMS' process.
- h. To be eligible to expend savings on DSIP:
- i. If Tennessee underspends the aggregate cap and demonstrates performance maintenance and improvement it will qualify for up to 45 percent of the savings for maintenance of performance, and for an additional ten percentage points up to 55 percent of the savings for improvement. There are further requirements related to underperformance and its effect on qualifying for these savings opportunities in (ii) below.
 - ii. Performance maintenance and determining the shared savings amount for the first 45 percent opportunity. To determine performance maintenance, the state will assess the value of each Shared Savings Metric for the demonstration year compared to the baseline year. The initial baseline year is 2019, and the baseline will be rebased in the 5th demonstration year. If the value for any of the Shared Savings Metrics for the demonstration year is lower than that of the baseline year, the state will follow the process outlined below:
 - 1. To be eligible for 45 percent of shared savings for performance maintenance, the observed percent change between the demonstration year and the baseline for each

Shared Savings Metric must either improve or not significantly decline as defined by a minimum effect size change relative to the starting baseline performance. This minimum effect size change is defined as:

<u>Baseline Metric Performance</u>	<u>Annual Minimum Effect Size Change</u>
<u>0-59</u>	<u>At least a 6 percentage point change</u>
<u>60-74</u>	<u>At least a 5 percentage point change</u>
<u>75-84</u>	<u>At least a 4 percentage point change</u>
<u>85-92</u>	<u>At least a 3 percentage point change</u>
<u>93-96</u>	<u>At least a 2 percentage point change</u>
<u>97-99</u>	<u>At least a 1 percentage point change</u>

For any shared savings metric where the trend of national performance has declined, any measurement of Tennessee’s performance on the shared savings metric will account for the decline in national trend in order to ensure there is no inconsistency with this decline. Inconsistent with the decline in national trend is defined to mean that any decline that Tennessee has experienced on the shared savings metrics must be more than aggregate total decline of the decline in the national trend and the minimum effect size change for that shared savings metric.

2. If performance in any of the Shared Savings Metrics exhibits a statistically significant decline as described in the bullet above, the state will be required to submit a performance improvement plan to CMS.
3. The performance improvement plan will be submitted to CMS 60 calendar days after the Shared Savings Metrics are submitted to CMS, and will describe the state’s plan for how it will improve performance on the measures which fall statistically significantly below the percent change of national average.
4. If the state experiences a consecutive year of such a decline in the same Shared Savings Metric, the amount of shared savings eligible for DSIP will be reduced in that demonstration year by 10 percentage points from the maintenance opportunity of 45 percent, not to be less than 20 percent unless the state does not qualify for any share savings as defined below.
5. If the state experiences a consecutive year of decline in four or more Shared Savings Metrics, the state will not be eligible in that demonstration year for any shared savings, with the exception that the state improves performance as defined in (iii and iv) below on all remaining Shared Savings Metrics
6. For Shared Savings Metrics for which there is no Medicaid Adult or Child Core Set national average, the state will propose in its Shared Savings Metrics Protocol an alternative comparison for CMS’s approval.

- iii. Performance improvement and determining the shared savings amount for the opportunity of an additional ten percentage points up to 55 percent. Only if the state qualifies for any shared savings under the maintenance opportunity, the state is also eligible to qualify for an additional ten percentage points up to 55 percent when the state is successful in achieving improvement on one or more of the shared savings metrics consistent with effect sizes described in STC 32.h.ii.1; the amount of shared savings for improvement within this ten percentage point opportunity will be proportionate to the number of Shared Savings metrics associated with this opportunity to demonstrate improvement.
- iv. Also subject to qualifying for any shared savings under the maintenance opportunity, if in any demonstration year the state performs with sufficient improvement on a shared savings metric to be in the 75th percentile or higher, the state may continue to access shared savings equivalent to the portion allowed for improvement on that metric even if a 2 percentage point improvement was not achieved. Once the state reaches the 90th percentile, the metric will be retired for purposes of achieving shared savings, and the state and CMS will jointly identify a replacement quality metric.
- v. In the event of a public health emergency during a performance measurement period, the state may submit for CMS approval an adjustment to the performance expectation for achieving shared savings.
- i. Implementation Plan: All DSIP (including any subsequent changes in programs) will be subject to the Implementation Plan requirements as outlined in STC 6754.
- j. Monitoring Protocol: As outlined in STC 55, the state is required to submit to CMS a draft or amended Monitoring Protocol no later than ninety (90) calendar days prior to the planned start date of the DSIP.
- k. DSIP Monitoring Reporting: As part of the monitoring reports required under STC 7, the state will report DSIP claims and expenditures to date, in addition to any metrics reporting applicable for DSIP.
- l. Claiming Process: Documentation of each DSIP's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS.
 - i. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSIPs.
 - ii. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSIPs, they shall not be used as a source of non-federal share.

- iii. The administrative costs associated with DSIPs, (that is not generally part of normal operating costs that would be included in rates) shall not be included in any way as demonstration and/or other Medicaid expenditures.
- m. **DSIP Claiming Protocol.** The state will develop a DSIP claiming protocol, subject to CMS approval, with which the state will be required to comply in order to draw down DSIP funds. State expenditures for the DSIP must be documented in accordance with the protocols. The state is not eligible to receive FFP until an applicable protocol is approved by CMS. Once approved by CMS, the protocol becomes Attachment Q to these STCs.

VI. CHOICES, ECF CHOICES, KATIE BECKETT, AND MEDICAID DIVERSION ENROLLMENT

33. Operations of the TennCare CHOICES Programs.

- 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 CHOICES At Risk Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. This group was closed 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 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 1902(a)(10)(A)(ii)(VI) 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 CHOICES At Risk Demonstration Group. Members of the CHOICES 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 STC 33.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 STC 29.i.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 STC 29.i.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 STC 29.i.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 accordance with STC 33.d.iv.(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 STC 33.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 Monitoring Report as set forth in STCs 56 (*Monitoring Reports*), 57 (*Enrollment Report*).
- i. The CHOICES targets will include both upper limits and lower limits, with the actual target number to be published in state rules. The upper limit will serve as a ceiling on the enrollment target; TennCare will not set the target above the upper limit. The lower limit will serve as an enrollment floor; TennCare will not set the target below the lower limit. To help ensure continuity of eligibility and benefits, the target for each benefit group will not be less than enrollment in that group at the time the target is established.
 - ii. The state will submit to CMS at least 60 days prior to the beginning of each program year a proposed enrollment target range for CHOICES 2 and CHOICES 3. The state may, during the course of each year, adjust the specific enrollment target for each group so long as the target remains within the approved enrollment target range for that group and the state provides notification to CMS at least 30 days prior to the desired effective date of the change. Except as specified in STC 33.d.iv, an amendment is required for any proposed adjustment in the enrollment target outside the approved range.
 - iii. At a minimum, any enrollment target for CHOICES 3 will be set at 10% of the enrollment target for CHOICES 2. There will be no enrollment target for Interim CHOICES 3.
 - iv. 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 Monitoring Report (see STC 56). 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 Monitoring Reports must reflect any such changes. In each Quarterly Monitoring 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,. (Consistent with STC 33.d.iv.(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 STC 33.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 F.
- g. Conflict of Interest.** The state assures that the entity that authorizes HCBS is external to the agency or agencies that provide HCBS, and that contracts with MCOs reflect this separation of assessment, treatment planning, and service provision functions.

- h. **Service Plan:** The state must demonstrate, through monitoring and oversight of its contracts with MCOs, that services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.
- i. **Community Participation.** The state, through its contracts with MCOs, must ensure that covered CHOICES benefits are provided in a manner that supports and promotes community engagement and community participation consistent with the needs and preferences of each enrollee.
- j. **HCBS Settings.** The state assures compliance with the characteristics of HCBS settings as described in 1915(c) and 1915(i) regulations in accordance with implementation and effective dates as published in the Federal Register.
- k. **Other Provisions Related to CHOICES Enrollment and Implementation**
 - i. The state must ensure that the Person Centered Support 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.

34. Operations of Employment and Community First (ECF) CHOICES

- a. **Determination of ECF CHOICES Benefits by Designation into an ECF CHOICES Benefit Group.** The ECF CHOICES Program provides long-term services and supports (LTSS) as identified in Tables 2c and 2d to five groups of people, as defined below:
 - i. **Essential Family Supports (ECF CHOICES Group 4):** Children under age 21 with I/DD living at home with family who meet the NF LOC, and need and are receiving HCBS as an alternative to NF Care, except for children described in Section 1902(e)(3), unless they are enrolled in ECF CHOICES upon implementation of Katie Beckett (Part A), age 17 or older, or transitioning from ECF CHOICES Group 7; children who, in the absence of HCBS, are “At risk of NF placement” and qualify for Medicaid under SSI deeming rules, and adults age 21 and older with I/DD living at home with family caregivers who meet the NF LOC and need and are receiving HCBS as an alternative to NF care, or who, in the absence of HCBS, are “At risk of NF placement,” and elect to be in this group. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Group, Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk Demonstration Group or ECF CHOICES Working Disabled Demonstration Group.
 - ii. **Essential Supports for Employment and Independent Living (ECF CHOICES Group 5):** Adults age 21 and older with I/DD who meet the NF LOC and whose needs can be safely met in this group, or who do not meet NF LOC but who, in the absence of HCBS, are “at risk of NF placement.” To qualify in this group, the adult must be SSI eligible or qualify in the Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

- iii. **Comprehensive Supports for Employment and Community Living (ECF CHOICES Group 6):** Adults age 21 and older with I/DD who meet the NF LOC and need and are receiving specialized services for I/DD. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group.
- iv. **Intensive Behavioral Family Supports (ECF CHOICES Group 7):**

Children under age twenty one (21) who live at home with family caregivers or other permanent guardian(s) in a long-term family living arrangement,¹⁷ guardians and have I/DD and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at imminent and significant risk of serious physical harm (that does not rise to the level of inpatient treatment or for which such treatment would not be appropriate), significantly strain the family's ability to adequately respond to the child's needs, threaten the sustainability of the family living arrangement, and place the child at imminent and significant risk of placement outside the home (e.g., State custody, hospitalization, residential treatment, incarceration). As a condition of enrollment, the child's family must provide informed consent, including a commitment to actively participate in a family-centered therapeutic approach to treatment and support. The child must meet the nursing facility level of care and need and receive HCBS as an alternative to NF Care. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. This group shall be implemented by MCOs based on TennCare's determination of the MCO's readiness to deliver services statewide and in accordance with program requirements.
- v. **Comprehensive Behavioral Supports for Employment and Community Living (ECF CHOICES Group 8):** Adults age twenty-one (21) and older, unless otherwise specified by TennCare, with I/DD and severe behavioral and/or psychiatric conditions, who are transitioning out of a highly structured and supervised environment, meet nursing facility level of care, and need and are receiving specialized services for I/DD. To qualify for enrollment, a person's psychiatric symptoms or behaviors must place the person or others at imminent and significant risk of serious physical harm (that does not rise to the level of inpatient treatment or for which such treatment would not be appropriate), and necessitate continuous monitoring and supervision by 24-hour staff to ensure the person's safety and/or the safety of others. (The intensity of supports needed is expected to lessen as the person achieves stabilization in the community and readies for transition to a different benefit group.) To enroll in this group, a person must be in one of the following target groups: 1) adults with severe psychiatric or behavioral symptoms whose family is no longer capable of supporting the individual due to the severity and frequency of behaviors; 2) emerging young adults (age 18-21) with I/DD and severe psychiatric or behavioral symptoms aging out of the foster care system; and 3) adults with I/DD and severe psychiatric or behavioral symptoms following a crisis event and/or psychiatric inpatient stay and/or transitioning out of the criminal justice system or a long-term institutional placement (including residential

¹⁷ See footnote 2.

psychiatric treatment facility). To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. On a case-by-case basis, TennCare may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 8, if they meet eligibility criteria. This group shall be implemented by MCOs based on TennCare's determination of the MCO's readiness to deliver services statewide and in accordance with program requirements.

- b. **Eligibility for TennCare ECF CHOICES Benefits.** Individuals can be eligible for one of the five ECF CHOICES benefit groups defined in STC 34.a. above depending upon their functional and/or medical needs, their TennCare eligibility group, their age, their I/DD status, the need for and receipt of HCBS under ECF CHOICES, and the ability of the state to provide them with safe, appropriate, and cost-effective LTSS.
 - i. I/DD and medical and/or functional needs are assessed according to criteria published by the state in the state rules.
 - ii. Financial eligibility:
 - A. Eligible for TennCare as an SSI recipient; or
 - B. Meet the criteria for the ECF CHOICES 217-Like Group; the Interim ECF CHOICES At-Risk Demonstration Group or, upon implementation of Phase 2 of ECF CHOICES, the ECF CHOICES At-Risk Demonstration Group or the ECF CHOICES Working Disabled Group.
 - iii. Need and receive home and community-based services under ECF CHOICES.
 - iv. The state's ability to provide applicants with appropriate ECF CHOICES home and community based services is determined by the availability of slots under an established enrollment target (see paragraph 32.d., *Enrollment Targets for ECF CHOICES*).
- c. **Enrollment in ECF CHOICES.** The effective date of enrollment in ECF CHOICES shall be established by the state based on a determination that an applicant is eligible for and will begin receiving LTSS. To be eligible for ECF CHOICES, individuals must be determined by TennCare to meet all applicable eligibility and enrollment criteria.
 - i. For enrollment in Comprehensive Supports for Employment and Community Living (ECF CHOICES Group 6) or Comprehensive Behavioral Supports for Employment and Community Living (ECF CHOICES Group 8), the state may grant an exception to individuals transitioning either from the Statewide or Comprehensive Aggregate Cap Waivers or from an ICF/IID who are "at risk" of institutionalization and meet the ICF/IID but not the NF LOC.

- ii. Individuals enrolled in a Section 1915(c) waiver shall not be permitted to transition into ECF CHOICES, even if they meet the criteria for ECF CHOICES eligibility, until such time that the state determines that such transitions can be permitted and in accordance with timeframes and procedures established by the state.
 - iii. Individuals enrolled in CHOICES Group 2 or 3 shall not be permitted to transition into ECF CHOICES, even if they meet the criteria for ECF CHOICES eligibility, unless the state determines that the individual qualifies for ECF CHOICES, the individual's needs can be more appropriately met in ECF CHOICES, and in accordance with timeframes and procedures established by the State.
- d. **Enrollment Targets for ECF CHOICES.** The state may establish enrollment targets for ECF CHOICES. The purpose of the targets is to permit ECF CHOICES 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 ECF CHOICES groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Monitoring Report as set forth in STCs 56 (*Monitoring Reports*), 57 (*Enrollment Report*).
- i. The ECF CHOICES targets will include both upper limits and lower limits; with the actual target number to be published in state rules. The upper limit will serve as a ceiling on the enrollment target; TennCare will not set the target above the upper limit. The lower limit will serve as an enrollment floor; TennCare will not set the target below the lower limit. To help ensure continuity of eligibility and benefits, the target for each benefit group will not be less than enrollment in that group at the time the target is established. Persons transitioning into ECF CHOICES from a Section 1915(c) waiver or from CHOICES Groups 2 or 3 shall not count against the enrollment target for the ECF CHOICES Group in which they are enrolled.
 - ii. The state will submit to CMS at least 60 days prior to the implementation of ECF CHOICES and at least 60 days prior to the beginning of each program year a proposed enrollment target range for each benefit group. The state may, during the course of each year, adjust the specific enrollment target for each group so long as the target remains within the approved enrollment target range for that benefit group and the state provides notification to CMS at least 30 days prior to the desired effective date of the change. Except as specified in STC 34.d.iv, an amendment is required for any proposed adjustment in the enrollment target outside the approved range.
 - iii. Any enrollment target for Essential Supports for Employment and Independent Living will be at least twice as high as any enrollment target for Comprehensive Supports for Employment and Community Living.
 - iv. If the enrollment target established by the state for ECF CHOICES is reached or exceeded, the state shall not enroll additional persons in ECF CHOICES, except as provided below. The state may also establish a waiting list, subject to the following:

- A. **Reserve Capacity.** The state may reserve slots in ECF CHOICES for individuals being discharged from a NF or an ICF/IID, and for individuals being discharged from an acute care setting who are in imminent risk of being placed in an NF or ICF/IID 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 Monitoring Report. The state may establish additional criteria or modify procedures for allocating reserve slots upon 30 days advance written notification to CMS; the operational procedure documents included as attachments to subsequent Annual Monitoring Reports must reflect any such changes. In each Quarterly Monitoring 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 ECF CHOICES, the number enrolled in each ECF 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 ECF CHOICES, but which cannot enroll the individual in ECF CHOICES because the enrollment target 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. 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 ECF CHOICES.
- C. **Exception to Enrollment Targets for ECF CHOICES 4 and 6 for Transitions from ECF CHOICES 7 or 8.** An enrollee being served in ECF CHOICES 7 or 8 who meets the requirements to enroll in ECF CHOICES 4 or 6 may enroll in ECF CHOICES 4 or 6 at any time such a transition can be accomplished, even if an enrollment target for ECF CHOICES 4 or 6 has been reached. Such an enrollee would be served in ECF CHOICES 4 or 6 outside the applicable enrollment target but moved within the applicable enrollment target at such a time as a slot becomes available.
- e. **Waiting Lists for ECF CHOICES.** The use of enrollment targets as described in STC 34.d. (*Enrollment Targets for ECF CHOICES*) may mean that there will be waiting lists for ECF CHOICES. These lists will be managed on a statewide basis 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.
- f. **Consumer Direction.** ECF CHOICES members will have the option for consumer direction, including budget authority. The consumer direction model will be a modified budget authority model. The consumer direction budget will be established in accordance with the benefit group, including expenditure cap, in which the person is enrolled and will be based on a comprehensive assessment of the individual's needs. Once determined, the member (or his/her representative) will be able to manage those services available through participant direction, so long as individual benefit limits (as applicable) and the member's total

participant direction budget is not exceeded. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment F.

- i. Individuals in the Comprehensive Supports for Employment and Community Living benefit group will have the option to use a “Health Partner Agency (HPA) with Choice” model. The HPA with Choice model will allow an individual with I/DD who has more significant needs to elect to work with a qualified provider of residential services to help direct his/her services and supports budget. In the HPA with Choice model, the enrollee will have the opportunity to help select and supervise his or her direct support staff, who will be employed by the Agency. The Agency will support the enrollee in deciding how s/he will direct his/her services and supports budget, based on the needs identified in the person-centered support plan. The enrollee’s MCO Support Coordinator will be involved in the planning process to ensure that the planning process remains conflict free and will monitor the ongoing provision of HCBS to ensure that the individual’s needs are met. In addition, the HPA Agency must agree to:
 - A. work with the MCO Support Coordinator and with the accountable primary care entity—Patient Centered Medical Home and/or Health Home to facilitate access to and coordination of physical and behavioral health services and LTSS;
 - B. support a comprehensive approach to preventive care, chronic disease and care management; assist in health promotion;
 - C. help facilitate comprehensive transitional care/follow-up; and
 - D. Health Information Technology (HIT), as can be made available, to help facilitate communication between and among providers, the member, and caregivers.

35. Operations of the TennCare Katie Beckett and Medicaid Diversion Programs

- a. **Eligibility for TennCare Katie Beckett and Medicaid Diversion Benefits.** Individuals can be eligible for one of the two TennCare groups defined in STC 21 above depending upon their medical and/or functional needs, and enrollment caps.
 - i. Medical and/or functional needs are assessed according to LOC criteria for children published by the state in state rules. For the purposes of re-determining whether a recipient continues to require the LOC provided in an institution, the state must use criteria consistent with those used to make the initial LOC.
 - ii. Financial eligibility for Katie Beckett, Medicaid Diversion, and Continued Eligibility groups is established according to the institutional income and resource criteria. The deeming of the parents’ income and assets to the child is waived for these groups; only the child’s income and assets are counted.

- iii. The state's ability to provide applicants with services in the Katie Beckett and Medicaid Diversion groups is determined by the availability of slots under an established enrollment target (see STC 35.d. *Enrollment Targets for Katie Beckett and Medicaid Diversion Groups*).
- b. **Enrollment in TennCare Katie Beckett and Medicaid Diversion.** The effective date of enrollment in Katie Beckett and Medicaid Diversion groups must be established by the state based on a determination that an applicant is eligible for and may begin receiving LTSS.
 - i. Persons not already enrolled in TennCare who wish to enroll in Katie Beckett (Part A) and Medicaid Diversion (Part B) group must apply through the state's online portal (with assistance as needed). Intake will be performed by the Department of Intellectual and Developmental Disabilities (DIDD).
 - ii. Applicants will be directed to the CHOICES or ECF CHOICES programs according to their needs and targeting criteria for each group.
- c. **Enrollment Targets for Katie Beckett and Medicaid Diversion groups.** The state may establish enrollment targets for Katie Beckett (Part A) and Medicaid Diversion (Part B) groups. There will be no enrollment target for the continued eligibility group. The purpose of the targets is to permit the Katie Beckett and Medicaid Diversion groups 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 Katie Beckett and Medicaid Diversion groups, targets, and enrollment numbers must be supplied to CMS in the Quarterly Monitoring Report as set forth in STCs 56 (*Monitoring Reports*), 57 (*Enrollment Report*).
 - i. To help ensure continuity of eligibility and benefits, the target for each benefit group will not be less than enrollment in that group at the time the target is established.
 - ii. If the enrollment target established by the state for the Katie Beckett and Medicaid Diversion groups is reached or exceeded, the state shall not enroll additional persons in Katie Beckett or Medicaid Diversion groups, except as indicated below. The state may also establish a waiting list for Katie Beckett and Medicaid Diversion group, subject to the following:
 - A. **Reserve Capacity.** The state may reserve slots in Katie Beckett and Medicaid Diversion groups for individuals with the highest level of need, those awaiting discharge from an institution, and for individuals who are in imminent risk of being placed in a facility institutional 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 Monitoring Report (see STC 56).
 - B. 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 Monitoring Reports must reflect any such changes. In each Quarterly Monitoring 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 Katie Beckett and Medicaid Diversion group, the number enrolled in each group, and the numbers of slots being held in reserve for various purposes.

- d. **Waiting Lists for Katie Beckett and Medicaid Diversion Groups.** The use of enrollment targets as described in STC 35.c. (*Enrollment Targets for Katie Beckett and Medicaid Diversion Groups*) may mean that there will be waiting lists for Katie Beckett and Medicaid Diversion groups. (There will be no enrollment target or waiting list for the Continued Eligibility 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 Katie Beckett and Medicaid Diversion groups, and may revise these upon notification to CMS.
- e. **Consumer Direction.** Katie Beckett and Medicaid Diversion group members who have been determined by an MCO Nurse Care Manager or DIDD Case Manager, as applicable, as a part of the needs assessment and plan of care processes, to require supportive home care, in-home respite services, 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 Katie Beckett and Medicaid Diversion 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 F.
- f. **Conflict of Interest.** The state assures that the entity that authorizes HCBS is external to the agency or agencies that provide HCBS, and that contracts with MCOs reflect this separation of assessment, treatment planning, and service provision functions.
- g. **Service Plan:** The state must demonstrate, through monitoring and oversight of its contracts with MCOs, that services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.
- h. **Community Participation.** The state, through its contracts with MCOs or DIDD, must ensure that covered Katie Beckett and Medicaid Diversion benefits are provided in a manner that supports and promotes community engagement and community participation consistent with the needs and preferences of each enrollee.
- i. **HCBS Settings.** The state assures compliance with the characteristics of HCBS settings as described in 1915(c) and 1915(i) regulations in accordance with implementation and effective dates as published in the Federal Register.

j. **Other Provisions Related to Katie Beckett Enrollment and Implementation**

- i. The state must ensure that the Person Centered Support Plan is considered part of the medical record of a Katie Beckett and Medicaid Diversion group participant, subject to all associated requirements and protections, and available for review by the state upon request.

VII. COST SHARING/PREMIUMS/PREMIUM ASSISTANCE

36. Cost Sharing. TennCare enrollees are subject to cost sharing as indicated in Table 4. Copay amounts are specified in Table 5.

Table 4 TennCare Demonstration Cost Sharing		
Program/Group	Pharmacy Copays	Non-Pharmacy Copays
TennCare Medicaid (state plan enrollees not exempt from cost sharing)	Yes	No
TennCare Standard Spend Down Adults (SSD)	Yes	No
TennCare Standard Uninsured Children	Yes	Yes
TennCare Standard Medically Eligible Children	Yes	Yes
CHOICES 1	No	No
CHOICES 2	No	No
CHOICES 3	Yes	No
Interim CHOICES 3	Yes	No
ECF CHOICES Comprehensive Supports for Employment and Community Living	No	No
ECF CHOICES Essential Family Supports Group (meet NF LOC and/or who are under age 21)	No	No
ECF CHOICES Essential Family Supports Group (who do not meet NF LOC and are age 21 or older)	Yes	No
ECF CHOICES Essential Supports for Employment and Independent Living	Yes	No
ECF CHOICES Intensive Behavioral Family Supports	No	No
ECF CHOICES Comprehensive Behavioral	No	No

Supports for Employment and Community Living		
Katie Beckett (Part A)	No	No
Medicaid Diversion (Part B)	N/A	N/A
Continued Eligibility	No	No

37. Copayments. Copayments are collected by the provider when services are rendered. The requirements at Section 1916A of the Act and in cost sharing regulation at 42 CFR 447 Subpart A will apply to cost sharing under the demonstration.

- a. **Non-Pharmacy Copays.** Non-pharmacy copay amounts are presented in Table 5 (TennCare Non-Pharmacy Copays).
- b. **Copays on Pharmacy.** Pharmacy copays differ based on a drug being brand name or generic. Brand name prescriptions are subject to a \$3.00 copay while generic prescriptions are subject to a \$1.50 copay.

Table 5 TennCare Demonstration Cost Sharing Co Pays		
Benefit	Copay for Enrollees with Incomes from 134% FPL to 199% FPL	Copay for Enrollees with Incomes from 200% FPL and higher
Non-emergency use of the emergency department (no copayment for emergency use and, for non-emergency use, waived if the individual is admitted as an inpatient)	\$8.20	\$50
Primary care provider and community mental health agency services (other than preventive care)	\$5	\$15
Physician specialist	\$5	\$20
Inpatient admission (waived if readmitted within 48 hours for the same episode)	\$5	\$100

38. Premiums and Mandatory Health Insurance Coverage

Table 6 Katie Beckett Premiums	
Household Income	Premium up to % of income for a household of two
>150% - 250% FPL	1.5%
>250% - 300% FPL	2.5%
>300% - 400% FPL	3%
>400% - 500% FPL	4%

>500% FPL - No limit	5%

- a. Premiums. Premiums are required as a condition of enrollment and continued eligibility for individuals enrolled in the Katie Beckett (Part A) benefit group whose families have income above 150 percent of the federal poverty level (FPL), using MAGI rules. Beneficiaries will be required to pay a monthly premium, as set forth in Table 6 above.
 - i. Consequences for non-payment of the premium: An individual subject to a premium will be subject to the following consequences:
 1. Suspension. After at least 10 days advance notice and 30-days after the premium was due, individuals who fail to make a premium payment will have benefits suspended.
 2. Termination. After 10-day advance notice and 60-days after the premium was due, individuals who fail to make a premium payment may be disenrolled.
 3. Re-enrollment after termination for non-payment of premium: An individual, who has been terminated from Part A coverage for nonpayment of a premium, may re-apply for Part A coverage at any time. However, any previously owed premiums must be repaid in full before he/she can re-enroll for Part A coverage. Reenrollment shall be subject to all applicable eligibility and enrollment criteria, including the availability of an open program slot, and in accordance with prioritization criteria. Owed premium for Katie Beckett Part A does not impact enrollment in other groups.
 - ii. Notice: The state will provide all applicants and beneficiaries with timely and adequate written notices of any decision affecting their eligibility, including an approval, denial, termination, or suspension of eligibility or a denial or change in benefits and services pursuant to 42 CFR 435.917. The state will provide beneficiaries with 10 days advance notice for any adverse action pursuant to 42 CFR 431.211.
 - iii. Fair hearing rights: The state will provide all beneficiaries with fair hearing rights consistent with 42 CFR 431, subpart E.
 - iv. Notice related to lockout and termination for non-payment of premiums: The state will provide notice to beneficiaries for suspension and termination of eligibility for failure to pay premiums. This notice must explain what this termination and lockout means, including but not limited to: their right to appeal, their right to apply for Medicaid on another basis, what this status means with respect to their ability to access other health insurance coverage, what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category, and the conditions under which they are eligible to re-enroll under Part A coverage.
- b. Mandatory insurance coverage. As a condition of enrollment and continued eligibility for individuals enrolled in the Katie Beckett (Part A) benefit group, families must purchase and maintain minimum essential private or employer-sponsored coverage, unless the family

qualifies for a hardship exception. The child’s portion of the premium for such coverage shall be deducted from the premiums reflected in Table 6 above. Families qualifying for a hardship exception shall not be required to purchase and maintain minimum essential private or employer-sponsored coverage; however, if cost-effective, TennCare may choose to offer assistance with paying premiums for such coverage in lieu of granting the exception.

VIII. DELIVERY SYSTEMS

39. Managed Care Entities. With the exception of the Medicaid Diversion eligibility groups defined in STC 24, TennCare III 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 ⁸	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 ¹⁸ for enrollees selected for participation in TennCare Select rather than enrolled in MCOs	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

¹⁸ LTSS refers to services for persons who are elderly or who have physical disabilities and certain HCBS for individuals with intellectual or developmental disabilities enrolled in the ECF CHOICES program or Katie Beckett (Part A) group.

Table 7 Types of Managed Care Entities			
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

40. 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 STCs 29 (*TennCare Benefits*). Individuals with intellectual and developmental disabilities must enroll in an at-risk MCO in order to participate in ECF CHOICES. 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.

41. 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. Covered outpatient drugs that are prescribed for medically accepted indication(s) (as defined in 1927(k)(6) of the Act) but not included on the state's preferred drug list will be covered subject to the requirements of prior authorization programs in accordance with 1927(d)(5) of the Act.

- 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 (SSI) and eligible for and enrolled in TennCare Select as of July 31, 2019. TennCare Select provides medical case management and all MCO covered services. On or after August 1, 2019, newly eligible children who are eligible for SSI and determined eligible for TennCare on or after August 1, 2019 will choose and enroll in an at-risk MCO, and will not be assigned to TennCare Select except as specified in subparagraphs ii-iv below.
 - 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. All children in the Katie Beckett (Part A) eligibility group as described in STC 23, will be assigned to TennCare Select. These children will be enrolled in a special component of TennCare Select called SelectCommunity, developed specifically for individuals with I/DD. Person- and family-centered planning will be conducted for children enrolled in SelectCommunity in a manner consistent with CFR 441.301(c)(1), using SelectCommunity Nurse Care Managers who have specialized training in developmental disabilities, and in a family-centered approach.
- v. Enrollees living in areas where there is insufficient capacity to serve them. TennCare Select provides medical case management and all MCO covered services.
- vi. After being assigned to TennCare Select, persons in categories i. and iii. above may choose to disenroll from TennCare Select and enroll in an at-risk 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 STCs 6 and 7) 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.

42. Plan Enrollment and Disenrollment. The state maintains a managed care enrollment and disenrollment process that must comply with 42 CFR Part 438. TennCare participants have 90 days in which to disenroll from an MCO without cause pursuant to 438.56(c)(2)(i). After 90 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) do not include the following:

- a. 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);
- b. The enrollee claims lack of access to services but the plan meets the state's access standards;
- c. The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- d. The enrollee is concerned that a current provider might drop out of the plan in the future;
- e. The enrollee is a Medicare recipient who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation; and
- f. 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 or ECF 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.

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

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

- e. The state has met its obligation to provide coverage of FQHC and RHC services by ensuring each of its MCOs contracts with at least one FQHC and RHC in each of its service areas.

44. The Medicaid Diversion (Part B) eligibility group, including redetermination of eligibility, will be directly administered by the Department of Intellectual and Developmental Disabilities (DIDD) outside of the managed care contracts.

45. Pharmacy Flexibilities

- a. Adults age 21 and over will receive their pharmacy benefit through this demonstration under the expenditure authority in section 1115(a)(2) and will not receive coverage through the state plan under sections 1902(a)(54) and 1905(a)(12) and 42 CFR 440.12 of the Social Security Act and 42 CFR 440.12.
- b. The state must provide drugs to such adults consistent with Essential Health Benefit (EHB) requirements as set forth in section 1937(b) of the Social Security Act, identify the EHB benchmark plan they are using, and should adopt an already approved EHB formulary and drug coverage that meets the EHB standard (i.e., use one that a qualified health plan (QHP) would use in the marketplace). This means the prescription drug coverage formulary already meets the requirements of prescription drug coverage at 45 CFR 156.122 including the greater of 1 drug per United States Pharmacopeia (USP) category and class; or the same number of prescription drugs in each category and class as the EHB-benchmark plan. In addition, drugs categories described below in item d. must also be covered.
- c. The state must maintain and publish in print and on a website an up-to-date, accurate, and complete lists of all covered drugs in their formularies. The state must also provide timely notice to beneficiaries of the changes to the pharmacy benefit in advance of the changes going into effect.
- d. The formulary must comply with: 1) the MAT drug coverage requirements under Section 1905(a)(29) and 1905(ee), 2) the “substantially all” Part D coverage rules for antidepressants, anticonvulsants, antipsychotics, immunosuppressants, antineoplastics, and antiretroviral drugs (including PreP). “Substantially all” in this context means that all drugs and unique dosage forms in these categories are expected to be included in the formulary, with the following exceptions:
 - i. Multi-source brands of the identical molecular structure;
 - ii. Extended release products when the immediate-release product is included;
 - iii. Products that have the same active ingredient or moiety; and
 - iv. Dosage forms that do not provide a unique route of administration (e.g., tablets and capsules versus tablets and transdermals).
- e. A P&T Committee (or use of the state’s current DUR Board as the P&T Committee) shall be used to manage the formulary. The responsibility of the P&T Committee is to provide Formulary Management which includes: (1) developing procedures to ensure appropriate review; (2) making clinical decisions based on scientific evidence; (3) considering therapeutic advantages of drugs; (4) reviewing new Food and Drug Administration (FDA)

approved drugs and biologicals and new uses for existing drugs; (5) ensuring state's formulary drug list covers a broad range of drugs across therapeutic categories consistent with adopted formulary structure; (6) requiring that the formulary provides appropriate access to drugs included in broadly accepted treatment guidelines and consistent with general best practices; (7) identifying the medical necessity criteria/ clinically appropriate criteria that will be used to determine whether specific drugs will be available to patients; (8) reviewing the utilization management techniques that the state will use in general to manage the pharmacy benefit as well as those for specific drugs.

- f. A state exception process shall be implemented for enrollees to request and gain access to clinically appropriate drugs (clinically appropriate being defined by the state) not on the plan's formulary; the state will publish an explanation of internal and external exceptions process and timeframe to obtain non-formulary drugs when clinically appropriate.
- g. The state ensures that non-discrimination clauses as provided in 45 CFR 156.125 and 45 CFR 156.225, which prevent discrimination on the basis of a number of factors, including health conditions, are applied to the formulary.
- h. Section 1927 DUR provisions: the state will apply their current DUR program, including SUPPORT Act requirements, to the population receiving the covered outpatient drug benefit through this demonstration.
- i. Because under section 1115(a)(2), expenditures under this section on outpatient drugs are "regarded as" expenditures under the State plan, section 1927(b) requirements pertaining to the obligation for a drug manufacturer with a drug rebate agreement to pay rebates will still apply pursuant to section 1115(a)(2) expenditure authority. The state is expected to report utilization data to CMS on a quarterly basis for rebate purposes consistent with current reporting requirements. CMS will work with the state to determine any additional information that may be required. The state will also seek approval of any modifications to its Supplemental Rebate Agreements with manufacturers.

IX. GENERAL REPORTING REQUIREMENTS

46. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days (30) after CMS has notified the state in writing that the

deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
- b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.
- c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
- d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.
- e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

47. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

48. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
- b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
- c. Submit deliverables to the appropriate system as directed by CMS.

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

50. Compliance with Specified HCBS Requirements. Beneficiaries receiving Medicaid HCBS and LTSS services furnished through the 1115 demonstration, including individuals who derive eligibility through the demonstration must receive services in residential and non-residential settings located in the community, which meet CMS standards for HCBS settings as articulated

in current 1915(c) policy and federal regulation. The state shall include a description of the steps taken to ensure compliance with these regulations as part of the Monitoring Report discussed in STC 56.

51. Quality Improvement Systems and Strategy for the CHOICES, ECF CHOICES, and Katie Beckett (Part A) Programs. The state is expected to implement systems that measure and improve its performance to meet the requirements set forth in 42 CFR 438.330. The Quality Review provides a comprehensive assessment of the state's capacity to ensure adequate program oversight, detect and remediate compliance issues, and evaluate the effectiveness of implemented quality improvement activities.

52. Quality Improvement Strategy for 1915(c) or 1915(i)-approvable HCBS Services. For services that could have been authorized to individuals under a 1915(c) waiver or under 1915(i) authority, the state's Quality Assessment and Performance Improvement Plan must encompass LTSS-specific measures set forth in the federal rule and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302, as follows:

- a. **Level of Care.** The state must demonstrate that it has an effective system in place to assure that applicants receive a level of care determination prior to receiving services provided by the program and that the processes for determining level of care are followed as documented.
- b. **Qualified Providers.** The state must have an effective system in place for assuring that providers meet licensure and certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to providers in accordance with the waiver. Evidence currently included in the state's Quality Assessment and Performance Improvement Strategy is sufficient for this assurance and as any changes are made going forward, will be approved by CMS prior to implementation.
- c. **Service Plan.** The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Evidence included in the state's Quality Assessment and Performance Improvement Strategy is sufficient for this assurance, and as any changes are made going forward, will be approved by CMS prior to implementation.
- d. **Health and Welfare.** The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants' health and welfare. Evidence that highlights the health and welfare deficiencies found during the monitoring and evaluation of the HCBS demonstration, with an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur will be reported to CMS as an attachment to the Monitoring Report detailed in STC 56.

CMS will evaluate each annual quality report to determine whether the state has demonstrated appropriate oversight of its programs and implemented its quality assessment and performance improvement strategy effectively.

53. CHOICES, ECF CHOICES, and Katie Beckett (Part A) Data.

- a. **CHOICES Data Plan.** The state will collect and submit data to CMS, including the following data elements:
 - i. Numbers of persons actively receiving HCBS and numbers of persons actively receiving institutional services at a point in time,
 - ii. Unduplicated numbers of persons receiving HCBS and unduplicated numbers of persons receiving institutional services during a 12 month period,
 - iii. HCBS expenditures and institutional expenditures on the elderly and disabled population during a 12 month period,
 - iv. HCBS expenditures and institutional 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),
 - v. Average per person HCBS expenditures and institutional expenditures on the elderly and disabled populations during a 12 month period,
 - vi. Average length of stay in HCBS during a 12 month period,
 - vii. Percent of new LTSS recipients admitted to institutions during a 12 month period,
 - viii. Average length of stay in institutions during a 12 month period,
 - ix. Number of persons transitioned from institutions to HCBS during a 12 month period.

“Point in time” refers to June 30 of each year.

- b. **ECF CHOICES and Katie Beckett Data Plan.** The state will collect and submit data to CMS, including the following data elements. “Point in time” refers to June 30 of each year.
 - i. Number of persons with ID actively receiving HCBS upon implementation and at a point in time. Data shall be reported for across Medicaid HCBS programs (including Section 1915(c) waivers).
 - ii. Number of persons with DD (other than ID) actively receiving HCBS upon implementation and at a point in time. Data shall be reported only for ECF CHOICES and Katie Beckett (Part A);

- iii. Number of persons with I/DD actively receiving HCBS upon implementation and at a point in time. Data shall be reported across Medicaid HCBS programs (including Section 1915(c) waivers);
 - iv. Unduplicated number of persons with ID actively receiving HCBS during a 12 month period prior to implementation and each demonstration year thereafter. Data shall be reported across Medicaid HCBS programs (including Section 1915(c) waivers);
 - v. Unduplicated number of persons with DD (other than ID) actively receiving HCBS during a 12 month period prior to implementation and each demonstration year thereafter. Data shall be reported only for ECF CHOICES and Katie Beckett (Part A);
 - vi. Unduplicated numbers of persons with I/DD receiving HCBS during a 12 month period prior to implementation and each demonstration year thereafter. Data shall be reported across Medicaid HCBS programs (including Section 1915(c) waivers);
 - vii. Average per person LTSS expenditures for individuals with I/DD during a 12 month period prior to implementation and each demonstration year thereafter. Data shall be reported for ECF CHOICES, Katie Beckett (Part A), ICF/IID services, and across Medicaid HCBS programs (including Section 1915(c) waivers);
 - viii. Total HCBS expenditures for individuals with I/DD during a 12 month period prior to implementation and each demonstration year thereafter, including as a percentage of total LTSS expenditures for individuals with I/DD.
 - ix. Number of persons with I/DD employed in an integrated setting at or above the minimum wage upon implementation of ECF CHOICES and at a point in time. Data shall be reported for ECF CHOICES and across Medicaid HCBS programs (including Section 1915(c) waivers);
 - x. Percentage of persons with I/DD reporting improved quality of life as measured by a standardized instrument.
- c. **Electronic Collection of CHOICES, ECF CHOICES, Katie Beckett (Part A), and Medicaid Diversion Data.** The systems must be in place to record the requisite data elements for these programs.
- d. **CHOICES, ECF CHOICES, and Katie Beckett Data Reporting.** The state must report to CMS, in the Quarterly and Annual Progress Reports, on data and trends of the designated CHOICES, ECF CHOICES, Katie Beckett (Part A), and Medicaid Diversion (Part B) data elements, as applicable. An electronic copy of the actual data addressing the required data elements must be submitted to CMS within 12 months following each point in time (e.g., by June 30 of the following DY).

- 54. Implementation Plan.** The state is required to submit an Implementation Plan to cover key policies being tested under this demonstration. The state will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. For example, the policies covered in the Implementation Plan will include fraud and the pharmacy benefits and additional policies the state may test under the flexibilities provided in this demonstration. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment M. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. The state must submit a draft Implementation Plan to CMS for review and comment no later than ninety (90) calendar days after the start date of the demonstration approval period. Likewise, in consultation with CMS, in the event the state chooses to exercise for the first time one of the flexibilities granted in this demonstration or to account for any changes to benefits or coverage (including modifications to DSIP or CNOM programs), the state is required to update this Implementation Plan, or submit a new Implementation Plan, and shall submit for CMS review and comment no later than ninety (90) calendar days prior to the planned implementation date of such changes. The state must submit a revised Implementation Plan within sixty (60) calendar days after receipt of CMS's comments.
- 55. Monitoring Protocol.** The state must submit to CMS a draft Monitoring Protocol no later than one hundred and fifty (150) calendar days after the start date of the demonstration approval period. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment N. In consultation with CMS, the state will be required to update this monitoring protocol based on any changes to benefits or coverage (including modifications to DSIP or CNOM programs) and must submit draft updates no later than ninety (90) calendar days prior to the planned implementation of any such changes.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS's templates and the STCs. For policies that have standard CMS monitoring templates, any proposed deviations from CMS's templates should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as broadly described in STC 56 below), CMS will provide the state with a set of required metrics and technical specifications for data collection and analysis covering the key policies being tested under this demonstration, including but not limited to, waivers of retroactive eligibility, premiums and suspension/disenrollment/lock-out for nonpayment of premiums for the Katie Beckett program, suspension for fraud, and DSIP or CNOM programs. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates as described in STC 56 below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

56. Monitoring Reports. The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis. These monitoring reports must include, but are not be limited to:

- a. Operational Updates – The operational updates will focus on progress towards meeting the milestones identified in CMS’s framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration. Additionally, the operational update should include enrollment data including member months for each demonstration population, with particular emphasis on enrollment data for any populations subject to enrollment targets.
- b. Performance Metrics – The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration’s annual goals and overall targets as will be identified in the approved Monitoring Protocol(s) and will cover key policies under this demonstration, including but not limited to waivers of retroactive eligibility, premiums and suspension/disenrollment/lock-out for nonpayment of premiums for the Katie Beckett program, and suspension for fraud. In addition, the performance metrics will cover policies such as pharmacy benefits and DSIP and CNOM programs. Overall, the performance metrics will account for all components of the state’s demonstration. For example, these metrics will cover enrollment, disenrollment or suspension by specific demographics (and policy, as applicable), reenrollment after suspension and reentry after disenrollment, access to care, and quality of care and health outcomes. As appropriate, the state will report these metrics for specific subgroups of demonstration populations.

Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

- c. **Budget Neutrality and Financial Reporting Requirements** – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64. The state will report all expenditures for DSIP payments on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name “DSIP” as well as on the appropriate forms CMS-64.9I and CMS-64PI. The reported DSIP claims and expenditures will be reconciled at the end of the demonstration with the state’s CMS-64 submissions. Any DHSP repayment required under this subparagraph will be accomplished by the state making an adjustment for its excessive claim for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the amount that equals the difference between claimed DSIP and actual expenditures made for these initiatives during the demonstration period.
- d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

57. Enrollment Report. 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. 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.

58. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring indicates indicate substantial and sustained directional change inconsistent with state targets (such as increased difficulty accessing services). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial, sustained directional change, inconsistent with state targets, and the state has not implemented corrective action. CMS would further have the ability

to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

59. Close Out Report. Within 120 days after expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments

- a. The draft report must comply with the most current guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the Close-Out report.
- c. The state must take into consideration CMS's comments for incorporation into the final Close Out Report.
- d. The final Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS's comments.
- e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties as described in STC 46.

60. Monitoring 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 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.

61. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (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 must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

X. GENERAL FINANCIAL REQUIREMENTS

62. Expenditure Groups (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking

expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 8: Master MEG Chart					
MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
EG1 Disabled	Main		X	X	Medical assistance expenditures for non-dual Disabled eligibles
EG2 Over 65	Main		X	X	Medical assistance expenditures for non-dual Aged eligibles
EG3 Children	Main		X	X	Medical assistance expenditures for non-dual Children eligibles
EG4 Adults	Main		X	X	Medical assistance expenditures for non-dual Adults eligibles
EG5 Duals	Main		X	X	Medical assistance expenditures for Dual Eligibles
EG6E Expan Adult	Hypo 1		X	X	
EG7E Expan Child	Hypo 1		X	X	
EG8 Med Exp Child	Hypo 3		X	X	Medical assistance expenditures for state exhausts its title XXI allotment
EG9 H-Disabled	Hypo 1		X	X	
EG10 H-Over 65	Hypo 1		X	X	
EG11 H-Duals	Hypo 1		X	X	
EG12E Carryover	Main			X	
EG13 Katie Beckett	Hypo 1		X	X	

Table 8: Master MEG Chart					
EG14E Medicaid Diversion	Main			X	
EG15 Continued Eligibility	Hypo 1		X	X	
EG16 MEC Additions	Hypo 1		X	X	
EG17E Less Than MEC Additions	Main			X	
GME	Main			X	
Virtual DSH	Main			X	
DSH Adjustme nt	Main		X		
UC Pool	Main			X	
DSIP	Main			X	

63. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-XXXXX). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

- a. Cost Settlements. The state will report any cost settlements attributable to the demonstration 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 settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

- b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.
- c. Pharmacy Rebates. Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.
- d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.
- e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in section XX, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual monitoring report certifying the accuracy of this information.
- f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system,

and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months and how the state tracks both carryover savings and newly accrued savings through the demonstration. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 9: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
EG1 Disabled	Described in STC 16	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG2 Over 65	Described in STC 16	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG3 Children	Described in STC 16	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG4 Adults	Described in STC 16	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG5 Duals	Described in STC 16	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG6E Expan Adult	Described in STC 20	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG7E Expan Child	Described in STC 18	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG8 Med Exp Child	Described in STC 18	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30

Table 9: MEG Detail for Expenditure and Member Month Reporting

EG9 H-Disabled	Described in STC 17	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG10 H-Over 65	Described in STC 17	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG11 H-Duals	Described in STC 16-17	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG12E Carryover	Described in STC 20	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG13 Katie Beckett	Described in STC 21	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG14E Medicaid Diversion	Described in STC 21	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG15 Continued Eligibility	Described in STC 21	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG16 MEC Additions	Described in expenditure authority 8 and defined as Type 2 in STC 84.b	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
EG17E Less Than MEC Additions	Described in expenditure authority 8 and defined as Type 3 in STC 84.c	None	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	No	1/8/21	12/31/30
GME	Described in expenditure authority 4	None	Use Line 1D Inpatient Hospital - GME Payments	Date of Payment	MAP	No	1/8/21	6/30/21

Table 9: MEG Detail for Expenditure and Member Month Reporting

Virtual DSH	Described in STC 67.a	None	Use Line 1B Inpatient Hospital - DSH for actual DSH, Line 1C Inpatient Hospital - Sup. Payments for Virtual DSH	Date of Payment	MAP	No	1/8/21	12/31/30
UC Pool	Described in STC 67.b	None	Use Line 1C Inpatient Hospital - Sup. Payments, or Line 10 Clinic Services	Date of Payment	MAP	No	1/8/21	12/31/30
DSIP	Described in expenditure authority 26	None	Use Line 49 Other Care Services	Date of Payment	MAP	No	1/8/21	12/31/30

- 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 the 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, STC 16 (*Eligibility and Covered Populations*), 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 STC 30, *Benefits for TennCare Medicaid Population Only that Are Not Included in the TennCare Standard Benefit Package*), 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 STCs 66.d. (*Extent of Federal Financial Participation for the Demonstration*) and 67. (*Permissible Uncompensated Care Payments*).
- iii. 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.

64. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 10: Demonstration Years		
DY1	January 8, 2021 to December 31, 2021	12 months
DY2	January 1, 2022 to December 31, 2022	12 months
DY3	January 1, 2023 to December 31, 2023	12 months
DY4	January 1, 2024 to December 31, 2024	12 months
DY5	January 1, 2025 to December 31, 2025	12 months
DY6	January 1, 2026 to December 31, 2026	12 months
DY7	January 1, 2027 to December 31, 2027	12 months
DY8	January 1, 2028 to December 31, 2028	12 months
DY9	January 1, 2029 to December 31, 2029	12 months
DY10	January 1, 2030 to December 31, 2030	12 months

65. Standard Funding Process.

- a. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. 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 thirty (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.

66. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding (see STC 70 *Sources of Non-Federal Share*), CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality limits described in Section XI:. When referenced, actual cash disbursements is intended to signify that certified public expenditures may not be used to establish expenditures for these pools.

- 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. Medical assistance expenditures and prior period adjustments, made under section 1115 demonstration authority with dates of service during the operation of the demonstration including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability..
- d. Graduate Medical Education (GME) Pool. Actual cash disbursements, up to \$50 million in total computable expenditures, 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 through June 30, 2021. 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.

67. Permissible Uncompensated Care Payments. Funds for uncompensated care payments under the demonstration may be used for health care costs that would be within the definition of medical assistance in section 1905(a) of the Act. For purposes of Tennessee uncompensated care, b there are two funds for which different types of uncompensated care may be paid under the demonstration.

- a. **Virtual DSH Fund.** The virtual DSH fund includes the state's DSH adjustment amount in budget neutrality described in Table 13 below, and subsumes the statutory DSH allotment provided in section 1923 of the Act. Funds in virtual DSH (which includes statutory DSH) will be used to reimburse hospitals for uncompensated care (consistent with the definition of uncompensated care in 42 CFR 447.299) and can serve the same purposes of a DSH allotment provided under the statute. The state is authorized for the DSH Adjustment set forth in Table 13; the total computable amount will depend on the state's FMAP in each DY. The DSH Adjustment (federal share) will be adjusted using a methodology consistent with the changes to the federal DSH allotments in other states under section 1923(f)(7) of the Act for federal fiscal year 2019 and thereafter, to the extent those changes to the federal DSH allotment are in effect for other states.
- b. **Uncompensated Care Fund for Charity Care.** Funds in the Uncompensated Care Fund for Charity Care will be used for health care costs that are incurred by the state, hospitals, or health care clinics to furnish uncompensated medical care as charity care for low-income individuals that are uninsured. The costs must be incurred pursuant to a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association.

68. Distribution of Uncompensated Care Payments. The state will develop a distribution methodology for eligible providers that will continue to participate in the state's uncompensated care payment program under this demonstration. The state must post a draft methodology for public comment and notify CMS of the changes at least 60 days prior to the effective date of the methodology. The public notice process must be completed before the state may claim federal match for uncompensated care costs incurred. The distribution methodology must be posted on the state's website and be made publicly available prior to implementation and throughout the demonstration period, in accordance with September 27, 1994 Federal Register guidance on public notice (59 FR 49249). The state will utilize the distribution methodology established in TennCare II and effective on December 31, 2020 until the above process and conditions are met.

69. Reconciliation of Uncompensated Care Payments. Upon approval of the distribution methodology described in paragraph 65 (*Distribution of Uncompensated Care Payments*), the state will develop an annual reconciliation process for each uncompensated care fund. The state must submit a draft of its proposed reconciliation processes for approval by CMS no later than 60 days after approval of the state's uncompensated care payments distribution methodology. The reconciliation processes will be included as an attachment to these STCs (Attachment I) and are subject to the amendment provisions in STC 7 (*Amendment Process*) should the state need to make changes to the reconciliation process.

70. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that the non-federal share is obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds.. The state further certifies that such funds must not be used as the match for any other Federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-Federal funding must be compliant with Section 1903(w) of the Act and applicable regulations. In addition, CMS reserves the right to prohibit the use of any sources of non-federal share funding that it determines impermissible.

- a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to fund the demonstration. C
- b. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to fund the demonstration.
- c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

71. Financial Integrity for Managed Care and Other Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR §438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74.
- b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR §447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

72. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

73. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing demonstration’s actual expenditures to the budget neutrality expenditure limits described in section XI. CMS will provide technical assistance, upon request.¹⁹

¹⁹ 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and

74. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

75. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

- a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, 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 Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
- b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall 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 federal law.
- c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

- d. To account for changes in enrollment beyond a 1 percentage point threshold above or below the baseline enrollment, an adjustment to the aggregate cap will be made using the following process each year.
 - i. The historical baseline year will be enrollment from State fiscal year 2019 (7/1/18 – 6/30/19). This base year enrollment will be used as the comparison point for risk corridor adjustments until the rebasing for Year 6 of the demonstration.
 - ii. The enrollment threshold will be applied to each of the five EG groups listed below.
 - A. Disabled
 - B. Child ≤ 18
 - C. Adult ≥ 65
 - D. Adult ≤ 64
 - E. Duals
 - iii. Once annually, the state has the ability to adjust the current DY WOW amounts with a risk corridor. The aggregate cap will be automatically adjusted by October 1 of each DY based on enrollment data for the prior DY and will be a retroactive adjustment to the cap for the full prior DY. For example, DY1 enrollment will be reviewed in DY2 and the aggregate cap will be adjusted up or down for any variance in enrollment greater than 1 percentage point.
 - A. The actual annual enrollment value is taken, and then 101% of the base enrollment value from state fiscal year 2019 for that EG is subtracted from it.
 - B. The resulting difference is multiplied by the corresponding year's projected PMPM for that particular EG. The corresponding year's PMPM is determined by taking the base year PMPM (SFY19 total expenditures for that EG divided by SFY19 total enrollment for that EG) and trending it forward annually using the President's budget trend rate for that EG.
 - C. The resulting amount is added to the annual cap for that EG for the demonstration year in which enrollment was exceeded.
 - iv. The state is at risk for any increase up to 1 percentage point above projected enrollment from the base period.
 - v. If the EG group annual enrollment is less than 99% of the baseline:
 - A. The actual annual enrollment value is subtracted from 99% of the base enrollment value from state fiscal year 2019 for that EG.
 - B. The resulting difference is multiplied by the corresponding year's projected PMPM for that particular EG. The corresponding year's PMPM is determined by taking the base year PMPM (SFY19 total expenditures for that EG divided by SFY19 total enrollment for that EG) and trending it forward annually using the President's budget trend rate for that EG group.
 - C. The resulting product is subtracted from the current annual cap for that EG group for that demonstration year in which enrollment was less than 99% of the projections.

vi. Projected PMPM

	Base Year	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5
EG1 Disabled	\$1,515.31	5.4%	\$1,728.83	\$1,822.19	\$1,920.59	\$2,024.30	\$2,133.61
EG2 Over 65	\$1,182.01	4.5%	\$1,319.83	\$1,379.22	\$1,441.28	\$1,506.14	\$1,573.92
EG3 Children	\$253.67	5.5%	\$290.11	\$306.06	\$322.89	\$340.65	\$359.39
EG4 Adults	\$442.62	5.3%	\$503.79	\$530.49	\$558.60	\$588.21	\$619.38
EG5 Duals	\$890.18	5.5%	\$1,018.04	\$1,074.03	\$1,133.10	\$1,195.42	\$1,261.17

76. Enforcement of Budget Neutrality. CMS will enforce budget neutrality over the life of the demonstration extension, which for this purpose will be from January 8, 2021 through December 31, 2030, rather than on an annual basis. CMS will rebase the “without waiver” expenditure amounts to better reflect actual expenditures after 5 years, consistent with the CMS budget neutrality policy. No later than July 1, 2025, the state will provide updated actual expenditure data to rebase the base year calculations and adjust the aggregate cap to reflect actual spending during the demonstration. The base year starting January 1, 2026 will be updated to reflect actual expenditures for the demonstration period of January 8, 2021 through December 31 2024. The budget neutrality test for the demonstration may incorporate net savings attributable to DY 15 through 6 months of DY 19 from the TennCare II demonstration (but not from any prior period). These carryforward savings from the TennCare II demonstration shall persist and be available to the state for the first ten (10) years of the TennCare III demonstration. If the state exceeds the calculated cumulative target limit for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

77. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS’s assessment of the state’s compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

78. Risk. Tennessee shall be at risk for the aggregate cap and the state accepts risk for both enrollment and per capita costs, subject to the enrollment risk corridors describe in these STCs. CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

- 79. Special Circumstances Adjustment.** Recognizing the dynamic health care landscape in which state Medicaid programs are operating, CMS will provide the state with the opportunity to propose updates to an approved demonstration to account for any changes to projected expenditures or enrollment in the current demonstration year due to unforeseen circumstances out of the state’s control, such as a public health crisis or major economic event. Under such circumstances, the state may submit new information and relevant data to justify an adjustment for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the enrollment estimate for a demonstration year must be submitted to CMS no later than X of the demonstration year for which the adjustment would take effect.
- 80. Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of the aggregate cap components specified in these STCs, which are calculated by trending forward the last full year of the state’s historical costs to project fixed total computable dollar expenditure amounts. This does not include any adjustments for enrollment variance greater than the risk corridor. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.
- 81. Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that demonstration waivers granted have not resulted in increased costs to Medicaid, and that federal Medicaid “savings” have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as “WOW Only” or “Both” are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as “Both.”
- 82. Medicaid Expenditure Groups (MEG).** MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.
- 83. 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) – counted in the “with” and “without” waiver calculations; 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.

Table 11: Main Budget Neutrality Test

MEG	PC or Agg-regate	DY 1	DY 2	DY 3	DY 4	DY 5
All	Agg Cap	\$9,356,603,867	9,721,165,197	\$10,133,757,745	\$10,566,395,812	\$11,020,053,654

84. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be “hypothetical;” that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS’s current view that states should not have to “pay for,” with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the supplemental test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

- a. **Hypothetical Budget Neutrality Test 1.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 12: Hypothetical Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR	TREND	DY 1	DY 2	DY 3	DY 4	DY 5
EG6E Expan Adult	Agg	Both	\$132,966	0%	\$132,966.00	\$132,966.00	\$132,966.00	\$132,966.00	\$132,966.00
EG7E Expan Child	Agg	Both	\$3,704,282	5.5%	\$3,908,017.51	\$4,122,958.47	\$4,349,721.19	\$4,588,955.85	\$4,841,348.43
EG8 Med Exp Child	Agg	Both	\$-	5.5%	\$-	\$-	\$-	\$-	\$-
EG9 H-Disabled	Agg	Both	\$21,589,906	5.4%	\$22,755,761	\$23,984,572	\$25,279,739	\$26,644,845	\$28,083,666
EG10 H-Over 65	Agg	Both	\$4,797,121	4.5%	\$5,012,991	\$5,238,576	\$5,474,312	\$5,720,656	\$5,978,085
EG11 H-Duals	Agg	Both	\$355,865,535	5.5%	\$375,438,140	\$396,087,237	\$417,872,035	\$440,854,997	\$465,102,022
EG13 Katie Beckett Part A	Agg	Both	\$36,000,000	5.4%	\$37,944,000	\$39,992,976	\$42,152,597	\$44,428,837	\$46,827,994
EG15 Katie Beckett Part C	Agg	Both	\$177,561	5.4%	\$187,149	\$197,255	\$207,907	\$219,134	\$230,967
EG 16 MEC Additions	Agg	Both	\$0	--	--	--	--	--	--

Hypothetical Budget Neutrality Test 2: The table above identifies the MEGs that are used for Hypothetical Budget Neutrality Test. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

85. DSH Adjustment. The DSH adjustment is based upon Tennessee’s DSH allotment for 1992 and was calculated in accordance with current law. Table 13 gives the DSH adjustments for DY 1 through DY 10, and shows the total computable. 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. Beginning in DY 10, the DSH adjustment was held constant while awaiting to determine the impact of Medicaid expansion under the Affordable Care Act on uncompensated care and DSH. Beginning with DY 15, the DSH adjustment is considered “Virtual DSH” for purposes of paying for uncompensated care due to Medicaid shortfall under the demonstration. The federal share of the DSH adjustment is based on the state’s federal medical assistance percentages (FMAP) for the applicable demonstration year.

Table 13	
	DSH Adjustment (total computable)
TennCare III DY 1	\$508,936,029 (this amount is contingent on close out reconciled expenditures in TennCare II DY19 <u>not exceeding the 6 month amount of this figure being claimed for the period end on December 31, 2020.</u>
TennCare III DYs 2-10	No less than \$508,936,029 or actual expenditures, whichever is less and up to actual documented and allowable costs within budget neutrality limit in each year thereafter

86. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. 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 by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration’s approval period, 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 to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

87. Exceeding Budget Neutrality.

- a. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from January 8, 2021 – December 31, 2030. CMS will rebase the “without waiver” expenditure amounts to better reflect actual expenditures after 5 years, consistent with the CMS budget neutrality policy applying rebasing every 5 years. No later than July 1, 2025, the state will provide updated actual expenditure data to rebase the base year calculations and CMS will adjust the aggregate cap to reflect actual spending during the demonstration. The base year starting January 1, 2026 will be updated to reflect actual expenditures for the demonstration period of July 1, 2023 through June 30, 2024, consistent with the same time period used to for the base for DY 1 of the TennCare III demonstration. This expenditure data will be trended forward 30 months (mid-point to mid-point) by the President’s budget trend to set the expenditure cap (prior to any enrollment risk corridor adjustment) for DY 6 of the TennCare III demonstration. At this time, the enrollment base for the enrollment risk corridor calculation will also be rebased to July 1, 2023 through June 30, 2024 (state fiscal year 2024). This rebased enrollment period will serve as the base for enrollment risk corridor calculations in DY 6 through DY 10. The Main Budget Neutrality Test may incorporate net savings from TennCare II prior demonstration period of DY15 through DY19 (but not from any earlier approval period). TennCare II carryover savings will be available for the 10-years of the demonstration and will not be affected by rebasing during the demonstration period.
- b. Up to 55 percent of newly accrued savings may be used for DSIP as described in STC 32 concerning quality performance.
- c. The state will be able to carry over the savings accrued during the TennCare II demonstration period from DY15 through DY19. However, those savings will be limited for use in this demonstration for the following expenditures:
 - i. Maintenance of TennCare II Medicaid benefits and coverage in place as of December 31, 2020.
 - ii. Uncompensated Care Fund for Charity Care up to the actual reconciled expenditures in TennCare II DY19, annualized.
- d. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.
- e. **Mid-Course Correction.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Main Budget Neutrality Test

Table 14: Main Budget Neutrality Test Mid-Course Correction Calculations		
	Cumulative Target Definition	Percentage
DY1	Cumulative budget neutrality limit plus:	2.0 percent

DY1 through DY2	Cumulative budget neutrality limit plus:	1.5 percent
DY1 through DY3	Cumulative budget neutrality limit plus:	1.0 percent
DY1 through DY4	Cumulative budget neutrality limit plus:	0.5 percent
DY1 through DY5	Cumulative budget neutrality limit plus:	0.0 percent

XII. EVALUATION OF THE DEMONSTRATION

88. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 46.

89. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

90. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design pertinent to this demonstration approval period, no later than one hundred eighty (180) days after the approval of the demonstration. The draft Evaluation Design must be developed in accordance with Attachment J (Developing the Evaluation Design) of these STCs, and must include a timeline for key evaluation activities including evaluation deliverables, as outlined in STCs 95 and 96.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

- a. Attachment J (Developing the Evaluation Design) of these STCs, and all applicable technical assistance on applying robust evaluation approaches, including using appropriate in-state or

out-of-state comparison groups and beneficiary surveys to develop a Draft Evaluation Design.

- b. All applicable evaluation design guidance, including guidance on premiums, non-eligibility or lock-out periods, waiver of retroactive eligibility, and overall demonstration sustainability.

91. Evaluation Design Approval and Updates. The state must submit the revised draft Evaluation Designs within sixty (60) calendar days after receipt of CMS's comments. Upon CMS approval of the draft Evaluation Designs, the documents will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within thirty (30) calendar days of CMS approval. The state must implement the evaluation designs and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the evaluation designs, if the state wishes to make changes to the design, the state must submit a revised evaluation design to CMS for approval. In consultation with CMS, the state will be required to update this evaluation design to account for any changes to benefits or coverage.

92. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF).

The evaluation must outline and address well-crafted hypotheses and research questions for all of the demonstration components. For example, the hypotheses for the demonstration evaluation must relate to (but are not limited to) efforts to improve population health through administrative and budget flexibilities, and whether these flexibilities with risk-sharing promote the goals of fiscal sustainability (providing a comprehensive understanding of how the state is using savings), the CHOICES program, ECF CHOICES program, and the state plan and demonstration populations enrolled in those programs. The DSIP program and other added benefits will also be assessed in their effectiveness, in particular focusing on the additional services covered and populations served. This assessment will study outcomes, such as coverage, beneficiary access to care and health outcomes, and any improvements in provider and service delivery networks.

Hypotheses for premiums under the Katie Beckett program must relate to (but are not limited to) outcomes, such as beneficiary familiarity with premiums as a feature of commercial coverage, and likelihood of enrollment and enrollment continuity. Hypotheses for suspension or disenrollment for non-compliance must relate to (but are not limited to) outcomes such as the following: beneficiary compliance with demonstration requirements, enrollment continuity, and health status (as a result of greater enrollment continuity). The evaluation will also assess

insurance and health outcomes of former beneficiaries disenrolled or suspended or voluntarily separating from the program. Furthermore, hypotheses for the waiver of retroactive eligibility must relate to (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity, enrollment when people are healthy, and health status (as a result of greater enrollment continuity). The state must include hypotheses and measures related to access to managed long term services and supports, improved health outcomes and beneficiary satisfaction for CHOICES and ECF CHOICES programs, as well as access to and cost of medically necessary prescription drugs.

In addition, the state must investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, provider uncompensated costs, and the impact of the DSIP program on generating net Medicaid costs or savings. Finally, the state must use hypothesis tests aligned with other demonstration goals and cost analyses together to assess the demonstration's effects on Medicaid program sustainability.

The findings from each evaluation component must be integrated to help inform whether the state met the overall demonstration goals, with recommendations for future efforts regarding all components.

93. Evaluation Budget. A budget for the evaluations must be provided with the draft Evaluation Designs. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

94. Interim Evaluation Reports. The state must submit three Interim Evaluation Reports for the applicable demonstration years, as specified in subparagraph c, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Reports should be posted to the state's website with the application for public comment.

- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.
- b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. The state must provide an Interim Evaluation Report on the dates described in subpart i, ii, and iii, below. The state must submit a revised Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report. The final version of each of the Interim Evaluation Reports must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS. Each Interim Evaluation Report shall cover the demonstration period through the date 12 months prior to the due date, except as noted in (d), below.
 - i. The first Interim Evaluation Report will be due December 31, 2023

- ii. The second Interim Evaluation Report will be due December 31, 2026
- iii. The third Interim Evaluation Report will be due December 31, 2029
- d. For policies and flexibilities being newly tested under this TennCare III demonstration, the first Interim Evaluation Report, as noted in c(i) above, shall cover the period from January 8, 2021 through December 31, 2022. For policies and flexibilities carried forward from the TennCare II demonstration, this first Interim Evaluation report will include the period from January 8, 2021 through December 31, 2022 and any as yet unevaluated period from the TennCare II demonstration. This Interim Evaluation Report replaces the Final Evaluation Report required under the TennCare II demonstration and must include all data and analysis that would have been in that Final Evaluation Report.
- e. If the state is seeking to extend the demonstration, the last draft Interim Evaluation report, as noted in c(iii) above, is due when the application for extension is submitted. If the state is proposing changes to the demonstration in its application for extension, the research questions and hypotheses, and how the evaluation design was adapted, should be included in the Interim Evaluation Report.
- f. If the state is not requesting a demonstration extension, the last draft Interim Evaluation report, as noted in c(iii) above, is due one year prior to the end of the demonstration. For demonstration phase-out prior to the expiration of this demonstration approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
- g. The Interim Evaluation Reports must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

95. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs. The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.
- b. The final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

96. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report(s). A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with state targets (such as substantial and sustained trends indicating increased difficulty accessing services). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS would further have the ability to suspend implementation of the

demonstration should corrective actions not effectively resolve these concerns in a timely manner.

- 97. State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the final evaluation design, the state's interim evaluation and/or its summative evaluation.
- 98. Public Access.** In accordance with 42 CFR 431.424, state evaluations must be published on the state's public Web site within 30 days of submission to CMS. The state will also publish the approved demonstration evaluation design within 30 days of CMS approval.
- 99. Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

ATTACHMENT A

Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

CMS expects evaluation designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups, identifying causal inferences, phasing implementation to support evaluation, and designing and administering beneficiary surveys are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-and-reports/index.html>. If the state needs additional technical assistance using this outline or developing the evaluation design, the state should contact the demonstration team.

Expectations for Evaluation Designs

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- A. General Background Information;
- B. Evaluation Questions and Hypotheses;
- C. Methodology;
- D. Methodological Limitations;
- E. Attachments.

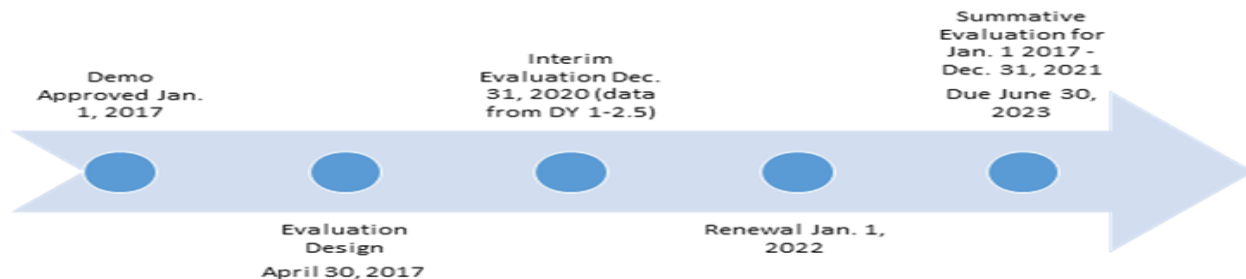
Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of a deliverables timeline for a 5-year demonstration). In

ATTACHMENT A

Developing the Evaluation Design

addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3. A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
5. Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

ATTACHMENT A

Developing the Evaluation Design

2. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams:
<https://innovation.cms.gov/files/x/hciatwoaimsdvrs.pdf>
3. Identify the state's hypotheses about the outcomes of the demonstration:
4. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
5. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1. Evaluation Design – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
2. Target and Comparison Populations – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. Evaluation Period – Describe the time periods for which data will be included.
4. Evaluation Measures – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
 - a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.

ATTACHMENT A

Developing the Evaluation Design

- b. Qualitative analysis methods may be used, and must be described in detail.
- c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
- d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
- e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
- 5. Data Sources – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.
- 6. If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).
- 7. Analytic Methods – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
 - a. a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
 - b. b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
 - c. c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
 - d. d. The application of sensitivity analyses, as appropriate, should be considered.

Other Additions – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

ATTACHMENT A

Developing the Evaluation Design

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

When the state demonstration is:

- a. Long-standing, non-complex, unchanged, or
- b. Has previously been rigorously evaluated and found to be successful, or
- c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes; and
 - b. No or minimal appeals and grievances; and
 - c. No state issues with CMS-64 reporting or budget neutrality; and
 - d. No Corrective Action Plans (CAP) for the demonstration.

ATTACHMENT A

Developing the Evaluation Design

E. Attachments

1. Independent Evaluator. This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.
2. Evaluation Budget. A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.
3. Timeline and Major Milestones. Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B

Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

ATTACHMENT B

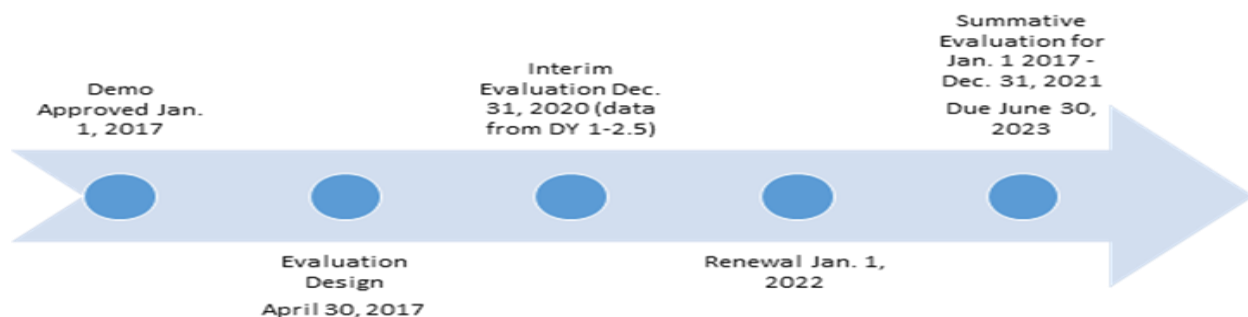
Preparing the Interim and Summative Evaluation Reports

The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;
- D. Methodology;
- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of a deliverables timeline for a 5-year demonstration). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS, pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



ATTACHMENT B

Preparing the Interim and Summative Evaluation Reports

Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
 - 1. The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
 - 2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
 - 3. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
 - 4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
 - 5. Describe the population groups impacted by the demonstration.
- C. Evaluation Questions and Hypotheses** – In this section, the state should:
 - 1. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
 - 2. Identify the state's hypotheses about the outcomes of the demonstration;
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

ATTACHMENT B

Preparing the Interim and Summative Evaluation Reports

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation. This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. Evaluation Design – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. Target and Comparison Populations – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. Evaluation Period – Describe the time periods for which data will be collected
4. Evaluation Measures – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. Data Sources – Explain where the data will be obtained, and efforts to validate and clean the data.
6. Analytic methods – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. Other Additions – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

2. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment - Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C
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 determined by their MCO to need one or more of the skilled or rehabilitative services specified in state rule and in accordance with the criteria set forth therein. . 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 determined by their MCO to need one or more of the skilled or rehabilitative services specified in state rule and in accordance with the criteria set forth therein.
 - (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.

ATTACHMENT C
Limitations On Home Health 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 D
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. Is ventilator dependent with a progressive neuromuscular disorder or spinal cord injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least 12 hours each day in order to avoid or delay tracheostomy (requires medical review); or

ATTACHMENT D
Limitations On Private Duty Nursing Services

- c. 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:

ATTACHMENT D
Limitations On Private Duty Nursing Services

- 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 E
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

ATTACHMENT E

Glossary Of Terms For TennCare Choices

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, community living supports, community living supports – family model, and companion care.

Community living supports (CLS). A community-based residential alternative service for seniors and adults with disabilities that encompasses a continuum of support options for up to four individuals living in a home that supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and comports fully with standards applicable to HCBS settings delivered under section 1915(c) of the Act, including those requirements applicable to provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need and set forth in the person-centered plan of care.

CLS services are individualized based on the needs of each resident and specified in the person-centered plan of care. Services may include hands-on assistance, supervision, transportation, and other supports intended to help the individual exercise choices such as:

- Selecting and moving into a home
- Locating and choosing suitable housemates
- Acquiring and maintaining household furnishings
- Selecting and moving into a home
- Locating and choosing suitable housemates
- Acquiring and maintaining household furnishings
- Acquiring, retaining, or improving skills needed for activities of daily living or assistance with activities of daily living as needed, such as bathing, dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility

ATTACHMENT E

Glossary Of Terms For TennCare Choices

- Acquiring, retaining, or improving skills needed for instrumental activities of daily living or assistance with instrumental activities of daily living as needed, such as household chores, meal planning, shopping, preparation and storage of food, and managing personal finances
- Building and maintaining interpersonal relationships with family and friends
- Pursuing educational goals and employment opportunities
- Participating fully in community life, including faith-based, social, and leisure activities selected by the individual
- Scheduling and attending appropriate medical services
- Self-administering medications, including assistance with administration of medications as permitted pursuant to T.C.A. 68-1-904 and 71-5-1414
- Managing acute or chronic health conditions, including nurse oversight and monitoring, and skilled nursing services as needed for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.
- Becoming aware of, and effectively using, transportation, police, fire, and emergency help available in the community to the general public
- Asserting civil and statutory rights through self-advocacy

Community living supports – Family Model (CLS-FM). A community-based residential alternative service for seniors and adults with disabilities that encompasses a continuum of support options for up to three individuals living in the home of trained family caregivers (other than the individual's own family) in an adult foster care arrangement. In this type of shared living arrangement, the provider allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and a family, and provide the individualized services that support each resident's independence and full integration into the community, ensure each resident's choice and rights, and support each resident in a manner that comports fully with standards applicable to HCBS settings delivered under section 1915(c) of the Act, including those requirements applicable to provider-owned or controlled homes, as applicable, including any exception as supported by the individual's specific assessed need and set forth in the person-centered plan of care.

CLS-FM services are individualized based on the needs of each resident and specified in the person-centered plan of care. Services may include hands-on assistance, guidance, supervision, transportation, and other supports intended to help the individual exercise choices such as:

- Selecting and moving into a home
- Locating and choosing suitable housemates
- Acquiring and maintaining household furnishings
- Acquiring, retaining, or improving skills needed for activities of daily living or assistance with activities of daily living as needed, such as bathing, dressing, personal hygiene and grooming, eating, toileting, transfer, and mobility
- Acquiring, retaining, or improving skills needed for instrumental activities of daily living or assistance with instrumental activities of daily living as needed, such as household

ATTACHMENT E

Glossary Of Terms For TennCare Choices

chores, meal planning, shopping, preparation and storage of food, and managing personal finances

- Building and maintaining interpersonal relationships with family and friends
- Pursuing educational goals and employment opportunities
- Participating fully in community life, including faith-based, social, and leisure activities selected by the individual
- Scheduling and attending appropriate medical services
- Self-administering medications, including assistance with administration of medications as permitted pursuant to T.C.A. 68-1-904 and 71-5-1414
- Managing acute or chronic health conditions, including nurse oversight and monitoring, and skilled nursing services as needed for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.
- Becoming aware of, and effectively using, transportation, police, fire, and emergency help available in the community to the general public
- Asserting civil and statutory rights through self-advocacy

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 System (EVVS). 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. The state will demonstrate compliance with the EVVS requirements for personal care services (PCS) by January 1, 2021 and with home health services by January 1, 2023, in accordance with section 120006 of the 21st Century CURES Act.

ATTACHMENT E
Glossary Of Terms For TennCare Choices

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).

ATTACHMENT E

Glossary Of Terms For TennCare Choices

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: When not available from other funding sources (including the individual’s landlord), and when a determination has been made that no household member is able to administer without assistance (consistent with the definition of an HCBS chore service), 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.

ATTACHMENT E
Glossary Of Terms For TennCare Choices

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, CHOICES 3, or ECF CHOICES 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 or ECF CHOICES member must meet the nursing facility level of care upon admission (which for CHOICES 3 and CHOICES 5 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, CHOICES 3 or ECF CHOICES, 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 home and community based services (which can include 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 F
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.

ATTACHMENT F
Best Practices Guidance Regarding Consumer Direction Of
Home And Community Based Services

- 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 G
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 53.d.). 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.

ATTACHMENT G
Certified Public Expenditures Protocol

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.

ATTACHMENT G
Certified Public Expenditures Protocol

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.

ATTACHMENT G
Certified Public Expenditures Protocol

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.

ATTACHMENT G
Certified Public Expenditures Protocol

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

ATTACHMENT G
Certified Public Expenditures Protocol

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.

ATTACHMENT G
Certified Public Expenditures 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.

ATTACHMENT G
Certified Public Expenditures Protocol

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

ATTACHMENT G
Certified Public Expenditures Protocol

plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

I. NON-RESIDENTIAL HABILITATION SERVICES:

All references to individualized integrated employment or self-employment in any of the following definitions shall have this meaning:

Individualized Integrated Employment: Sustained paid employment in a competitive or customized job with an employer for which an individual is compensated at or above the state's minimum wage, with the optimal goal being not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Individualized Integrated Self-Employment: Sustained paid self-employment that is home-based or conducted in an integrated setting(s) where net income in relation to hours worked is equivalent to no less than the state's minimum wage, after a reasonable self-employment start-up period.

Limitations on Braiding of Non-Residential Habilitation Services for an ECF Member: An individual's PCSP may include more than one non-residential habilitation service; however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time).

When any combination of non-residential habilitation services, which does not include at least one employment service, are authorized for an ECF member who is not working in Individualized Integrated Employment or Self-Employment, the maximum combined authorization shall be limited to twenty (20) hours per week.

When any combination of non-residential habilitation services, which includes at least one employment service, are authorized for an ECF member who is not working in Individualized Integrated Employment or Self-Employment, the maximum combined authorization shall be limited to thirty (30) hours per week.

When any combination of non-residential habilitation services are authorized for an ECF member who is working in Individualized Integrated Employment and/or Self-Employment, the maximum combined authorization shall be limited to forty (40) hours per week. The member's hours spent working without paid supports in Individualized Integrated Employment and Self-Employment shall be included in the forty (40) hour limit. The only exception to this policy shall be for individuals working thirty (30) or more hours per week in Individualized Integrated Employment and/or Self-Employment; for these individuals, the maximum combined authorization shall be limited to fifty (50) hours per week. The member's hours spent working without paid supports in Individualized Integrated Employment and Self-Employment shall be included in the fifty (50) hour limit.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

Other limitations that may apply to authorizing specific non-habilitation services in combination with other specific non-habilitation services will be noted in the individual service definitions below.

A. Employment Services/Supports

Supported Employment—Individual Employment Support

These services are provided on an individual basis²⁰ for a person who, because of his or her disabilities, needs support that is not available to the person through a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) in order to obtain, maintain and/or advance in a competitive or customized job, or self-employment, in an integrated community setting for which the individual is compensated at or above the minimum wage.

The expected outcome of these services is individualized integrated employment or self-employment defined as follows:

- (1) Sustained paid employment in a competitive or customized job with an employer for which an individual is compensated at or above the state's minimum wage, with the optimal goal being not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities; or
- (2) Sustained paid self-employment that is home-based or conducted in an integrated setting(s) where net income in relation to hours worked is equivalent to no less than the state's minimum wage, after a reasonable self-employment start-up period.

These services are designed to support the achievement of individualized integrated employment and self-employment outcomes consistent with the individual's personal and career goals, as determined through Exploration, Discovery and/or other similar career planning processes and which include an introduction to the variety of work incentives available to individuals receiving SSI and/or SSDI, Medicaid and/or Medicare.

The Supported Employment—Individual Employment Support provider shall be responsible for any personal assistance needs during the time that Supported Employment-Individual Employment Support services are provided; however, personal assistance services may not comprise the entirety of the Supported Employment—Individual Employment Support

²⁰ Note that Integrated Employment Path Services may include services provided to support participation in internship programs as approved by TennCare with a minimum staffing ratio of 1:4, as further defined in this attachment. In some circumstances, Integrated Employment Path Services may also be provided with a staffing ratio of 1:2. Except for Integrated Employment Path Services as described herein, all individual employment support services must be provided on a 1:1 basis.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

service(s) being rendered at any given time. All providers of personal assistance under Supported Employment—Individual Employment Support shall meet the Personal Assistance service provider qualifications, except that a separate PSSA license shall not be required.

Transportation of the individual to and from these services is not included in the rates paid for these services. Transportation during the provision of these services is included in the rates paid for these services.

An individual's person-centered support plan may include more than one non-residential habilitation service; however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time).

ECF CHOICES will not cover Supported Employment-Individual Employment Support services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If one or more of these services are authorized, documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

These services will not duplicate other services provided through ECF CHOICES or the Medicaid State Plan.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
- Payments that are passed through to users of supported employment services; or
- Payments for training that is not directly related to an individual's supported employment program.

A provider of Supported Employment-Individual Employment Support services may also receive Social Security's Ticket to Work Outcome and Milestone payments. These payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided.

Supported Employment—Individual Employment Support services are individualized and may include one or more of the following components:

1. Exploration:

This is a time-limited and targeted service designed to help a person make an informed choice about whether s/he wishes to pursue individualized integrated employment or self-employment, as defined above. The Exploration service shall be completed no more than thirty (30) calendar days from the date of service initiation. This service is not

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

appropriate for ECF members who already know they want to pursue individualized integrated employment or self-employment.

This service includes career exploration activities to identify a person's specific interests and aptitudes for paid work, including experience and skills transferable to individualized integrated employment or self-employment. This service also includes exploration of individualized integrated employment or self-employment opportunities in the local area that are specifically related to the person's identified interests, experiences and/or skills through four to five uniquely arranged business tours, informational interviews and/or job shadows. (Each person receiving this service should participate in business tours, informational interviews and/or job shadows uniquely selected based on his or her individual interests, aptitudes, experiences, and skills most transferable to employment. All persons should not participate in the same experiences.) Each business tour, informational interview and/or job shadow shall include time for set-up, prepping the person for participation, and debriefing with the person after each opportunity.

This service also includes introductory education on the numerous work incentives for individuals receiving publicly funded benefits (e.g. SSI, SSDI, Medicaid, Medicare, etc.). This service further includes introductory education on how Supported Employment services work (including Vocational Rehabilitation services). Educational information is provided to the person and the legal guardian/conservator and/or most involved family member(s), if applicable, to ensure legal guardian/conservator and/or family support for the person's choice to pursue individualized integrated employment or self-employment. The educational aspects of this service shall include addressing any concerns, hesitations or objections of the person and the legal guardian/conservator and/or most involved family member(s), if applicable.

This service is expected to involve, on average, forty (40) hours of service. The provider shall document each date of service, the activities performed that day, and the duration of each activity. This service culminates in a written report summarizing the process and outcomes, using a standard template prescribed by TennCare. The written report is due no later than fourteen (14) calendar days after the last date of service is concluded. Exploration is paid on an outcome basis, after the written report is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

After an individual has received the service for the first time, re-authorization may occur a maximum of once per year (with a minimum 365-day interval between services) and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment.

2. Benefits Counseling:

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

A service designed to inform the individual (and guardian, conservator and/or family, if applicable) of the multiple pathways to ensuring individualized integrated employment or self-employment results in increased economic self-sufficiency (net financial benefit) through the use of various work incentives. This service should also repudiate myths and alleviate fears and concerns related to seeking and working in individualized integrated employment or self-employment through an accurate, individualized assessment. The service provides information to the individual (and guardian, conservator and/or family, if applicable) regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, ECF, housing subsidies, food stamps, etc.

The service also will provide information and education to the person (and guardian, conservator and/or family, if applicable) regarding income reporting requirements for public benefit programs, including the Social Security Administration.

Benefits counseling provides work incentives counseling and planning services to persons actively considering or seeking individualized integrated employment or self-employment, or career advancement in either of these types of employment.

This service is provided by a certified Community Work Incentives Coordinator (CWIC). In addition to ensuring this service is not otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), ECF may not fund this service if CWIC Benefits Counseling services funded through the Federal Work Incentives Planning and Assistance (WIPA) program are available to the individual.

Service must be provided in a manner that supports the person's communication style and needs, including, but not limited to, age-appropriate communications, translation/interpretation services for persons of limited English-proficiency or who have other communication needs requiring translation including sign language interpretation, and ability to communicate with a person who uses an assistive communication device.

Benefits Counseling services are paid for on an hourly basis and limited in the following ways:

- a. Initial Benefits Counseling for someone actively considering or seeking individualized integrated employment or self-employment, or career advancement in these types of employment: up to twenty (20) hours. This service may be authorized no more than once every two (2) years (with a minimum of two 365-day intervals between services).
- b. Supplementary Benefits Counseling for someone evaluating an individualized integrated job offer/promotion or self-employment opportunity: up to an additional six (6) hours. This service may be authorized up to three (3) times per year if needed.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

- c. PRN Problem-Solving services for someone to maintain individualized integrated employment or self-employment: up to eight (8) hours per situation requiring PRN assistance. This service may be authorized up to four (4) times per year if necessary for the individual to maintain individualized integrated employment or self-employment.

3. Discovery

This is a time-limited and targeted service for an individual who wishes to pursue individualized integrated employment or self-employment but for whom more information is needed to determine the following prior to pursuing individualized integrated employment or self-employment:

- Strongest interests toward one or more specific aspects of the labor market;
- Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment;
- Conditions necessary for successful employment or self-employment.

Discovery involves a comprehensive analysis of the person in relation to the three bullets above. Activities include observation of person in familiar places and activities, interviews with family, friends and others who know the person well, observation of the person in an unfamiliar place and activity, identification of the person's strong interests and existing strengths and skills that are transferable to individualized integrated employment or self-employment, Discovery also involves identification of conditions for success based on experience shared by the person and others who know the person well, and observation of the person during the Discovery process. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized integrated employment or self-employment.

Discovery results in the production of a detailed written Profile, using a standard template prescribed by TennCare, which summarizes the process, learning and recommendations to inform identification of the person's individualized integrated employment or self-employment goal(s) and strategies to be used in securing this employment or self-employment for the person.

If Discovery is paid for through ECF, the person will be assisted by his or her Support Coordinator to apply to Vocational Rehabilitation (VR) for services to obtain individualized integrated employment or self-employment. The Discovery Profile will be shared with VR staff to facilitate the expeditious development of an Individual Plan for Employment (IPE). Discovery shall be limited to no more than ninety (90) calendar days from the date of service initiation. This service is expected, on average, to involve fifty (50) hours of service.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

The provider shall document each date of service, the activities performed that day, and the duration of each activity. The written Profile is due no later than fourteen (14) days after the last date of service is concluded. Discovery is paid on an outcome basis, after the written Profile is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

After an individual has received the service for the first time, re-authorization may occur a maximum of once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within twelve (12) months.

4. Situational Observation and Assessment

This is a time-limited service that involves observation and assessment of an individual's interpersonal skills, work habits and vocational skills through practical experiential, community integrated volunteer experiences and/or paid individualized, integrated work experiences that are uniquely arranged and specifically related to the interests, preferences and transferable skills of the job seeker as established through Discovery or a similar process. This service involves a comparison of the actual performance of the individual being assessed with core job competencies and duties required of a skilled worker in order to further determine the work competencies and skills needed by the individual to be successful in environments similar to where the Assessment is taking place. It also permits the individual to evaluate and confirm areas of employment interest based on real-life experience. The individual shall be reimbursed at least the minimum wage and all applicable overtime for work performed, except as permitted pursuant to the Fair Labor Standards Act for unpaid internships.

Situational Observation and Assessment shall be completed within thirty (30) calendar days from the date of service initiation, provided that this period may be extended for up to thirty (30) additional calendar days when needed for completion of all four (4) work experiences. Situational Observation and Assessment shall be limited to more than sixty (60) calendar days from the date of service initiation. Each job seeker may be authorized for up to four (4) such experiences within the sixty (60) calendar day period. A summary report, using a standard template prescribed by TennCare, is due within ten (10) days after the last date of service is concluded. Reimbursement is paid on an outcome basis for each individual experience, which is expected to involve an average of twelve (12) hours of service per individual experience. The Situational Observation and Assessment outcome payment is made after the written summary report is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

The learning from this service described in the summary report is to be used to help inform the job development plan or self-employment plan.

After an individual has received the service for the first time, re-authorization may occur a maximum of once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within twelve (12) months.

5. Job Development Plan or Self-Employment Plan

This is a time-limited and targeted service designed to create a clear and detailed plan for Job Development or for the start-up phase of Self-Employment. This service is limited to thirty (30) calendar days from the date of service initiation. This service includes a planning meeting involving the individual and other key people who will be instrumental in supporting the individual to become employed in individualized integrated employment or self-employment.

This service culminates in a written plan, using a template prescribed by TennCare that incorporates the results of Exploration, Discovery, and/or Situational Observation and Assessment, if previously authorized. The written plan is due no later than thirty (30) calendar days after the service commences. For self-employment goals, this service results in the development of a self-employment business plan, including potential sources of business financing (such as VR, Small Business Administration loans, PASS plans), given that Medicaid funds may not be used to defray the capital expenses associated with starting a business. This service is paid on an outcome basis, after the written plan is received and approved, and the provider submits documentation detailing each date of service, the activities performed that day, and the duration of each activity.

After an individual has received the service for the first time, re-authorization may occur a maximum of once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within twelve (12) months.

Job Development may not include placement services of an employment agency or business/financial services.

6. Job Development or Self-Employment Start Up

This is a time-limited service designed to implement a Job Development or Self-Employment Plan as follows:

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

- **Job Development** is support to obtain an individualized competitive or customized job in an integrated employment setting in the general workforce, for which an individual is compensated at or above the minimum wage, but ideally not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The Job Development strategy should reflect best practices and adjusted based on whether the individual is seeking competitive or customized employment.
- **Self-Employment Start Up** is support in implementing a self-employment business plan.

The outcome of this service is expected to be the achievement of an individualized integrated employment or self-employment outcome consistent with the individual's personal and career goals, as determined through Exploration, Discovery and/or the Situational Observation and Assessment, if authorized, and as identified in the Job Development or Self-Employment Plan that guides the delivery of this service.

This service will be paid on an outcome basis once the person begun participation in individualized integrated employment or self-employment. Outcome payment amounts are tiered based upon the assessed level of challenge anticipated to achieve the intended outcome of this service for the individual being served. Outcome payments are also paid over three phases (two calendar weeks, six calendar weeks, and ten calendar weeks following the start of individualized integrated employment or self-employment, so long as employment or self-employment is sustained) to incentivize retention of the job or self-employment situation.

After an individual has received the service for the first time, re-authorization may occur a maximum of once per year (with a minimum 365-day interval between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within nine (9) months.

7. Job Coaching

- **Job Coaching for Individualized, Integrated Employment** includes identifying, through job analysis, and providing services and supports that assist the individual in maintaining individualized integrated employment that pays at least minimum wage but ideally not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Job coaching includes supports provided to the individual and his/her supervisor and/or co-workers, either remotely (via technology) or face-to-face. Supports during each phase of employment must be guided by a Job Coaching Fading Plan which incorporates an appropriate mix of best practices for the individual to achieve fading goals as identified in the Plan

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

(e.g. systematic instruction utilizing task analysis to teach the individual to independently complete as much of his/her job duties as possible; high or low tech assistive technology; and effective engagement of natural supports including co-workers and supervisor(s) as needed). If progress on fading ceases at some point, adaptations to job duties, negotiated with the supervisor/employer, or transition to Co-Worker Supports may be utilized if no reduction in hours or hourly pay results.

The amount of time authorized for this service is a percentage of the individual's hours worked and is tiered, based on the individual's level of disability and the length of time the person has been employed on the job. An exception policy applies for individuals with exceptional circumstances.

Transportation of the supported employee to and from the job site is not included in the rate paid for the service. Transportation of the supported employee, if necessary, during the provision of job coaching is included in the rate paid for the service.

- **Job Coaching for Individualized, Integrated Self-Employment** includes identification and provision of services and supports that assist the individual in maintaining self-employment. Job coaching for self-employment includes supports provided to the individual, either remotely (via technology) or face-to-face. Supports must enable the individual to successfully operate the business (with assistance from other sources of professional services or suppliers of goods necessary for the type of business). Job Coaching supports should never supplant the individual's role or responsibility in all aspects of the business. Supports during each phase of self-employment must be guided by a Job Coaching Fading Plan which incorporates an appropriate mix of best practices for the individual to achieve fading goals as identified in the Plan (e.g. systematic instruction utilizing task analysis to teach the individual to independently complete as much of his/her roles and responsibilities as possible; high or low tech assistive technology; and effective engagement of any business partners and/or associates and/or suppliers of goods or services. If progress on fading ceases at some point, business plan adaptations may be utilized if no reduction in paid hours or net hourly pay results.

The amount of time authorized for this service is a percentage of the individual's hours engaged in self-employment and is tiered, based on the individual's level of disability and the length of time the person has been self-employed in the current business. An exception policy applies for individuals with exceptional circumstances.

Transportation of the supported self-employed person to and from the place of work is not included in the rate paid for the service. Transportation of the supported self-employed person, if necessary, during the provision of job coaching is included in the rate paid for the service.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

8. Co-Worker Supports

This service involves a provider of Job Coaching for Individualized Integrated Employment entering into an agreement with an individual's employer to reimburse the employer for supports provided by one or more supervisors and/or co-workers, acceptable to the individual, to enable the person to maintain individualized integrated employment with the employer. This service cannot include payment for the supervisory and co-worker supports rendered as a normal part of the business setting and that would otherwise be provided to an employee without a disability. As well, additional natural supports for the individual, already negotiated with the employer, and provided through supervisors and co-workers, are not eligible for reimbursement under Co-Worker Supports. Only supports that must otherwise be provided by a Job Coach may be reimbursed under this service category. Co-Worker Supports would be authorized in situations where any of the following is true:

1. From the start of employment or at any point during employment, if the employer prefers (or the individual prefers and the employer agrees) to provide needed Job Coach supports, rather than having a Job Coach, either employed by a third party agency or self-employed, present in the business. Fading expectations should still be in place to maximize independence of the employed individual.
2. At any point in the individual's employment where needed Job Coaching supports can be most cost effectively provided by Co-Worker Supports and both the employer and individual agree to the use of Co-Worker Supports. Fading of Job Coaching supports may or may not still be occurring, but Co-Worker Supports should always be considered when on-going fading of Job Coaching has stopped occurring.
3. For individuals who are expected to be able to transition to working only with employer supports available to any employee and additional negotiated natural supports if applicable. In this situation, Co-Worker Supports are authorized as a temporary (maximum twelve months) bridge to relying only on employer supports, and additional negotiated natural (unpaid) supports if applicable, to maintain employment.

The supervisor(s) and/or co-worker(s) identified to provide the support to the individual must meet the qualifications for a legally responsible individual as provider of this service. The provider is responsible for ensuring these qualifications are met and also for oversight and monitoring of paid co-worker supports.

The amount of time authorized for this service is negotiated with the employer and reflective of the specific needs the individual has for co-workers supports above and beyond negotiated natural supports and supervisory/co-worker supports otherwise available to employees without disabilities. A 10% add-on to the 15 minute unit rate for

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

the employer is applied to cover the service provider's role in administering Co-Worker Supports.

9. Career Advancement:

This is a time-limited career planning and advancement support service for persons currently engaged in individualized integrated employment or self-employment who wish to obtain a promotion and/or a second individualized integrated employment or self-employment opportunity. The service is time-limited and focuses on developing and successfully implementing a plan for achieving increased income and economic self-sufficiency through promotion to higher paying position or through a second individualized integrated employment or self-employment opportunity.

The outcomes of this service are: (1) the identification of the person's specific career advancement objective; (2) development of a viable plan to achieve this objective; and (3) implementation of the plan which results in the person successfully achieving his/her specific career advancement objective.

Career Advancement is paid on an outcome basis, after key milestones are accomplished:

- a. Outcome payment number one is paid after the written plan to achieve the person's specific career advancement objective is reviewed and approved. Note: The written plan must follow the template prescribed by TennCare.
- b. Outcome payment number two is paid after the person has achieved his/her specific career advancement objective and has been in the new position or second job for a minimum of two (2) weeks.

This service may not be included on a Person-Centered Support Plan if the PCSP also includes any of the above services numbered one (1) through six (6). This service may not be authorized retroactive to a promotion or second job being made available to a person. Supports for Career Advancement may be authorized and paid once every three (3) years (with a minimum of three 365-day intervals between services), if evidence exists that the individual is eligible for promotion or able to present as a strong candidate for employment in a second job (e.g. has strong reference, performance reviews and attendance record from current employer). The only exception is in situations where the provider previously authorized and paid for outcome payment number one did not also earn outcome payment number two (because they did not successfully obtain a promotion or second job for the person). In this situation, reauthorization for outcome payments number one and two may occur a maximum of once per year (with a minimum 365-day interval between services), so long as the reauthorization involves the use of a new/different provider.

Supported Employment – Individual Employment Supports Service Limitations:

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

- These services are *only* for individuals seeking or engaged in individualized integrated employment or self-employment. These services are not for group employment of any size or variation.
- Job Coaching services do not include supports for volunteering or any form of unpaid internship, work experience or employment.
- These services do not include supporting paid employment or training in a sheltered workshop or similar facility-based setting.

These services do not include supporting paid employment or training in a business enterprise owned or operated by a provider of these services. These services do not include payment for supervisory activities rendered as a normal part of the business setting and supports otherwise available to employees without disabilities filling the same or similar positions in the business.

Supported Employment – Small Group Supports (max of 3 persons supported together as a small group)

This service provides employment services and training activities to support successful transition to individualized integrated employment or self-employment, or to supplement such employment and/or self-employment when it is only part-time. Service may involve small group career planning and exploration, small group Discovery classes/activities, other educational opportunities related to successful job acquisition and working successfully in individualized integrated employment. Service may also include employment in integrated business, industry and community settings. Examples include mobile crews, small enclaves and other small groups participating in integrated employment that is specifically related to the identified interests, experiences and/or skills of each of the persons in the small group and that results in acquisition of knowledge, skills and experiences that facilitate transition to individualized integrated employment or self-employment, or that supplement such employment or self-employment when it is only part-time. Minimum staffing ratio is 1:3 for this service.

- a. Career planning and exploration activities, Discovery classes/activities, other educational opportunities related to successful job acquisition and working successfully in individualized integrated employment or self-employment must be conducted in appropriate non-disability-specific settings (e.g. Job Centers, businesses, post-secondary education campuses, libraries, etc.) All settings must meet all HCBS setting standards and must not isolate participants from others who do not have disabilities.
- b. In the **enclave** model, a small group of people with disabilities (no more than 3 people) is trained and supervised to work among employees who are not disabled at the host company's work site. Persons in the enclave may work as a team at a single work area or may work in multiple areas throughout the company. The Supported Employment— Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in integrated

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others in the setting who do not have disabilities. The experience should allow opportunities for routine interactions with others without disabilities in the setting and involvement from supervisors and co-workers without disabilities (not paid to deliver this service) in the supervision and support of individuals receiving this service.

- c. In the **mobile work crew** model, a small crew of workers (including no more than three persons with disabilities and ideally also including workers without disabilities) work as a distinct unit and operate as a self-contained business that generates employment for their crew members by selling a service. The crew typically works at several locations within the community. The Supported Employment—Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in integrated business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. The experience should allow opportunities for routine interactions with people without disabilities (including fellow crew members, customers, etc.) in the course of performing services.

Paid work under Supported Employment—Small Group must be compensated at minimum wage or higher.

Supported Employment—Small Group does not include vocational or prevocational services, employment or training provided in facility based work settings. Supported Employment—Small Group service settings cannot be provider-owned, leased or operated settings. The settings must be integrated in, and support full access of participants to the greater community, including opportunities to learn about and seek individualized integrated employment or self-employment, engage in community life, and control their earned income.

The expected outcome of this service is the acquisition of knowledge, skills and experiences that facilitate career development and transition to individualized integrated employment or self-employment, or that supplement such employment and/or self-employment when it is only part-time. The individualized integrated employment or self-employment shall be consistent with the individual's personal and career goals.

Supported Employment—Small Group services shall be provided in a way that presumes all participants are capable of working in individualized integrated employment and/or self-employment. Participants in this service shall be encouraged, on an ongoing basis, to explore and develop their interests, strengths, and abilities relating to individualized integrated employment and/or self-employment. In order to reauthorize this service, the Person-Centered Support Plan (PCSP) must document that such opportunities are being provided through this service, to the individual, on an on-going basis. The PCSP shall also document and address any barriers to the individual transitioning to individualized integrated employment or self-employment if the person is not already participating in individualized integrated employment or self-employment. Any individual using this service to supplement part-time individualized

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

integrated employment or self-employment shall be offered assistance to increase hours in individualized integrated employment and/or self-employment as an alternative or partial alternative to continuing this service.

As a component part of this service, Supported Employment—Small Group service providers shall support individuals in identifying and pursuing opportunities that will move them into individualized integrated employment or self-employment. A one-time incentive payment for full transition of a person from Supported Employment-Small Group services to individualized integrated employment or self-employment shall be paid to the Supported Employment—Small Group provider upon successful transition (defined as successfully completing at least four weeks in the individualized integrated employment or self-employment situation) out of Supported Employment—Small Group services to individualized integrated employment or self-employment.

Transportation of participants to and from the service is not included in the rate paid for the service; however transportation provided during the course of Supported Employment—Small Group services is considered a component part of the service and the cost of this transportation is included in the rate paid to providers of this service.

The Supported Employment—Small Group provider shall be responsible for any personal assistance needs during the hours that Supported Employment-Small Group services are provided; however, the personal assistance services may not comprise the entirety of the Supported Employment—Small Group service. All providers of personal care under Supported Employment—Small Group shall meet the Personal Assistance service provider qualifications, except that a separate PSSA license shall not be required.

Supported Employment—Small Group services exclude services available to an individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
- Payments that are passed through to users of supported employment services; or
- Payments for training that is not directly related to an individual's supported employment program.

Supported Employment—Small Group does not include supports provided in facility based (sheltered, prevocational, vocational or habilitation) work settings and does not include supports for volunteering.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

Integrated Employment Path Services (Time-Limited, Community-Based Prevocational Training)

The provision of time-limited learning and work experiences, including volunteering opportunities, where a person can develop general, non-job-task-specific strengths and skills that contribute to employability in individualized integrated employment or self-employment. Services are expected to specifically involve strategies that facilitate a participant's successful transition to individualized integrated employment or self-employment.

Individuals receiving Integrated Employment Path Services must have a desire to obtain some type of individualized integrated employment or self-employment and this goal must be documented in the PCSP as the goal that Integrated Employment Path Services are specifically authorized to address.

Services should be customized to provide opportunities for increased knowledge, skills and experiences specifically relevant to the person's *specific* individualized integrated employment and/or self-employment goals and career goals. If such *specific* goals are not known, this service can also be used to assist a person to identifying his/her specific individualized integrated employment and/or self-employment goals and career goals.

The expected outcome of this service is measurable gains in knowledge, skills and experiences that contribute to the individual achieving individualized integrated employment or self-employment.

Integrated Employment Path Services are intended to develop and teach general skills that lead to individualized integrated employment or self-employment including but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; and general workplace safety and mobility training.

Service limitations:

- This service is limited to no more than twelve (12) months. One extension of up to twelve (12) months can be allowed only if the individual is actively pursuing individualized integrated employment or self-employment in an integrated setting and has documentation that a service(s) (i.e., Job Development or Self-Employment Start-Up funded by Tennessee Rehabilitation Services, ECF CHOICES or another similar source) is concurrently authorized for this purpose. The twelve (12) month authorization and one twelve (12) month reauthorization may be repeated only if a person loses individualized integrated employment or self-employment and is seeking replacement opportunities.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

- This service must be delivered in integrated, community settings and may not be provided in sheltered workshops or other segregated facility-based day, vocational or prevocational settings.
- Integrated Employment Path Services shall not be provided or reimbursed if the person is receiving Job Coaching (for Individualized Integrated Employment or Self-Employment) Co-Worker Supports or is working in individualized integrated employment or self-employment without any paid supports. Integrated Employment Path Services are only appropriate for individuals who are not yet engaged in individualized integrated employment or self-employment.

Transportation of the individual to and from this service is not included in the rate paid for this service but transportation during the service is included in the rate.

ECF CHOICES will not cover services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

This service will not duplicate other services provided through the waiver or Medicaid state plan services.

Integrated Employment Path Services may be used in ECF CHOICES to support participation in paid and unpaid internship opportunities²¹ as approved by TennCare²². The provider must ensure, and service documentation must reflect, that skills being taught through Integrated Employment Path Services as part of the approved internship program are transferable to more than one type of job after the internship, and not job/task-specific. Integrated Employment Path Services may be provided for coaching and skill development during work-based components of the internship program. It is expected that interns will be dispersed throughout the place of business hosting the internship program, and support staff being funded under Integrated Employment Path Services will float between the participants to provide individualized supports as needed for learning and skill development. Only for Integrated Employment Path Service provided as part of an approved internship program, the minimum staffing ratio is 1:4.

²¹ A *paid internship* mirrors the aspects of individualized integrated employment, including integrated setting, competitive wage, and benefit opportunities, with potential for interns to become hired as employees, but is expected to be time-limited. An *unpaid internship* mirrors certain aspects of individualized integrated employment such as integrated setting, and teaches general job skills that may be used for diverse opportunities to obtain employment. An *unpaid internship* is also expected to be time-limited and preparation for individualized integrated employment.

²² Internship opportunities approved by TennCare include Project Search; REDI (Walgreens Retail-Store Internship Program for People with Disabilities); BEST (Building Economic Strength Together); the Union EDGE Program; and Next Steps at Vanderbilt University. Additional internship programs may be submitted to TennCare for review and consideration of approval.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

Integrated Employment Path Services cannot be used during classroom instruction time or to offset tuition for post-secondary internship programs, but may be used when a person enrolled in a post-secondary internship program needs more support than the program can provide during their internship experience.

For youth still enrolled in school, the MCO must document that the specific supports being funded through Integrated Employment Path Services are not otherwise available to the individual through the school (IDEA (20 U.S.C. 1401 et seq.)) or through Vocational Rehabilitation (Section 110 of the Rehabilitation Act of 1973).

For adults no longer enrolled in school, the MCO must document that the specific supports being funded through Integrated Employment Path Services are not otherwise available to the individual through Vocational Rehabilitation (Section 110 of the Rehabilitation Act of 1973).

B. Other (non-Employment) Non-Residential Habilitation Services and Supports

Community Integration Support Services: Services which coordinate and provide supports for valued and active participation in integrated daytime and nighttime activities that build on the person's interests, preferences, gifts, and strengths while reflecting the person's goals with regard to community involvement and membership. This service involves participation in one or more integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers. Community Integration Support Services are designed to promote maximum participation in integrated community life while facilitating meaningful relationships, friendships and social networks with persons without disabilities who share similar interests and goals for community involvement and participation.

Community Integration Support Services shall support and enhance, rather than supplant, an individual's involvement in public education, post-secondary education/training and individualized integrated employment or self-employment (or services designed to lead to these types of employment).

Community Integration Support Services enable the person to increase or maintain his/her capacity for independent participation in community life and to develop age-appropriate social roles valued by the community by learning, practicing and applying skills necessary for full inclusion in the person's community, including skills in arranging and using public transportation for individuals aged 16 or older.

Community Integration Support Services provide assistance for active and positive participation in a broad range of integrated community settings that allow the person to engage with people who do not have disabilities who are not paid or unpaid caregivers. The service is expected to result in the person developing and sustaining a range of valued, age-appropriate social roles and relationships; building natural supports; increasing independence; and experiencing meaningful community integration and inclusion. Activities are expected to increase the individual's opportunity to build connections within his/her local community and include (but are not limited to) the following:

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

- Supports to participate in age-appropriate community activities, groups, associations or clubs to develop social networks with community organizations and clubs;
- Supports to participate in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness (e.g. yoga class, walking group, etc.);
- Supports to participate in adult education and postsecondary education classes;
- Supports to participate in formal/informal associations or community/neighborhood groups;
- Supports to participate in volunteer opportunities;
- Supports to participate in opportunities focused on training and education for self-determination and self-advocacy;
- Supports for learning to navigate the local community, including learning to use public transportation and/or private transportation available in the local area;
- Supports to maintain relationships with members of the broader community (e.g. neighbors, co-workers and other community members who do not have disabilities and who are not paid or unpaid caregivers) through natural opportunities and invitations that may occur.

This service includes a combination of training and supports as needed by the individual. The Community Integration Support Services provider shall be responsible for any personal assistance needs during the hours that Community Integration Support Services are provided; however, the personal assistance services may not comprise the entirety of the Community Integration Support Service. All providers of personal care under Community Integration Support Services meet the Personal Assistance provider qualifications.

This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve his or her personally identified goals for community integration, involvement, exploration and for developing and sustaining a network of positive natural supports. All settings where Community Integration Support Services are provided must be non-disability specific and meet all federal standards for HCBS settings. This service is provided separate and apart from the person's place of residence. This service does not take place in licensed facilities, sheltered workshops or any type of facility owned, leased or operated by a provider of this service.

This service is available only:

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

- For children not yet old enough to work and/or not yet eligible for employment services who are enrolled in Essential Family Supports;
- As “wrap-around” supports to employment or employment services (Supported Employment Individual or Small Group services and/or Integrated Employment Path Services) for individuals not receiving Community Living Supports or Community Living Supports-Family Model; or
- For individuals who are of legal working age (16+) not receiving Community Living Supports or Community Living Supports-Family Model who are completing an Employment Informed Choice Process as defined by TennCare (see below), or who, after completing such Employment Informed Choice Process, have decided not to pursue employment; or
- For individuals of retirement age not receiving Community Living Supports or Community Living Supports-Family Model who have made a choice not to pursue further employment opportunities.

For individuals receiving Community Integration Support Services and not participating in employment or employment services, the option to pursue employment should be discussed at least semi-annually.

For individuals receiving Community Living Supports or Community Living Supports-Family Model, all services necessary to support community integration and participation are part of the scope of benefits provided under the CLS or CLS-FM benefit.

For individuals of appropriate age (18+), it is expected that individuals will be supported to become more independent in their community activities and to develop natural supports. Fading of the service and less dependence on paid support for on-going participation in community activities and relationships is expected. Strategies to increase independence, build natural supports, and fade paid services, similar to those used in Supported Employment Job Coaching, should be utilized. Milestones for increasing independence, building natural supports, and the reduction/fading of paid supports must be established and monitored for this service and reviewed on an ongoing basis.

Payment for registration, materials and supplies for participation in classes, conferences and similar types of activities, or club/association dues can be covered, but cannot exceed \$500 per year for children under age 21 or \$1,000 per year for adults age 21 and older. These costs are not included in the rates paid to the providers of Community Integration Support Services and must be prior approved before being incurred.

Transportation to and from the service is not included in the rate paid for the service; but transportation during the service (when no-cost forms of transportation are not available or not being accessed) is included in the rate paid for the service.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

Independent Living Skills Training

Independent Living Skills Training services provide education and skill development or training to improve the person's ability to independently perform routine daily activities and utilize community resources as specified in the person's person-centered support plan. Services are instructional, focused on development of skills identified in the person-centered support plan and are not intended to provide substitute task performance. Independent Living Skills training may include only education and skill development related to:

- Personal hygiene;
- Food and meal preparation;
- Home upkeep/maintenance;
- Money management;
- Accessing and using community resources;
- Community mobility;
- Parenting;
- Computer use; and
- Driving evaluation and lessons.

This service is available only:

- For children not yet old enough to work and/or not yet eligible for employment services who are enrolled in Essential Family Supports;
- As “wrap-around” supports to employment or employment services (Supported Employment Individual or Small Group services and/or Integrated Employment Path Services) for individuals not receiving Community Living Supports or Community Living Supports-Family Model; or
- For individuals who are of legal working age (16+) not receiving Community Living Supports or Community Living Supports-Family model who are completing an Employment Informed Choice Process as defined by TennCare (see below) or who, after completing such Employment Informed Choice Process, have decided not to pursue employment; or
- For individuals of retirement age not receiving Community Living Supports or Community Living Supports-Family Model who have made a choice not to pursue further employment opportunities.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

Independent Living Skills Training is intended as a short-term service designed to allow a person not receiving Community Living Supports or Community Living Supports-Family Model to acquire specific additional skills that will support his/her transition to or sustained independent community living. Individuals receiving Independent Living Skills Training must have specific independent-living goals in their person-centered support plan that Independent Living Skills Training is specifically designed to support.

The provider must prepare and follow a specific plan and strategy for teaching specific skills for the independent living goals identified in the person-centered support plan. Systematic instruction and other strategies used in Supported Employment Job Coaching should also be employed in this service. The provider must document monthly progress toward achieving each independent living skill identified in the person-centered support plan.

This service will typically originate from the person's home and take place in the person's home and their home community. Providers of this service should meet people in these natural environments to provide this service rather than maintaining a separate service location. Transportation during the service (when no-cost forms of transportation are not available or not being accessed) is included in the rate paid for the service.

Individuals receiving Community Living Supports or Community Living Supports-Family Model are not eligible to receive this service, since the scope of benefits provided to a person under the CLS and CLS-FM benefits include habilitation training and supports to help the person achieve maximum independence and sustained community living.

NON-RESIDENTIAL HABILITATION SERVICES

Employment Informed Choice Process

As part of Support Coordination responsibilities, an Employment Informed Choice Process must be initiated by the MCO for all working age individuals prior to authorization of Non-Work Services/Supports included in the ECF Non-Residential Habilitation Services Category (Community Integration Support Services and Independent Living Skills Training that do not wrap employment or employment services (Supported Employment Individual or Small Group services, Integrated Employment Path Services, or comparable Vocational Rehabilitation/Special Education services). For purposes of this Employment Informed Choice Process, "employment" shall mean Individualized Integrated Employment or Individualized Integrated Self-Employment as defined in this attachment.

Employment Informed Choice Process required components:

1. Initial meeting with individual and involved family, guardian and conservator (as applicable) to provide an orientation to employment, including Supported Employment services, how it works, including the role of VR and basic benefits education. Describe Exploration and Discovery Services, and discuss questions/concerns/hopes.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

2. Authorize Exploration service included under Supported Employment-Individual Employment Supports. Non-work services/supports included in the ECF Non-Residential Habilitation Services Category (i.e., Community Integration Support Services and Independent Living Skills Training) may be authorized up to applicable limits, along with the Exploration service, as long as the Exploration service is authorized and the individual receives the Exploration service simultaneously with Community Integration Support Services and/or Independent Living Skills Training.
3. Upon completion of Exploration services and receipt of the written report, if the individual wishes to pursue individualized, integrated employment or self-employment, proceed with authorization of necessary employment service(s) and/or referral to Vocational Rehabilitation, as appropriate, to ensure progress toward employment continues to be made without delay or gap.
4. If the individual has not decided to pursue individualized, integrated employment or self-employment, meet with the individual and involved family, guardian, conservator (if applicable) to review results of Exploration services, provide re-education or additional education on the benefits of employment and supports available for employment. If the person still declines to pursue employment and declines to participate in any employment service, obtain written confirmation of the person's informed choice not to pursue individualized, integrated employment or self-employment at this time. For persons not receiving Community Living Supports or Community Living Supports-Family Model services, Non-Work Services/Supports included in the ECF Non-Residential Habilitation Services Category (i.e., Community Integration Support Services and Independent Living Skills Training) may continue to be authorized up to a combined maximum of twenty (20) hours per week.

II. OTHER ECF SERVICES:

Personal Assistance:

A range of services and supports designed to assist an individual with a disability to perform activities and instrumental activities of daily living at the person's own home, on the job or in the community that the individual would typically do for themselves if he/she did not have a disability. Personal Assistance services may be provided outside of the person's home as long as the outcomes are consistent with the supports defined in the person-centered support plan with the goal of ensuring full participation and inclusion.

Personal Assistance services may be used to:

- Support the person at home in getting ready for work and/or community participation;
- Support the person in getting to work and/or community participation opportunities; and
- Support the person in the workplace and/or in the broader community.

The only exception is if Supported Employment Services or Community Integration Support Services are being provided, in which case the provider of Supported Employment and/or Community Integration Support Services shall be responsible for personal assistance needs

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

during the hours that Supported Employment services are provided as long as the Personal Assistance Services do not comprise the entirety of the Supported Employment or Community Integration Support Service. If a person only needs personal assistance to participate in employment or community opportunities, then this service should be authorized rather than Supported Employment or Community Integration Support Services.

Personal Assistance services that are covered also include the following:

- Support, supervision and engaging participation with eating, toileting, personal hygiene and grooming, and other activities of daily living as appropriate and needed to sustain community living, except when provided as a component of another covered service the person is receiving at that time; and
- Direction and training to individuals in the person's social network or to his/her co-workers who choose to learn how to provide some of the Personal Assistance services.

In the Comprehensive Supports for Employment and Community Living Benefit Group, Personal Assistance services will be limited to 215 hours per month. An MCO may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered benefits.

Community Transportation:

Community Transportation services are non-medical transportation services offered in order to enable individuals, and their personal assistants as needed, to gain access to employment, community life, activities and resources that are identified in the person-centered support plan. These services allow individuals to get to and from typical day-to-day, non-medical activities such as individualized integrated employment or self-employment (if not home-based), the grocery store or bank, social events, clubs and associations and other civic activities, or attending a worship service. This service is made available when public or other no-cost community-based transportation services are not available and the person does not have access to transportation through any other means (including natural supports).

Whenever possible, family, neighbors, co-workers, carpools or friends are utilized to provide transportation assistance without charge. When this service is authorized, the most cost-effective option should be considered first. This service is in addition to the medical transportation service offered under the Medicaid State Plan, which includes transportation to medical appointments as well as emergency medical transportation.

Community Living Supports:

As defined in Attachment E.

Community Living Supports-Family Model:

As defined in Attachment E.

Assistive Technology, Adaptive Equipment and Supplies:

An item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities and to support

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

the individual's increased independence in the home, community living and participation, and individualized integrated employment or self-employment. The service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required by the person to increase, maintain or improve his/her functional capacity to perform daily tasks in the community and in employment that would not be possible otherwise. All items must meet applicable standards of manufacture, design and installation. The person-centered support plan must include strategies for training the individual and any others who the individual will or may rely on in effectively using the assistive technology or adaptive equipment (e.g. his/her support staff; co-workers and supervisors in the place of employment; natural supports).

Assistive Technology Equipment and Supplies also covers the following:

- Evaluation and assessment of the assistive technology and adaptive equipment needs of the individual by an appropriate professional, including a functional evaluation of the impact of the provision of appropriate assistive technology and adaptive equipment through equipment trials and appropriate services to him/her in all environments with which the person interacts over the course of any 24 hour day, including the home, integrated employment setting(s) and community integration locations;
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, updating, repairing, or replacing assistive technology devices and adaptive equipment;
- Adaptive equipment to enable the individual to feed him/herself and/or complete oral hygiene as indicated while at home, work or in the community (e.g. utensils, gripping aid for utensils, adjustable universal utensil cuff, utensil holder, scooper trays, cups, bowls, plates, plate guards, non-skid pads for plates/bowls, wheelchair cup holders, adaptive cups that are specifically designed to allow a person to feed him/herself or for someone to safely assist a person to eat and drink, and adaptive toothbrushes);
- Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the person-centered support plan;
- Training, programming, demonstrations or technical assistance for the individual and for his/her providers of support (whether paid or unpaid) to facilitate the person's use of the assistive technology and adaptive equipment;
- Adaptive switches and attachments;
- Adaptive toileting equipment;
- Communication devices and aids that enable the person to perceive, control or communicate with the environment, including a variety of devices for augmentative communication;
- Assistive devices for persons with hearing and vision loss (e.g. assistive listening devices, TDD, large visual display services, Braille screen communicators, FM systems, volume control telephones, large print telephones and tele touch systems and long white canes with appropriate tips to identify footpath information for people with visual impairment);
- Computer equipment, adaptive peripherals and adaptive workstations to accommodate active participation in the workplace and in the community;

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

- Software also is approved when required to operate accessories included for environmental control;
- Pre-paid, pre-programmed cellular phones that allow an individual who is participating in employment or community integration activities without paid or natural supports and who may need assistance due to an accident, injury or inability to find the way home. The person's Person Centered Support Plan outlines a protocol that is followed if the individual has an urgent need to request help while in the community;
- Such other durable and non-durable medical equipment not available under the state Plan that is necessary to address functional limitations in the community, in the workplace, and in the home;
- Repairs of equipment is covered for items purchased through this waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The individual must own any piece of equipment that is repaired.

A written recommendation by an appropriate professional must be obtained to ensure that the equipment will meet the needs of the person. The recommendation of the Job Accommodation Networks (JAN) will meet this requirement for worksite technology. Depending upon the financial size of the employer or the public entity, those settings may be required to provide some of these items as part of their legal obligations under Title I or Title III of the ADA. Federal financial participation is not claimed for accommodations that are the legal responsibility of an employer or public entity, pursuant to Title I or Title III of the ADA.

ECF CHOICES will not cover Assistive Technology or Adaptive Equipment and services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If this service is authorized, documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Assistive Technology, Adaptive Equipment and Supplies shall be limited to \$5,000 per person per calendar year. An MCO may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered benefits.

Minor Home Modifications:

As defined in Attachment E, including applicable limitations.

Individual Education and Training Services:

Reimbursement up to \$500 per year to offset the costs of training programs, workshops and conferences that help the person develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. This service may include education and training for participants, their caregivers and/or legal representatives that is directly related to building or acquiring such skills. Managed care organizations assure that information about educational and/or training opportunities is available to participants and their caregivers and legal representatives. Covered expenses may include enrollment fees, books and

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

other educational materials and transportation related to participation in training courses, conferences and other similar events. Limited to \$500 per individual per year.

Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living:

These services assist an individual and his/her family member(s) or conservator in one or more of the following areas:

- Directing the person-centered planning process;
- Understanding and considering self-direction;
- Understanding and considering individualized integrated employment/self-employment; and
- Understanding and considering independent community living options.

The service involves addressing questions and concerns related to such options. Services are provided by a peer who has successfully directed his or her person-centered planning process, self-directed his or her own services, successfully obtained individualized integrated employment or self-employment and/or utilized independent living options.

Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living services are provided by individuals with intellectual or developmental disabilities (with paid supports if needed) who have successfully directed their person-centered planning processes, and/or self-directed their own services, and/or successfully utilized independent living options. Individuals with intellectual or developmental disabilities qualified to provide these services will have also completed training in best practices for offering peer to peer supports in the areas covered by this service.

Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living services are focused on mentoring and training others based upon their personal experience and success in one or more areas this service is focused on. A qualified service provider understands, empathizes with and can support three important areas important for enhancing self-esteem:

- The human need for connections;
- Overcoming the disabling power of learned helplessness, low expectations and the stigma of labels; and,
- Supporting self-advocacy, self-determination and informed choice in decision making.

The Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living service provider offers:

- One-on-one training and information to encourage the person to lead their person-centered planning process, pursue self-direction, seek integrated employment/self-employment and/or independent community living options;
- Education on informed decision making, risk taking, and natural consequences;
- Education on self-direction, including recruiting, hiring and supervising staff;

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

- Planning support regarding integrated employment;
- Planning support regarding independent community living opportunities, including selection of living arrangements and housemates; and
- Assistance with identifying potential opportunities for community participation, the development of valued social relationships, and expanding unpaid supports to address individual needs in addition to paid services.

These services are intended to support an individual in knowledge and skill acquisition and should not be provided on an ongoing basis, nor should these services be provided for companionship purposes. Reimbursement shall be limited to \$1,500 per person per lifetime.

Specialized Consultation and Training:

Expertise, training and technical assistance in one or more specialty areas (behavior services, occupational therapy, physical therapy, speech language pathology, nutrition, orientation and mobility, or nurse education, training and delegation) to assist paid or natural or co-worker supports in supporting individuals who have long-term intervention needs, consistent with the person-centered support plan, therefore increasing the effectiveness of the specialized therapy or service. This service also is used to allow the specialists listed above to be an integral part of the person-centered planning team, as needed, to participate in team meetings and provide additional intensive consultation for individuals whose functional, medical or behavioral needs are determined to be complex. The consultation staff and the paid support staff are able to bill for their service time concurrently. Activities that are covered include:

- Observing the individual to determine and assess functional, medical or behavioral needs;
- Assessing any current interventions for effectiveness;
- Developing a written, easy-to-understand intervention plan, which may include recommendations for assistive technology/equipment, workplace and community integration site modifications; the Intervention plan will clearly define the interventions, activities and expected timeline for completion of activities;
- Identification of activities and outcomes to be carried out by paid and natural supports and co-workers;
- Training of family caregivers or paid support personnel on how to implement the specific interventions/supports detailed in the intervention plan; in the case of nurse education, training and delegation, shall include specific training, assessment of competency, and delegation of skilled nursing tasks to be performed as permitted under state law;
- Development of and training on how to observe, record data and monitor implementation of therapeutic interventions/support strategies;
- Monitoring the individual, family caregivers and/or the supports personnel during the implementation of the plan;
- Reviewing documentation and evaluating the activities conducted by relevant persons as detailed in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes or revision of the plan as needed;
- Participating in team meetings; and/or,
- Tele-Consulting, as permitted under state law, through the use of two-way, real time-interactive audio and video between places of greater and lesser clinical expertise to

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

provide clinical consultation services when distance separates the clinical expert from the individual.

Specialized Consultation Services are provided by a certified, licensed, and/or registered professional or qualified assistive technology professional appropriate to carry out the relevant therapeutic interventions.

Specialized Consultation Services are limited to \$5,000 per person per calendar year, except for adults in the Comprehensive Supports for Employment and Community Living benefit group determined to have exceptional medical and/or behavioral support needs.

For adults in the Comprehensive Supports for Employment and Community Living benefit group determined to have exceptional medical and/or behavioral support needs, Specialized Consultation Services shall be limited to \$10,000 per person per calendar year.

An MCO may authorize services in excess of the benefit limit as a cost-effective alternative to institutional placement or other medically necessary covered benefits.

Adult Dental Services:

Preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments to relieve pain and infection) which have dental procedure codes listed in the current TennCare Maximum Reimbursement Rate Schedule for Dental Services that is used specifically for adult dental services provided under the state's Section 1915(c) waivers for individuals with intellectual disabilities; and intravenous sedation or other anesthesia services provided in the dentist's office by, and billed by, the dentist or by a nurse anesthetist or anesthesiologist who meets the waiver provider qualifications.

Orthodontic services are excluded from coverage.

All Dental Services for children enrolled in the waiver are provided through the TennCare EPSDT program. Dental Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

Adult Dental Services shall be limited to a maximum of \$5,000 per member per calendar year, and a maximum of \$7,500 per member across three (3) consecutive calendar years.

Respite:

Respite shall mean services provided to a person supported when unpaid caregivers are absent or need relief from routine caregiving responsibilities.

Respite shall be limited to 30 days of service per person per calendar year or to 216 hours per person per calendar year, depending on the needs and preferences of the individual as reflected in the Person Centered Support Plan. (The 2 limits cannot be combined in a calendar year.) Respite services shall be provided in settings that meet the federal HCBS regulatory standards,

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

which promote community involvement and inclusion and which allow individuals to sustain their lifestyle and routines when an unpaid caregiver is absent for a period of time.

Supportive Home Care (SHC):

This service involves the provision of services and supports in the home and community by a paid caregiver who does not live in the family home to an individual living with his or her family that directly assist the individual with activities of daily living and personal needs to insure adequate functioning in their home and maintain community living. Supportive Home Care services may be provided outside of the person's home as long as the outcomes are consistent with the supports defined in the person-centered support plan with the goal of ensuring full participation and inclusion.

Services include:

- Hands-on assistance with activities of daily living such as dressing/undressing, bathing, feeding, toileting, assistance with ambulation (including the use of a walker, cane, etc.), care of hair and care of teeth or dentures. This can also include preparation and cleaning of areas used during personal care activities such as the bathroom and kitchen.
- Observation of the person supported to assure safety, oversight direction of the person to complete activities of daily living or instrumental activities of daily living.
- Routine housecleaning and housekeeping activities performed for the person supported (and not other family members or persons living in the home, as applicable), consisting of tasks that take place on a daily, weekly or other regular basis, including: washing dishes, laundry, dusting, vacuuming, meal preparation and shopping for food and similar activities that do not involve hands-on care of the person.
- Necessary cleaning of vehicles, wheelchairs and other adaptive equipment and home modifications such as ramps.

Family Caregiver Stipend in lieu of Supportive Home Care:

A monthly payment to the primary family caregiver of a person supported when the person lives with the family in the family home, the family is providing daily services and supports that would otherwise be defined within the scope of Supportive Home Care services, the person supported wishes to maintain this living arrangement and to have the family caregiver provide these supports, and the person is receiving all necessary services to support: 1) age-appropriate community integration and involvement with persons not limited to family members or other persons with disabilities; 2) development of age-appropriate skills for independence and personal growth; and 3) individualized integrated employment for members age 14-62. The Family Caregiver Stipend is appropriate only when it supports and sustains the family to “*guide their member with a disability toward being self-determined individuals and achieving the nation's goals for people with disabilities as set out in federal legislation, namely, equal opportunity, economic productivity, independent living, and full participation.*”²³

²³ From the *Joint Position on Family Support from the AAIDD* (American Association on Intellectual and Developmental Disabilities) and *The Arc*, available at: <https://aaid.org/news-policy/policy/position-statements/family-support>

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

This service is available only in lieu of Supportive Home Care (including Personal Assistance) services and shall not be authorized for a person receiving Supportive Home Care (including Personal Assistance) services.

The Family Caregiver Stipend is not intended to supplant natural family caregiving supports by providing a payment for family caregiver supports that were already being provided prior to program enrollment and that are expected to continue at the same level. ECF CHOICES benefits are intended to sustain and enhance natural supports, rather than replacing or supplanting them with paid supports. The Family Caregiver Stipend is used to compensate lost wage earning opportunities that are entailed in providing support to a family member with a disability and to help offset the cost of other services and supports the person needs that are not covered under this program.

When needed and appropriate, this service wraps around ECF CHOICES HCBS and other services the individual is actively receiving that support(s) age-appropriate community integration and involvement, development of age-appropriate skills for independence and personal growth and, for members age 14 and older, services that support employment. The ongoing service(s), around which the Family Caregiver Stipend wraps shall be identified in the Person-Centered Support Plan, customized to the person's age and individualized goals/needs, and authorized through the program unless they are otherwise available through other programs, as verified by the MCO and documented in the Person-Centered Support Plan. Other programs may include special education, vocational rehabilitation, workforce or other programs pre-approved by TennCare.

For a child under age 18, the Family Caregiver Stipend shall be limited to an amount between \$100 and \$500 per month. For an adult age 18 or older, the Family Caregiver Stipend shall be limited to an amount between \$100 and \$1,000 per month. The specific amount authorized shall be determined based on: (1) the needs of the person supported; (2) the family's need for support in order to support the person's continued growth, independence, and self-determination; (3) the availability of funds within the member's Expenditure Cap, after supports for age-appropriate community integration, the development of age-appropriate skills for independence and personal growth and, for members age 14 and older, supports for employment have been addressed; and (4) the extent of the supports being provided by the family caregiver; and may take into account the family's intent to use some or all of the funds to provide other services and supports that are not covered under this program.

Family-to-Family Support:

These services provide information, resources, guidance, and support from an experienced and trained parent or other family member to another parent or family caregiver who is the primary unpaid support to a child with intellectual or developmental disabilities enrolled in ECF CHOICES. The service shall include facilitation of parent or family member "matches" and follow-up support to assure the matched relationship meets peer expectations.

Community Support Development, Organization and Navigation:

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

Assists individuals and families in 1) promoting a spirit of personal reliance and contribution, mutual support and community connection; 2) developing social networks and connections within local communities, and 3) emphasizes, promotes and coordinates the use of unpaid supports to address individual and family needs in addition to paid services.

Supports provided include:

- Helping individuals and family caregivers to develop a network for information and mutual support from others who receive services or family caregivers of individuals with disabilities;
- Assisting individuals with disabilities and family caregivers with identifying and utilizing supports available from community service organizations, such as churches, schools, colleges, libraries, neighborhood associations, clubs, recreational entities, businesses and community organizations focused on exchange of services (e.g. time banks); and
- Assisting individuals with disabilities and family caregivers with providing mutual support to one another (through service/support exchange), and contributions offered to others in the community.

These services are provided by a Community Navigator and reimbursed on a per person (or family) per month basis, based on specific goals and objectives as specified in the person-centered support plan.

Family Caregiver Education and Training:

This service provides reimbursement up to \$500 per year to offset the costs of educational materials, training programs, workshops and conferences that help the family caregiver to:

- Understand the disability of the person supported;
- Achieve greater competence and confidence in providing supports;
- Develop and access community and other resources and supports;
- Develop advocacy skills; and
- Support the person in developing self-advocacy skills.

Family Caregiver Education and Training is offered only for a family caregiver who is providing unpaid support, training, companionship, or supervision for a person participating in ECF CHOICES who is living in the family home. The intent of the service is to provide education and support to the caregiver that preserves the family unit and increases confidence, stamina and empowerment. Education and training activities are based on the family/caregiver's unique needs and are specifically identified in the person-centered support plan prior to authorization.

Decision Making Supports and Options:

This service offers up to \$500 in one-time consultation, education and assistance to family caregivers in understanding legal, financial, and other decision making supports and options for a person supported who cannot make some or all of their own decisions. These services shall be provided in a manner that seeks to provide support in the least-restrictive manner, preserving the rights and freedoms of the individual to the maximum extent possible and appropriate.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

This service begins with education and consultation from a qualified professional to help ensure understanding of the array of options available, including less restrictive options that can be used to preserve the person's rights and freedoms to the maximum extent possible and appropriate, while addressing decision making needs.

Reimbursable services may then include: (1) assistance with completing necessary paperwork and processes to establish an alternative to conservatorship, such as supported decision making, limited (and revocable) power of attorney, health care proxy, or trust; or limited or full or conservatorship that is specifically tailored to the individual's capacities and needs, if it is determined to be the least restrictive alternative; (2) evaluating the appropriateness of a decision-making instrument currently in place and assistance with costs associated with terminating or revoking a conservatorship when less restrictive options would be appropriate; and (3) training associated with decision-making support,

Health Insurance Counseling/Forms Assistance:

Health Insurance Counseling/Forms Assistance services offers training and assistance to individuals enrolled in ECF CHOICES and/or their family caregiver and policy holder in understanding the benefits offered through their private or public insurance program, completing necessary forms, accessing covered benefits, and navigating member appeal processes regarding covered benefits. An insurance company or its affiliate shall not be reimbursed for providing this service.

This is a time-limited service intended to develop the person and/or family caregiver's understanding and capacity to self-manage insurance benefits. Reimbursement shall be limited to 15 hours per person per year.

Persons choosing to receive this service must agree to complete an online assessment of its efficacy following the conclusion of counseling and/or forms assistance.

Intensive Behavioral Family-Centered Treatment, Stabilization and Supports:

Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS) is an integrated behavioral health and HCBS benefit targeted to providing intensive in-home, family-centered²⁴ behavior supports, behavioral-focused supportive home care, caregiver training and support, combined with crisis intervention and stabilization assistance that is available 24 hours a day, 7 days a week, and in-home behavioral respite when needed for a relatively small group of children (under age 21) who live with their family and have intellectual and/or developmental disabilities (I/DD) and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at imminent and significant risk of serious physical harm (that does not

²⁴ *Family-centered* behavior supports include working with family members to understand their strengths, needs, preferences, goals and challenges; developing a collaborative relationship with the family; and providing support in a way that helps to engage, strengthen, support, and build the capacity and confidence of the family in order to help ensure safety, well-being, and permanency.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

rise to the level of inpatient treatment or for which such treatment would not be appropriate), and threaten the sustainability of the family living arrangement.²⁵

These are children at imminent and significant risk of placement outside the home (e.g., state custody, hospitalization, residential treatment, incarceration). The benefit is available only for children eligible for and enrolled in Intensive Behavioral Family Supports (ECF CHOICES 7).

IBFCTSS combines family-centered behavioral health treatment services with family-centered HCBS. Qualified providers are licensed by the Department of Mental Health and Substance Abuse Services (DMHSAS) for the delivery of behavioral health services and by the Department of Intellectual and Developmental Disabilities for the delivery of HCBS for individuals with I/DD.²⁶ Behavioral health assessment, planning and treatment components of the new benefit are provided by a Masters level licensed Mental Health professional and tailored to the needs of children with I/DD. Supportive service components (i.e., “Intensive Behavioral Supportive Home Care”) are provided by Bachelor level²⁷ Behavior Support Specialists and organized around the needs of the person served, their preferences, and their stated goals including (a) enhancement of their understanding of and ability to manage and cope with their psychiatric disabilities and/or behavioral challenges; (b) self-care and independent living skills; (c) relationship building and use of leisure time; (d) employment; and (e) economic self-sufficiency and income budget maintenance. These HCBS will utilize a trauma informed care approach and be integrated with treatment services and with ongoing implementation of Behavior Support (or other behavior management) Plans and the PCSP, and will provide supportive services in a way that helps to engage, strengthen, support, and build the capacity and confidence of the family in the consistent and effective implementation of the child’s behavior support (or other behavior

²⁵ “*Significant risk of harm*” means that serious physical injury to the person or other persons in the home is more than likely to happen imminently (very soon). Generally, “*imminent and significant risk of serious physical harm*” is evidenced by a well-documented, persistent and continuing pattern of behaviors that has resulted in serious physical injury to the person or others, and regarding which previous interventions (also documented) have been unsuccessful in reducing the risk to an acceptable level. The terms “*threaten the sustainability of the family living*” and “*significant risk of placement outside the home*” mean that as a result of the ongoing challenge of trying unsuccessfully to manage the behaviors which place the child and others at “*imminent and significant risk of serious physical harm*” as described above, the family has recently placed (in the last 180 days) or is actively pursuing placement outside the home for the child in order to keep the child or other family members safe, as evidenced by out-of-home placement, requests for out of home placement, or intervention by DCS.

²⁶ Pursuant to State law, the provider’s Personal Services Supports Agency license could be issued by DMHSAS, in which case, a provider must have significant experience and expertise serving individuals with I/DD and complex behavior support needs, in order to meet provider qualifications for this benefit.

²⁷ Behavior Support Specialists are expected to have substantial education, training, and experience in providing these types of supports to persons with I/DD in a family-centered way (i.e., a Bachelor’s degree in a relevant field plus at least one year experience working with individuals with I/DD who have challenging behavior support needs, including internship experience. Equivalent experience may be substituted for educational requirements, when appropriate—e.g., an Associates’ degree with three years of experience, or five years of experience if no post-secondary degree.) TennCare may establish alternative competency-based requirements to deliver these services, while ensuring the appropriate level of expertise to deliver high quality and effective supports.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

management) plan in all aspects of daily life²⁸ in order to help ensure safety, well-being, and permanency. Behavior Support Specialists will have ongoing access to direct guidance from the Masters level mental health professionals who are employed by or contracted with the IBFCTSS provider. Providers of IBFCTSS must maintain a written agreement with or employ a psychiatrist or other appropriately licensed psychiatric professional to facilitate timely access to psychiatric care, as needed. While the service is intended to provide support for family caregivers, it is not intended to supplant the supports provided by natural caregivers, but rather to build the capacity of families to better provide natural supports by teaching, training and supporting them in their caregiving role.

Intensive Behavioral Community Transition and Stabilization Services

Intensive Behavioral Community Transition and Stabilization Services (IBCTSS) is an integrated benefit that combines generally short-term²⁹ intensive 24/7 community-based residential services with behavioral health treatment and supports to assist certain adults aged 18 years and older with intellectual and/or developmental disabilities (I/DD) and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment to achieve and maintain stable, integrated lives in their communities. The benefit is available only for adults eligible for and enrolled in Comprehensive Behavioral Supports for Employment and Community Living (ECF CHOICES 8).

IBCTSS offers a short-term (initial authorization period of up to 90 days with limited extensions) behavioral-focused residential planning, stabilization and treatment program that addresses the mental health and stabilization needs of: 1) adults³⁰ with severe psychiatric or behavioral symptoms whose family is no longer capable of supporting the individual due to the severity and frequency of behaviors; 2) emerging young adults (age 18-21) with I/DD and severe psychiatric or behavioral symptoms aging out of the foster care system; and 3) adults with I/DD and severe psychiatric or behavioral symptoms following a crisis event and/or psychiatric inpatient stay and/or transitioning out of the criminal justice system or a long-term (two or more years) institutional placement (including residential psychiatric treatment facility). The purpose of Comprehensive Behavioral Supports for Employment and Community Living (Group 8) is to help stabilize the individual in the community and to help plan and prepare for transition to the

²⁸ IBFCTSS is an integrated family-centered behavioral health treatment and home and community-based service, not an educational or related service. These benefits will not be provided in education settings. However, the MCO and IBFCTSS provider is expected to coordinate with the Local Education Agency to help ensure consistent implementation of behavior support (or other behavior management) plans across daily environments.

²⁹ In rare instances, IBCTSS may be utilized to support longer term implementation of a plan to fade from high intensity community-based supports following a transition or when necessary to support continued stability in the community and diversion from (re)institutionalization. A tiered structure of reimbursement will provide for stepdown intensity of supports in these limited instances.

³⁰ As it relates to ECF CHOICES, “adults” generally refers to individuals no longer eligible for the EPSDT benefit, i.e., individuals age 21 and older. However, IBCTSS and enrollment into ECF CHOICES Group 8 may be permitted for emerging young adults, and on a case-by-case basis, for late adolescents with severe psychiatric or behavioral symptoms in one of the circumstances described above in order to avoid placement in DCS custody.

ATTACHMENT H

Employment and Community First CHOICES Service Definitions

appropriate ECF CHOICES Group (likely to be Group 6 in most cases), once it is possible to conduct appropriate assessments and determine the level of services and supports that will be needed going forward.

Qualified providers are licensed by the Department of Mental Health and Substance Abuse Services for the delivery of behavioral health services and by the Department of Intellectual and Developmental Disabilities for the delivery of residential services for individuals with I/DD. Behavioral health assessment, planning and treatment components of the new benefit are provided by a Masters level licensed Mental Health professional and tailored to the needs of individuals with I/DD. Residential service components are provided by Bachelor level³¹ Behavior Support Specialists with training and expertise in serving individuals with I/DD who have a severe behavioral and/or psychiatric condition.

This team provides comprehensive person-centered (including behavior supports) planning; coordination with the treating mental health practitioner (i.e., psychiatrist or other licensed prescriber); and intensive therapeutic support and intervention, up to 24 hours a day, as needed, across the person's day-to-day life domains, including home, school,³² work³³ and community, in order to achieve stability, support the person in building healthy relationships, and successfully plan and transition to other long-term services and supports with appropriate behavioral health treatment services. Providers of IBCTSS must maintain a written agreement with or employ a psychiatrist or other appropriately licensed psychiatric professional to facilitate timely access to psychiatric care, as needed.

³¹ Behavior Support Specialists are expected to have substantial education, training, and experience in providing these types of supports to persons with I/DD in a family-centered way (i.e., a Bachelor's degree in a relevant field plus at least one year experience working with individuals with I/DD who have challenging behavior support needs, including internship experience. Equivalent experience may be substituted for educational requirements, when appropriate—e.g., an Associates' degree with three years of experience, or five years of experience if no postsecondary degree.) TennCare may establish alternative competency-based requirements to deliver these services, while ensuring the appropriate level of expertise to deliver high quality and effective supports.

³² IBCTSS is an integrated behavioral health treatment and home and community-based service, not an educational or related service. These benefits are not provided for individuals under age 22 in secondary education settings. However, the MCO and IBCTSS provider is expected to coordinate with the Local Education Agency to help ensure consistent implementation of behavior support (or other behavior management) plans across daily environments.

³³ The IBCTSS provider is responsible for the provision of therapeutic support and intervention during the provision of employment services/supports, as needed.

Attachment I
Reconciliation of Uncompensated Care Payments (Reserved)

Attachment J
Evaluation Design (Reserved)

Attachment K
COVID-19 Emergency HCBS Flexibilities

ATTACHMENT K: Emergency Preparedness and Response

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.¹ This attachment may be applied retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State: Tennessee

B. Waiver Title(s): TennCare II

C. Control Number(s):

11-W-00151/4

D. Type of Emergency (The state may check more than one box):

<input checked="" type="checkbox"/>	Pandemic or Epidemic
<input type="checkbox"/>	Natural Disaster
<input type="checkbox"/>	National Security Emergency
<input type="checkbox"/>	Environmental
<input type="checkbox"/>	Other (specify):

E. **Brief Description of Emergency.** *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

Attachment K COVID-19 Emergency HCBS Flexibilities

This Attachment K submission pertains to the COVID-19 pandemic. Tennessee Governor Bill Lee TN Governor issued Executive Order 14 declaring a State of Emergency to facilitate COVID-19 response on March 12, 2020, one day after the World Health Organization officially characterized COVID-19 as a “pandemic” and one day before the declaration of a national emergency by President Trump.

Effective retroactively to March 13, 2020, through March 12, 2021, the State of Tennessee seeks section 1115(a) demonstration authority to operate its Medicaid program without regard to the specific statutory or regulatory provisions (or related policy guidance) described below, in order to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19. These temporary flexibilities will be implemented as determined by TennCare to be needed during the COVID-19 emergency and discontinued as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved demonstration.

F. Proposed Effective Date: Start Date: March 13, 2020 **Anticipated End Date:** March 12, 2021

G. Description of Transition Plan.

These temporary flexibilities will be implemented as determined by TennCare to be needed during the COVID-19 emergency and discontinued as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications.

H. Geographic Areas Affected:

Each of these waivers and the populations they serve are statewide, as is the impact of the COVID-19 emergency.

I. Description of State Disaster Plan (if available) *Reference to external documents is acceptable:*

Attachment K COVID-19 Emergency HCBS Flexibilities

The Tennessee Department of Health (TDH) activated its State Health Operations Center (SHOC) on January 16, 2020 to maximize capacity and available resources in preparation to respond to identified COVID-19 cases throughout the State. COVID-19 was designated as a “reportable disease” by TDH later that month, and a Task Force was formed under direction of Governor Bill Lee on March 4, 2020 to enhance Tennessee’s coordinated efforts to prevent, identify, and treat potential cases. A small contingent of the State Emergency Operations Center was activated on March 6, 2020 to respond to COVID-19 operations in the State, and to support TDH. Governor Bill Lee issued Executive Order 14 declaring a State of Emergency to facilitate COVID-19 response on March 12, 2020. The State of Tennessee Emergency Management Plan (TEMP) was activated and the State Emergency Operations Center (SEOC) is at a Level 3—State of Emergency. The Tennessee Emergency Management Agency (TEMA) supports local government needs; anticipates, responds to and remediates life threatening situations; supports the TDH; protects critical infrastructure; and ensures shared situational awareness and unified operations across Tennessee Government. On March 23, Governor Lee established the COVID-19 Unified Command, a joint effort to be led by Finance and Administration Commissioner Stuart McWhorter, to streamline coordination across the TEMA, TDH and Tennessee Department of Military during the COVID-19 emergency.

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state’s response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. X Access and Eligibility:

i. X Temporarily increase the cost limits for entry into the waiver.

[Provide explanation of changes and specify the temporary cost limit.]

COVID-related payment flexibilities described in this Appendix K to the TennCare II 1115 demonstration waiver, including temporary rate increases, retainer payments, and the COVID+ Residential Special Needs Adjustment (RSNA) and Personal Care Rate Differential (PCRD) shall not be counted against a CHOICES or ECF CHOICES member’s expenditure cap for purposes of determining continued eligibility for the program. A person enrolled in CHOICES or ECF CHOICES shall not be dis-enrolled if the sole reason the person’s expenditure cap would be exceeded is the payment flexibilities as described in this appendix. Except as provided in this section, all other policies applying to expenditure caps in CHOICES and ECF CHOICES continue to apply.

ii. ___ Temporarily modify additional targeting criteria.

Attachment K
COVID-19 Emergency HCBS Flexibilities

b. _ Services

i. _ Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. _ Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

[Explanation of changes]

iii. ___ Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

iv. _X Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

Residential habilitation services (i.e., Assisted Care Living Facility, Adult Care Home, Community Living Supports, Community Living Supports-Family Model, Intensive Behavioral Community Transition and Stabilization Services), Companion Care, Personal Assistance, Personal Care Visits, Attendant Care, and any other supportive services a person might otherwise receive in the setting where they live may be temporarily provided in alternative community-based settings or locations when necessary to minimize risk of COVID-19 exposure or spread.

Alternative settings may include previously utilized, larger Residential Habilitation dwellings (group homes). There are several of these homes available across the state that we have tentatively planned for use during cases of potential cluster infection or for isolation as needed. This will allow us to continue supports in community settings and avoid institutional placement, while also minimizing the risk of further spread. Additionally, we have contemplated isolation supports in the homes of asymptomatic COVID positive staff who are also supporting persons with a positive diagnosis, and have received offers of availability of space in local churches and community centers as needed.

Utilization of any alternative support location would be under emergency pretense, only because the individual has been displaced due to the COVID-19 emergency. This could include the need for isolation supports due to COVID-19 diagnosis or, potentially, agency or network viability concerns.

Attachment K
COVID-19 Emergency HCBS Flexibilities

v. ___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c. ___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d. ___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i. ___ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii. ___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

iii. X Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

For licenses which have not received a licensure survey, the current license will be placed in "Extended Status" until such time as surveys can be completed. An extension letter will be emailed to each licensee when a license is placed in "Extended Status".

Flexibility may also be provided with respect to allowing a licensed provider to deliver services in a different setting—for example, allowing an Adult Day Care provider to deliver services in the home.

e. X Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

Attachment K
COVID-19 Emergency HCBS Flexibilities

During the period of the COVID-19 emergency, annual level of care evaluations may be temporarily extended, and level of care evaluations or re-evaluations may be conducted remotely.

f. X Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

Attachment K

COVID-19 Emergency HCBS Flexibilities

HCBS providers are facing severe hardships and without quick financial assistance, some are at risk of closure placing the adequacy of the provider networks in jeopardy. HCBS providers support some of the state's most vulnerable populations. Medicaid is the most significant revenue source for HCBS providers. Most HCBS providers are not well-capitalized and depend on regular cash flow to meet payroll and day-to-day operating expenses. Certain HCBS providers have been most significantly impacted by the COVID-19 emergency—both in terms of reduced revenues and increased costs of service delivery, including staffing and PPE. Providers serving individuals confirmed COVID-19 positive are experiencing severe staff shortages and additional costs to ensure continuity of services in the home and avoid hospitalization, except when medically appropriate.

The intent of these rate increases is to help offset increased staffing, PPE, and other costs related to the COVID-19 pandemic, and to help ensure the sustainability of the HCBS workforce and provider network.

As a condition of eligibility for the enhanced rates, the provider must agree to continue to pay staff at current wage/salary levels (but can use the increase to pay staff more) and commit to continuing service delivery both during and beyond the public health emergency. All COVID-19 related rate increases are subject to audit and recoupment if these conditions are not met.

The Residential Special Needs Adjustment (RSNA) and COVID+ Personal Care Rate Differential (PCRD) are specifically intended to reimburse hazard pay to direct support staff, as well as overtime and PPE costs for services provided to a person confirmed COVID-19+.

As a condition of eligibility for these payments, the \$5/hour hazard pay must have been made to direct support staff, as supported by payroll records. Payments are subject to audit and adjustment or recoupment if it is determined that the \$5/hour hazard pay was not paid to direct support staff, or the person for which such RSNA or PCRD, as applicable, was billed was not confirmed COVID-19+.

10% and 30% rate increases (described below) are effective beginning dates of service March 13, 2020 for a two-month period (3/13/20 – 5/12/20).

A 10% temporary rate increase for residential services

CHOICES:

- Assisted Care Living Facility
- Adult Care Home
- Community Living Supports
- Community Living Supports – Family Model

ECF CHOICES:

- Community Living Supports
- Community Living Supports – Family Model
- Intensive Behavioral Community Transition and Stabilization Services

A 30% temporary rate increase for CHOICES Attendant Care

- 30% rate increase for Attendant Care aligns with CHOICES Personal Care Visits and ECF CHOICES Personal Assistance

A 10% temporary rate increase for CHOICES Personal Care Visits and ECF CHOICES

Attachment K
COVID-19 Emergency HCBS Flexibilities

Personal Assistance, Supportive Home Care, and Intensive Behavioral Family-Centered Treatment, Stabilization Services.

COVID+ Residential Special Needs Adjustment (RSNA)

- A per diem add-on payment to the existing residential rate to reimburse hazard pay to direct support staff, as well as overtime and PPE costs for services provided to a person confirmed COVID-19+, including:

CHOICES:

- Assisted Care Living Facility
- Adult Care Home
- Community Living Supports
- Community Living Supports – Family Model

ECF CHOICES:

- Community Living Supports
- Community Living Supports – Family Model
- Intensive Behavioral Community Transition and Stabilization Services

COVID+ Personal Care Rate Differential (PCRD)

- A per unit add-on to the existing unit rate to reimburse hazard pay to direct support staff, as well as overtime and PPE costs for services provided to a person confirmed COVID-19+

g. ~~X~~ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

Effective March 13, 2020, during the period of the COVID-19 emergency, Care Coordination (in CHOICES) and Support Coordination (in ECF CHOICES) visits may be conducted remotely, using phone or video conferencing solutions. When either of these responsibilities are completed in place of a required face-to-face meeting, the CC or SC should document the occurrence in a corresponding service note. For CC and SC meetings that require signature sheets, CCs and SCs should write down people's names (the name of everyone who participates in the meeting) on the signature sheet. The CC/SC should sign and date the form and identify somewhere on the signature sheet the phone call was held in lieu of a face-to-face meeting due to the COVID 19 emergency. Electronic signature and/or verbal authorizations may be permitted during this period. The state will ensure that the service plan is implemented and that individuals receive services as authorized during the period of the emergency, with the exception of services significantly impacted by state and federal orders and recommendations to practice social distancing (i.e., Community Integration Support Services, Employment Services, etc.), which will resume as the risk of exposure and spread of COVID-19 are reduced, and as providers are able to safely resume provision of services as described in the currently approved waiver applications.

Attachment K
COVID-19 Emergency HCBS Flexibilities

- h. ___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]**

- i. X Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.**

[Specify the services.]

Personal Care Services, including Personal Care Visits and Attendant Care in CHOICES and Personal Assistance in ECF CHOICES providers in an acute-care hospital or short-term institutional stay when the waiver participant is displaced from home because of COVID-19 and such supports are not otherwise available in these settings.

- j. X Temporarily include retainer payments to address emergency related issues.**

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

Expenditure authority is requested to offer retainer payments for Adult Day Care (ADC) services in CHOICES and Job Coaching, Supported Employment - Small Group (SE-SG), Integrated Employment Path (IEP), and Community Integration Support Services (CISS) in Employment and Community First CHOICES authorized to be provided between March 13, 2020 through May 12, 2020. Retainer payments will provide partial payment (75% of the expected Medicaid payment rate) to help offset the financial impact of significant reductions in Medicaid revenue when a service is not currently being delivered or has been substantially reduced—in this case, because of social distancing and stay-at-home orders related to the pandemic.

As a condition of payment, the provider must agree to continue to pay all ADC, Job Coaching, SE-SG, IEP, and CISS staff at current wage/salary levels and commit to resuming service delivery once the quarantine period has concluded. For ECF CHOICES providers, this includes a commitment to expanding capacity to serve additional members as such services are needed by ECF CHOICES members and as funds are available to serve additional members beginning July 1, 2020. Retainer payments are subject to audit and recoupment if it is determined that the authorized ADC, Job Coaching, SE-SG, IEP, or CISS (or alternative services) were in fact provided and billed, resulting in duplicate payment.

- k. ___ Temporarily institute or expand opportunities for self-direction.**

Attachment K
COVID-19 Emergency HCBS Flexibilities

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

--

Attachment K
COVID-19 Emergency HCBS Flexibilities

l. ___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m. ___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

- a ☒ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

- a ☐ Add an electronic method of service delivery (e.g., telephonic) allowing services to continue to be provided remotely in the home setting for:
- i ☐ Case management
 - i ☐ Personal care services that only require verbal cueing
 - i ☐ In-home habilitation – limited to flexibility regarding staffing standards in residential services during the COVID-19 emergency, in order to allow essential services delivery to continue in circumstances where staffing resources are limited due to the pandemic, and in accordance with written guidance approved by TennCare and issued by DIDD; day services are not included
 - ix ☐ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
 - v ☐ Other [Describe]:

- b ☐ Add home-delivered meals
- c ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)

Attachment K
COVID-19 Emergency HCBS Flexibilities

- d ☐ Add Assistive Technology

3. Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.

- a ☐ Current safeguards authorized in the approved waiver will apply to these entities.
b ☐ Additional safeguards listed below will apply to these entities.

4. Provider Qualifications

- a ☐ Allow spouses and parents of minor children to provide personal care services
b ☐ Allow a family member to be paid to render services to an individual.
c ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

- d ☐ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

- a ☒ Allow an extension for reassessments and reevaluations for up to one year past the due date.
b ☒ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
c ☒ Adjust prior approval/authorization elements approved in waiver.
d ☒ Adjust assessment requirements
e ☒ Add an electronic method of signing off on required documents such as the person-centered service plan.

Attachment K
COVID-19 Emergency HCBS Flexibilities

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name: Aaron
Last Name Butler
Title: Director of Policy
Agency: Division of TennCare
Address 1: 310 Great Circle Road
Address 2: Click or tap here to enter text.
City Nashville
State Tennessee
Zip Code 37243
Telephone: 615-507-6448
E-mail Aaron.c.Butler@tn.gov
Fax Number 615-741-1092

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name: Patti
Last Name Killingsworth
Title: Assistant Commissioner,
Chief of LTSS
Agency: Division of TennCare
Address 1: 310 Great Circle Road
Address 2: Click or tap here to
enter text.
City Nashville
State Tennessee
Zip Code 37243
Telephone: 615-507-6468
E-mail Patti.Killingsworth@tn.gov
Fax Number 615-741-1092

Attachment L

Glossary of Terms for Katie Beckett Program

Assistive Technology, Adaptive Equipment and Supplies (limited to children enrolled in Katie Beckett Part A or Part B): As defined in Attachment H, including applicable limitations.

Automated Health Care and Related Expense Reimbursement (limited to children enrolled in Katie Beckett Part B):

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

- Private insurance deductibles and co-payments for physician and nursing services, therapies, and prescription drugs;
- Medical equipment and supplies;
- Dental, vision, and hearing services;
- Medical mileage; and
- Other eligible medical expenses as determined by the Internal Revenue Service to be eligible as an itemized medical and dental expenses deduction on Schedule A (Form 1040 or 1040-SR) or qualified for payment or reimbursement under a Healthcare Reimbursement Account, Health Savings Account or Flexible Spending Account, except that health insurance premiums shall be covered only as part of the Health Insurance Premium Assistance benefit (and not as part of this benefit).

Payments or reimbursement for Automated Health Care and Related Expenses Reimbursement shall be limited to the amount specified in the child's approved PCSP.

The child's parent or legal guardian shall specify the annual amount to be available for payment or reimbursement through the Automated Health Care and Related Expenses each year, in accordance with processes established by DIDD, subject to the \$10,000 per child per year limit on total benefits available through Katie Beckett Part B and approval of the PCSP by DIDD. Once established, this amount shall not be changed for the year.

In order to be covered and eligible for reimbursement, the child's parent (or other legal guardian) shall submit acceptable documentation to the vendor contracted by DIDD, as requested, confirming the expense's eligibility for payment or reimbursement. The child's parent(s) or other legal guardian shall comply with all applicable requirements of DIDD's contracted vendor in order to receive this benefit.

A reasonable period shall be provided at the end of each year for submission of final expenditures incurred during the annual period.

Any funds remaining in the child's Automated Health Care and Related Expenses Reimbursement benefit at the end of the year shall be forfeited to the Katie Beckett program and shall not be permitted to "roll over" to the next year.

Community Integration Support Services (limited to children enrolled in Katie Beckett Part A or Part B):

Services which coordinate and provide supports for valued and active participation in integrated daytime and nighttime activities that build on the person's interests, preferences, gifts, and strengths while

Attachment L

Glossary of Terms for Katie Beckett Program

reflecting the person's goals with regard to community involvement and membership. This service involves participation in one or more integrated community settings, in activities that involve persons without disabilities who are not paid or unpaid caregivers. Community Integration Support Services are designed to promote maximum participation in integrated community life while facilitating meaningful relationships, friendships and social networks with persons without disabilities who share similar interests and goals for community involvement and participation.

Community Integration Support Services shall support and enhance, rather than supplant, an individual's involvement in public education and individualized integrated employment or self-employment (or services designed to lead to these types of employment).

Community Integration Support Services enable the person to increase or maintain his/her capacity for independent participation in community life and to develop age-appropriate social roles valued by the community by learning, practicing and applying skills necessary for full inclusion in the person's community, including skills in arranging and using public transportation for individuals aged 16 or older.

Community Integration Support Services provide assistance for active and positive participation in a broad range of integrated community settings that allow the person to engage with people who do not have disabilities who are not paid or unpaid caregivers. The service is expected to result in the person developing and sustaining a range of valued, age-appropriate social roles and relationships; building natural supports; increasing independence; and experiencing meaningful community integration and inclusion. Activities are expected to increase the individual's opportunity to build connections within his/her local community and include (but are not limited to) the following:

- Supports to participate in age-appropriate community activities, groups, associations or clubs to develop social networks with community organizations and clubs;
- Supports to participate in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness (e.g. yoga class, walking group, etc.);
- Supports to participate in formal/informal associations or community/neighborhood groups;
- Supports to participate in volunteer opportunities;
- Supports to participate in opportunities focused on training and education for self-determination and self-advocacy;
- Supports for learning to navigate the local community, including learning to use public transportation and/or private transportation available in the local area; and
- Supports to maintain relationships with members of the broader community (e.g., neighbors, co-workers and other community members who do not have disabilities and who are not paid or unpaid caregivers) through natural opportunities and invitations that may occur.

This service includes a combination of training and supports as needed by the individual. The Community Integration Support Services provider shall be responsible for any personal assistance needs during the hours that Community Integration Support Services are provided; however, the personal assistance services may not comprise the entirety of the Community Integration Support Service. All providers of personal care under Community Integration Support Services meet the Personal Assistance provider qualifications.

Attachment L

Glossary of Terms for Katie Beckett Program

This service shall be provided in a variety of integrated community settings that offer opportunities for the person to achieve his or her personally identified goals for community integration, involvement, exploration and for developing and sustaining a network of positive natural supports. All settings where Community Integration Support Services are provided must be non-disability specific and meet all federal standards for HCBS settings. This service is provided separate and apart from the person's place of residence. This service does not take place in licensed facilities, sheltered workshops or any type of facility owned, leased or operated by a provider of this service.

Payment for registration, materials and supplies for participation in classes, conferences and similar types of activities, or club/association dues can be covered, but cannot exceed \$500 per year. These costs are not included in the rates paid to the providers of Community Integration Support Services and must be prior approved before being incurred.

Transportation to and from the service is not included in the rate paid for the service; but transportation during the service (when no-cost forms of transportation are not available or not being accessed) is included in the rate paid for the service.

Community Support Development, Organization and Navigation (limited to children enrolled in Katie Beckett Part A or Part B):
As defined in Attachment H.

Community Transportation (limited to children enrolled in Katie Beckett Part A or Part B):
As defined in Attachment H and limited to no more than \$225 per month for persons electing to receive this service through consumer direction.

Comparable Cost of Institutional Care: For purposes of Katie Beckett Part A and the Katie Beckett Continued Eligibility Group, the requirement that in order to qualify for enrollment in Katie Beckett Part A or in the Katie Beckett Continued Eligibility Group, the estimated amount that would be expended by the Medicaid program for the child's care outside an institution cannot be greater than the estimated amount that would otherwise be expended by the Medicaid program for the child's care within an appropriate institution.

Decision Making Supports (limited to children enrolled in Katie Beckett Part A or Part B):
As defined in Attachment H, including applicable limitations.

Family Caregiver Education and Training (limited to children enrolled in Katie Beckett Part A or Part B):

- As defined in Attachment H, provided that in the Katie Beckett Program, the benefit is available to a child enrolled in Katie Beckett Part A or Part B.

Family-to-Family Support (limited to children enrolled in Katie Beckett Part A or Part B):
As defined in Attachment H, provided that in the Katie Beckett Program, the benefit is available to a child enrolled in Katie Beckett Part A or Part B.

Attachment L

Glossary of Terms for Katie Beckett Program

Hardship Exception (applicable only to children at the time of enrollment in Katie Beckett Part A): The state's authority to grant an exception to the requirement to purchase and maintain minimum essential coverage[1] private or employer-sponsored insurance as a condition of the child's eligibility and enrollment into Katie Beckett (Part A) under circumstances defined by the state, or if cost effective, to offer assistance with payment of the child's portion of the premium for such coverage.

Health Insurance Counseling/Forms Assistance (limited to children enrolled in Katie Beckett Part A or Part B):

As defined in Attachment H, provided that in the Katie Beckett Program, the benefit is available to a child enrolled in Katie Beckett Part A or Part B.

Assistance with Premium Payments (limited to children enrolled in Katie Beckett Part A or Part B): Reimbursement to assist with the cost of the eligible child's portion only of employer-sponsored or other private health insurance. Assistance with premium payments may be offered at TennCare's discretion to a child in Part A only if a child does not have private health insurance coverage upon enrollment, a hardship exception to the requirement to obtain/maintain employer-sponsored or private insurance is requested upon initial enrollment, hardship criteria as defined by the state are met, and the state determines that offering assistance to pay premiums is cost effective. In such cases, assistance for premium payments shall not count against the \$15,000 per calendar year expenditure cap for Part A wraparound HCBS.

Individualized Therapeutic Support Reimbursement (limited to children enrolled in Katie Beckett Part B):

Reimbursement, using DIDD's contracted vendor, of therapeutic supports determined by DIDD to be medically necessary for the child, but not eligible for automated reimbursement as part of the Automated Health Care and Related Expenses Reimbursement benefit.

Individualized Therapeutic Support Reimbursement shall be limited to the amount specified in the child's approved PCSP and subject to the \$10,000 per child per year limit on total benefits available through Katie Beckett Part B.

Each type and amount of therapeutic support shall be requested and approved by DIDD as part of the child's PCSP in advance of such support being purchased.

In order to be covered and eligible for reimbursement, the child's parent (or other legal guardian) shall submit acceptable documentation to DIDD, confirming that the approved therapeutic support has been received and paid, and is eligible for reimbursement. The child's parent(s) or other legal guardian shall comply with all applicable DIDD requirements in order to receive this benefit.

A reasonable period shall be provided at the end of each year for submission of final expenditures incurred. Any funds remaining in the child's Individualized Therapeutic Support Reimbursement benefit at the end of the year shall be forfeited to the Katie Beckett program and shall not be permitted to "roll over" to the next year.

Minor Home Modifications (limited to children enrolled in Katie Beckett Part A or Part B):

Attachment L

Glossary of Terms for Katie Beckett Program

As defined in Attachment E with a limit of \$6,000 per project, \$10,000 per calendar year, and \$20,000 per lifetime.

Respite (limited to children enrolled in Katie Beckett Part A or Part B):

As defined in Attachment H with only hourly respite available through Consumer Direction. Daily respite is not available through Consumer Direction.

Supportive Home Care (limited to children enrolled in Katie Beckett Part A or Part B):

As defined in Attachment H.

Vehicle Modification ((limited to children enrolled in Katie Beckett Part A or Part B):

A structural change or alteration to a vehicle that is the child's primary means of transportation in order to accommodate the unique needs of the child, enable the child's full integration into the community, and ensure the child's health, welfare, and safety.

All modifications shall be based on an assessment and recommendation by a licensed occupational therapist, physician, or other qualified professional and included in the Person-Centered Support Plan.

Vehicle Modifications shall not impede routine local and state safety and emission inspections, as required by law.

Vehicle Modifications shall be limited to no more than \$10,000 per child per year; and \$20,000 per child per lifetime. The Vehicle Modifications benefit may be combined with other sources of funding such as community grants. Vehicle Modifications in excess of the Katie Beckett benefit limit (which are not covered by TennCare) may be privately paid. The parent or other legal guardian may utilize pre-approved vendors/dealerships for direct billing if they follow the approval and payment process established by the MCO.

Excluded are the following:

- purchase or lease of a vehicle;
- upkeep and maintenance of a vehicle;
- assistance with vehicle registration and licensing; and
- modifications that are of general utility without direct medical or remedial benefit to the child.

Attachment M
Implementation Plan (reserved)

Attachment N
Monitoring Protocol (reserved)

Attachment O

Designated State Investment Programs

The state may claim FFP for health programs, funded as of December 31, 2020, subject to the restrictions described below unless otherwise specified. Expenditures are limited to costs not otherwise covered under the state plan, but consistent with Medicaid demonstration objectives that enable the state to continue to improve health outcomes and increase the efficiency and quality of care. DSIPs must meet all criteria in STC 32.

Community and Faith-Based Clinics

This program provides safety net health care services provided through a network of designated community and faith-based clinics via the Tennessee Department of Health. These outpatient services have a direct impact on the health and well-being of low-income uninsured Tennesseans.

Behavioral Health Safety Net

This program provides behavioral health safety net services through the Tennessee Department of Mental Health and Substance Abuse Services. These outpatient services fall into three major categories: behavioral health services, substance abuse services, and children's behavior services. Behavioral health safety net services are targeted to qualifying low-income Tennesseans with severe mental illness. Substance abuse services are targeted to qualifying low-income Tennesseans with Substance Use Disorder (SUD). Children's behavior services are targeted to qualifying low-income Tennesseans whose children are exhibiting disruptive behaviors that are sufficiently severe as to put the child at risk of being removed from the home and placed in custody. These outpatient services have a direct impact on the health and well-being of uninsured/underinsured low-income Tennesseans.

ID/DD: Safety Net – ID/DD Services

This program provides safety net services through the Tennessee Department of Intellectual and Developmental Disabilities. These services fall into three broad categories: community/family support services, assistive technology services, and residential treatment services. Community/family support services are targeted to qualifying persons with intellectual and developmental disabilities and include therapy, adult day, supported employment, and other community-based support services. Assistive technology services are targeted to qualifying persons with intellectual and developmental disabilities and include custom positioning and transport equipment including wheelchairs. Residential treatment services are provided to qualifying persons with intellectual and developmental disabilities and include behavior stabilization services and highly structured ICF services in a residential setting. These services have a direct impact on the health and well-being of qualifying persons with intellectual and developmental disabilities.

Education: K-12 Nurses

This program provides nurses in the state's K-12 public schools. These nurses provide direct services to support the health and well-being of students enrolled in the state's K-12 public schools, of whom a majority are Medicaid eligible.

Education: K-12 Psychologists

This program provides psychologists in the state's K-12 public schools. These psychologists provide direct services to support the health and well-being of students enrolled in the state's K-12 public schools, of whom a majority are Medicaid eligible.

Attachment O
Designated State Investment Programs

Education: K-12 Social Workers

This program provides social workers to be present in the state's K-12 public schools. These social workers provide direct services to support the health and well-being of students enrolled in the state's K-12 public schools, of whom a majority are Medicaid eligible.

Education: At-Risk Student Services

This program provides services for students in the state's K-12 public schools who are identified as being at-risk. At-risk students are defined as those students meeting direct certification eligibility guidelines pursuant to 42 U.S.C. §§ 1751-1769. This includes children participating in other federal benefits programs. All of these programs are targeted to needy children and that need is based on income. The students for whom this funding is tied are also overwhelmingly eligible for Medicaid.

CoverRx Prescription Medication Support

This program provides prescription medication support for qualifying low-income Tennesseans. This includes significant support for low-income Tennesseans who receive services through one or more of the safety net programs outlined above.

Attachment P
Shared Savings Quality Measures Protocol (reserved)

Attachment Q
DSIP Claiming Protocol (reserved)